



CENTRAL
BAYSIDE
COMMUNITY
HEALTH
SERVICES

Central Bayside Community Health Services

Service Development Plan for Strategic Planning

April 2006

Prepared by:



United Medical Group Australia

In conjunction with:



HDG Consulting Group

Executive Summary

Central Bayside Community Health Services (CBCHS) and the Department of Human Services (DHS) engaged United Medical Group Australia Pty Ltd (UMGA), in conjunction with HDG Consulting Group, to develop a Strategic Services Plan for the organisation.

The Strategic Services Plan includes snapshots of current programs and services, information on service utilization rates, an analysis of patterns of population growth and demographic change, projections about patterns of ill-health and government policy information.

The document provides the data and rationale for the recommendations regarding the delivery of services by CBCHS in the future, and the allocation of resources to ensure the best possible health outcomes for the community served by CBCHS.

The document also includes information that can be utilised by local management to inform decisions about the strategic planning of individual services and whole of service direction. The recommendations of the report are therefore focussed on strategic issues for the whole organisation.

In summary, the five recommended strategic directions are: (note numbering)

1. **Ensuring capital development** caters to forecast service growth based on the population projections and targeting of resources to high needs groups. This includes increases in capacity at the Chelsea site, increases in capacity at the Clarinda site, exploration of a satellite site at Westall and the development of a Community Centre in Edithvale to provide a blended model of community health, disability and community services.
2. **Continuing to develop and target clinical capacity** in high priority services for high priority population groups in accordance with community need and government policy directions.
3. **Increasing the focus on ambulatory care** through the development of a clinical intake and triage capacity and the introduction of new models of care to achieve economic benefits for the health system and service provision benefits for the community.
4. **Continuing to enhance partnership relations.** This includes four priority areas identified with Southern Health (reducing hospital admissions, ambulatory care, disease management and health promotion) and the ongoing and positive relation with Kingston Council, as well as the diverse range of other partnerships already in place.
5. **Continuing to provide leadership in health promotion** through integrated health promotion, catchment planning, increased collaboration, the development of health promotion benchmarks and an increased focus on evaluation.

The implementation of these recommendations will ensure that CBCHS is well positioned to meet the health needs of the local community, in accordance with government policy and achieving improvements in population health for the next ten years and beyond.

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1 Introduction

1.1 Background

Central Bayside Community Health Services (CBCHS) and the Department of Human Services (DHS) engaged United Medical Group Australia Pty Ltd (UMGA), in conjunction with HDG Consulting Group, to develop a Strategic Services Plan for the organisation.

The overall objectives of the project were to:

- Provide a vision for future program and service delivery by CBCHS
- Clarify the arguments for the program and service mix and service delivery sites and locations
- Provide an analysis of how existing services can be improved to better meet community demand and reflect government policy direction
- Demonstrate how future capital expenditure will provide improved services to the community
- Identify partners essential to providing a holistic approach to program and service delivery and improving the health of the local community.

The Strategic Services Plan includes snapshots of current programs and services, information on service utilization rates, an analysis of patterns of population growth and demographic change, projections about patterns of ill-health and government policy information. The report concludes with recommendations regarding the delivery of services by CBCHS in the future, and the allocation of resources to ensure the best possible health outcomes for the community served by CBCHS.

1.2 Overview of Victorian Community Health System

Community Health Services in Victoria play a vital role in supporting population health and well-being. Community Health Services deliver a range of programs and primary health services to meet local community needs. There are approximately 100 Community Health Services in Victoria, of which 30 are independent organisations as defined in the Health Services Act (1998) and the remainder are attached to larger health services.

Services and programs provided by Community Health Services vary according to a mix of factors including the local demographics, historical context, funding base, and organisational culture. Services and programs tend to be targeted towards those population groups most in need and typically service users are recipients of health care cards and government benefits. The strong clinical role provided by CHS through direct service provision includes allied health services (physiotherapy, occupational therapy, dietetics, podiatry, speech pathology), community nursing, counselling, dental, general practice, drug treatment, mental health, youth services, disability services, day programs for the aged and rehabilitation services. In recent years there has been an increasing focus on health promotion programs both at a service user level as well as a systemic level, with health promotion programs and services accounting for an increasing proportion of activity.

The DHS Community Health Program funds approximately 25% of the services provided by Community Health Services with additional funding sources including Home and Community Care, Dental, Disability Services, Drug Treatment, Mental Health, Primary Care Partnerships, Commonwealth Department of Health and Ageing and National Respite for Carers .

The future role of Community Health Services in the broader health and community service system is seen as one in which Community Health Services are a platform for integrated community based services, provide leadership in improving health outcomes for local communities whilst targeting service delivery to those with the poorest health status and greatest needs. Population orientated planning combined with capacity building and partnerships to facilitate collaborative responses underpins the community based model of care, recognising that better access to primary health care services prevents unnecessary hospital and residential care presentations, assists in managing demand and promotes population health. As the population ages and the incidence of complex and chronic conditions increases, interventions by Community Health Services and collaborative partnerships and integrated care models will become increasingly important.

Within this context, CBCHS is planning for and configuring the service delivery profile to ensure that, in collaboration with strategic partners, the organisation is well positioned to respond to both the current and future needs of the local population. Building on a strong history of service delivery, the organisation is in the process of reviewing the service delivery profile and utilisation in conjunction with forecasting future need to enable a systematic and planned approach to future capital requirements and service development.

1.2.1 ROLE OF PRIMARY AND COMMUNITY HEALTH

As a provider of primary and community health services, CBCHS plays an important role in providing for the health needs of the local community – particularly those who are disadvantaged and may not have access to services available to other parts of the community.

Creating a Healthier Victoria outlines the policy directions for Community Health and suggests the role for Community Health is to:

1. Provide leadership in improving health outcomes and reducing health inequalities of local communities throughout Victoria
2. Be a major platform for integrated community-based health services
3. Be a strong partner in the broader health and community service system
4. Provide services and programs that are high quality, affordable and delivered in a timely way
5. Provide services and programs that are high quality, affordable and delivered in a timely way

In line with the 1978 Alma Mater Declaration which charts the way for primary health care, the role of community health includes:

- Addressing the main health problems of the community through health promotion, prevention, curative and rehabilitative services.
- Providing integrated referral systems that lead to progressive improvement of health care for all while giving priority to those most in need.

2 The Current Situation

2.1 Overview of CBCHS

2.1.1 MISSION STATEMENT

CBCHS is committed to enhancing the individual's and the community's health, independence and general well being. CBCHS does this by developing and delivering innovative, responsive and targeted health services that are delivered in co-operation with the community and other agencies. We strive to ensure access and linkage to services for those in the community who may not readily access mainstream services.

2.1.2 VALUES

In achieving its mission, the CBCHS is an organisation which commits to integrity as its guiding principle; the Service values:

- Active client and community participation in service development and delivery;
- Innovative, quality services that are client focussed, responsive and outcome oriented;
- Services that address issues of access and equity;
- Pro-active and responsive service delivery to marginalised groups within our communities;
- Our staff and an environment where skills are developed and encouraged;
- Fostering partnerships which achieve the best outcomes for our communities;
- Good governance, ethical management and transparency in decision making;
- For the ongoing provision of efficient and effective services in our community, the BOM recognises the practice of client co-payment towards service delivery. However, the BOM clearly specifies that no client will be denied service on the basis of an inability to pay.

2.1.3 PHILOSOPHY - A COMMITMENT TO COMMUNITY INVOLVEMENT

CBCHS's underlying principle is that individuals and communities have a right to affordable and accessible health care and that they are best served by an integrated, co-ordinated system of care that is well researched and responsive to the needs of the community and reduces the dependence on hospital and other specialist institutional health facilities.

CBCHS believes that community participation is one of the pillars of the social model of health. It is well documented that the best results are achieved when community

members are involved in the management of their own health and their community's health care; as well as the development of public health policy that promotes social cohesion and a sense of community.

An example of this commitment to community consultation is the recent community engagement strategy for Clarinda which commenced in 2002 and involved a broad range of activities. Clarinda is a community with over 30 culturally and linguistically diverse (CALD) communities with a significant proportion of the community born overseas.

2.1.4 GEOGRAPHICAL EXTENT

The location map below depicts the geographical extent of the community which CBCHS serves. It is contiguous with the City of Kingston. Also indicated on the location map are the suburbs, as defined by City of Kingston, which make up the City of Kingston. Some CBCHS programs cover areas greater than the City of Kingston. Examples include ACO which covers the Cities of Bayside, Glen Eira and Port Philip. The Alcohol and Drug program services Bayside and Glen Eira and the SPAS and the Give it a Go program covers these LGAs and the City of Stonington. The Telelink program is a statewide service.



Map 1 Location Map: City of Kingston and CBCHS Catchment Area

2.1.5 CURRENT SITES

The following sites are key service delivery points for community health services for CBCHS:

Parkdale: 335 Nepean Highway

The Parkdale site is the main service delivery site for CBCHS and provides about 70% of the current services. The buildings are well maintained and well utilised. Some of the facilities are utilised by Southern Health and the City of Kingston but there is little room for further expansion of services within the existing buildings.

Chelsea: 23 Bath Street

The Chelsea site is well located in the middle of a major shopping precinct and close to public transport facilities. The current site will become part of an expansion of the local Safeway supermarket, so the developers have agreed to build a new replacement facility for CBCHS on an adjoining site. As a result, CBCHS will have access to a brand-new, purpose-built facility at no cost to the organisation. The new facility will also provide accommodation for up to 3 additional EFT with a resulting improved capacity to deliver services to the local community.

Clarinda: 58 Viney Street

The Clarinda facility is also in the process of being re-developed and will be housed in a new community facility being built with funding from the Community Support Fund. The new facility will provide improved accommodation but not any significant increase in space. In the meantime, CBCHS are operating from a temporary, demountable building.

Mentone: 31 Venice Street

This facility is utilised primarily for Planned Activity Groups. The building is well maintained with attractive outdoor areas including a BBQ area for group activities. A modern kitchen located in a very accessible part of the building provides a further social focus. A range of other group rooms and some smaller treatment rooms are also available.

Cheltenham:	299 Centre Dandenong Road
Cheltenham:	Glebe Avenue
Edithvale:	6 Edithvale Road
Clayton South:	45 Oakes Avenue
Mentone:	13 Southern Road
Mentone:	Corner of Remo and Venice Street
Sandringham:	25 Trentham Street
Parkdale:	Cafe Escape 2 Carrier Avenue

The above listed venues are day program sites for adults with an intellectual disability.

2.2 Service Delivery Profile

CBCHS provides a diverse range of program and services, reflecting the social model of health on which the community health sector was founded. Programs and services range from those that have a strong clinical component – such as allied health services providing specialist clinical treatment and rehabilitation, through to those that are more orientated to social wellbeing – such as the community visitor’s scheme. Health promotion (and illness prevention) is a critical aspect of service delivery and is incorporated into programs and services as well as reflecting specific health promotion initiatives.

The following snapshots provide a summary of the programs and services provided by CBCHS in terms of the service model, resources (EFT), service gaps and infrastructure requirements. Each snapshot includes a paragraph regarding the potential outlook for the future based on a mix of demographic, policy and other considerations.

As a whole, they illustrate the diversity of programs and services offered, an extensive range of partnerships and the need for strategic decision-making with respect to the future allocation of resources to maximise service delivery and health outcomes.

2.2.1 SNAPSHOT: CENTRAL BAYSIDE CHS PLANNED ACTIVITY GROUPS (PAG)

Current Service Model	PAG provides day programs for frail older people and younger people with disabilities and carer respite. Services are provided across four sites: Mentone, Parkdale, Clarinda and Chelsea, with groups occurring Monday through to Saturday. There are different types of groups dependent upon need (eg: Dementia specific, social, Italian, walking)
Emerging models or practice trends	An emerging model is ‘Health for Active Living’.
Partnership details	Close working relationships have been established with: <ul style="list-style-type: none"> • Aged Care Assessment Service (ACAS) • Bayside Community Options • Case managers • Community health nurses • Local government (City of Kingston).
Service gaps	An identified service gap is client access to services for those who do not clearly fit HACC guidelines. For example, younger persons with an ABI
Issues	Issues identified include: <ul style="list-style-type: none"> • Funding • Culturally and linguistically diverse (CALD) groups • Clients receiving Community Aged Care Packages (CACPs) packages and the subsequent inability to access Planned Activity Group (PAG) services.

Infrastructure	PAG groups require program rooms for group activities, cooking facilities attached to group rooms, and safe outdoor areas. The Mentone site is a purpose built facility providing PAGs over 6 days of the week.	
	Current EFT	Patterns of Utilisation
Parkdale PAG site	.4	1 group of 8-10 clients each
Chelsea PAG site	1.6	4 groups of 6 –10 clients
Mentone PAG site	7	10 groups of 7-24 clients
Oakleigh PAG Site	1.2	3 groups of 10-11 clients

Broad Outlook:

PAG is funded through the HACC program (targeted at frail older people, younger people with disabilities and their carers) and the National Respite for Carers Program, with the staff ratio reflecting the needs of clients, whose levels of need are assessed as either high (1 staff member to 5 consumers) or core (1 staff member to 7 consumers). PAG services also tend to have a number of volunteers. PAG services are designed to maintain an individual's ability to live at home by providing respite and support for carers. Population projections indicate substantial growth within the frail older people target group; the need for services for those with dementia; and government priorities focussed on retaining independence and maintaining people within the community to avoid inappropriate admission to acute services or residential care illustrate the importance of this program.

Direction:

New resources are likely to be required for this program, on the rationale that the increasing incidence of dementia as a result of the ageing population, and desire to assist people to remain living independently in their own homes for as long as possible, means that the need to access PAG services is likely to increase steadily over the next decade.

Forecasts based on utilisation data and population changes indicate that the need for this service is anticipated to grow at around 6% per annum over the next decade. Whilst this need may not be able to be fully met, it is critical that service planning and capital development take into account the specific infrastructure needs (eg: security of people with dementia, program rooms, cooking facilities, bathroom design) to maximise the functionality of PAGs.

2.2.2 SNAPSHOT: CENTRAL BAYSIDE CHS ALCOHOL AND OTHER DRUGS PROGRAM (AOD)

Current Service Model	<p>The AOD program provides the following services:</p> <ul style="list-style-type: none"> • AOD Counselling at three sites (Bentleigh, Chelsea and Parkdale). • Youth Outreach and forensic counselling at three sites (Bentleigh, Chelsea and Parkdale). • Outpatient Withdrawal at three sites (Bentleigh, Chelsea and Parkdale). • Home Based Withdrawal.
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Emerging models or practice trends	<p>General practice trends are:</p> <ul style="list-style-type: none"> ▪ Minimum clinician qualification standardisation and upgrading through assessment and training for those without qualifications ▪ Emphasis on prevention and youth and family as areas where services should be more consciously focused. 	
Partnership details	<p>Partnership arrangements have been established with:</p> <ul style="list-style-type: none"> • Community Health Services • Southern Dual Diagnosis initiative • A resident CHS GP located at the Parkdale site who is involved with the program through medical intervention and methadone prescription. A client case management model is used to treat these clients. 	
Service gaps	<p>Both Inpatient Detoxification beds and Residential AOD Rehabilitation Programs are not readily accessible. As a result of the delays, this makes referrals difficult and puts pressure on staff to extend their services.</p>	
Issues	<p>A short term issue is balancing the provision of general acute services with time consuming and high-planning aspects of preventative service provision.</p> <p>A longer term issue is balancing the provision of general acute services with the capacity to target specific client populations. For example: Youth at Risk, Cannabis Withdrawal Groups, Women's Only services, ethnic minority targeting, etc.</p>	
Infrastructure	<p>Counsellors currently have their own offices that are used as interviews rooms and are seen as adequate.</p>	
	Current EFT	Patterns of Utilisation
Parkdale (Combined with BBCHS all 3 LGAs covered)	4.8	<p>2,484 episodes of care were recorded in the four year period 2000/01 to 2003/04. Slightly more males access the service than females (56% to 44%) and the pattern of usage with age is reasonably reflective of the underlying age profile (after adjusting for the young) of the program's catchment. However, there is an over representation of people in the middle years, from 25 to 45.</p>
Chelsea	0.48	
Clarinda	0.48	
Mentone	Nil	

Broad Outlook:

The AOD program is funded by DHS Drug Treatment Services. The 4.8 EFT work across the 3 LGAs of Kingston, Bayside and Glen Eira. Community Health Services are identified as a major platform for the delivery of primary healthcare. This includes being the preferred provider (not the only provider) for services that are best placed in wider community based health settings including drug treatment services such as counselling, needle exchange and GP and Pharmacotherapy. Likewise the increased focus on those clients with co-morbidities (eg: substance abuse and mental health issues) may see an increased community based response to this group to assist in the diversion of Emergency Department presentations. New service models able to respond to this group in accordance with Ambulatory Care

Framework (ACF) catchments based on population profiles and burden of disease are likely to be seen as a priority.

Direction:

Specialist AOD services are identified as part of an integrated ambulatory care service system focussing on those with chronic and complex conditions. As such they require significant support in the community to manage their conditions, requiring an integrated response from tertiary/intensive and maintenance/support focussed service providers. The ACF provides an opportunity for CBCHS to consider the current AOD service delivery models and if appropriate reconfigure these to reflect increasingly integrated models of care and partnering arrangements across program boundaries, in line with the Government ACF. AOD services should be targeted towards those sub catchment areas identified within the ACF as high priority and AOD services can be seen as taking a lead role, in partnership with associated services, in improving outcomes for those with co-morbidities such as those identified above. Further consideration in relation to proposed approaches and potential changes will be needed upon release of the ACF. New developments in Chelsea and Clarinda should cater for an expansion in this program area.

2.2.3 SNAPSHOT: CENTRAL BAYSIDE CHS COMMUNITY DEVELOPMENT PROGRAM

Current Service Model	The Community Development program provides a centre based and outreach (attending groups, homes, schools, networks and other agencies) service. Services are provided across the Parkdale, Clarinda, Clayton South and Oakleigh South areas.
Emerging models or practice trends	Emerging models are: <ul style="list-style-type: none"> • Capacity building model • Community inclusiveness and community participation • Access and equity models (Empowering disadvantaged community groups, accessing services and programs to isolated groups, community education and community consultation).
Partnership details	Partnerships have been established with: <ul style="list-style-type: none"> • AMES • Centre Link • City of Kingston • Clarinda Family & Children Services Network • Clayton South/Clarinda Community Network • Connected Community Project • Ethno-specific agencies • Greater Dandenong Community Health services • Local schools • South Central Region Migrant Resource Centre • Sudanese Group.
Service gaps	The following service gaps were identified: <ul style="list-style-type: none"> • Access issues particularly to new emerging communities • CBCHS knowledge and skills to work with CALD Groups. Particularly, in relation to community consultation and health promotion.
Issues	Issues identified include: <ul style="list-style-type: none"> • Accessing services and programs to CALD Groups

	<ul style="list-style-type: none"> • Developing community consultation programs to assess needs • Not providing programs in Clarinda/Clayton South Area. For example, Dental, Medical, etc • Lack of available transport for clients to travel to Parkdale. 	
Infrastructure	The position requires access to office space (shared) at a range of sites pending projects/strategies being evaluated, and access to space for community consultations and forums. The arrangements at Parkdale are currently adequate; issues at Clarinda/Chelsea will be resolved when these sites are redeveloped.	
	Current EFT	Patterns of Utilisation
Clarinda (based at Parkdale)	0.5	The Community Development program provided 1,824 hours of service in 2004/2005.

Broad Outlook:

Community Development plays a key role in ensuring services are targeted at and meeting the needs of particular communities. Reports have shown under representation by particular community groups to community services (eg: CALD communities use of HACC services) and this Community Health funded position will be important in developing strategies/linking programs (eg: child and family health, health promotion strategies) to more marginalised communities. Marginalised communities, such as new refugees, are hesitant to use public health services however often have specific health needs. This is evident through newly arrived groups in the Clarinda area who require proactive strategies and the development of trust and engagement to access services. The Community Development Scheme is critical in identifying and engaging with such communities.

Direction:

Staff training in cultural awareness working with CALD communities, the use of language services and possibly the recruitment of bi-lingual and bi-cultural workforce are relevant issues across all CHS program areas. The increasing focus on marginalised communities, such as those in the Clarinda area, will see increasing demands placed on this program area. Opportunities to increase the resources associated with this program should be considered.

2.2.4 SNAPSHOT: CENTRAL BAYSIDE CHS COMMUNITY HEALTH NURSING

Current Service Model	The Community Health Nursing (CHN) program provides services to a broad range of ages in the catchment area ranging from school aged children to older people and people with disabilities. The program receives Community Health funding and HACC funding. . The program operates from the three sites and offers both centre based and home based consultations. Education programs include asthma care and diabetes.
Partnership details	Partnership arrangements have been established with: <ul style="list-style-type: none"> • Mental Health Case Review. This is a partnership comprising CBCHS, PrimeHealth, City of Kingston and Southern Health Home Based Service • City of Kingston and CBCHS. Good working relationships have been established particularly with the Community Connections worker and the Aged Care Assessment officers

	<ul style="list-style-type: none"> Carer's Support Group, Bentleigh Bayside Community Health Services, Southern Carer's Respite Service and Sandy Beach Centre. The aim being to provide ongoing support to carers. 	
Service gaps	Increasing numbers of referrals (anecdotal evidence) are being received for clients with mental health issues. To reduce the pressure on the CHN program to accept referrals, it would be beneficial to have more mental health trained case workers to assist those clients with mental health issues who are not in a psychotic state but require ongoing assistance.	
Issues	<p>Issues identified include:</p> <ul style="list-style-type: none"> Addressing an increasing ageing population, with only limited EFT Assisting clients with mental health issues Addressing the needs of CALD community particularly at the Clarinda site Providing services to the Clarinda community. 	
Infrastructure	Staff members report the need for a larger office space at Chelsea as clients are treated in the office space. Storage space for health education equipment and display items is inadequate at present. The Young Women's program requires access to a suitable room at Chelsea to hold group sessions which is safe to accommodate young children.	
	Current EFT	Patterns of Utilisation
Parkdale	2.1 + 0.5 HARP + 1 HACC Case Manager	The CHN program provided 4164.3 hours of service in 2004/2005. Of this 762.6 was for HACC care management. The CHNs provide a broad range of service ranging from health promotion, group education, school education and clinical 1:1.
Chelsea	2.1 CHN plus 0.8 Care Manager	
Clarinda	0.5 Care Manager	
Mentone	1.0 CHN	

Broad Outlook:

The Community Nursing program is funded through both the Community Health and the HACC program (targeted at frail older people, younger people with disabilities and their carers). Nursing in the HACC program is defined as professional nursing care provided by a Registered Nurse Division 1 that includes clinical assessment, direct clinical nursing, personal care for consumers with unstable health and/or complex needs and provision of health information and education (eg: managing daily care in their home such as in relation to diabetes or incontinence). A 0.8 HACC funded position also provides assessment and care management to provide an assessment of an individual's need for community support services and the development and implementation of a care plan to meet consumer needs and maximise independence. In addition, the Hospital Admission Risk Program (HARP) fund 0.5 EFT of a position targeted at paediatric asthma education. This position is funded only until June 2006. A health promotion position located at Chelsea is service wide. A 0.9 EFT position provides the young women's and parenting program.

Emerging government policies and health priorities in relation to diabetes, HARP and health promotion illustrate the importance of the provision of services.

Direction:

New resources for the Community Nursing program should be targeted at the Chelsea and Clarinda sites to service these currently under represented groups. Whilst the percentage of the 70+ population served by this program is relatively low at 2.2%, forecasts based on utilisation data and population changes indicate that the need for this service is anticipated to grow at 2% per annum over the next decade. It is critical that service planning and capital development take into account the infrastructure needs of this service.

2.2.5 SNAPSHOT: CENTRAL BAYSIDE CHS COMMUNITY VISITORS SCHEME (CVS)

Current Service Model	The Community Visitors Scheme (CVS) matches 105 volunteers with 105 isolated residents in aged care facilities (nursing homes and hostels). The CVS services 48 aged care homes between Mt Eliza and Brighton. To be eligible for the service, the recipient must live in a hostel or nursing home.	
Emerging models or practice trends	The CVS is currently under review by independent consultants. It is anticipated that there may be changes to service delivery as a result of this review.	
Partnership details	Partnership arrangements have been established with: <ul style="list-style-type: none"> • Aged care facilities that have elected to have a CVS volunteer for their residents • Current Community Visitors whose friends and relatives also join the program • Local newspapers. Free promotion of the Scheme is provided • Other community organisations. For example, those where the details of the CVS are registered including: Support and Information Centres, Volunteering Victoria, Monash Volunteer Centre and Volunteering Australia. 	
Service gaps	Identified service gaps include: <ul style="list-style-type: none"> • Six aged care homes in CBCHS catchment do not have the Community Visitors Scheme (according to a recent CVS Census undertaken by the Department) • Over 30 residents are currently on the waiting list who require Visitors. 	
Issues	Issues include: <ul style="list-style-type: none"> • Funding. Additional funding is required to recruit and support more Community Visitors • Shortage of potential volunteers • Reporting issues and the accuracy of statistics 	
Infrastructure	The work is generally external to the centre however the position requires office space and access to rooms to meet with volunteers and hold forums. Space is inadequate at present but will be resolved when the Chelsea site is redeveloped.	
	Current EFT	Patterns of Utilisation
Parkdale	0	105 volunteers visiting their elderly resident at least once per fortnight.
Chelsea	1.0 Located at Chelsea but covers all areas	

Clarinda	0	
Mentone	n/a	

Broad Outlook:

The CVS position is Commonwealth funded and provides volunteer coordination.

2.2.6 SNAPSHOT: CENTRAL BAYSIDE CHS COUNSELLING/CASEWORK PROGRAM

Current Service Model	The Counselling Program is located at three sites and provides centre based counselling to children and adults. The program provides preventative programs such as anxiety groups, the Parents and Infant Relationship Service (PAIRS) and family therapy.
Emerging models or practice trends	A model currently being developed is the single session model.
Partnership details	The following partnership arrangements have been established: <ul style="list-style-type: none"> • Two staff attend meetings of CBCHS Child Development Service regarding cross referrals • Two staff are engaged in development of health promotion activity 'bullying in preschools' with City of Kingston Child and Family Service • An Anxiety Group held at the Parkdale site is a joint venture led by CBHS psychologist & Gamblers Help psychologist • A PAIRS group is held at the Parkdale site with cross program relationships with Maternal and Child Health nurses from the City of Kingston and CBCHS Child Development Service.
Service gaps	Service gaps identified include: <ul style="list-style-type: none"> • Access to services after hours • Adolescents and families • At this time the service offers counselling to adults and children (birth to 12 years old).
Issues	Short term issues include: <ul style="list-style-type: none"> • Referrals with complex mental health issues • Increase in referrals due to health education programs like Beyond Blue. <p>A longer term issue is that one full time position may not receive ongoing funding when the staff member retires as they are seconded by DHS.</p>
Infrastructure	Staff require office space and a duty room for the program. Access to a family counselling room and activity area for children's play therapy is also required. When Kingston Centre vacates offices at the Parkdale site the space will be adequate.

	Current EFT	Patterns of Utilisation
Parkdale	0.9 + 1.0 = 1.9	In 2003/04 6010 contacts were made with 1721 clients providing 3,621 contact hours.
Chelsea	1.0	
Clarinda	1.0	
Mentone	n/a	

Broad Outlook:

The increased focus on child and family health as part of government policy may see an increased emphasis on intervention and service provision in this area. Given the trend towards single session counselling, access to appropriate and private interviews rooms is critical. Likewise with the increased focus on child and family health, access to family counselling rooms should be considered a priority. The implementation of a risk screen for mental health may result in the need for increased relationships with GPs and specialist mental health service providers.

Direction:

New resources for the Counselling program should be targeted at the Chelsea and Clarinda sites to service these currently under represented groups.

2.2.7 SNAPSHOT: CENTRAL BAYSIDE CHS DENTAL PROGRAM

Current Service Model	The Community Dental and Youth Dental programs are centre based services located at the Parkdale site. The programs aim to provide the best quality range of restorative and prosthetic care to the eligible population, including emergency care.
Emerging models or practice trends	Emerging practice trends include: <ul style="list-style-type: none"> • Dental Health Services Victoria (DHSV) Clinical Guidelines • Clinical Indicators.
Service gaps	The following service gaps have been identified: <ul style="list-style-type: none"> • Eligibility of preschool children to receive treatment. If eligibility for pre-school children is available then the following requires consideration: <ul style="list-style-type: none"> ○ Staff will need to improve knowledge and skills to be able to treat young children ○ Treating pre-school children will affect clinic's productivity • Providing health promotion.
Issues	Issues include: <ul style="list-style-type: none"> • Waiting list problems <ul style="list-style-type: none"> ○ Reduced staff turnover and all chairs filled ○ Bank staff in operation to fill casual vacancies caused through permanent staff taking leave

	<ul style="list-style-type: none"> ○ Improved matching of patients treatment and appointments times ○ Reduction of short unfilled periods ○ Maximisation of treatment during appointment times <ul style="list-style-type: none"> ● Funding formula and associated productivity requirements. Treating preschoolers will affect productivity and wait lists ● Including and developing community participation in health promotion activities. For example: to include open day activities and oral health promotion activities targeted at identified high risk groups. 	
Infrastructure	Limited space in the building and there needs to be a concerted effort to better use the space which is available.	
	Current EFT	Patterns of Utilisation
Parkdale	6.6	<p>During the 2004/2005 financial year the Dental program reduced its waiting list by 1919 clients.</p> <p>The number of patients seen was 3,421 requiring 8,527 visits.</p>

Broad Outlook:

The program is funded by DHSV and provides a four chair dental service co-located with a four chair school dental service. Increasing service responsiveness could include expansion of the service hours available to clients (open on Saturday from 8am to 1pm i.e. for Year11/12 students). Continuing education is required for staff to update and improve their skills.

Direction:

Directions for the dental program are governed by the provision of resources based on a funding formula which is productivity based. This hampers any options to be proactive with health education and health promotion. DHSV advises that additional resources are not planned for the CBCHS area.

2.2.8 SNAPSHOT: CENTRAL BAYSIDE CHS DIETETICS

Current Service Model	The Dietetics program is located at three sites and provides centre based, home based and outreach (primary and secondary schools) services.
Emerging models or practice trends	<p>Emerging practice trends are:</p> <ul style="list-style-type: none"> ● Provision of health promotion activities in preference to one on one work ● Dietitians Association Australia/Deakin & Monash Universities.
Partnership details	<p>Partnership arrangements have been established with:</p> <ul style="list-style-type: none"> ● City of Kingston for the school nutrition project ● Various childcare centres and kindergartens for puppet shows.
Service gaps	<p>The following service gaps have been identified:</p> <ul style="list-style-type: none"> ▪ Increased resources required to provide health promotion programs e.g. School Nutrition program. ▪ Balance between direct service delivery and health promotion.

	<ul style="list-style-type: none"> ▪ Strong demand for dietetic services. ▪ Infrastructure requirements for adequate EFT, in particular at Clarinda site. 										
Issues	<p>Identified issues include the need to:</p> <ul style="list-style-type: none"> • Offer a wider range of education programs • Undertake a review of additional community health promotion issues • Continue to assess needs for dietetic services in the community • Expand dietetic services in areas of need • Expand schools nutrition project to: <ul style="list-style-type: none"> ○ Encompass more schools ○ Further develop puppet show to meet the needs of primary school children. 										
Infrastructure	<p>Infrastructure is reported as adequate at Parkdale; not adequate at Clarinda however this will be resolved with the redevelopment.</p>										
	<table border="1"> <thead> <tr> <th></th> <th>Current EFT</th> <th>Patterns of Utilisation</th> </tr> </thead> <tbody> <tr> <td>Parkdale</td> <td>1.1</td> <td rowspan="3">2,362 contacts (1022 contact hours plus 182 support hours) were made with 881 clients in 2003/04. Although the elderly are over-represented as clients, the middle-aged still account for a significant share. For instance, people under fifty account for 36% of contacts and 29% of clients (and therefore have a higher average contact per client than the over fifties).</td> </tr> <tr> <td>Chelsea</td> <td>0.2</td> </tr> <tr> <td>Clarinda</td> <td>0.2</td> </tr> </tbody> </table>		Current EFT	Patterns of Utilisation	Parkdale	1.1	2,362 contacts (1022 contact hours plus 182 support hours) were made with 881 clients in 2003/04. Although the elderly are over-represented as clients, the middle-aged still account for a significant share. For instance, people under fifty account for 36% of contacts and 29% of clients (and therefore have a higher average contact per client than the over fifties).	Chelsea	0.2	Clarinda	0.2
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Chelsea	0.2										
Clarinda	0.2										

Broad Outlook:

The Dietetics program is funded through both the Community Health and the HACCC program (targeted at frail older people, younger people with disabilities and their carers). Population projections indicate substantial growth within the frail older people target group; reports indicate an increasing need for access to dietetics expertise in relation to delivered meals programs for this group. Emerging Government policies and health priorities in relation to nutrition and food security across all population age cohorts illustrate the importance of this program. An increasing focus on early intervention is contradicted by a lack of services available to younger children (under 12 years of age) which is an important target group in terms of establishing good food habits for life. The majority of current EFT resources are located Parkdale.

Direction:

The percentage of the 70+ population served by this program is 5.8% and forecasts based on utilisation data and population changes indicate that the need for this service is anticipated to grow at 5.6% per annum over the next decade. In line with the DHS Policy Framework, an increased focus and the allocation of resources for child and family health is likely to be required, and will need to be balanced against the increasing demand pressures from the aging population by this service. It is critical that service planning and capital development take into account the infrastructure needs of this service. New resources for the Dietetics program should be targeted at the Clarinda site to service those currently under represented groups.

2.2.9 SNAPSHOT: CENTRAL BAYSIDE CHS ADULT COMMUNITY OPTIONS (ACO), FORMERLY KNOWN AS DISABILITY SERVICES

Current Service Model	ACO provides centre based activities and community programs focussing on therapeutic, further education, recreation and work experience opportunities for those adults with an intellectual disability (based on the Adult Training and Support Service model). All seven service outlets provide a base for programs to support clients in the community or at the centre.
Emerging models or practice trends	Emerging practice trends identified include: <ul style="list-style-type: none"> • The development of Person Centred Planning approach. The aim being to support service users to pursue their own individual lifestyles and to enhance the traditional Individual Program Plans • Developing community partnerships to promote inclusion for all service users to access, participate and be included in the general community. (Based on the State Disability Service Plan 2002- 2012).
Partnership details	A vast number of partnership arrangements have been established with: JCAAA (Joint Council Access for All Abilities), Basketball competition, Coatesville Bowls club, Cricket competition with Prahran Cricket club; Edithvale Church of Christ OP shop; Social groups; Chelsea Private Nursing Home; Safeway Chelsea work experience program; Edithvale Friends of Wetlands Group; Edithvale Primary School; Work with Garden projects; Wesley Connecting Communities; Betty Day Community Centre Argyle St (Formal partnership with Eroke City Of Port Phillip); Mordialloc Community Centre; St Kilda Eco Centre, City Of Port Phillip; Waves Pool; Leisure Link Up Gym/swim program; Caulfield Recreational Centre; Temple Beth Israel Informal Friendship Club and social groups; Highett Neighbourhood House; Meals on Wheels; City of Kingston Disability and Diversity office; Metro Access; Alpha- Autism Incorporated; St Augustine’s Anglican Church Social; Long Beach Community Centre in Chelsea.
Service gaps	Service gaps include: <ul style="list-style-type: none"> • Transport to and from programs and service outlets is not available for all service users • Inadequate funding to enable staff to support community programs.
Issues	Identified issues include: <ul style="list-style-type: none"> • The current funding model is not adequate to enable new service directions to be implemented. For example, individualised programs and greater access of and participation in the community for all service users • Traditional day program hours are often not consistent with Service User needs and community recreational options. Service users may benefit from accessing after hour options with support from agency management.
Infrastructure	The increasing number of clients with complex needs means that physical space is required to be more reflective of high support client needs and requirements; and that buses for transport are required.

ACO Sites	Client EFT	Staff EFT	Description of Activities	Bus	Infrastructure
Centre Dandenong Rd, Cheltenham	34	9.6	High support needs	5	Purpose built facility owned by CHS, now at maximum capacity
Southern Rd, Mentone	13	4.4	General	1	Rented property, adequate
Sandringham	16.6	2.5	Independence	1	Rental property (Girl Guide Hall), adequate
Clayton South	19	5.1	Challenging behaviours	2	Owned by CHS, adequate
Mentone Beach	18.4	4.1	General	1	Rented from council, adequate
Glebe Ave, Cheltenham	17	3.8	Older age group, social recreation	1	Rental property (Girl Guide Hall), adequate
Edithvale	11.4	4	Independence	1	House beside CRC rented from Peninsula Health. Peninsula Health vacating CRC which would provide suitable location if appropriately refitted
Other: Administration Drivers		2.4 6			

Broad Outlook:

The Disability program is a large program with approximately 42 EFT providing services to approximately 130 clients, with 75% of clients residing in Community Residential Units. The Disability State Plan places increased emphasis on community participation and a decreased emphasis on centre based activities for clients with all levels of abilities and needs. The program has been successful in developing extensive community partnerships and accessing multiple community facilities, however for clients with extensive physical or behavioural needs community options may not be able to achieve full time activities, so that appropriate centre based infrastructure is still required.

Direction:

People with disabilities exiting the Special School System and those relocating from Kew Residential Services are priorities for the government. In the Southern region, in the vicinity of 160 students exit special schools per year and following an extensive facilitation of choices a small proportion of these elect to attend community based disability programs. In the last year the CB CHS Disability program was the preference for 2-3 of these students and similar numbers are anticipated in future years. Whilst this appears a small number the extensive needs of these consumers means that access to appropriate infrastructure is vital.

Four Community Residential Units to house people exiting Kew Residential Services are also planned for the region. It is assumed that these clients will have access to the specific Out and About Program as part of the relocation however it is possible that clients/families will prefer a centre based activities such as some of those offered by the CB CHS Disability program.

Whilst future demand for the program is likely to remain relatively stable with incremental growth (ie. new entrances balance exits plus a small number of additional clients estimated to be between 6 and 10) the high support needs of these clients mean that appropriate capital (for buildings and transport) is required to ensure physical and personal care needs can be met and therefore access to community activities maximised. The service is the only one of its type operating in the area catering to the high needs client group so that options for clients are limited and access to facilities that are appropriately fitted to meet the physical and personal care needs of clients are critical (ie. buildings need to be wheelchair accessible and have the necessary ceiling hoists to cater for personal care needs). Capital funding to refurbish the Peninsula Health CRC site in Edithvale Road would enable the program to cater for the future needs of high support needs clients requiring specialist services to enable community participation. Access to additional transport is also required.

Recognising these two strategies as high priorities would address the current barriers and with appropriate capital works would cater to the anticipated growth over the next 5 years. This would ensure the program is able offer quality services to additional clients with high support needs in accordance with the future projections for the 2005- 2010 period.

2.2.10 SNAPSHOT: CENTRAL BAYSIDE CHS HACC OCCUPATIONAL THERAPY

Current Service Model	The Home and Community Care (HACC) Occupational Therapy program provides home modification, scooter and wheelchair assessments to the HACC target group.	
Emerging models or practice trends	An emerging practice trend is client centred holistic home assessments.	
Partnership details	A partnership arrangement has been established with the Primary Care Partnership (PCP).	
Issues	Issues identified include: <ul style="list-style-type: none"> • Referrals from appropriate sources • Funding bodies. 	
Infrastructure	Requires office space for staff and a large space for equipment storage, which is adequate at present	
	Current EFT	Patterns of Utilisation
Located at Parkdale, covers all areas	1.5 OT 0.4 Allied Health Assistant (AHA).	3051 contacts were made with 938 clients in 2003/04 from almost 1062 contact hours. Over 70% of clients are women and the over 70s age group accounts for around 80% of clients and contacts.

Broad Outlook:

The Occupational Therapy program is funded through both the Community Health Service and HACC programs (1.5 EFT). HACC allied health programs such as Occupational Therapy provide clinical assessment, treatment, therapy and information. The purpose of HACC Occupational Therapy is to prevent disability, improve health, functioning and independence, assessment and recommendations regarding aids and home modifications. Population projections indicate substantial growth within the frail older people target group; and government priorities focussed on retaining independence and maintaining people within the community to avoid inappropriate admission to acute services or residential care illustrate the importance of this program. There is a clear link between this service and discharge planning for those exiting hospitals. Current EFT resources are minimal and are located at Parkdale.

Direction:

The percentage of the 70+ population served by this program is 6.2% and forecasts based on utilisation data and population changes indicate that the need for this service is anticipated to grow at around 6.5% per annum over the next decade.

2.2.11 SNAPSHOT: CENTRAL BAYSIDE CHS HEALTH PROMOTION

Current Service Model	The Health Promotion program offers activities on site and in settings such as schools and community locations (shopping centres, senior citizens, maternal and child health services, kindergartens and preschools).
Emerging models or practice trends	An emerging practice trend is the DHS Organisational Integrated Health Promotion Plan requirement to be developed on a three year planning cycle. CBCHS Organisational Integrated Health Promotion Plan is consistent with the Kingston Bayside Primary Care Partnership (KBPCP) Community Health Plan.
Partnership details	Partnership arrangements have been established with: <ul style="list-style-type: none"> • KBPCP. CBCHS is actively involved in the PCP, including having representation on the health promotion committee and working groups • Men’s Health Interest Group. The group comprises consumers, RDNS, City of Kingston, Bentleigh Bayside CHS and Rotary • The community development worker has also formed a number of relationships with agencies that provide services to the CALD community in the Clarinda/South Clayton area. • CBCHS is represented on the Southern Region Community Health and Health Promotion Network and Advisory Groups. A partnership with Department of Human Services health promotion officers and health promotion coordinators from community health services.
Service gaps	<ul style="list-style-type: none"> • The report on depression and older people commissioned by the KBPCP has recommended a number of strategies. The KBPCP Health Promotion Committee is currently working through these recommendations. CBCHS participates in a working group which is implementing a range of activities to address these issues. • Working with CALD communities and those people who are most

	<p>marginalised in our community has been identified as requiring a shifting of resources to address their needs. The development of the IHP 2006/2009 will identify these community groups as the priority population groups.</p> <ul style="list-style-type: none"> Men's Health has been identified as requiring specific resources to respond to the needs of men in the Kingston area. 	
Issues	<p>Issues include:</p> <ul style="list-style-type: none"> Community participation. Consideration should be given to developing a CBCHS community participation policy Increasing the targets for health promotion 	
Infrastructure	Adequate	
	Current EFT	Patterns of Utilisation
Parkdale		<p>Health promotion data for the 2004/2005 financial year as new reporting codes were implemented during this time. These new codes will improve how HP activities are reported and will improve future reporting. Health Promotion activities provided in the 2004/2005 financial year were 3,424 hours.</p>
Located at Chelsea, covers all areas	1.0	
Clarinda		
Mentone	n/a	

Broad Outlook:

The formal Health Promotion Program includes only 1.0 EFT. The Health Promotion Program has however developed partnerships with a range of service providers. Leadership in health promotion is identified as a key strategic direction in the DHS/CHS policy framework – see Chapter 6 for further discussion on this.

2.2.12 SNAPSHOT: CENTRAL BAYSIDE CHS NEEDLE AND SYRINGE EXCHANGE PROGRAM (NSP)

Current Service Model	The Needle and Syringe Program is a centre based service located at the Chelsea site
Partnership details	<p>Partnership arrangements have been established with:</p> <ul style="list-style-type: none"> DHS SHARPS Frankston. CBCHS works in partnership with BBCHS, Caulfield CHS and DHS to develop the existing NSP of these services.
Service gaps	<p>Service gaps include:</p> <ul style="list-style-type: none"> Clients being unable to return used fits after hours Apart from single syringes in toilet block located opposite CHS, investigations have commenced in relation to the feasibility of external sharps bins in the local area.
Issues	<p>Issues include:</p> <ul style="list-style-type: none"> How to improve access to other services and programs for NSP users Limited program provision. For example, the program is only available at the Chelsea site Access to safe syringe disposal 'out of hours'.

Infrastructure	The program currently utilises an office but would be more appropriately positioned in an area off reception	
	Current EFT	Patterns of Utilisation
Chelsea	0 – Managed by all staff	Current patterns of usage are that circa 60 to 80 males and 20 to 30 females access the service each month. A consultation is being undertaken on the NSP in the Kingston, Bayside and Glen Eira LGAs and its findings are due later in 2005.

Broad Outlook and Direction:

The continued provision of staff development and training sessions will enhance staff skills, knowledge and confidence in dealing with this program. All sites should provide access to on-site or external NSEP facilities to support harm minimisation.

2.2.13 SNAPSHOT: CENTRAL BAYSIDE CHS CHILD DEVELOPMENT SERVICE (CDS)

Current Service Model	The Child Development Service is a centre based service located at Parkdale and Clarinda. The program provides one to one clinical intervention, early speech and language programs, occupational therapy programs, group work such as school readiness programs, Parents and Infant Relationship Service (PAIRS) and kindergarten and school visits when required. Child and family counselling is also provided at Chelsea.	
Partnership details	Partnerships have been established with: <ul style="list-style-type: none"> • Alfred Child and Adolescent Mental Health (CAMHS) • Dept. of Education Speech pathologists • Maternal & Child Health nurses • Specialist Children's Services DHS 	
Service gaps	The Clarinda site is an identified service gap.	
Issues	<p>Short term issues identified include:</p> <ul style="list-style-type: none"> • The need to develop Clarinda site • Room/space shortage • Access to pool cars. <p>Longer term issues identified:</p> <ul style="list-style-type: none"> • Staffing shortages • Increased Occupational Therapy hours. 	
Infrastructure	Office space for 5 staff, a large treatment space, and storage space for equipment is required. When Kingston Centre vacates offices at the Parkdale site the space will be adequate.	
	Current EFT	Patterns of Utilisation
Parkdale	1.8 speech + 1 OT + 0.2 physio + 0.4 AHA + Paediatrician 0.4	During 2004/2205 CDS provided- 2145 hours of Speech Pathology. 1165 hours of Occupational therapy.

Chelsea	0	254 hours of Physiotherapy. Paediatrician treated 406 patients.
Clarinda	0	
Mentone	n/a	

Broad Outlook:

The Community Health funded Child Development Service is provided from the Parkdale site at present as other sites do not have the required infrastructure. Service provision from other sites would improve access for service users. The increasing focus on child and family health as a key policy direction may expand the capacity of CHS to provide early intervention and health promotion programs. Increasing multi disciplinary child development services is seen as important particularly where services target health disadvantage.

Direction:

Paediatric services require strong partnerships with other programs/services targeting children and families. Multi disciplinary allied health paediatric teams should focus on those sub catchment areas demonstrating poor child health/socio economic status such as Clarinda and Clayton South and locations with emerging/newly arrived communities such as Westall.

2.2.14 SNAPSHOT: CENTRAL BAYSIDE CHS PHYSIOTHERAPY

Current Service Model	Physiotherapy is a centre based service and is located at three sites. CBCHS hires a hydrotherapy pool at BBCHS for the important aquatic physiotherapy treatment model.
Emerging models or practice trends	An emerging practice trend is the implementation of a central intake system for all services with highly skilled staff.
Partnership details	Partnerships have been established with: <ul style="list-style-type: none"> • Primary Care Partnerships- Falls Prevention and Physical Activity. • Sthn Health Community Rehabilitation Centre at Parkdale and Home Based Allied Health. • Bentleigh Bayside Community Health Service.
Service gaps	The capacity of the service to manage urgent clients with immediate response requirements is inadequate.
Issues	Issues identified include: <ul style="list-style-type: none"> ▪ Managing increasing number of clients due to increases in the aged population. ▪ Increase demand from referrals from paediatric service. ▪ Increase in clients with conditions such as arthritis, diabetes, and mobility and balance problems. ▪ CALD communities requiring interpreters and specific cultural needs.
Infrastructure	The Physiotherapy program requires office space for four staff, a large space for treatment and equipment storage space. At the Chelsea site the treatment room is

	shared with the Women's Health program. Sufficient space is required to hold forums and groups exercise sessions. At the Clarinda site the treatment room is currently shared with Podiatry and is poorly designed. These issues will be resolved with the planned redevelopments.	
	Current EFT	Patterns of Utilisation
Parkdale	1.9 + 0.4 AHA	In 2004/05 physio services at CBCHS made 3,380 client contacts, spending a total of 2,760 contact hours with 853 separate clients and 847 support hours. Almost three quarters of clients were women and almost two thirds were in the 70 years plus age bracket. The 60 to 69 years age bracket accounts for another 15 – 20%.
Chelsea	0.6	
Clarinda	0.4	
Mentone	n/a	

Broad Outlook:

The Physiotherapy program is funded through the both Community Health and the HACC program (targeted at frail older people, younger people with disabilities and their carers). HACC allied health programs such as Physiotherapy provide clinical assessment, treatment, therapy and information. Population projections indicate substantial growth within the frail older people target group; and government priorities focussed on retaining independence and maintaining people within the community to avoid inappropriate admission to acute services or residential care illustrate the importance of this program.

The increasing demand for specialist skills requires multi skilled therapists. Some of the skills can be acquired with professional development but not all. Specialist therapists are available in the private sector but not in community health.

Direction:

The percentage of the 70+ population served by this program is 10.0% and forecasts based on utilisation data and population changes indicate that the need for this service is anticipated to grow. Overall demand for physiotherapy services is expected to increase by around 30% over the next five years. It is critical that service planning and capital development take into account the infrastructure needs of this service. New resources for the physiotherapy program should be targeted at the Chelsea and Clarinda sites to service these currently under represented groups.

2.2.15 SNAPSHOT: CENTRAL BAYSIDE CHS PODIATRY

Current Service Model	The Podiatry program is a centre based service located at three sites.
Emerging models or practice trends	Emerging practice trends are: <ul style="list-style-type: none"> To base service models on self-care and education Access to electronic-based patient assessment and notes.

Partnership details	Partnership arrangements have been established with: <ul style="list-style-type: none"> • Assoc Podiatry Australia • Home Based Podiatry in Southern Network • International Diabetes Institute • Local private podiatrists who have diabetes care knowledge. 	
Service gaps	There is a deficit in Community Based Paediatric Podiatry.	
Issues	Issues include: <ul style="list-style-type: none"> • Priority vs. Eligibility • Health Promotion • Proliferation of diabetes. 	
Infrastructure	The Podiatry program requires office space for three staff, space for treatment and a sterilisation area. Parkdale is the only site with the appropriate sterilisation area. The Chelsea site also requires space for group education sessions.	
	Current EFT	Patterns of Utilisation
Parkdale	1.9	In 2003/04 a total of 2075 were treated during 7,256 client contacts (average of 3.6 contacts per client). Total contact hours were 2,658 with an additional 2,282 support hours. Around 80% of clients are aged 70 years or more and women out number men by around 3 to 1.
Chelsea	1.0	
Clarinda	0.6	
Mentone	n/a	

Broad Outlook:

HACC allied health programs such as Podiatry provide clinical assessment, treatment, therapy and information. Burden of disease data in relation to diabetes establishes the importance of podiatry in managing diabetes. The ageing population in conjunction with emerging government policies in relation to chronic conditions and Ambulatory Care Sensitive Conditions and integrated service provision, indicate the importance of multi disciplinary and multi program collaboration and coordination of services. In this context service planning requires an appropriate allocation of time to maximise outcomes.

Direction:

The percentage of the 70+ population served by this program is 13.7% and forecasts based on utilisation data and population changes indicate that the need for this service is anticipated to grow. At an anticipated annual rate of between 5 and 10% per annum this suggests a rapid increase in the need for podiatry services. It is critical that service planning and capital development take into account the infrastructure needs of this service. New resources for the podiatry program should be targeted at the Chelsea and Clarinda sites to service these currently under represented groups.

2.2.16 SNAPSHOT: CENTRAL BAYSIDE CHS SEXUAL AND REPRODUCTIVE HEALTH

Current Service Model	The Women's Health Service (sexual and reproductive health) is centre based at 2 sites (Parkdale and Chelsea). The Women's disability outreach program is provided throughout the City of Kingston. Sexual and reproductive health education is provided in both primary and secondary schools. The Sexual and Reproductive Health Service is staffed by two Doctors and two Nurses all trained in sexual health.	
Emerging models or practice trends	The Women's Health nurses are currently developing an outreach service for women with disabilities. The program aims to empower these women to access services which have previously been unavailable to them, including Pap Smear screening. In addition, the program aims to work in conjunction with Breast Screen thereby providing advice on mammogram screening.	
Service gaps	Service gaps include: <ul style="list-style-type: none"> • Time constraints and an inability to share resources, limiting the scope and potential of the service. • The location and hours of operation can limit accessibility for younger people. 	
Issues	Identified issues include: <ul style="list-style-type: none"> • Continuing to provide a service which offers clients information, advice and counselling about any sexual and reproductive health issue • The need to provide a service which is more accessible to young people and CALD groups • The need to continue to develop the Disability Outreach Program for women. 	
Infrastructure	Office space for three staff and an appropriate treatment space for the doctor and nurse. At Parkdale the office space is shared with the GP practice which is becoming busier but unable to increase hours due to limitation with space. When Kingston Centre vacates offices at the Parkdale access to additional space will be considered. At the Clarinda site the treatment room is currently shared with physiotherapy.	
	Current EFT	Patterns of Utilisation
Parkdale	0.3	Approximately 800 hours of service was provided by the nursing staff and doctors during 2004/2005.
Chelsea	0.3	
Clarinda	0	
Mentone	n/a	

Broad Outlook:

The aging of the population may increase the demand for mammogram screening. The increased access of people with disabilities to mainstream health and community services is in accordance with Government policy and should be supported. The CHS policy framework emphasis on child and family health supports expanded primary medical care and a focus on child and family health for those most in need.

Direction:

Appropriate consultation rooms for the GP practice and practice nurses are critical to an efficient and high quality practice. The current arrangements at Parkdale and Clarinda require upgrading to maximise the service outcomes. Future resources should focus on expanded primary medical care and opportunities for service coordination initiatives, the role of practise nurses and nurse practitioners.

2.2.17 SNAPSHOT: CENTRAL BAYSIDE CHS SOUTHERN PSYCHOGERIATRIC ACTIVITY SERVICE (SPAS)

Current Service Model	The SPAS model is based on the principals of psychosocial rehabilitation. It is a model of community integration for older people with a psychiatric disability. The program is staffed by six health professionals who provide a home based outreach service to individual clients.
Emerging models or practice trends	DHS has recently funded three pilot programs to provide psychosocial rehabilitation to older adults with a psychiatric disability. The main difference with this program is the focus on broader rehabilitation goals and it is staffed by less qualified and experienced workers. Several APATT teams are also looking at developing a similar program.
Partnership details	SPAS has a close alliance with the Kingston Centre APATT (Southern Health). The consultant Psychogeriatrician at Kingston provides SPAS with fortnightly clinical supervision. SPAS also has a partnership with Carer Respite Centre Southern Region. This partnership operates the 'Give It A Go' program. SPAS also works closely with a range of other services (mostly PAG) in identifying gaps & developing new programs.
Service gaps	Previously SPAS worked in five local government areas. In 2003, Port Phillip and Stonington local government areas no longer received SPAS services. Since this time, DHS has funded several small services however, a major gap in the provision of services, particularly in the City of Stonington remains.
Issues	Short Term issues include: <ul style="list-style-type: none"> Funding not 'kept in step' with salary increases and other costs. For example 5 EFT used to be 6 EFT Developing a service model to meet the needs of Supported Residential Services (SRS). Long Term issues include the need to: <ul style="list-style-type: none"> Continue to promote the service Build a relationship with funding bodies Undertake research and provide data to show the importance of this service model..
Infrastructure	Office space for 6 staff currently inadequate however when Kingston Centre vacates offices at the Parkdale site this may be resolved.

	Current EFT	Patterns of Utilisation
Located at Parkdale, works across 3 LGAs	5 + 0.6 AHA	6,737 hours of service were provided in the 2004/2005 financial year.

Broad Outlook:

SPAS receive funding through DHS HACC Program and Mental Health Branch. Six mental health workers (5 EFT) work across the 3 LGA's of Bayside, Kingston and Glen Eira to provide intensive and individually tailored psychosocial rehabilitation programs to aged clients with mental health issues (psychiatric disability and /or dementia).

The SPAS model of service has been evaluated to be highly successful and cost effective. Clients with very high needs and/ or challenging behaviors are connected to mainstream activities and services in their communities. This model of short-term intensive psychosocial rehabilitation allows all clients the best possible opportunity to connect with their communities and prevent some of the illnesses associated with inactivity, isolation and loneliness.

In 1996 SPAS received the Gold Award at the Australia and New Zealand Mental Health Service Achievement Awards, and the service continues to maintain its reputation as a model of best practice and innovation.

SPAS work with over 300 individual clients each year, with a primary focus on community integration and social connectedness. This work falls in line with many health promotion and community health priority documents ie. The Integrated Health Promotion Priority for Mental Wellbeing and Social Connectedness and the Dementia Framework for Victoria 2005.

SPAS also fills a community development role in the region whereby they offer consultation, support and advice to the social support system and aged care networks.

Direction:

SPAS provide a service to a 100% aged clientele, so growth in the service should coincide with the rate of the aging population in the 3 LGA's.

All SPAS clients are diagnosed with either Dementia or another mental illness (mostly depression). People with Dementia and Depression show the highest-ranking YTD (years lost to disability) in Bayside, Kingston and Glen Eira. This should be taken into account when planning the SPAS service in the future.

SPAS are looking to provide a greater focus on residents of pension-level Supported Residential Services in the region. This group of potential clients has poor levels of access to all health and community services, and they are an isolated and marginalised group. There are over 200 pension-level SRS residents in the 3 LGA's covered by SPAS.

It is hoped that the SPAS service may expand into neighbouring areas, or be replicated in other regions.

2.2.18 SNAPSHOT: CENTRAL BAYSIDE CHS 'GIVE IT A GO' PROGRAM

Current Service Model	The 'Give It A Go' Program operates weekly on Wednesdays and provides outing based activities and a respite program for clients with early onset dementia.
Emerging models or practice trends	Other community services are considering commencing a similar program or replicating the 'Give It A Go' program. For example: NZ, France and South Australia.
Partnership details	The 'Give It A Go' program operates in partnership with Carer Respite Centre Southern Region (CRCSR) and SPAS. CRCSR provide most of the funds and SPAS at CBCHS provides some staffing and program management. An agreement has also been established with Girrawheen Day Centre. A small fee pays for utilisation of their venue for one hour per week and bus.
Service gaps	The program is currently funded until June 2005. It has been successful in being able to address a large gap in dementia services in the region. Without funding, the service gap will not be addressed.
Issues	Short term issues include the need: <ul style="list-style-type: none"> • For recurrent funding • To determine the best 'home' for the program • To manage the waiting list. Longer term issues include: <ul style="list-style-type: none"> • Replication of program. Consideration be given to inclusion in the National Plan for dementia care • Promotion of the program.

Broad Outlook:

The "Give it a Go" program is offered through a partnership between CBCHS and Commonwealth Carer Respite Centre- Southern Region. Ongoing funding is dependant on this partnership.

The program offers an opportunity for those people under the age of 70, and in the early stages of dementia, to access an age-appropriate and therapeutic community based activity group. It is a transitional program whereby clients and carers are introduced to activity services and respite, and are linked to other services as their needs change.

"Give it a Go" has accommodated 21 clients and their carers since the pilot program commenced in 2002. The service has received a positive evaluation and is recognised as a model of best practice. It is one of the very few programs across Victoria that provides a model of intervention in the 'early stages' of dementia. This falls in line with recommendations made in the Dementia Framework for Victoria 2005.

Direction:

Dementia is an age-related illness, so growth in this service should coincide with the rate of the aging population in the 5 LGA's. It should also be noted that many people are now

receiving a diagnosis of dementia much earlier than was previously the case. It is important that appropriate support services are available once a diagnosis is made.

All "Give it a Go" clients are diagnosed with Dementia. People with Dementia show the highest-ranking YTD (years lost to disability) in Bayside and Glen Eira, and the second highest in Kingston. This should be taken into account when planning the "Give it a Go" service in the future.

It is hoped that the "Give it a Go" service may be replicated to meet high demand, and the predicted future need.

2.2.19 SNAPSHOT: CBCHS SPEECH PATHOLOGY

Current Service Model	The Inner South Communication Service aims to increase the community participation of people with complex communication needs. This service uses a Community Capacity Building model to increase the accessibility of community services and business to people with communication difficulties. Short term direct Speech Pathology services are available to people from 18 to 65 years of age who do not have access to other Speech Pathology services. Consultation and training is offered to disability and community organisations.	
Partnership details	The Inner South Communication Service is auspiced by Central Bayside on behalf of Inner South, Bentleigh Bayside and Caulfield Community Health Services. The service works in partnership with: <ul style="list-style-type: none"> ▪ Department of Human Services ▪ Statewide network of Regional Communication Services ▪ Communication Resource Centre ▪ Metro Access Partnerships with other agencies have been developed for specific projects.	
Service gaps	Service gaps include: <ul style="list-style-type: none"> • Lack of ongoing therapy services in the region, particularly for people with developmental disabilities • Lack of services for people over 65 years of age in supported accommodation 	
Issues	Identified issues include: <ul style="list-style-type: none"> • Limited staffing levels for the size of the region covered • Need for ongoing therapy services to refer on to • Capacity to support clients with implementation of recommendations • Lack of involvement by project partners 	
Infrastructure	Office space for one staff member	
	Current EFT	Patterns of Utilisation
Parkdale	0.6	471 hours of service were provided during the 2004/2005 financial year, covering service establishment, community capacity building and direct therapy services.

Broad Outlook:

This is a DHS Disability Services Division funded position for people with disabilities with complex communication needs. The position commenced in October 2004, and covers the cities of Kingston, Bayside, Glen Eira, Stonnington and Port Phillip.

The service is part of the new 'hub and spoke' model of service delivery being used for people with complex communication needs across Victoria.

The Inner South Communication Service works in partnership with a range of agencies and may have the capacity to attract additional funding to specific projects.

2.2.20 SNAPSHOT: CENTRAL BAYSIDE CHS TELELINK

Current Service Model	CBCHS coordinates approximately 20 agencies across Victoria who provide Telelink programs. Service Telelink programs operate in NSW, Qld, WA and SA with the assistance of Telstra.	
Partnership details	CBCHS delivers funding provided by DHS to agencies across Victoria that provide Telelink programs. CBCHS provides information, in liaison with DHS and Telstra to agencies in relation to: <ul style="list-style-type: none"> • Planning and implementing groups • Training for staff and support. 	
Service gaps	Service gaps include: <ul style="list-style-type: none"> • Inability to allow new agencies to start Telelink programs due to a Telstra review being undertaken • Lack of data regarding program numbers and type • Lack of consultation between DHS, Telstra and service providers. 	
Issues	Identified issues include: <ul style="list-style-type: none"> • Communication from Telstra in relation to the Telelink program review • The need to hold securing meetings with Telstra in relation to improving and expanding Telelink programs and the delivery model of delivery • Promoting a cost effective Telelink model to DHS and the community. 	
Infrastructure	Adequate	
	Current EFT	Patterns of Utilisation
Parkdale	1.0	2,080 hours of service were provided in the 2004/2005 financial year.
Chelsea	0	
Clarinda	0	
Mentone	n/a	

Broad Outlook:

The 1.0 EFT is a statewide position located at Parkdale. A Telelink Review with Telstra is currently underway.

2.2.21 SNAPSHOT: CENTRAL BAYSIDE CHS YOUTH SERVICES 10 – 24 YEARS

Current Service Model	The Youth Services (10 – 24 years) program provides group work with young people. The program provides services at 2 sites and on an outreach basis at primary and secondary schools as required.	
Emerging models or practice trends	Currently, plans are being developed to address gaps in the service delivery of the secondary school based sexual health program by introducing a complimentary program. (Information sourced from Commonwealth Department of Family and Community Services and South Australian Community Health Research Unit.)	
Partnership details	<p>Through participation in KBPCP, support is being provided by funding this program and facilitation is being augmented through established working relationships between CBCHS and BBCHS.</p> <p>Other partnership arrangements have been established with:</p> <ul style="list-style-type: none"> • City of Kingston Youth Services. City of Kingston provides funding to CBCHS to deliver services to young women • Southern Family Life. The Association convenes a School Focussed Service and CBCHS is represented on the Advisory Committee. 	
Service gaps	<p>Limited resources for youth services necessitate program development focussing on sexual and reproductive health and in particular school based sexual health programs.</p> <p>Youth counselling is an identified gap in the Kingston area with limited number of services offering assistance to young people and their families.</p>	
Issues	<p>Issues include:</p> <ul style="list-style-type: none"> • Sustainable funding • Training and availability of peer educators • Reduced staffing levels 	
Infrastructure	Adequate	
	Current EFT	Patterns of Utilisation
Parkdale	.4	Work within schools, case work with young pregnant or parenting women , including home and centre based visits. Young women’s program which includes group work and Talking realities program.
Chelsea	.75	
Clarinda	0	
Mentone	n/a	

Broad Outlook:

This service is comparatively small and not likely to be targeted by new government resourcing initiatives.

2.3 Socio-demographic Profile

2.3.1 SOCIOECONOMIC STATUS OF KINGSTON

This section provides information on the key social, physical and environmental factors influencing the health and well-being of the Kingston communities. The project is supported by previous research showing that health status of communities varies according to certain population characteristics such as sex, ethnicity, socio-economic status and geographic location.

2.3.2 DEMOGRAPHICS

A comprehensive demographic and social profile of the City of Kingston is available through the City of Kingston website www.id.com.au/kingston/atlas.

The City of Kingston covers 91.33 square kilometers on the eastern side of Port Phillip Bay in the south east section of metropolitan Melbourne and comprises the following suburbs:

Aspendale, Aspendale Gardens, Bonbeach, Carrum, Chelsea, Chelsea Heights, Cheltenham, Clarinda, Clayton South, Dingley Village, Edithvale, Heatherton, Highett, Mentone-Moorabbin Airport, Moorabbin, Mordialloc-Braeside, Oakleigh South, Parkdale, Patterson Lakes and Waterways.

Population Projection

The Kingston Population is estimated to increase 9.6% from 133, 887 in 2001 to 146,751 in 2011. Population is expected to have grown more rapidly in the period to 2006 (9,094 persons or 6.8%) and then less rapidly from 2006 to 2011 (3,771 persons or 2.6%)

2.3.3 AGE STRUCTURE

The table below outlines the population, age structure and projection obtained from the Kingston web site:

Age Structure	Forecast Year					
	2001	%	2006	%	2011	%
Service age groups						
0 to 4	7,930	5.9	7,989	5.6	7,590	5.2
5 to 11	11,305	8.4	12,044	8.4	11,844	8.1
12 to 17	9,552	7.1	10,164	7.1	10,471	7.1
18 to 24	11,790	8.8	11,702	8.2	11,611	7.9
25 to 34	20,834	15.6	19,816	13.9	18,893	12.9

35 to 49	29,659	22.2	32,525	22.7	32,900	22.4
50 to 59	16,253	12.1	18,426	12.9	19,416	13.2
60 to 69	11,436	8.5	13,771	9.6	16,080	11.0
70 to 84	12,828	9.6	13,691	9.6	14,788	10.1
85 and over	2,299	1.7	2,852	2.0	3,158	2.2
Total	133,886	100.0	142,980	100.0	146,751	100.0

Worth Noting:

The city has an older population than the Melbourne Statistical Division (MSD) with the proportion of population aged over 85 and 70-84 years , 19% and 13.7% respectively over that for the MSD, and the proportion aged 0 -17 at 6.3% under that for the MSD.

Kingston has the 7th highest veteran population in Australia – providing part of the explanation for the high percentage of older persons.

While the population is expected to increase by 6.8% from 2001 -2006 and only 2.5% from 2006 – 2011, the increase in persons aged 70+ is expected to be 9.4% (15,127 to 16,543 person) from 2001 – 2006 and a further 8.5% (to 17,946 persons) from 2006 – 2011. Reductions in numbers of younger persons and increases in older person results in a disproportionate increase in health needs because of the significantly greater health needs of older persons.

2.3.4 COUNTRY OF BIRTH

The 2001 Census revealed 28.9% of residents of Kingston community were not born in Australia; however, the majority came from English-speaking countries (74.8%), which is higher than the MSD average of 73 %.

In 2001 there were 32,123 Kingston residents who came from non-English speaking countries.

12.4% of the population is not fluent in English compared with 14.7% in the Melbourne Statistical Division. This level still represents a significant language and communication problem for providers and consumers.

2.3.5 ATSI POPULATION

The 2001 ABS Census data indicates that the City of Kingston had population of 279 Aboriginal and Torres Strait Islanders which is approximately 0.2% of the population compared with the MSD average of 0.4%

2.3.6 HOUSEHOLD TYPES

	City of Kingston (%)	MSD (%)
Couples with Children	31.2	33.0

Couples without child	35.2	32.8
One parent family	7.1	7.5
Lone person households	26.3	23.2
Other	0.2	3.5

Worth Noting:

The high proportion of single person households is consistent with the higher aged population and could indicate a social problem of loneliness and isolation.

2.3.7 HOUSEHOLD SIZE AND DWELLING TYPE

A smaller percentage of Kinston residents (12.3%) live in flats, units or apartments than the in MSD (13.2) and separate houses (66% compared with 68.4).

Office of Housing – Rental Stock

The Office of Housing has 921 (1.8%) rental properties scattered throughout the City compared with 2.9% in MSD. Large proportions of these are located in Mordialloc/Braeside (115 or 4.6%), Clarinda (113 or 4.6%) and Carrum (59 of 4.1%) while the balance are reasonably evenly distributed throughout the municipality.

2.3.8 HOUSEHOLD INCOME

	Kingston City (%)	MSD (%)
< \$400	19.3	18.1
\$401 – 1,199	52.7	51.4
>\$1,200	28	30.5

Worth Noting:

Lack of income restricts consumer access and choice of health services.

2.3.9 PENSION RECIPIENTS

Old Age Pension

Number and percentage of people receiving the Age Pension by Age, Kingston, Dec 2000			
Age	Population	No. receiving the Aged Pension	%
60-64	6,242	1,342	21.5

65-69	5,460	3,777	69.2
70-74	5,147	3,693	71.8
75+	8,522	5,705	66.9
Total	25,371	14,517	57.2

Other Pensions			
Type of Pension	Period	No of recipients	%
DVA	April 2000	3,161	17.8
Disability Support	Dec 2000	3,766	4.8
Carer Payments	Dec 2000	1,005	1.5

2.3.10 DISABILITY

Statistics regarding incidence of disability have been obtained from the City of Kingston Community Services Report 2001 Socio-demographic Profile and were derived from the ABS Statistics for 1998 Disability Small Area Predictor Data. It estimates that 16.6% of the population of Kingston living in private dwellings has a disability compared with 17.1% for Victoria and 18.4% for Australia.

	Disability by Type and Age Group for Kingston (1998)									
	0-4	5-14	15-24	25-34	35-49	50-59	60-69	70-84	85+	Total
Physical	297	576	898	1370	3071	2532	2803	3347	382	15,276
Sensory	12	141	86	164	355	319	521	949	152	2,699
ABI	11	21	65	53	72	64	104	117	13	520
Intellectual	15	1	71	28	62	107	17	32	37	473
Psychological	20	141	150	204	381	202	84	83	7	1,258
Total	355	1,048	1,213	1,853	3,986	3,125	3,544	4,528	558	20,226

	Restriction Types for Disability in Kingston (1998)			
	Number	Percentage	% Victoria	% Australia
Self Care	5,575	17.6	18.0	17.7
Mobility	13,630	43.1	41.5	42.7
Communication	3,701	11.7	10.7	10.9
Schooling	1,197	3.8	4.0	3.9
Employment	7,541	23.8	25.9	24.8
Total	31,644	100.0	100.0	100.0

Severity of Disability

The ABS has identified four levels of core activity restriction based on whether a person needs help, has difficulty, or use aides or equipment. Estimates for Kingston are:

	Severity of Disability in Kingston	
	Percentage	Number
Profound	12.5	2,531
Severe	13.2	2,676
Moderate	20.0	4,015
Mild	32.4	6,550
Education/Employ	9.0	1,816
No restrictions	13.0	2,639
	Assistance Required	
Accommodation	42.4	9,284
Personal Health	32.8	7,197
Transport	24.8	5,429

Worth Noting:

Assistance required is expected to be more substantial than indicated because these figures do not take into account people already living in non-private dwellings.

<p>Physical Disability 15,276 persons</p>	<p>The largest number of people with physical disability is in the older age groups. People aged 40-49 with a physical disability constitute 50% of all people with disabilities. For people between 65 and 74 years with a physical disability there is also a higher incidence of brain injury for which there is no explanation</p>
<p>Sensory Disability 2,699 persons</p>	<p>Sensory disabilities are more prevalent in older age groups. This is often linked to the natural process of ageing. This trend will be noticeable in future years.</p>
<p>Psychological Disability 1,258 persons</p>	<p>Psychological disability is much more prevalent than intellectual disability and ABI combined and is most prevalent in 30-49 age groups.</p>
<p>Acquired Brain Injury 520 persons</p>	<p>2.6% of the Kingston community is estimated to have ABI (compared with 3.0% in Australia and 2.5% in Victoria)</p>
<p>Intellectual Disability 473 persons</p>	<p>2.3% of the population are estimated to have an intellectual disability with the highest proportion (171 persons or 36.2%) being the 5-14 age group and 98 persons (20.7%) in the 30-39 age group.</p>

2.3.11 EMPLOYMENT

Unemployment rate within Kingston (2001) lies at 5.6% which is lower than the average for the MSD which lies at 6.6%. However, there are pockets which experience relatively high unemployment such as Clayton South (9.6%), Bonbeach (7.9%), Chelsea (7.8%) and Clarinda (7.1%)

Labour force participation was higher in Kingston at 61.8% than for the MSD (61.7%) although the male participation rates was 62.9% compared with 61.5% for MSD while the female participation rate was 28.2% compared with 29.1% in the MSD.

Kingston has a lower proportion of **persons employed in management, administrative and professional occupations** (24.8% compared with the MSD (29%) and a higher proportion employed in manufacturing (19%) compared with the MSD (16%).

2.3.12 SOCIO-ECONOMIC INDEX FOR AREAS (SEIFA)

The SEIFA index provides a measurement of Socioeconomic disadvantage which takes into account both social and economic factors. Victoria has a SEIFA Index of disadvantage of 1014.59. The table below shows the most disadvantaged suburbs in Kingston.

Suburbs in Kingston ranked from greatest to least disadvantage		
Rank	Suburb	SEIFA index
1.	Clayton South	893.0
2.	Clarinda	951.47
3.	Chelsea	975.34
4.	Carrum	986.05
5.	Oakleigh South	989.69
6.	Bonbeach	991.96
7.	Heatherton	1006.48
8.	Chelsea Heights	1011.59
9.	Mordialloc	1025.62
10.	Edithvale	1035.64
Victoria	Average	1014.59

Worth noting:

Clayton South and Clarinda have a population of 18,888 (14.1%). These two suburbs are among the top 10% of the most socio-economically disadvantaged areas in Victoria as measured by the index. Chelsea, Carrum, Oakleigh South and Bonbeach are in the top 25% of the most disadvantaged and have a combined population of 18,715 (14%). Hence 28.1% of the population of the municipality resides in areas which are amongst the top 25% of the most disadvantaged in Australia.

3 Community Health Policy Directions

The following chapter provides a philosophical context for planning at CBCHS. The earlier section shows the difficulties that come from defining ‘need’ in primary and community health. This is followed by a summary and overview of current policies of the Victorian Government that needs to be taken into consideration for planning.

3.1 The Relationship between Usage, Demand and Need

In planning for the future of a primary and community health service, the following use of definitions may be useful in distinguishing between need, demand and utilisation. From the explanation below it will become obvious that the focus of this discussion will, of necessity, be based on community need. Particularly where resources are limited, the allocation of priorities will become a primary planning tool.

The following model developed by the Canadian Policy Research Networks is an attempt to explain the importance of differentiating between need, demand and utilisation which is based on common definitions within health economics. These can be summarised as follows:

Demand is the amount of goods or services consumers are willing and able to buy at varying prices. The level of demand is determined by the individual who might receive care and is not influenced externally

Utilization is the amount of services actually used.

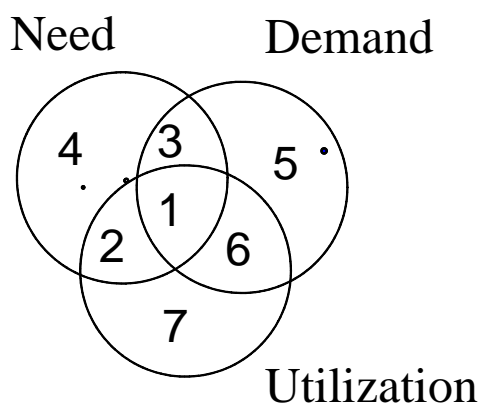
Need relates to the amount of goods or services which should be consumed based on professional value judgements. This judgement is not made by the individual receiving the services but by experts.

Ideally, community health services should focus on need, but inevitably it is the subset of need defined by domains 1, 2 and to a lesser extent 3 that receive attention, simply because of what might be called the need/utilization logic trap; viz “if services are being well used then it must be a good use of public money”.

Figure 2 shows three circles representing the above three concepts.

In an ideal CHS, the biggest zone should be Zone 1 with 3,4,6,7 being very small.

Ideally, services should aim to focus on domains 1 and 3 below.



Demand, the amount of a good or service consumers are willing and able to buy, should be distinguished from **utilization**, the amount of services actually used and **need**, which has a normative connotation and relates to the amount of goods or services which should be consumed based on professional value judgments. (*Glossary of terms: U.S. Academy for Health Services Research and Health Policy*)

Figure 2 The relationship between utilization, demand and need

Source: Hollander, M.J., Deber, R. & Jacobs, P. (2001). *Myths and Realities: Models of Financing, Resource Allocation and Reimbursement in Health Care*. (Unpublished).

3.2 Key Policy and Planning Documents

The Department of Human Services (DHS) provides direction for the planning of community health services in a range of policy statements. It is important that CBCHS takes these into consideration when planning services. More particularly, the information contained in policy documents will:

- Ensure that planning for individual programs is in keeping with key government strategies
- Provide guidance on priorities for service delivery
- Indicate the role of Community Health within the Victorian context
- Suggest where funding priorities will lie in the future

The section below provides a summary of the individual policy documents that may be of relevance to CBCHS followed by a summary of the themes that are common to the various policy documents.

3.2.1 SUMMARY OF KEY POLICY STATEMENTS RELATING TO CBCHS SERVICE AREAS

Community Health Services - Creating a Healthier Victoria DHS, September 2004
This document is the key policy framework for Community Health. It outlines the following key strategic priorities for Community Health Services: <ul style="list-style-type: none">• Platform for primary care• Leadership in health promotion• Co-ordinated Community-based disease management and ambulatory care• Expanded primary medical care• Child and family health The following 'Enablers' are seen as means of developing the key strategic areas and include: <ul style="list-style-type: none">• Capital investment and service planning• Research and workforce development• Governance and effective leadership• Business systems and quality initiatives
Integrated Health Promotion Priorities DHS, 2004-2006
To provide greater direction and leadership for health promotion, DHS has established key topics as priorities for IHP in Victoria. The five key topics are: <ul style="list-style-type: none">• Physical activity• Food and nutrition• Mental wellbeing and social connectedness• Tobacco, alcohol and other drug issues

- Healthy weight

Consolidating catchment-planning IHP to focus on these priorities will enable PCP agencies/organisations and community representatives (key stakeholders) to align their local health promotion program activity to contribute to, and benefit from, state-wide and national directions.

Foundations for Primary Care Mental Health Treatment Services in Victoria

Department of Health and Aging & DHS, August 2004

A three-level schema is suggested based on the severity and complexity of mental health problems. It also suggests settings in which services should be delivered.

Level 1: Adjustment problems

Adjustment to specific problems of living that cause tolerable distress that will ease over time.

Settings: GPs, families, friendship networks, churches, telephone counselling.

Level 2: Focal Problems

Specific mental health needs responsive to evidence-based interventions. Includes panic attacks, PTSD, episodic depression, problem drinking.

Settings: GPs, Community Health Services, telephone counselling.

Level 3: Severe/complex/disabling

At high risk of harm to self or others and /or difficult to engage or unresponsive to Level 1,2 interventions and/or with enduring and serious mental health disability.

Settings: GPs with specialist skills, community health counselling and specialist mental health services.

General Practitioners in Community Health Services strategy

DHS, May 2004

The General Practitioners (GPs) in Community Health Services (CHSs) Strategy is the Government strategy for the delivery of their commitment to recruit GPs and expand general practice services within CHSs.

The GPs in CHSs strategy aims to:

1. Improve access to general practice, particularly for Victorians experiencing difficulty accessing a GP
2. Generate genuine service integration and coordination between GPs and CHSs
3. Improve workforce capacity for CHS medical teams.

The strategy outcomes will include:

- Increased numbers and capacity of GPs and other medical staff in CHSs
- Increased quality bulk billing services, including extended hours, new medical sites and specialised medical services
- More financially viable and sustainable CHS GP services
- CHSs that are integrated and coordinated with general practices
- Reduced demand on hospital emergency departments
- Increased revenue to CHSs through Medicare and Health Insurance Commission (HIC) incentive payments.

Implementation Plan for Primary Care Partnerships 2004-2006

DHS, August 2004

PCPs were initiated in 2000 and have been able to achieve a number of excellent health outcomes through collaboration of primary care providers to date. Major partners in PCPs include: GP Division, CHSs, LGAs, District Nursing, and metropolitan health services.

The following implementation goals have been set for July 2004 to July 2006: (only those relevant to this project have been listed)

Partnerships

- Partnerships for flexible and effective responses to new initiatives
- Common staff development opportunities
- Integrated approaches to chronic and complex disease management approaches

Integrated Health Promotion

- Common approach to health and well-being of a catchment area
- Improved outcomes for disadvantaged communities, esp. Neighbourhood Renewal programs
- Programs to measure change in catchment priority areas

Service Co-ordination

- Integrated service delivery for specific population groups across programs and GPs
- E-referral
- Integrated waiting lists for common services
- Simplified entry and streamlined assessment processes.

Key topic areas: These topic areas are vital to reducing avoidable hospital admissions (ACSCs) and the overall burden of disease.

- Physical activity
- Food and nutrition,
- Mental well-being and social connectedness,
- Tobacco, Alcohol and other Drugs,
- Healthy weight

These topic areas link in with various State and Federal policy initiatives including:

- Obesity and diabetes prevention strategies with emphasis on physical activity, health eating and weight management.
- Neighbourhood renewal.
- Australian National health priorities (diabetes, Cardio Vascular Disease, mental health, injury, arthritis, asthma).
- Australian Government "Be Active Australia" initiative.

Hospital Admissions Risk Program (HARP): Reducing the avoidable use of hospitals, DHS

This funding initiative is aimed at providing better health for Victorians through preventing the avoidable use of hospitals.

HARP will do this by:

1. Developing preventive models of care that involve both the hospital and the

<p>community,</p> <ol style="list-style-type: none">2. Focusing on people who have a manifest health need, often where their disease or condition is chronic or complex, and3. Giving priority to high volume and/or frequent users of the acute public hospital system. <p>HARP funding has been provided to create additional capacity to treat, care for and proactively manage people in the most appropriate environment possible. It will support people's ability to remain in their normal living environment by emphasising an integrated approach to their care.</p> <p>The HARP working parties reflect the key priorities for this funding initiative:</p> <ul style="list-style-type: none">• Chronic Health Disease• Chronic Obstructive Pulmonary Disease (COPD)• GP/Hospital interface• Community Health/ Hospital interface• Mental Health• Technology
Dementia Framework for Victoria, 2005 and Beyond DHS December 2004
<p>This framework is still being finalised but the following main areas of focus are being suggested:</p> <ul style="list-style-type: none">• Risk reduction and prevention of dementia through health and active living• Early, middle and late stages of dementia <p>The main role for community health is likely to be in risk reduction and the early stages of dementia. More specifically, these include:</p> <ul style="list-style-type: none">• Community awareness raising and risk reduction through quitting smoking, reducing hypertension and high cholesterol, mental and physical activity, healthy diet and weight• Encourage options for travel and mobility such as community transport• Early planning for dementia• Community education and accessibility to information• Out-post community practitioners including nurses and allied health practitioners to help keep people out of hospital• HARP initiatives• Support for carers• Providing social activity groups
Improving Care for Older People DHS, November 2003
<p>The policy recommends three fundamental principles in considering how to improve and integrate care of older people:</p> <ol style="list-style-type: none">1. A person-centred approach to providing care and service2. A need for service providers to have a better understanding of the complexity of needs3. Improved integration between community-based programs, support services, providers and health services. <p>The policy also outlines planning for Centre Promoting Health Independence for each of the DHS regions. These centres will provide a wide range of services for the elderly, including</p>

services for the prevention, treatment and management of disabling conditions.

Community Health Plan 2004 - 2006

Kingston/Bayside Primary Care Partnership

The Kingston/Bayside PCP members consider that the alliance is one of cooperation where integrated health promotion plans are the priority. The priorities for this period include:

Mental Well Being and Social Connectedness

- Older People
- Younger Women at risk of homelessness who are at risk of homelessness and who are pregnant or parenting

Physical Activity

- Older People

Capacity Building

- Increased health outcomes in Kingston and Bayside communities

Victorian State Disability Plan 2002-2012

The State Disability Plan outlines a new approach to disability for the Victorian Government and the Victorian community as a whole. The approach reaffirms the rights that people with a disability have, to live and participate in the community as citizens of Victoria.

The three key goals are:

- Pursuing individual lifestyles – including the reorientation of disability supports so that they are more responsive and more focussed on people’s individual needs and choices, and to the needs of their families and carers
- Building inclusive communities – strengthening communities so that people with a disability have the same opportunities as all other citizens to participate in the life of the community – socially, economically, politically and spiritually
- Leading the way – improving the accessibility and responsiveness of public services and making them more inclusive of people with a disability.

Five priority strategies are listed as:

- Reorient disability support – including introducing an individualised planning and support framework; development of housing options; strengthening links with generic agencies; and targeting disability supports.
- Develop strong foundations for disability supports – including developing an Industry Plan to reorient supports; improving quality through introduction of a provider approval program; strengthening the workforce; and reviewing legislation.
- Promote and protect people’s rights – including strengthening the advocacy sector; increasing accountability; and enhancing community supports and services to better respond to the needs of people with a disability.
- Strengthen local communities – including building more inclusive communities and increasing community awareness of disability; promoting opportunities for community participation; and integrated approaches to planning.
- Make public services accessible – including inclusive education environments; more accessible transport; improved access to health services; promotion of employment opportunities; and providing advice to other government organisations to develop Disability Action Plans.

Fairer Victoria

Department of Premier and Cabinet, April 2005

This policy is the most recent social policy statement provided by the Victorian Government and will set the direction for social policy priorities for the foreseeable future. Although the policy does not include specific health initiatives, the resulting funding priorities will have an impact on community health service providers.

The key aim of this policy is addressing pockets of extreme disadvantage that exist in spite of the many advances within this state in recent years.

The key principles of the framework are:

- Ensuring that universal services provide equal opportunity for all
- Reducing barriers to opportunity
- Strengthening assistance to disadvantaged groups
- Providing targeted support to the highest risk area
- Involving communities in decisions affecting their lives and making it easier to work with Government

Key initiatives will be focussed on:

- Access to universal services
- Reducing barriers to opportunity
- Support for disadvantaged groups
- Support for disadvantaged places
- Making it easier to work with Government

In addition, the DHS is in the process of finalising an Ambulatory Care Framework – public submissions on the draft closed in early September 2005 – which gathers together many of the policy themes mentioned above into a coherent framework. Reference is made throughout the rest of this document to many elements of the Ambulatory Care Framework (ACF).

3.2.2 KEY THEMES IN POLICY AND PLANNING DOCUMENTS

It is worth noting that there is considerable consistency in the priorities set by these policy initiatives. The key themes are summarised below.

Service Planning

- Coordination and collaboration between various providers of health care and community services
- Integrated Health Promotion and Prevention
- Reduction of avoidable hospital admissions
- Integrated planning
- Community capacity building and improved access for the disadvantaged
- Building partnerships with other community organisations

Disease Management

- Diabetes
- Chronic heart disease
- Mental Health
- Asthma
- Chronic Obstructive Pulmonary Disease (chronic bronchitis and emphysema)

Health Promotion Priorities

The following health promotion priorities provide prevention and control of the major diseases that contribute to the burden of disease in Victoria and represent cost-effective and simple measures for improving a range of health outcomes.

- Physical activity
- Healthy weight/healthy eating
- Smoking, alcohol and other drugs
- Social connectedness/capacity building

3.2.3 IMPLICATIONS FOR CBCHS

These themes should be taken into account when planning services that are “future proof” and help to position CBCHS as a leading provider of health services. They are also reflected in the suggested strategic priorities at the end of this report.

4 Community Health Outlook 2005 - 2016

This chapter aims to provide an overview of the health of the local community. An improved understanding of the causes of ill-health, disability and death, provides a focus for health promotion planning and for the prevention and treatment of conditions that have a negative impact on the health of the community. The overview will take into account burden of disease and health risk factors and then consider the financial implications of improving the health of the local community.

This information will provide a context for planning and decision making at CBCHS and suggest priorities for long-term service planning for CBCHS. However, additional data will need to be taken into account when planning for individual services and is outlined in the utilisation projections and service snapshots which form part of this report.

Another limitation of this data is that it does not measure the impact on quality of life caused by individual contributors to burden of disease. The measure for Years Lost through Disability (YLDs) does provide some indication of those factors that impact upon the quality of life through being unwell.

4.1 Burden of Disease

In assessing the likely areas of need for the community, an analysis of burden of disease and health risk factors provides some guidance for clinical and health promotion planning.

Traditionally this information has focussed on causes of death, but increasingly there is good data on causes of disability. "Disability" in this context is best defined as ill health or disease with non-fatal outcomes. This measure is particularly important for Community Health where the focus is on providing preventative care as well as support for chronic illness or disability.

Victoria is one of the only states in Australia to have conducted a detailed analysis of the burden of disease by LGA and region. The information relevant to the Southern Metropolitan region has been compiled in *The Southern Metropolitan Burden of Disease Study: Mortality and Morbidity, 2000*. The study uses the methods developed for the Global Burden of Disease Study adapted to the Victorian context. It provides a comprehensive assessment of the amount of ill health, the 'burden of disease', in Victoria, Australia in 1996 and projected to the year 2016.

The information most relevant to service planning in Kingston has been compiled in the sections below.

4.1.1 LIFE EXPECTANCY

Life Expectancy measures are frequently used to reflect the overall improvement of health in a geographical region over time. The following statistics provide a comparison between Kingston and neighbouring LGAs as well as Victoria and the

SMR. Overall these statistics indicate that rates of life expectancy are high in Kingston compared with other geographical regions.

Life Expectancy Changes	Life Expectancy 1992-1996	Life Expectancy 1997-2001	% Change between 1992-1996 and 1997-2001
MALES			
Victoria	75.6	77.4	2.3%
SMR	75.8	78.2	2.6%
Kingston	75.7	78.2	3.2%
Bayside	77.6	79.5	2.6%
Glen Eira	76.8	78.6	2.3%
FEMALES			
Victoria	82.4	82.7	1.6%
SMR	81.4	82.8	1.8%
Kingston	81.5	82.5	1.3%
Bayside	82.5	83.9	1.6%
Glen Eira	82.3	83.8	1.9%

From the Victorian Burden of Disease Study: Mortality and Morbidity 2000 Data Tables

Worth noting

- The overall improvement for male life expectancy (3.2%) was one of the highest in the state with an increase from 75.7 to 78.2 years in one decade. If this trend continues, the gap between these LGAs is likely to narrow.
- The rate of improvement for life expectancy in women is significantly lower than elsewhere in the state, suggesting that health promotions targeted at women should be considered in Kingston.

4.1.2 CAUSES OF DEATH

The causes of death listed below represent averages of five years for the Kingston LGA and provide an indication of factors contributing to Burden of Disease.

Causes of Death for Males and Females in Kingston, 1996							
Males				Females			
Rank	Disease		%	Rank	Disease		%
1	Ischaemic heart disease	150	26.9	1	Ischaemic heart disease	140	26.7
2	Stroke	44	7.8	2	Stroke	64	12.2
3	Lung cancer	43	7.8	3	Breast cancer	27	5.1
4	COPD	36	6.4	4	COPD	23	4.4
5	Colon/Rectum Cancer	22	3.9	5	Lung cancer	22	4.2
6	Prostate cancer	20	3.6	6	Colon/Rectum Cancer	22	4.1
7	Diabetes mellitus	17	3.0	7	Dementia	17	3.3
8	Suicide	14	2.5	8	Ovarian cancer	11	2.1
9	Dementia	9	1.7	9	Diabetes mellitus	11	2.1
10	Lymphoma	9	1.6	10	Peripheral vascular disease	10	1.9

Source: Victorian Burden of Disease Study: Mortality and Morbidity 2000

Worth noting:

- Deaths (male) caused through smoking (lung cancer and COPD) are responsible for 14.2% of deaths in the catchment. If combined, these two causes would rank as the second leading cause of death. If other smoking related illnesses were added, the impact of smoking in this region would become even more significant. Interventions to reduce the level of smoking will clearly have a significant impact on improving the health of the community. Reducing levels of smoking will also have a positive effect on incidence of diabetes and heart disease.
- Smoking related illnesses are of less significance for women than for men. However, given that predictions are for a 25% increase in smoking for women, this issue will continue to merit significant attention.
- Dementia is already a significant cause of death for women. With a predicted rise of 68% to 2016, this will become a very significant contributor to the burden of disease in the future. This is likely to increase the need for carer support, adult day activities, occupational therapy, podiatry and other services for the elderly.

4.1.3 HEALTH STATUS BY DISABILITY ADJUSTED LIFE YEARS (DALYS)

Traditionally, the burden of disease was measured by collecting information on causes of death. However, increasingly the interest of health professionals has been in the causes of disability or lost quality of life.

The DALY is a measure of the disease burden in a population combining the loss of years of life due to premature mortality and the loss of healthy years of life due to disease or injury. One DALY can be thought of as one lost year of healthy life. The DALY is a so-called health gap measure. This means that the burden of disease is measured as the gap between the current health status of the population and an ideal where everyone lives into old age, free of disease or injury. The term disability is used quite broadly, in this sense, to include all departures from complete health due to disease or injury.

The DALY estimates provide insight into the potential for further health gain at the population level. The total burden estimates portray the relative ranking of the importance of the major diseases confronting the populations in LGAs. However, the burden of disease is an estimate of health status, which cannot be divorced from past and present efforts to address the health needs of the population. The burden attributable to many diseases is small, due to the continuing successful health programs to contain and address these conditions. This is particularly true of maternal and early childhood conditions, along with certain infectious diseases. Other diseases such as cardiovascular disease, cancer and mental disorders, continue to be major contributors to the overall burden of disease despite efforts to prevent and treat them. (from *The Southern Metropolitan Burden of Disease Study: Mortality and Morbidity, 2000*)

Ranking by DALYs for MALES, 1996					
Kingston			Southern Metropolitan Region		
Rank	Disease	%	Rank	Disease	%
1	Ischaemic heart disease	15.3	1	Ischaemic heart disease	14.2
2	Lung cancer	5.3	2	Stroke	4.8
3	Stroke	5.2	3	Lung cancer	4.6
4	COPD	4.7	4	COPD	4.4
5	Diabetes mellitus	3.3	5	Diabetes mellitus	3.2

6	Suicide	3.3	6	Depression	3.0
7	Colon/Rectum Cancer	3.0	7	Suicide	3.0
8	Depression	2.9	8	Colon/Rectum Cancer	2.9
9	Prostate cancer	2.8	9	Prostate cancer	2.8
10	Hearing loss	2.7	10	Dementia	2.8

From the Victorian Burden of Disease Study: Mortality and Morbidity 2000

Worth noting

- Lung cancer is a major cause of death in men in Kingston with 5.3% of DALYs. This is 2.2% higher than for females in the same LGA and 0.7% higher than for males in the SMR.
- Diabetes rates for men in Kingston are also higher than in the SMR and higher than for females.
- Rates for depression and dementia are slightly lower for males in Kingston than for the SMR. However, with the predicted increase in the aged population, this is likely to rise considerably.

Ranking by DALYs for FEMALES, 1996					
Kingston			Southern Metropolitan Region		
Rank	Disease	%	Rank	Disease	%
1	Ischaemic heart disease	12.6	1	Ischaemic heart disease	11.7
2	Stroke	6.6	2	Stroke	6.6
3	Breast cancer	5.7	3	Breast cancer	5.6
4	Depression	4.7	4	Dementia	4.9
5	Dementia	4.5	5	Depression	4.7
6	COPD	3.7	6	COPD	3.5
7	Osteoarthritis	3.3	7	Osteoarthritis	3.3
8	Lung cancer	3.1	8	Diabetes mellitus	3.0
9	Colon/Rectum Cancer	3.1	9	Colon/Rectum Cancer	3.0
10	Diabetes mellitus	2.9	10	Asthma	2.9

From the Victorian Burden of Disease Study: Mortality and Morbidity 2000

Worth noting

- **Lung Cancer** is ranked 8th largest contributor to DALYs for Kingston while it is 11th highest for SMR, suggesting that the use of tobacco is particularly high in Kingston.
- **Ovarian Cancer** rates are 0.6% higher than in the SMR and are ranked 12th in Kingston compared with 16th for SMR
- After heart diseases and cancer, **depression and dementia** are the biggest causes of death and disability for women in Kingston

BURDEN OF DISEASE DUE TO DISABILITY

Years Lived with Disability (YLD) are the morbidity component of the DALY that captures the burden in a population due to years lived in less than full health. It represents the years of healthy life lost due to living with disability, disease or injury, adjusted for severity. The estimates of YLD allow the relative ranking of the importance of non-fatal disease and injury.

The inclusion of the non-fatal health outcomes component provides a substantially different picture from that of traditional mortality based assessments of population health. It allows for the impact of mental disorders, hearing loss, arthritis and other painful or disabling but non-fatal conditions to be included. The importance of these diseases to the population, which has been hidden in earlier health status measures, is now made more explicit.

Particularly for Community Health, where service provision is focussed on non-acute and chronic conditions, the YLD provides a useful picture of the health support needs of the local population.

The table below provides some information on rankings for Kingston, with information about neighbouring LGAs provided for comparison.

Ranking of YLD by Causes for 3 LGA's, 1996								
Bayside			Glen Eira			Kingston		
Rank	Disease	%	Rank	Disease	%	Rank	Disease	%
1	Dementia	7.7	1	Dementia	7.6	1	Depression	8.7
2	Depression	6.8	2	Depression	7.1	2	Dementia	6.0
3	Osteoarthritis	6.7	3	Osteoarthritis	6.0	3	Osteoarthritis	5.6
4	Hearing loss	5.6	4	Hearing loss	5.2	4	Hearing loss	4.8
5	Stroke	4.1	5	Asthma	4.0	5	Asthma	4.7
6	Asthma	4.1	6	Stroke	3.9	6	Diabetes	4.0

							mellitus	
7	Ischaemic heart disease	3.6	7	Ischaemic heart disease	3.6	7	Alcohol abuse/depend	3.9
8	Diabetes mellitus	3.4	8	Diabetes mellitus	3.3	8	COPD	3.9
9	Other vision disorders	3.4	9	COPD	3.2	9	Stroke	3.7
10	Alcohol abuse/depend	3.0	10	Alcohol abuse/depend	3.0	10	Ischaemic heart disease	3.2
11	COPD	2.8	11	Other vision disorders	3.0	11	GAD	2.8
12	Parkinson's	2.8	12	Parkinson's	2.6	12	Other vision disorders	2.3
13	GAD	2.4	13	GAD	2.4	13	Parkinson's	2.2
14	Breast cancer	2.3	14	Breast cancer	2.2	14	Breast cancer	1.7
15	Colon/Rectum Cancer	1.8	15	Colon/Rectum Cancer	1.8	15	BPD	1.6

Worth noting

- For all three LGAs, **dementia and depression** account for the two greatest causes of ill-health (YLD). While these conditions do not lead to death at the same rate as cardiovascular conditions, for example, they tend to cause problems over the longer term and thus contribute to significant increase in the levels of ill-health for the population
- Although Kingston has a higher proportion of elderly persons, it has a slightly lower burden through dementia but a significantly higher burden through depression.
- Alcohol abuse/dependency is 0.9 % higher for Kingston than the other two LGAs.

4.1.5 BURDEN OF DISEASE PROJECTIONS FOR 2016 FOR VICTORIA

The Victorian Burden of Disease Study 2000 uses some of the data collected to project forward to the year 2016 to indicate changes in the burden of disease or the health status of Victorians.

Fortunately, the overall projections are for a 17% reduction of the major disease groups for men and 25% for women.

These projections are based on fairly simple mathematical extrapolations with some adjustments for particular risk factors. However, the burden attributable to risk factors is particularly difficult to predict.

Projections of differences of age-standardised DALY rates compared between 1996 and 2016				
Causes	Males	Trend	Females	Trend
All Causes	-25%	↓	-17%	↓
All Causes YLL	-35%	↓	-30%	↓
All Causes YLD	-11%	↓	-4%	↓
Cardiovascular Diseases	-54%	↓	-50%	↓
All Cancers	-16%	↓	-12%	↓
Lung Cancer	-38%	↓	25%	↑↑
Prostate Cancer	22%	↑↑		
Mental Disorders	19%	↑↑	-1%	
Neurological and sense disorders	-2%	↓	28%	↑↑
Dementia	4%	↑↑	68%	↑↑
Chronic respiratory diseases	-44%	↓	-15%	↓
Diabetes Mellitus	24%	↑↑	13%	↑↑
Heroin Abuse	152%	↑↑	-3%	↓

Source: Victorian Burden of Disease Study: Morbidity 2000

Worth noting

- The large gap in YLL and YLD rates suggests that gains in life expectancy may occur at the expense of loss of quality of life.
- Dementia is predicted to rise by 68% for women.
- Lung Cancer is likely to rise by 25% in women.
- Neurological and sense disorders are predicted to rise by 28% for women.
- Diabetes will increase at a faster rate in men than in women and become the fifth largest disease group.
- Death from heroin abuse is likely to rise if the trends from the 1990's continue but are difficult to predict.
- Significant improvements are expected in cardiovascular health except inflammatory heart disease.

4.2 Risk Factors

Health risk factors are useful in assessing the extent to which the health and lifestyle behaviours of the population may contribute to current and future burden of disease.

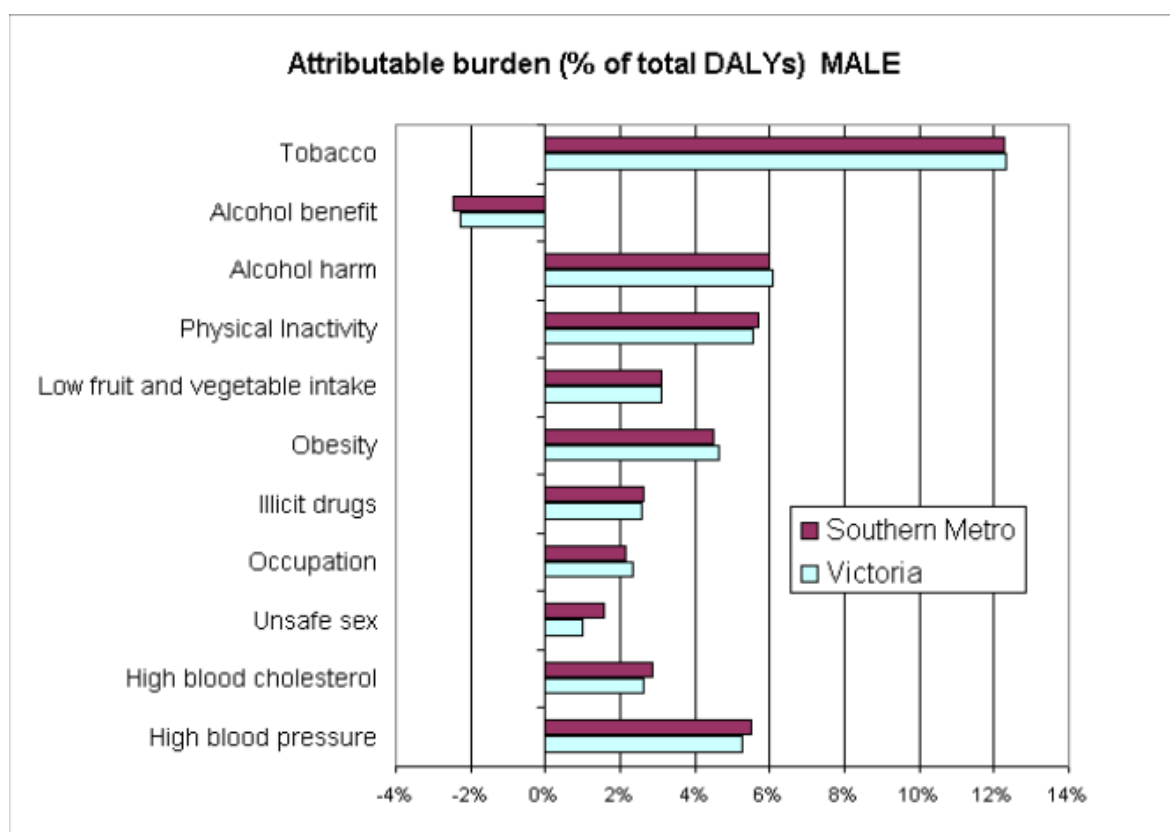
In most cases, health promotion and screening activities are the most effective means of changing lifestyle habits. However, it is difficult to predict the effectiveness of health promotion strategies unless they have been tested in a population-based longitudinal study in an environment with similar population characteristics.

4.2.1 AVAILABILITY OF LOCAL DATA

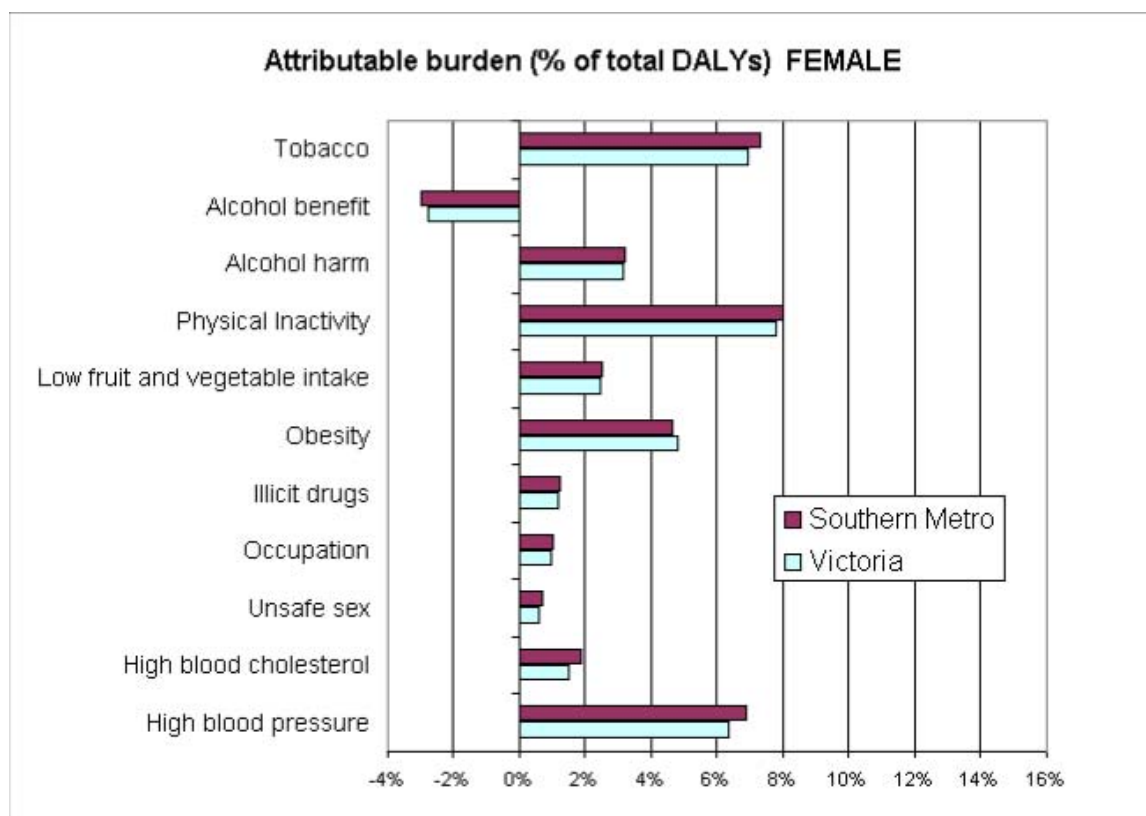
This data is only available at the regional level and so a separate analysis of Kingston is not possible. However, data on risk is collected much more frequently than the data on disease and disability, thus making it relevant to the planning of CBCHS services.

4.2.2 GENERAL RISK FACTORS

The following graphs demonstrate the risk factors and the percentage contribution to overall burden of disease in the SMR.



Females



Worth noting

- For both males and females, but particularly for men, tobacco use is the largest contributor to health risk. However, for females the profile is slightly worse than for the rest of Victoria.
- Lifestyle issues such as low fruit and vegetable intake and lack of physical activity present greater risk than some of the more widely acknowledged risks, such as high blood cholesterol
- For women lack of physical activity is the second biggest risk factor.

4.2.3 PREVALENCE OF KEY RISK FACTORS

The table below indicates the prevalence of selected risk factors for the Southern Metropolitan Region and Victoria. This information is not currently available at the LGA level.

Risk Factor	Measure	Victoria		SMR	
		Males %	Females %	Males %	Females %
Fruit intake	Meeting recommended intake level	43.7	57.6	39.9	53.5

Veg intake	Meeting recommended intake level	9.9	13.9	10.9	12.3
Fruit & Veg	Meeting recommended intake level	n/a	n/a	4.6	4.6
Alcohol	Drinking at risk levels weekly	47.0	61.1	n/a	n/a
Obesity	Overweight/Obese using BMI	54.3	37.9	52.5	34.6
Dental	Check in past two years	61.3	67.4	n/a	n/a
Isolation	Not able to get help from family/friends	9.6	7.8	n/a	n/a

Victorian Population Health Survey, DHS, 2003

Of particular concern:

- Two thirds of women are at risk of weekly harmful drinking
- Less than 10% of men eat enough vegetables
- Less than 5% of men and women eat enough fruit and vegetables
- Almost 10% of men lack basic social support
- More than half of the men in the SMR are obese or overweight.

4.2.4 WHY FOCUS ON RISK FACTORS? - CONSEQUENCES OF KEY RISK FACTORS

It is important to acknowledge the wide-ranging implication of some of the key health and lifestyle risk factors. Three examples are outlined below:

Tobacco is a major risk factor for:

- Coronary Heart Disease
- Stroke
- Peripheral vascular disease
- Numerous cancers – especially lung cancer

Obesity is a major risk factor for the following conditions (taken from the Australian Society for the Study of Obesity):

- Cardiovascular / heart disease
- Type 2 diabetes / insulin resistance
- High blood pressure / hypertension
- High blood cholesterol
- Gallbladder disease
- Osteoarthritis
- Gout
- Certain types of cancer (breast, endometrial, cervical, colon, prostate, etc.)
- Polycystic ovary syndrome
- Impaired fertility
- Breathlessness
- Sleep apnoea
- Premature death
- Depression and low self-esteem

Lack of physical activity

Physical activity is a key means of improving health. Apart from contributing to improved mental health and less risk of falls and injury, it also benefits health by reducing the risk of:

- Coronary Heart Disease
- Stroke
- Hypertension
- Type 2 Diabetes
- Colon Cancer
- Osteoporosis

4.2.5 RISK THROUGH SOCIOECONOMIC DISADVANTAGE

There is increasing amount of evidence that socioeconomic disadvantage and/or poverty is one of the biggest predictors of health risk. *The Victorian Population Health Survey, 2003*, provides a detailed analysis. The table below provides a selection of findings for the Southern Metropolitan Region:

Annual Household Income	% adults reporting poor health	% adults seeking help for mental health problem in past 12 months	% reporting severe mental stress *
< \$20,000	21.6	7.9	5.3
\$20 -40,000	15.0	7.8	2.4
\$40-60,000	8.22	2.8	0.0
> \$60,000	10.3	5.5	1.5

- Study utilises the Kessler 10 score of 30 or more

4.2.6 IMPLICATIONS FOR CBCHS

This brief analysis of risk factors suggests that CBCHS could have a significant impact on improving the health of its population by focussing on reducing the level of risk caused by:

- Poor diet
- Lack of exercise
- Smoking, drugs and alcohol
- Social isolation

Specific strategies for different parts of the population are best determined by health professionals working in different CBCHS services. Unfortunately, it is very difficult to predict the impact of individual initiatives or to measure their impact in improving the health of the population, but this should not discourage service

providers from employing those strategies that are widely known to result in improved health.

4.3 Some Economic Dimensions

Clearly one of the biggest challenges for planning health services is dealing with growing needs without unnecessarily increasing the cost of providing health services

The primary and community health sector has the ability to make a significant contribution towards preventing a “blow-out” of costs by improving prevention and control of costly health conditions.

The section below provides a focus on the potential for savings by demonstrating:

- The opportunity to reduce hospital admissions through a reduction of Ambulatory Care Sensitive Conditions (ACSCs) in the combined catchment area for CBCHS and Bentleigh Bayside Community Health Service.
- Using diabetes and smoking related illness to illustrate the cost of preventable conditions

4.3.1 AMBULATORY CARE SENSITIVE CONDITIONS (ACSCs)

ACSCs are conditions for which hospitalisation is thought to be avoidable through a combination of prevention and early disease management. Generally the best setting for providing this care is in ambulatory or community settings. This has led to the concept of **preventable or avoidable hospitalisation as an indicator of health outcomes for evaluating quality of primary care.**

In recent times, rates of ACSCs have also been used to monitor a range of indicators of the Victorian health system and to provide planning tools for health services.

They are used to:

- Develop targeted strategies to reduce use of hospitals and Emergency Department services
- Evaluate existing strategies for primary care
- Develop performance indicators for the health system
- Suggest degrees of potential avoidability of certain presentations

4.3.2 WHY SHOULD CBCHS USE ASCS AS A FOCUS FOR PLANNING?

Targeting ACSCs has the potential to produce significant savings for the health system. The cost of one hospital bed day lies between \$500 and \$900 per person with ICU beds costing \$2,000 or more per day. Reducing hospital admissions therefore represents a good way of managing scarce health resources.

More importantly, hospitalisation is not a good health outcome for any member of the community. Hospital admissions are associated with significant ill-health and discomfort for individuals and their families. Reducing the burden of ill-health for our community should be the aim of any health service – particularly for primary

and community health where such interventions can be carried out very appropriately.

It is also clear that targeting of ASCs will continue to be a major focus for government funding decisions. Initiatives such as HARP (hospital admission risk program) have been a very prominent part of recent budgets for primary and community health. All indications are that HARP-like initiatives will continue to feature in future government planning because it is widely recognised that this is one of most effective ways of reducing health expenditure while also achieving better health outcomes.

As outlined in the following sections, even a relatively modest reduction of ACSCs can result in significant reduction of hospital bed days – potentially creating savings for the health system.

Expenditure on ACSCs is particularly high in the Southern Metropolitan Region thus making the potential for savings worth considering. *The Victorian Ambulatory Care Sensitive Conditions Study* provides some information at the PCP level while other information is only available for the region. The report makes a number of observations:

- The SMR's expenditure of funding for ACSCs admissions was more than double that of other metropolitan regions
- Admissions for ACSCs in the region equated to about \$109m in hospital expenditure in 2000-01. More than 84% of this hospital expenditure was attributable to the top 10 ACSCs
- The SMR has the highest rate for diabetes complications for Victoria
- There were 35,329 admissions for ACSCs in this region in 2000-01 with an average of 4.95 bed days. This would account for a total of 174,878 bed days
- Diabetes complications accounted for the highest number of ACSCs in the SMR and resulted in expenditure of \$39.7m

4.3.3 OPPORTUNITIES FOR TARGETED INTERVENTIONS

A number of Ambulatory Care Sensitive Conditions have been selected by DHS as most likely to achieve improvement in hospital admission rates. They fall into three basic groups:

1. Vaccine preventable ACSCs
2. Acute ACSCs
3. Chronic ACSCs

The following information has been selected from the *Victorian Ambulatory Care Sensitive Conditions Study: Opportunity for Targeted Interventions, 2001*. The information about the local catchment area includes the area serviced by Bentleigh Bayside Community Health and therefore includes data about Glen Eira, Bayside and Kingston.

ASTHMA

Asthma in Victoria

Asthma Admissions in Victoria	
Admissions in 1999-00	10,079
Average stay	2.71 bed days
Bed days (approx)	27,300
Decline in admission rates in metro regions	26% in 7 years

Victorian Ambulatory Care Sensitive Conditions Study: 2001

The report further states that if admission rates were reduced we would achieve the following savings:

- 8,161 bed days through a 30% reduction in admissions
- \$3.5m of hospital expenditure through a 40% reduction in the PCPs with the highest incidence and 23% reduction in the remaining PCPs

Asthma in the target catchment:

The following table shows that in 1996 more than 21,000 people in the local catchment area had Asthma.

Prevalent Cases, for the Sum of Males & Females with Asthma in 3 LGAs, 1996										
	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75+	Total
Bayside	257	1124	591	529	717	736	435	431	380	5199
Glen Eira	365	1386	932	998	1011	869	600	615	487	7263
Kingston	476	1830	1164	1117	1135	1103	804	639	427	8694

From the Victorian Burden of Disease Study: Mortality and Morbidity 2000

Asthma admissions to public hospitals in 2003/04 in local catchment			
Region	Separations	Approx. Bed days (avg stay =2.71)*	Savings thru 20% reduction
Bayside	143	387	295 bed days potentially saved
Glen Eira	163	441	
Kingston	235	636	
Totals	541	1,464 bed days	

From VAED data 2003/04 supplied by DHS Southern Metropolitan Regional Office

**Bed days estimates based on *Victorian Ambulatory Care Sensitive Conditions Study: 2001 as outlined above*

Worth noting

If asthma admissions in the catchment area were reduced by 20 %, approximately 295 bed days could be saved each year.

CARDIOVASCULAR CONDITONS

Cardiovascular conditions include three major groups: angina, hypertension and congestive cardiac failure. These have been analysed in detail below.

ANGINA

Angina Admissions in Victoria	
Admissions in 200-01	13,814
Average stay	2.78 bed days
Total bed days (approx)	38,400
Admissions through ED	70% or 9,908
Highest rate in metro regions	Southern Metro

The report further concludes that if admission rates were reduced by 20% then:

- There would be a savings of 7,680 bed days
- \$4.7 million of hospital expenditure would be saved

Angina in the Catchment Area

Prevalent Cases, for the Sum of Males & Females with IHD: Angina, 1996										
	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75+	Total
Bayside	0	0	0	4	17	69	137	287	491	1004
Glen Eira	0	0	0	8	25	86	197	432	675	1423
Kingston	0	0	0	8	26	100	242	412	541	1329

From the Victorian Burden of Disease Study: Mortality and Morbidity 2000

Angina admissions for public hospitals in 2003/04 in 3 LGAs			
	Separations	Approx. Bed days* (avg stay 2.8 days)	Savings thru 20% reduction*
Bayside	397	1,111	530 bed days potentially saved
Glen Eira	203	568	
Kingston	348	974	
Totals	948	2,652	

From VAED data 2003/04 supplied by DHS Southern Metropolitan Regional Office

**Bed days estimates based on *Victorian Ambulatory Care Sensitive Conditions Study: 2001 as outlined above*

Worth noting

If angina admissions in the catchment area were reduced by 20 %, approximately 530 bed days could be saved each year.

HYPERTENSION

Hypertension Admissions in Victoria	
Admissions in 2000-01	989
Average stay	3.76 bed days
Total Bed days (approx)	3,700
Admissions through ED departments	60%
Decline in admission rates of past 8 years	None

Victorian Ambulatory Care Sensitive Conditions Study: 2001

The report further concludes that if admission rates were reduced by 20% then:

- ➔ There would be a savings of 743 bed days
- ➔ \$2.5 million of hospital expenditure would be saved

Prevalent Cases, for the Sum of Males & Females with Hypertensive heart disease, 1996										
Region	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75+	Total
Bayside	0	0	0	0	0	0	1	3	30	34
Glen Eira	0	0	0	0	0	0	1	4	38	44
Kingston	0	0	0	0	0	0	1	4	29	35

From the Victorian Burden of Disease Study: Mortality and Morbidity 2000

Hypertension admissions for public hospitals in 2003/04 in Catchment Area			
Region	Separations	Approx. Bed days (avg stay =3.76)	Savings thru 20% reduction
Bayside	230	977	615 bed days potentially saved
Glen Eira	280	1,052	
Kingston	307	1,154	
TOTALS	817	3,071	

From VAED data 2003/04 supplied by DHS Southern Metropolitan Regional Office

**Bed days estimates based on *Victorian Ambulatory Care Sensitive Conditions Study: 2001 as outlined above*

Worth noting

If hypertension admissions in the catchment area were reduced by 20 %, approximately 615 bed days could be saved each year.

CONGESTIVE CARDIAC FAILURES (CCF)

CCF Admissions in Victoria	
Admissions in 200-01	8,359
Average stay	7.37 bed days

Total Bed days (approx)	61,600
Admissions through ED	74% or 6,215
Decline in admissions over 8 years	Significant

Victorian Ambulatory Care Sensitive Conditions Study: 2001

The report further concludes that if admission rates in Victoria were reduced by 20% then:

- ➔ There would be a savings of 12,321 bed days
- ➔ \$4.7 million of hospital expenditure would be saved

CCF admissions for public hospitals in 2003/04 in Catchment Area			
Region	Separations	Approx. Bed days (avg stay =7.37)	Savings thru 20% reduction
Bayside	183	1,348	958 bed days potentially saved
Glen Eira	228	1,680	
Kingston	239	1,761	
TOTALS		4,789	

From VAED data 2003/04 supplied by DHS Southern Metropolitan Regional Office

**Bed days estimates based on *Victorian Ambulatory Care Sensitive Conditions Study: 2001 as outlined above*

Worth noting

If CCF admissions in the catchment area were reduced by 20 %, approximately 958 bed days could be saved each year.

Chronic Obstructive Pulmonary Disease (COPD)

COPD Admissions in Victoria	
Admissions in 2000-01	10,137
Average stay	7.33 bed days
Total Bed days (approx)	74,300
Admissions through ED	70%
Increase in admissions over 8 years	Double

Victorian Ambulatory Care Sensitive Conditions Study: 2001

The report further concludes that if admission rates were reduced by 20% then:

- ➔ There would be a savings of 14,860 bed days
- ➔ \$6.1 million of hospital expenditure would be saved

COPD admissions for public hospitals in 2003/04 in Catchment Area			
Region	Separations	Approx. Bed days* (avg = 7.33)	Savings thru 20% reduction*
Bayside	170	1,246	963 bed days potentially saved
Glen Eira	182	1,334	

Kingston	305	2,235
Totals	657	4,815 bed days

* From VAED data 2003/04 supplied by DHS Southern Metropolitan Regional Office

**Bed days estimates based on *Victorian Ambulatory Care Sensitive Conditions Study: 2001 as outlined above*

Worth noting

If COPD admissions in the catchment area were reduced by 20 %, approximately 963 bed days could be saved each year.

DIABETES COMPLICATIONS

Diabetes is one of the most significant ACSCs for the Southern Metropolitan Region.

The SMR has the highest number of admissions for any DHS region.

Diabetes Complications are generally grouped into two main groups:

1. Short-term complication including ketoacidosis and diabetic coma
2. Long-term complications including:
 - renal complications
 - ophthalmic complication
 - neurological complications
 - peripheral complications (including foot ulcers)
 - and other unspecified complications

Some facts about Diabetes Complications in Victoria:

Trends for Diabetes in Victoria

Overall trends in Victoria indicate that the burden of disease from diabetes is not likely to reduce in the near future.

The worst affected group is males over 65 years. Rates of long-term and short-term complications for all age – sex groups have risen similarly over the period. The following examples illustrate this trend:

Admissions with diabetes complications		
Year	Admissions	Rate per 1,000 population
1993-94	11,038	2.48
1998-99	13,618	2.88
2000-01	38,900	7.88
2001-02	43,884	8.67

Victorian Ambulatory Care Sensitive Conditions Study: 2001

Diabetes Complications in Victoria	
Admissions in 2001-02	43,884
Average stay	6.97 bed days
Bed days (approx)	305,870
Admissions with long-term complications	95.08 %
Repeat Admissions in one year	39.60 %
Increase in admission rates between 1993 and 2002	Tripled (partly due to more accurate records)

Victorian Ambulatory Care Sensitive Conditions Study: 2001

Diabetes Complications in Southern Metro Region and PCPs	
Admissions in 2001-02	10,004
Average stay	6.69 bed days
Bed days (approx)	66,926
Repeat Admissions in one year	41.83% (particularly for renal failure)
Increase in admission rates between 1993 and 2002	Tripled (partly due to more accurate records)

From the Victorian Burden of Disease Study: Mortality and Morbidity 2000

Diabetes complications admissions for public hospitals in 2003/04 in Catchment Area			
Region	Separations	Approx. Bed days (avg stay =6.69)	Savings thru 20% reduction
Bayside	482	3225	2,821 bed days potentially saved
Glen Eira	731	4890	
Kingston	896	5995	
Totals	2,109	14,109	

From VAED data 2003/04 supplied by DHS Southern Metropolitan Regional Office

**Bed days estimates based on *Victorian Ambulatory Care Sensitive Conditions Study: 2001 as outlined above*

Worth noting

If admissions from diabetes complications could be reduced in the catchment area by 20%, approximately 2,821 bed days could be saved each year.

4.3.4 IMPLICATIONS FOR CBCHS

As outlined in Section 4.3.2, ASCSs are likely to continue to be a major focus for funding bodies and decision makers. The arguments are too compelling to be ignored.

CBCHS has the opportunity to position itself as a significant provider of services that will help to improve hospitalisation rates. While community health in general has worked in relative isolation from the acute sector in the past, this will become increasingly untenable. Almost all government policy initiatives also emphasize the need for different parts of the health sector to work collaboratively, signalling that

services demonstrating their ability to respond to these directions are most likely to attract new funding. Proposals for new funding will be strengthened by a demonstrated ability to work collaboratively with other health services as well as being able to address the need to reduce hospital admission rates.

On the more positive side, many of the services currently being provided by CBCHS already have a significant role in reducing ASCs locally. The challenge now is to ensure that these services are more explicit in demonstrating their contribution in this regard.

4.4 Illustrating the Cost of Preventable Conditions

As indicated earlier, there is a direct link between burden of disease and health care costs. An exhaustive study of costs is not within the scope of this report but some examples will serve to illustrate the cost to the community.

The selected examples represent some of the biggest contributors to overall health costs in the Southern Metropolitan Region i.e.

- Diabetes and its complications
- Smoking related illness

4.4.1 THE COST OF DIABETES:

The most recent study on diabetes costs in Australia, *DiabCo\$t Australia* examines cost of diabetes in our community. The analysis examines four dimensions of cost:

1. Direct costs to the health system
2. Out-of-pocket expenses borne by people with Type 2 diabetes and their carers
3. Community resources used
4. Impact on quality of life.

Cost per person:

According to the study, the following average costs apply for Diabetes Type 2:

Cost dimension	Actual average cost per person per year
Direct Healthcare (hospital and ambulatory care)	\$ 4,260
Non health costs (special food, home support etc)	\$1,065
Additional cost for microvascular complications (eye problems, kidney damage, foot or leg ulcers)	\$3,000
Additional cost for macro vascular complications (heart attack, stroke, amputation)	\$5,030
Commonwealth Benefits (applies to most people with Type 2 diabetes)	\$5,540

Total cost for persons without complications (direct and indirect healthcare costs plus commonwealth benefits)	\$10,865
--	-----------------

Cost to the Kingston Community:

According to the studies on Ambulatory Care Sensitive Conditions conducted by DHS, the rate of Diabetes in the Southern Metropolitan Region (SMR) is 8.67%. If we assume that the rate in Kingston is similar to the SMR, we can assume the following:

- Approximately 12,000 people in Kingston suffer from Type 2 diabetes
- Their illness costs the community \$1.3 million each year without taking into account any costs for complications such as COPD, foot disease, kidney failure, loss of vision and much more.
- In addition the Kingston community bears the cost of some 6,000 bed days as a result of diabetes complications.

4.4.2 THE COST OF SMOKING RELATED ILLNESS

Smoking is the greatest contributor to risk of ill health as illustrated in the earlier discussion about health risks.

In March 2005 a study by the Cancer Council and Quit in Victoria resulted in a report called "The Tobacco Tragedy". It measures the cost of smoking in non-financial terms by indicating the causes of death.

Deaths including avoidable causes	Glen Eira	Kingston	Bayside	Kingston/ Bayside PCP
All deaths	(4154)	(4222)	(3144)	(7366)
Smoking	486	532	325	857
Alcohol	90	96	53	149
Other Drugs	19	15	12	27
Road accidents	34	38	13	51
Deaths due to Smoking				
Lung Cancer	185	204	111	315
Mouth and throat cancer	10	8	4	12
Other cancers	53	51	35	86
Heart disease	89	88	62	150
Stroke	31	32	25	56
Chronic bronchitis & emphysema	114	142	83	226

Taken from "The Tobacco Tragedy" Smoking in Victoria 1999-2002. Data for deaths during the four-year period 1999 – 2002 provided by the Cancer Epidemiology Centre, The Cancer Council Victoria, 1 Rathdowne Street, Carlton Vic 3053

4.4.3 IMPLICATIONS FOR CBCHS

The information provided on Burden of Disease and Ambulatory Care Sensitive Conditions in the sections above is valuable in providing an understanding of the needs of the local catchment. Individual services should utilise this information to inform decision-making about service provision.

At an organisational level, this information suggests priorities for management and prevention of chronic disease in the local catchment. It also suggests the areas where CBCHS can have the most significant impact in improving the health of the community are as follows:

Reducing levels of smoking

This will have significant impact on ASCSs such as COPD but will also help to reduce the level of diabetes complications and stroke. Over the longer term it will result in a reduction of lung cancer and other cancers as well as a range of conditions listed in *Section 4.2.4*.

Promoting physical activity and good eating habits

As indicated in *Section 4.2.2*, inactivity is the second highest risk factor for men and the highest risk factor for women. *Section 4.2.3* highlights the poor eating habits of our community. These lifestyle issues combine to contribute to growing obesity which also increases risk of a range of conditions and even cancers. (*Section 4.2.4*)

Promotion of a healthy lifestyle should not be left to dieticians alone. CBCHS should encourage all staff to increase their knowledge of the seriousness of this problem and be encouraged to recognise that it is within the capacity of all health professionals to encourage better lifestyle habits.

Providing support for mental health problems and dementia

It is clear from the burden of disease data that mental health problems, including those resulting in suicide, are significant contributors to ill-health and death in the local catchment. In addition the predicted increases in dementia and the ageing of the local population are alarming.

CBCHS should continue to have a significant role in meeting the needs of the community by continually increasing adult day care programs, carer support and counselling services. Staff should continue to be encouraged to recognise these conditions as chronic diseases that need to be treated as seriously as other chronic conditions.

In conclusion, all of these strategies should be employed across the various service areas within CBCHS to achieve greater impact on the health of the community. Some of these can be implemented through increased awareness with minimal cost and should therefore be encouraged wherever possible.

5 Projections of Service

5.1 Overview of Methodology

5.1.1 FORECASTING: A CHALLENGE FOR COMMUNITY HEALTH

To complete the picture of the overall role that CBCHS plays in the life of the community it serves, some measure of how much each service is used is necessary. The rigour with which usage data is routinely collected, and more importantly, analysed varies and is generally not as rigorous as is the case in acute health services, for example. For public hospitals, extensive, systematic data collection is vital as it underpins the case mix payment method as well as supporting clinical quality control. Clinicians (especially epidemiologists) analyse these data in order to establish trends and to hone treatment regimes in a cycle of continuous quality improvement. No such culture of rigorous data capture and analysis exists in the primary / community health care system in Victoria or in the rest of Australia. As a result, it is relatively difficult to measure usage trends in community health reliably.

However, even if the data was more complete, it would still be difficult to make reliable assessments of *demand, need and utilization* of services. Forecasting models used in other parts of the health sector are not applicable. In the acute sector for example, *demand, need and utilization* equate to the same set of numbers (ignoring factors such as changes in the lengths of waiting lists) and trends are generally consistent over time. At the risk of being pedantic, it should be understood that acute sector “demand forecasting models” are actually “utilization forecasting models”.

However, in the community health sector, application of utilization forecasting models will only lead to a reinforcement of the current service profile, in both scope and intensity.

In addition, a number of other factors which are peculiar to community health make reliable projections difficult. These include:

1. Historically, the community has been quick to take up any new services that become available. This means that the biggest limitation on utilization (i.e. throughput) of a service is availability of funding, rather than demand or need.
2. Data on past utilisation is often incomplete or inconsistent. This is partly due to changes in reporting systems, data storage and retrieval systems and partly to a focus in community health on the client and little on administrative chores such as data collection.
3. Changes in service delivery methods may cause variability in how data is reported

5.1.2 INTERPRETING PROJECTIONS

This chapter provides a picture of current usage patterns and suggests how these might change over a period of ten years. However, instead of utilising one particular methodology, these projections provide the opportunity to create a composite picture

of the future based on an analysis of the present situation and a range of scenarios based on differing assumptions about the future.

Four Scenarios

Four scenarios will provide perspectives that will assist in making the final recommendations for this report. Each scenario will answer a particular question about the service provision, as measured by effective full-time (EFT) resources dedicated to the service in question.

Scenario 1: No change	
Question	What happens if there is not further growth in funding or service provision?
Answer	Shows how coverage of the target population will decrease as the population grows.
Scenario 2: Maintain current coverage	
Question	How quickly will the service need to grow in order to ensure that the current level of service is maintained?
Answer	Shows how rapidly new staff resources will need to be added in order to maintain the current coverage of the target population
Scenario 3: Increase coverage in line with community need	
Question	If we were to aim to increase services by 50% over ten years, what staff resources would be required?
Answer	Shows how much more rapid growth will need to be in order to respond to increased need for services based on changing demographic and patterns of disease.
Scenario 4: Growth rate same as the past	
Question	If growth in the next ten years is assumed to be at the same rate as the previous ten years, how quickly will services need to grow?
Answer	Shows how staffing levels will need to grow in the next ten years given that services have approximately doubled in the past ten years.

The detailed projections that follow embody much information already presented in other parts of this report; in particular:

- Snapshots of current services, including utilization patterns
- Burden of disease data
- Ambulatory Care Sensitive Conditions in the catchment area
- Analysis of health risk factors

This information has been “distilled” into numerical “drivers” of change for each service. In the context of the discussion in section 3.1, the “drivers” are of *need* not demand or utilization. The key drivers for each service are itemised for each service type in the summaries below.

Definitions:

The following definitions will assist with interpretation.

Total catchment population	City of Kingston
Target clientele	The population cohort(s) most likely to utilise this particular service
% of Catchment population	Shows the target client group as percentage of Kingston residents
Number of CBCHS contacts	Shows number of episodes of service in a given year
Number of CBCHS clients	Indicates number of persons receiving service in a given year
CBCHS Clients as % of target population	Indicates what percentage of the target population is being served by CBCHS

5.2 Summary of Projections

Projections by service type, presented in the same order as followed in the snapshots presentation in section 2.2, now follow in a standardised, single page per service, format to facilitate easier reading. Appendix A provides some detail on why some services could not be analysed using this format. Section 5.1.2 provides some definitions and explanations that will assist in understanding the data presented below.

It is acknowledged that these projections form only one part of the picture and have to be seen within the context of the rest of the report. However, they provide valuable planning information as they help to quantify the likely resources required in the future.

Planned Activity Groups (formerly ADASS)

Central Bayside

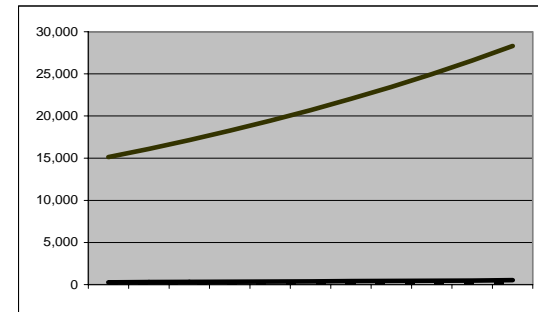
Base Year Data

Total Catchment Population	133,886
Target Clientele: Frail aged, young disabled	15,127
% of Catchment Population	11%
Number of CBCHS contacts 2003/04	12,500
Number of CBCHS Clients 2003/04	275
CBCHS Clients as a target clientele	1.8%
Current EFT	9.5

Growth drivers:

Ageing, Disability, dementia

producing a total projected change over next five years of: 136.8%
at an average annual rate of: 6.5%



Ten Year Projections

	Year =>	Base	1	2	3	4	5	6	7	8	9	10
Underlying Need for This Service =>		15,127	16,104	17,144	18,252	19,431	20,686	22,022	23,445	24,960	26,572	28,288
<u>Scenario 1 : No change in EFT or Workload</u>												
Clients serviced by CBCHS - current level		275	275	275	275	275	275	275	275	275	275	275
Percentage coverage by CBCHS		1.8%	1.7%	1.6%	1.5%	1.4%	1.3%	1.2%	1.2%	1.1%	1.0%	1.0%
Required EFT assuming current productivity		9.5	9.5	9.5	9.5	9.5	9.5	9.5	9.5	9.5	9.5	9.5
<u>Scenario 2 : EFT required to maintain relative coverage</u>												
Clients serviced by CBCHS		275	293	312	332	353	376	400	426	454	483	514
Percentage coverage by CBCHS		1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%
Required EFT assuming current productivity		9.5	10.1	10.8	11.5	12.2	13.0	13.9	14.8	15.7	16.7	17.8
<u>Scenario 3 : EFT required to Increase relative coverage by 50%</u>												
			<i>104% (p.a.)</i>									
Clients serviced by CBCHS		275	305	338	375	415	461	511	566	628	696	771
Percentage coverage by CBCHS		1.8%	1.9%	2.0%	2.1%	2.1%	2.2%	2.3%	2.4%	2.5%	2.6%	2.7%
Required EFT assuming current productivity		9.5	10.6	11.7	13.0	14.4	16.0	17.7	19.6	21.7	24.1	26.7
<u>Scenario 4 : Maintain EFT growth of previous decade viz: 204%</u>												
Clients serviced by CBCHS		275	295	317	341	366	393	422	453	487	523	561
Percentage coverage by CBCHS		1.8%	1.8%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	2.0%	2.0%	2.0%
EFT (Note: current productivity assumed to determine coverage).		9.5	10.2	11.0	11.8	12.7	13.6	14.6	15.7	16.9	18.1	19.5

Alcohol & Other Drugs

Central Bayside

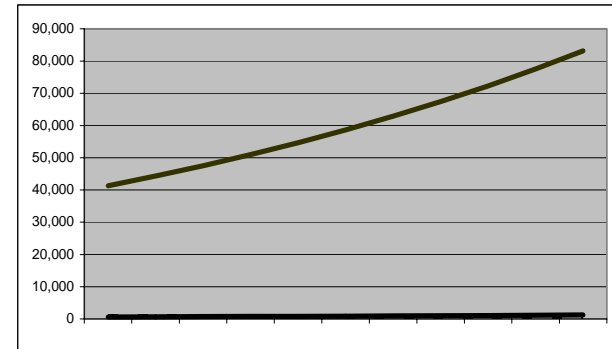
Base Year Data

Total Catchment Population	133,886
Target Clientele: Persons aged between 25 & 44	41,353
% of Catchment Population aged between 25 & 44	31%
Number of CBCHS contacts 2003/04	621
Number of CBCHS Clients 2003/04	621
CBCHS Clients as a percent of popn between 25 & 44	1.5%
Current EFT	4.8

Growth drivers:

Drugs, Mental Health

producing a total projected change over next five years of: 141.8%
at an average annual rate of: 7.2%



Ten Year Projections

Year =>	Base	1	2	3	4	5	6	7	8	9	10
Underlying Need for This Service =>	41,353	44,345	47,554	50,994	54,684	58,641	62,884	67,434	72,313	77,545	83,156
<u>Scenario 1 : No change in EFT or Workload</u>											
Clients serviced by CBCHS - current level	621	621	621	621	621	621	621	621	621	621	621
Percentage coverage by CBCHS	1.5%	1.4%	1.3%	1.2%	1.1%	1.1%	1.0%	0.9%	0.9%	0.8%	0.7%
Required EFT assuming current productivity	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8
<u>Scenario 2 : EFT required to maintain relative coverage</u>											
Clients serviced by CBCHS	621	666	714	766	821	881	944	1,013	1,086	1,164	1,249
Percentage coverage by CBCHS	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
Required EFT assuming current productivity	4.8	5.1	5.5	5.9	6.3	6.8	7.3	7.8	8.4	9.0	9.7
<u>Scenario 3 : EFT required to Increase relative coverage by 50%</u>											
		104% (p.a.)									
Clients serviced by CBCHS	621	693	774	865	966	1,079	1,204	1,345	1,502	1,677	1,873
Percentage coverage by CBCHS	1.5%	1.6%	1.6%	1.7%	1.8%	1.8%	1.9%	2.0%	2.1%	2.2%	2.3%
Required EFT assuming current productivity	4.8	5.4	6.0	6.7	7.5	8.3	9.3	10.4	11.6	13.0	14.5
<u>Scenario 4 : Maintain EFT growth of previous decade, viz: 204%</u>											
Clients serviced by CBCHS	621	667	716	769	826	887	953	1,023	1,099	1,181	1,268
Percentage coverage by CBCHS	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
EFT (Note: current productivity assumed to determine coverage).	4.8	5.2	5.5	5.9	6.4	6.9	7.4	7.9	8.5	9.1	9.8

Community Nursing

Central Bayside

Base Year Data

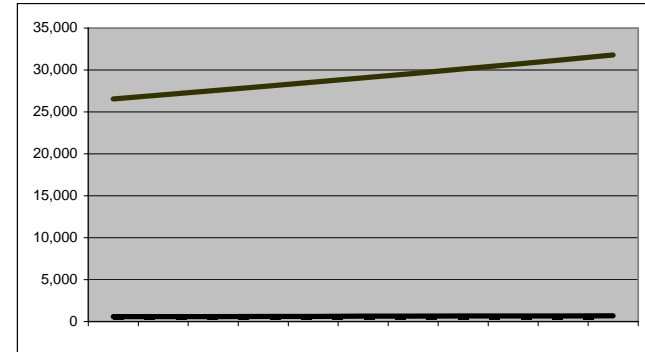
Total Catchment Population	133,886
Target Clientele: Aged 60 plus	26,563
% of Catchment Population aged 60 years plus	20%
Number of CBCHS contacts 2003/04	1,912
Number of CBCHS Clients 2003/04	584
CBCHS Clients as a percent of 70 popn.	2.2%
Current EFT	3.4

Growth drivers:

Ageing

producing a total projected change over next five years of: **109.4%**

at an average annual rate of: **1.8%**



Ten Year Projections

	Year =>	Base	1	2	3	4	5	6	7	8	9	10
Underlying Need for This Service =>		26,563	27,045	27,535	28,034	28,542	29,060	29,587	30,123	30,669	31,225	31,792
<u>Scenario 1: No change in EFT or Workload</u>												
Clients serviced by CBCHS - current level		584	584	584	584	584	584	584	584	584	584	584
Percentage coverage by CBCHS		2.2%	2.2%	2.1%	2.1%	2.0%	2.0%	2.0%	1.9%	1.9%	1.9%	1.8%
Required EFT assuming current productivity		3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.4
<u>Scenario 2: EFT required to maintain relative coverage</u>												
Clients serviced by CBCHS		584	595	605	616	628	639	650	662	674	687	699
Percentage coverage by CBCHS		2.2%	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%	2.2%
Required EFT assuming current productivity		3.4	3.5	3.5	3.6	3.7	3.7	3.8	3.9	3.9	4.0	4.1
<u>Scenario 3: EFT required to Increase relative coverage by 50%</u>												
			104% (p.a.)									
Clients serviced by CBCHS		584	619	657	696	738	782	830	880	933	989	1,048
Percentage coverage by CBCHS		2.2%	2.3%	2.4%	2.5%	2.6%	2.7%	2.8%	2.9%	3.0%	3.2%	3.3%
Required EFT assuming current productivity		3.4	3.6	3.8	4.1	4.3	4.6	4.8	5.1	5.4	5.8	6.1
<u>Scenario 4: Maintain EFT growth of previous decade, viz: 204%</u>												
Clients serviced by CBCHS		584	627	674	723	777	834	896	963	1,034	1,110	1,192
Percentage coverage by CBCHS		2.2%	2.3%	2.4%	2.6%	2.7%	2.9%	3.0%	3.2%	3.4%	3.6%	3.8%
EFT (Note: current productivity assumed to determine coverage).		3.4	3.7	3.9	4.2	4.5	4.9	5.2	5.6	6.0	6.5	6.9

Counselling

Base Year Data

Total Catchment Population	133,886
Target Clientele: population 60 plus	26,563
% of Catchment Population	20%
Number of CBCHS contacts 2003/04	6,010
Number of CBCHS Clients 2003/04	1,721
CBCHS Clients as a percent of Target Clientele	6.5%
Current EFT	2.9

Growth drivers:

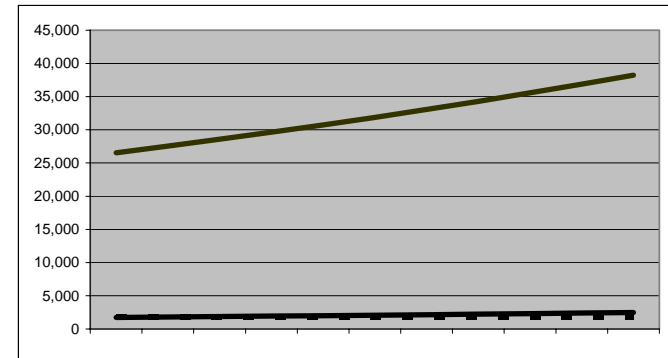
Mental Health

producing a total projected change over next five years of: 120.0%
at an average annual rate of: 3.7%

Ten Year Projections

Year =>	Base	1	2	3	4	5	6	7	8	9	10
Underlying Need for This Service =>	26,563	27,549	28,573	29,634	30,734	31,876	33,059	34,287	35,560	36,881	38,251
<u>Scenario 1: No change in EFT or Workload</u>											
Clients serviced by CBCHS - current level	1,721	1,721	1,721	1,721	1,721	1,721	1,721	1,721	1,721	1,721	1,721
Percentage coverage by CBCHS	6.5%	6.2%	6.0%	5.8%	5.6%	5.4%	5.2%	5.0%	4.8%	4.7%	4.5%
Required EFT assuming current productivity	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9
<u>Scenario 2: EFT required to maintain relative coverage</u>											
Clients serviced by CBCHS	1,721	1,785	1,851	1,920	1,991	2,065	2,142	2,221	2,304	2,390	2,478
Percentage coverage by CBCHS	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%	6.5%
Required EFT assuming current productivity	2.9	3.0	3.1	3.2	3.4	3.5	3.6	3.7	3.9	4.0	4.2
<u>Scenario 3: EFT required to Increase relative coverage by 50%</u>											
		104% (p.a.)									
Clients serviced by CBCHS	1,721	1,859	2,008	2,168	2,342	2,529	2,732	2,951	3,187	3,442	3,717
Percentage coverage by CBCHS	6.5%	6.7%	7.0%	7.3%	7.6%	7.9%	8.3%	8.6%	9.0%	9.3%	9.7%
Required EFT assuming current productivity	2.9	3.1	3.4	3.7	3.9	4.3	4.6	5.0	5.4	5.8	6.3
<u>Scenario 4: Maintain EFT growth of previous decade, viz: 204%</u>											
Clients serviced by CBCHS	1,721	1,848	1,985	2,132	2,290	2,459	2,641	2,836	3,046	3,272	3,514
Percentage coverage by CBCHS	6.5%	6.7%	6.9%	7.2%	7.4%	7.7%	8.0%	8.3%	8.6%	8.9%	9.2%
EFT (Note: current productivity assumed to determine coverage).	2.9	3.1	3.3	3.6	3.9	4.1	4.5	4.8	5.1	5.5	5.9

Central Bayside



Dietetics

Base Year Data

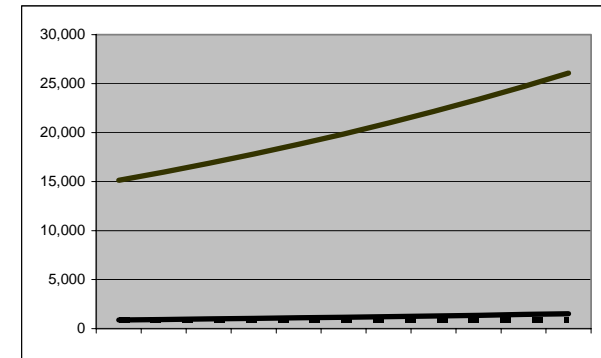
Total Catchment Population	133,886
Target Clientele: Population aged 70 plus	15,127
% of Catchment Population aged 70 years plus	11%
Number of CBCHS contacts 2003/04	2,362
Number of CBCHS Clients 2003/04	881
CBCHS Clients as a percent of 70+ popn.	5.8%
Current EFT	1.5

Growth drivers:

Ageing, Diabetes

producing a total projected change over next five years of: 131.3%
at an average annual rate of: 5.6%

Central Bayside



Ten Year Projections

Year =>	Base	1	2	3	4	5	6	7	8	9	10
Underlying Need for This Service =>	15,127	15,973	16,867	17,810	18,807	19,859	20,970	22,143	23,381	24,689	26,071
<u>Scenario 1: No change in EFT or Workload</u>											
Clients serviced by CBCHS	881	881	881	881	881	881	881	881	881	881	881
Percentage coverage by CBCHS	5.8%	5.5%	5.2%	4.9%	4.7%	4.4%	4.2%	4.0%	3.8%	3.6%	3.4%
Required EFT assuming current productivity	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
<u>Scenario 2: EFT required to maintain relative coverage</u>											
Clients serviced by CBCHS	881	930	982	1,037	1,095	1,157	1,221	1,290	1,362	1,438	1,518
Percentage coverage by CBCHS	5.8%	5.8%	5.8%	5.8%	5.8%	5.8%	5.8%	5.8%	5.8%	5.8%	5.8%
Required EFT assuming current productivity	1.5	1.6	1.7	1.8	1.9	2.0	2.1	2.2	2.3	2.4	2.6
<u>Scenario 3: EFT required to Increase relative coverage by 50%</u>											
		104% (p.a.)									
Clients serviced by CBCHS	881	969	1,065	1,171	1,288	1,417	1,558	1,713	1,884	2,071	2,278
Percentage coverage by CBCHS	5.8%	6.1%	6.3%	6.6%	6.8%	7.1%	7.4%	7.7%	8.1%	8.4%	8.7%
Required EFT assuming current productivity	1.5	1.6	1.8	2.0	2.2	2.4	2.7	2.9	3.2	3.5	3.9
<u>Scenario 4: Maintain EFT growth of previous decade, viz: 204%</u>											
Clients serviced by CBCHS	881	946	1,016	1,091	1,172	1,259	1,352	1,452	1,559	1,675	1,799
Percentage coverage by CBCHS	5.8%	5.9%	6.0%	6.1%	6.2%	6.3%	6.4%	6.6%	6.7%	6.8%	6.9%
EFT (Note: current productivity assumed to determine coverage).	1.5	1.6	1.7	1.9	2.0	2.1	2.3	2.5	2.7	2.9	3.1

Occupational Therapy

Central Bayside

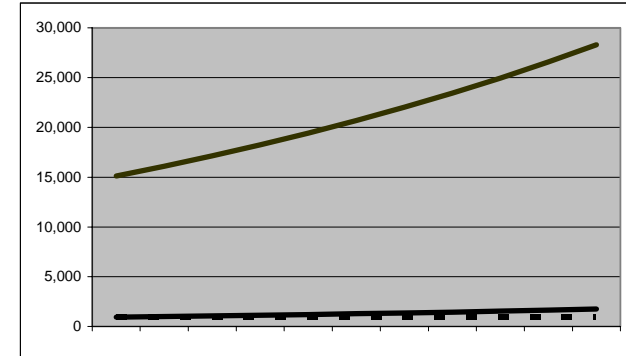
Base Year Data

Total Catchment Population	133,886
Target Clientele: Population aged 70 plus	15,127
% of Catchment Population aged 70 years plus	11%
Number of CBCHS contacts 2003/04	3,051
Number of CBCHS Clients 2003/04	938
CBCHS Clients as a percent of 70+ popn.	6.2%
Current EFT	1.5

Growth drivers:

Ageing, Dementia

producing a total projected change over next five years of: 136.8%
at an average annual rate of: 6.5%



Ten Year Projections

Year =>	Base	1	2	3	4	5	6	7	8	9	10
Underlying Need for This Service =>	15,127	16,104	17,144	18,252	19,431	20,686	22,022	23,445	24,960	26,572	28,288
<u>Scenario 1: No change in EFT or Workload</u>											
Clients serviced by CBCHS - current level	938	938	938	938	938	938	938	938	938	938	938
Percentage coverage by CBCHS	6.2%	5.8%	5.5%	5.1%	4.8%	4.5%	4.3%	4.0%	3.8%	3.5%	3.3%
Required EFT assuming current productivity	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
<u>Scenario 2: EFT required to maintain relative coverage</u>											
Clients serviced by CBCHS	938	999	1,063	1,132	1,205	1,283	1,366	1,454	1,548	1,648	1,754
Percentage coverage by CBCHS	6.2%	6.2%	6.2%	6.2%	6.2%	6.2%	6.2%	6.2%	6.2%	6.2%	6.2%
Required EFT assuming current productivity	1.5	1.6	1.7	1.8	1.9	2.1	2.2	2.3	2.5	2.6	2.8
<u>Scenario 3: EFT required to Increase relative coverage by 50%</u>											
		104% (p.a.)									
Clients serviced by CBCHS	938	1,040	1,153	1,278	1,417	1,571	1,742	1,931	2,141	2,373	2,631
Percentage coverage by CBCHS	6.2%	6.5%	6.7%	7.0%	7.3%	7.6%	7.9%	8.2%	8.6%	8.9%	9.3%
Required EFT assuming current productivity	1.5	1.7	1.8	2.0	2.3	2.5	2.8	3.1	3.4	3.8	4.2
<u>Scenario 4: Maintain EFT growth of previous decade, viz: 204%</u>											
Clients serviced by CBCHS	938	1,007	1,082	1,162	1,248	1,340	1,439	1,546	1,660	1,783	1,915
Percentage coverage by CBCHS	6.2%	6.3%	6.3%	6.4%	6.4%	6.5%	6.5%	6.6%	6.7%	6.7%	6.8%
EFT (Note: current productivity assumed to determine coverage).	1.5	1.6	1.7	1.9	2.0	2.1	2.3	2.5	2.7	2.9	3.1

Physiotherapy

Central Bayside

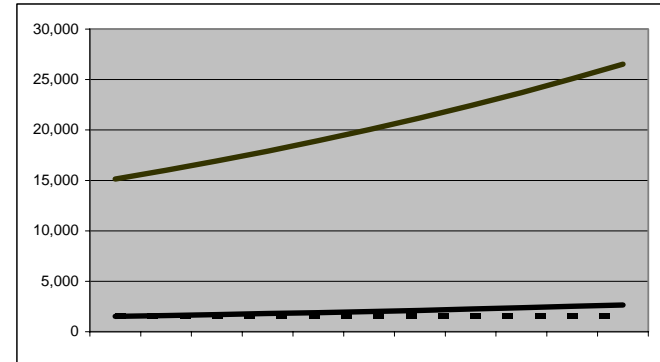
Base Year Data

Total Catchment Population	133,886
Target Clientele: Aged 70 plus	15,127
% of Catchment Population aged 70 years plus	11%
Number of CBCHS contacts 2003/04	5,138
Number of CBCHS Clients 2003/04	1,512
CBCHS Clients as a percent of 70 popn.	10.0%
Current EFT	2.7

Growth drivers:

Ageing, Drugs and Mental Health

producing a total projected change over next five years of: 132.4%
at an average annual rate of: 5.8%



Ten Year Projections

Year =>	Base	1	2	3	4	5	6	7	8	9	10
Underlying Need for This Service =>	15,127	16,000	16,923	17,899	18,932	20,024	21,180	22,401	23,694	25,061	26,507
<u>Scenario 1 : No change in EFT or Workload</u>											
Clients serviced by CBCHS - current level	1,512	1,512	1,512	1,512	1,512	1,512	1,512	1,512	1,512	1,512	1,512
Percentage coverage by CBCHS	10.0%	9.5%	8.9%	8.4%	8.0%	7.6%	7.1%	6.7%	6.4%	6.0%	5.7%
Required EFT assuming current productivity	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7
<u>Scenario 2 : EFT required to maintain relative coverage</u>											
Clients serviced by CBCHS	1,512	1,599	1,692	1,789	1,892	2,001	2,117	2,239	2,368	2,505	2,649
Percentage coverage by CBCHS	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%
Required EFT assuming current productivity	2.7	2.9	3.0	3.2	3.4	3.6	3.8	4.0	4.2	4.5	4.7
<u>Scenario 3 : EFT required to Increase relative coverage by 50%</u>											
		104% (p.a.)									
Clients serviced by CBCHS	1,512	1,665	1,834	2,021	2,226	2,451	2,700	2,974	3,276	3,608	3,974
Percentage coverage by CBCHS	10.0%	10.4%	10.8%	11.3%	11.8%	12.2%	12.7%	13.3%	13.8%	14.4%	15.0%
Required EFT assuming current productivity	2.7	3.0	3.3	3.6	4.0	4.4	4.8	5.3	5.8	6.4	7.1
<u>Scenario 4 : Maintain EFT growth of previous decade, viz: 204%</u>											
Clients serviced by CBCHS	1,512	1,624	1,744	1,873	2,012	2,160	2,320	2,492	2,676	2,874	3,087
Percentage coverage by CBCHS	10.0%	10.1%	10.3%	10.5%	10.6%	10.8%	11.0%	11.1%	11.3%	11.5%	11.6%
EFT (Note: current productivity assumed to determine coverage).	2.7	2.9	3.1	3.3	3.6	3.9	4.1	4.4	4.8	5.1	5.5

Podiatry

Base Year Data

Total Catchment Population	133,886
Target Clientele: Population aged 70 plus	15,127
% of Catchment Population aged 70 years plus	11%
Number of CBCHS contacts 2003/04	7,526
Number of CBCHS Clients 2003/04	2,075
CBCHS Clients as a percent of 70+ popn.	13.7%
Current EFT	3.5

Growth drivers:

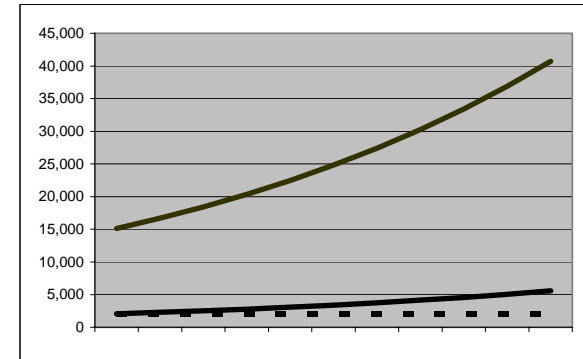
Diabetes, Ageing, Disability

producing a total projected change over next five years of: 164.1%
at an average annual rate of: 10.4%

Ten Year Projections

Year =>	Base	1	2	3	4	5	6	7	8	9	10
Underlying Need for This Service =>	15,127	16,702	18,441	20,362	22,482	24,823	27,408	30,263	33,414	36,893	40,735
<u>Scenario 1: No change in EFT or Workload</u>											
Clients serviced by CBCHS - current level	2,075	2,075	2,075	2,075	2,075	2,075	2,075	2,075	2,075	2,075	2,075
Percentage coverage by CBCHS	13.7%	12.4%	11.3%	10.2%	9.2%	8.4%	7.6%	6.9%	6.2%	5.6%	5.1%
Required EFT assuming current productivity	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5
<u>Scenario 2: EFT required to maintain relative coverage</u>											
Clients serviced by CBCHS	2,075	2,291	2,530	2,793	3,084	3,405	3,760	4,151	4,583	5,061	5,588
Percentage coverage by CBCHS	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%	13.7%
Required EFT assuming current productivity	3.5	3.9	4.3	4.7	5.2	5.7	6.3	7.0	7.7	8.5	9.4
<u>Scenario 3: EFT required to increase relative coverage by 50%</u>											
		104% (p.a.)									
Clients serviced by CBCHS	2,075	2,386	2,743	3,154	3,627	4,170	4,795	5,514	6,340	7,289	8,382
Percentage coverage by CBCHS	13.7%	14.3%	14.9%	15.5%	16.1%	16.8%	17.5%	18.2%	19.0%	19.8%	20.6%
Required EFT assuming current productivity	3.5	4.0	4.6	5.3	6.1	7.0	8.1	9.3	10.7	12.3	14.1
<u>Scenario 4: Maintain EFT growth of previous decade, viz: 204%</u>											
Clients serviced by CBCHS	2,075	2,229	2,393	2,570	2,761	2,965	3,184	3,420	3,673	3,945	4,236
Percentage coverage by CBCHS	13.7%	13.3%	13.0%	12.6%	12.3%	11.9%	11.6%	11.3%	11.0%	10.7%	10.4%
EFT (Note: current productivity assumed to determine coverage).	3.5	3.8	4.0	4.3	4.7	5.0	5.4	5.8	6.2	6.7	7.1

Central Bayside



Speech Pathology (Adult)

Central

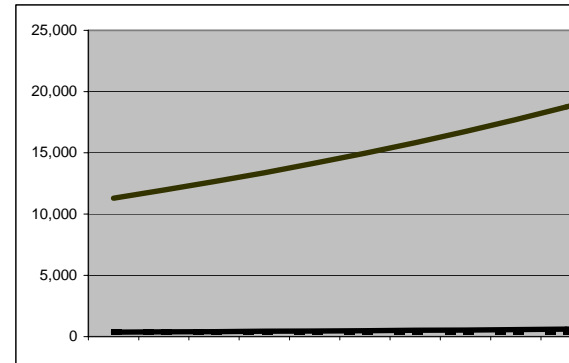
Base Year Data

Total Catchment Population	133,886
Target Clientele: Children 5 to 11	11,305
% of Catchment Population aged 5 to 11	8%
Number of CBCHS contacts 2003/04	1,956
Number of CBCHS Clients 2003/04	364
CBCHS Clients as a percent of popn between 5 and 11.	3.2%
Current EFT	0.4

Growth drivers:

Children aged between 5 and 11

producing a total projected change over next five years of: 132.4%
at an average annual rate of: 5.8%



Ten Year Projections

Year =>	Base	1	2	3	4	5	6	7	8	9
Underlying Need for This Service =>	11,305	11,957	12,647	13,377	14,149	14,965	15,828	16,741	17,707	18,729
<u>Scenario 1: No change in EFT or Workload</u>										
Clients serviced by CBCHS - current level	364	364	364	364	364	364	364	364	364	364
Percentage coverage by CBCHS	3.2%	3.0%	2.9%	2.7%	2.6%	2.4%	2.3%	2.2%	2.1%	1.9%
Required EFT assuming current productivity	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4
<u>Scenario 2: EFT required to maintain relative coverage</u>										
Clients serviced by CBCHS	364	385	407	431	456	482	510	539	570	603
Percentage coverage by CBCHS	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%	3.2%
Required EFT assuming current productivity	0.4	0.4	0.4	0.5	0.5	0.5	0.6	0.6	0.6	0.7
<u>Scenario 3: EFT required to Increase relative coverage by 50%</u>										
Clients serviced by CBCHS	364	401	442	486	536	590	650	716	789	869
Percentage coverage by CBCHS	3.2%	3.4%	3.5%	3.6%	3.8%	3.9%	4.1%	4.3%	4.5%	4.6%
Required EFT assuming current productivity	0.4	0.4	0.5	0.5	0.6	0.6	0.7	0.8	0.9	1.0
<u>Scenario 4: Maintain EFT growth of previous decade, viz: 204%</u>										
Clients serviced by CBCHS	364	391	420	451	484	520	559	600	644	692
Percentage coverage by CBCHS	3.2%	3.3%	3.3%	3.4%	3.4%	3.5%	3.5%	3.6%	3.6%	3.7%
EFT (Note: current productivity assumed to determine coverage).	0.4	0.4	0.5	0.5	0.5	0.6	0.6	0.7	0.7	0.8

6 Conclusion and Recommended Strategic Directions

6.1 Planning for Strategic Impact

CBCHS has a long and proud history of providing services to the community in Kingston and some of the surrounding areas. It is well regarded for the services it provides and for the commitment and dedication of its staff. CBCHS has also been able to ensure that disadvantaged members of the community have better access to affordable healthcare.

Programs have been funded through a variety of funding streams – mostly provided by the State or Federal Governments. Like other community health services around Victoria, CBCHS therefore provides a wide range of programs including, disability support, day programs for the aged, allied health services, dental care, social support and capacity building – particularly for the elderly, counselling, alcohol and other drugs support services, community nursing and others. All services are well utilised by the local community and most are over-subscribed. However, usage and demand for services may not always reflect the patterns of greatest need – nor will they always be focussed on the areas of greatest potential impact. Likewise, it is important to acknowledge that CBCHS is not the only provider of community health services. A range of service providers including church and community organisations, local government, private providers and public healthcare services also fulfil a significant part of this role. While CBCHS will need to continue providing its current suite of services, new funding should be focussed on areas of greatest impact for the local catchment.

6.1.1 IDENTIFYING PRIORITY AREAS

The greatest potential for health impact can be informed by combining information provided in this report about health needs based on Burden of Disease projections, the potential to avert hospital admissions for Ambulatory Care Sensitive Conditions (ACSCs) in the local catchment, prevalence of health risk factors and the role and capability of primary health care. Combining this information as outlined in previous chapters, the areas where CBCHS is likely to have the greatest impact in improving the health from a burden of disease perspective, of the local catchment from an illness prevention/health promotion perspective are:

- Prevention and control of diabetes and its complications
- Prevention of smoking related illness
- Prevention and management of depression and earlier stages of dementia.

These priorities¹ are currently reflected in CBCHS programs and services and should be strengthened where appropriate in future service development.

Increasing the health promotion component of program delivery is recommended in DHS guidelines, which allow for the health promotion component of a program to be as high as 40%. This approach is strongly supported by many of the best practice models for the delivery of primary health care and would provide a means of having an impact in priority areas without requiring a significant increase in funding.

6.1.2 DEALING WITH DISADVANTAGE

As demonstrated from the data presented earlier, Clarinda, Clayton and Chelsea represent some of the most disadvantaged suburbs in Victoria. With disadvantage comes increased risk of ill health, disease and injury and an increased contribution to the burden of disease. By definition, socio-economic disadvantage also limits the capacity of individuals to access health services.

The community consultation process for this report has also shown that the needs of these suburbs have changed in recent times due to a number of important social changes especially in Clayton and Clarinda. These include, but are not limited to:

- Increased numbers of new arrivals from the Horn of Africa and other refugees
- A relatively large Indian population
- A relatively large cohort of aging southern Europeans who do not speak English well and who have limited access to transport

These groups present additional challenges as they are often suspicious of public institutions and have poor understanding of how to access services in Australia. In addition, many are unwilling or unable to travel to access these services.

Community health workers in these suburbs find that their clients will only access services they can reach on foot. As with other CALD groups, there are additional challenges posed through a diversity of language, cultures and sensitivities.

Dealing with these pockets of disadvantage and complexity will present a major challenge for management and staff at CBCHS in the future.

¹ Heart disease and stroke do not appear as recommended program priorities even though heart disease and stroke are among the most significant contributors to burden of disease because: the projections for burden of disease predict a significant decline in all of cardiovascular conditions due to current interventions; and the recommended interventions for diabetes and prevention of smoking related illness are similar to those required for prevention of heart disease. Therefore, implementing the program priorities will have a positive impact on heart disease as well.

6.2 Implementing Key Policy Drivers

As indicated earlier, CBCHS will benefit from aligning its planning priorities with government policy drivers as this will help to position the organisation more strongly when bidding for new or additional funding. Likewise, demonstrating the organisation's ability to deliver on key priority areas, will strengthen its position to bid for new opportunities in the future.

The table below indicates how CBCHS could continue to demonstrate its ability to deliver services in accordance with current government policy frameworks.

Strategic Directions in the Community Health Policy 2004	Current CBCHS	Recommended CBCHS Future Priorities
Leadership in Health Promotion	<ul style="list-style-type: none"> ▪ 1.0 EFT dedicated health promotion resources ▪ Current CBCHS integrated Health Promotion Plan (IHP) 	<ul style="list-style-type: none"> ▪ Continue to ensure all programs and services provide an element of health promotion. ▪ Where relevant, consolidate health promotion resources to further support integrated health promotion planning and programs. ▪ Identify areas/ neighbourhoods for integrated health promotion action in accordance with identified health promotion priorities and IHP ▪ Improved data collection to provide evidence base
Platform for delivery of primary health care	<ul style="list-style-type: none"> ▪ Current provision of a broad range of services ▪ Extensive partnership arrangements in place across many programs 	<ul style="list-style-type: none"> ▪ Strengthened and expanded clinical roles in high priority areas ▪ Increased targeting of services to high need population groups ▪ Development of new service models ▪ Ensure capital development plans for growth, particularly at Chelsea and Clarinda sites
Co-ordinated community based disease management and ambulatory care	<ul style="list-style-type: none"> ▪ Current provision of a broad range of clinical services ▪ Implementation of service coordination ▪ HARP projects 	<ul style="list-style-type: none"> ▪ Improved coordination of ambulatory care and management of chronic disease ▪ Increased targeting for those with co-morbidities ▪ Integration with primary medical care ▪ Expansion of services in line with ACF ▪ Participation in development of health precinct
Expanded primary medical care	<ul style="list-style-type: none"> ▪ Current Sexual and Reproductive Health program, GP and paediatric service 	<ul style="list-style-type: none"> ▪ Expanded primary medical care including nurse practitioners ▪ Improved infrastructure and facilities
Focus on child and family health	<ul style="list-style-type: none"> ▪ Current provision of some services to this cohort 	<ul style="list-style-type: none"> ▪ Expansion of services to this group in particular those from disadvantaged populations ▪ Focus on prevention of diabetes during childhood through improved

		<p>health promotion</p> <ul style="list-style-type: none"> ▪ Possibility of support services for children and families as part of new Monash Medical Centre development
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6.3 Summary of Current and Forecast EFT by site for Community Health Programs

The following forecasts provide an overview of planning requirements for CBCHS community health programs. In particular, these forecasts suggest how services should be distributed to reflect the level of need of each part of the CBCHS catchment. A more detailed analysis at the individual service and site level, which was utilised to calculate the resource allocations below, has been included in Appendix B.

Important information to consider when interpreting the following forecasts:

- The suggested distribution is intended as a guide for allocation of overall resources to a particular service delivery site. It assumes that with the exception of dental programs, all services will be delivered from each site. Clearly, this may need to be modified to account for a range of practical considerations.
- The percentages below have been adjusted to reflect the SEIFA index of disadvantage and the size of population in the particular suburbs that form the catchment for each site
- These forecasts do not include administration or disability staff, but do include community health and dental programs. Disability projections have been provided in earlier chapters. Gambler's Help has also not been included as it is funded at a regional level.
- Dental services are forecast to be delivered from the Parkdale site only as the Clarinda and Chelsea sites are unlikely to have the capacity to accommodate dental chairs.
- Some services may be based in Parkdale but still deliver outreach services to residents of the whole catchment area. It is not possible to accurately account for this factor in developing the forecasts for each site.
- The forecasts do not include new program areas that may be funded in the future as a result of new growth funding or changes to government policy directions. As a result, the indicated growth of EFTs should be considered a minimum level only.
- These forecasts are provided based on Scenarios 2 and 4. Scenario 2 provides a conservative estimate because it assumes that CBCHS simply aims to maintain current levels of coverage for a particular service. Scenario 4 suggests a slightly more ambitious level of growth and is based on the rate of growth over the past 10 years. The two tables together therefore, indicate a range of probable requirements.

- Resource distributions for Clarinda assume a potential new delivery site at Westall. If the new site was to be established, most of the new growth would be delivered from Westall as Clarinda will have limited capacity for increase in the new building.

Resource Distribution according to Scenario 2 (maintain current coverage)					
	Recommended resource allocation using SEIFA index	Current distribution of resources	Current EFT excluding admin and disability	Recommended EFT to 2010 using SEIFA weighted distribution	Recommended EFT to 2015 using SEIFA weighted distribution
CBCHS	100%	100%	53	72	95
Parkdale	59%	70%	38.6	39	52.5
Clarinda (including Westall)	20%	10%	5	13	17
Chelsea	21%	19%	9.4	14.5	19

Resource Distribution according to Scenario 4 (assume future growth = past growth)					
	Recommended resource allocation using SEIFA index	Current distribution of resources	Current EFT excluding admin and disability	Recommended EFT to 2010 using SEIFA weighted distribution	Recommended EFT to 2015 using SEIFA weighted distribution
CBCHS	100%	100%	53	77.2	108.3
Parkdale	59%	70%	38.6	46	64
Clarinda (including Westall)	20%	10%	5	15.6	21.5
Chelsea	21%	19%	9.4	15.6	22.8

Implications for CBCHS

- The most urgent need for an increase in resources will be in Clarinda. At present only 10% of services are provided from this location whereas a more equitable distribution would mean a substantial increase in services. As the

new facility at Clarinda will only provide room for limited growth, an additional site at Westall would enable a higher level of service provision for this area which is clearly under-serviced at present.

- In addition, there will be significant growth requirements for both the Parkdale and Chelsea sites to enable further growth.

6.4 Recommended Strategic Directions

1. Ensure capital development caters to estimated service growth by:

- a. Ensuring the Chelsea site can accommodate at least six additional EFT in community health programs by 2010. In addition, the facility will need to accommodate new programs that may be required to meet the growing needs of the local population. Some of the new growth could be located at Edithvale if the recommendation (f) below is carried out.
- b. Securing the Edithvale Road site and funds for refurbishment as a Community Centre. This site would both cater for an overflow of service from the Chelsea area, as well as cater to the estimated growth in the number of clients with a disability and specialist personal care needs requiring day services to further implement the Victorian State Disability Plan 2002-2012. In total it is anticipated the site would provide the infrastructure for service provision by approximately 5 staff EFT (CHS, PAG, ambulatory care) plus up to 25 disability client EFT and the requisite number of staff EFT, over a four year period. It is envisaged that this Community Centre would provide an integrated blend of community health services, disability services and have strong links with local community organisations, such as the Mordialloc Community Centre to ensure a strong element of community participation..
- c. Exploration of a new Westall site to cater for both the established migrant communities and the emerging new communities. This site may act as a satellite of the Clarinda site and could accommodate some of the new growth projected in this report. This centre would also service the established and ageing migrant community as well as provide proactive health promotion and child and family services into schools for newly arrived communities.
- d. Ensuring the Clarinda catchment is provided with accommodation for eight to ten additional EFT in community health programs by 2010 to meet the growing needs of the local population. Some of these services will need to be provided in a location that is accessible by foot for the communities that will not travel to access health services. An expansion of the current site may therefore not be the most appropriate way of meeting these needs.
- e. Recognising that although the Parkdale site currently provides adequate levels of services for its catchment area, innovative solutions to providing additional accommodation and infrastructure will be

needed to cater for future levels of need. Assuming that current co-location with Southern Health services will continue, further facilities may be required within the next three to five years.

- f. Modelling the estimated service growth based on population projections and targeting high needs groups.

2. Continue to develop and target clinical capacity by:

- a. Strengthening and expanding clinical roles in government priority areas such as early childhood development, child and family health and primary medical care.
- b. Increasing targeting of programs and services to high needs population groups and areas of greatest disadvantage.
- c. Targeting clinical capacity to address the health needs of the local catchment by focussing on prevention and control of diabetes, prevention of smoking related illness, and prevention and management of depression and earlier stages of dementia.
- d. Ensuring efficiency in service provision by consolidating and locating services where they will maximise utilisation of facilities and staff resources as appropriate.
- e. Developing a central intake model for clients accessing services at CBCHS. Apart from achieving greater efficiency, a central intake model will enable a more patient centred approach to patient care and support a more holistic, educative approach to managing the health of the community.
- f. Ensuring capital development at the Clarinda and Chelsea sites caters for expanded clinical roles, particularly in relation to equipment storage, appropriate consulting rooms and meeting rooms that can accommodate health education sessions.
- g. Ensuring appropriate facilities for primary medical care.
- h. Ensuring Information Technology and Information Management systems support efficient clinical practices.
- i. Developing an improved clinical evidence base.

3. Focus on ambulatory care by:

- a. Investigation of new models and appropriate reconfiguration of services in line with the Ambulatory Care Framework when released. Amongst other things this may include working towards contributing to the development of health precincts.
- b. Ensuring a clinical intake/triage capacity with links to local health services, but recognises the unique role of CBCHS in providing community based services.

- c. Implementing models for the improved coordination and management of chronic diseases. By also improving the evidence base for work done in these areas, CBCHS will be able to enhance capacity to deliver new services if further funding becomes available in the future.
- d. Developing a process of continuing improvement for clinical governance.

4. Continue to enhance partnership relations by:

- a. Continuing to work with the diverse range of partnership agencies.
- b. Fostering collaborative projects with Southern Health, particularly in relation to the four areas identified during consultation process. These include reducing hospital admissions, ambulatory care, disease management and health promotion.
- c. Continuing to enhance the relationship with tertiary/intensive providers to streamline and coordinate complex care in the community to the maximum extent possible.
- d. Continuing to work collaboratively with the City of Kingston.
- e. Adopting sub-regional approaches for the planning and delivery of programs where relevant eg: disability services, gambler's help.

5. Continue to provide leadership in health promotion by:

- a. Developing a broader definition of health promotion that ensures that educative and preventative elements are built into all programs, rather than treating health promotion as a separate program.
- b. Ensuring all programs and services include an element of health promotion or health education.
- c. Where relevant, consolidating health promotion resources to increase the scale and impact.
- d. Continuing as a leader in integrated health promotion catchment planning.
- e. Actively progressing along the health promotion continuum from cooperation- coordination to collaboration between services.
- f. Providing a benchmark for the provision of health promotion by each program or service.
- g. Increasing the health promotion component of all programs and ensuring existing health promotion activities support the program priorities outlined.
- h. Developing a partnership with an academic institution to facilitate access to academic information in the field of health promotion. Such a relationship would also provide the opportunity for clinical

placements for allied health, medical and nursing students; increased exposure to emerging health promotion theory and practice models; potential for research; and an increased capacity to evaluate the impact of various health promotion strategies.

Glossary of Terms & Abbreviations

Abbreviation/Acronym	Full Term
ACAS	Aged Care Assessment Service
ACF	Ambulatory Care Framework
ACO	Adult Community Options
ACSC	Ambulatory Care- Sensitive Conditions
ADASS	Adult Day Activity & Support Services
AHA	Allied Health Assistant
AOD	Alcohol and Other Drugs
BBCHS	Bentleigh Bayside Community Health Service
CACP	Community Aged Care Package – deliver aged care services in a home and community setting
CALD	Culturally and Linguistically Diverse
CBCHS	Central Bayside Community Health Services
CCF	Congestive Cardiac Failure
CH	Community Health
COPD	Chronic Obstructive Pulmonary Disease
CVS	Community Visitor Scheme
DALY	Disability Adjusted Life Years
DHS	Department of Human Services
EFT	Effective Full Time (employees)
FFYA	Futures For Young Adults
HACC	Home and Community Care
HARP	Hospital Admissions Risk Program
PAG	Planned Activity Group
PCP	Primary Care Partnerships
SEIFA	Socio-Economic Index for Areas
SMR	Southern Metropolitan Region
SPAS	Southern Psychogeriatric Activity Services
YLD	Years Lost to Disability
YLL	Years Life Lost

Consultation

The following organisations were consulted in relation to the Strategic Services Plan, either through meetings or attendance at information sessions:

- Bayside City Council
- Bayside Community Options
- Bentleigh Bayside Community Health Service
- CBCHS Auxillary
- CBCHS Members
- Central Bayside Division of General Practice
- City of Kingston
- Clarinda/South Oakleigh Village Committee
- Commonwealth Carer Respite Centre (Caulfield)
- Psychologist, McDonald Street Medical Centre
- Southern Ethnic Advisory Council
- Southern Health