



Bellarine Community Health Service Plan

February 2004

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Part 1: BCH the current situation

1.1 Introduction to Bellarine Community Health

Bellarine Community Health (BCH) is a declared Community Health Service under the Health Services Act 1988. BCH has progressively developed as a significant multifaceted primary care service. Formed in 1992 from the amalgamation of the Drysdale, Portarlington and Queenscliff community health services, BCH has continued to expand, as service needs and delivery development opportunities have been identified. BCH is a major provider of community based primary health and aged residential care services on the Bellarine Peninsula. The State funded primary care services are provided through four community health centres, a shopfront in one township and in people's homes. The residential care services are provided through three aged care facilities, one of which is dementia specific. There are a total of 100 low care beds (including 30 which are currently being built). BCH also provides accommodation through 16 independent living units.

A strength of BCH has always been a focus on community participation at all levels, resulting in an organization which has set the strategic directions of the Service to meet changing needs and demands. There is a strong membership base of over 1100, which increases on an annual basis and has a strong volunteer component.

The Bellarine Peninsula with its urban/rural character and its range of communities presents a planning challenge. The incorporation of residential aged care within the aegis of the BCH adds a further dimension for service planning.

1.2 BCH major objectives

BCH is currently in a transition phase of moving towards full implementation of a set of major strategic directions, adopted by the BCH Board following two major strategic reviews undertaken in 2002. This service plan is a further key step in achievement of these objectives.

The directions are based around the four service themes of; improving health status, rehabilitation, maintenance of function and well-being. A 'whole of community approach' is the principle that underpins the objectives to achieve the strategic directions.

The objectives include:

- Service planning will take account of opportunities to work with a range of providers in the provision of services to the community.
- Integrated service delivery where opportunities exist: The emphasis is on the needs of individuals and the community, and not exclusively on funding streams.
- Supporting communities: The objective is to provide a basis for community development by providing services and facilitating opportunities to participate in fulfilling activity.

- Optimal access to services: Frequently used services will be delivered locally; less frequently used services requiring larger service catchments will be provided at a district level; and infrequently used and home-based services will be planned on whole-of-area basis.
- Wider scope of services: There will be a stronger emphasis on health promotion, preventative health services (such as gerodentics), management of chronic conditions, sub-acute ambulatory rehabilitation, youth counseling and community development.

1.3 BCH target groups

BCH operates by the following philosophy regarding targeting of services: “*BCH offers a service which everyone in the community may need at sometime.*” At present the people who mainly use our services include:

- Individuals and families eligible for Home and Community Care (HACC) home nursing, adult day activities and physiotherapy services
- Individuals and families requiring nursing, allied health, maternal and child health, family counselling and dental services
- Individuals and families who can benefit from health promotion/education activities
- Individuals requiring low care residential services (although some residents are classified at a ‘high’ RCS level)
- Community members who require primary care GP services through private fee for service.

In an environment of scarce resources, it is critical to constantly review how services are targeted to those most in need, and to aim to address health inequities. This service plan allows an opportunity to consider this issue in the context of refocusing services to best meet the increasing and changing needs of our community.

1.4 Current Governance, Management and Staffing Structure

BCH has a governance structure consisting of eight Board members, three of whom have been appointed by the Governor in Council. Four have been elected by the BCH membership, with the eighth position currently filled through co-option to a vacant appointed position. In 2004 all Board positions are due for renewal, which must occur prior to the Annual General Meeting in October.

The Board membership brings a range of skills and qualities, which combined, provide a skill base to ensure the organization provides accountability to its various stakeholders, manages risk, provides the strategic directions and complies with all relevant State and Commonwealth legislation. The Board has a range of Governance policies which are reviewed annually, including a Board Effectiveness Review policy.

The Board recruits and appoints the Chief Executive Officer (CEO) and delegates the management of the organization to the CEO through a documented delegation instrument. The CEO reports to the Board through an established Key Result Area reporting policy.

The CEO is responsible for the recruitment and appointment of the senior Management team, which includes: Primary Care Manager (1EFT), Residential Care Manager (0.9 EFT), Development Manager (0.6 EFT) and Accountant (0.4 EFT).

The Management Team is responsible for the recruitment and appointment of Program Coordinators and approval of the appointment of other staff members.

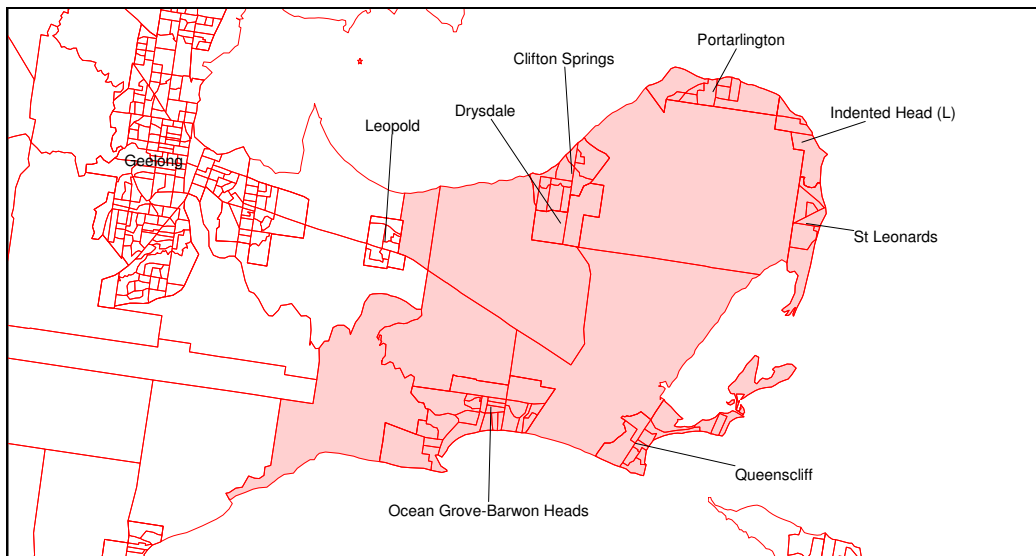
There are currently 220 staff members (EFT 100 approximately). A current organizational staff structure is at Appendix 1, together with further details about staffing.

1.5 BCH catchment area

BCH catchment area spans two local government areas, which include the Borough of Queenscliff and eastern part of the City of Greater Geelong (COGG). There are however exceptions to this, for example individuals outside this area do move to the BCH aged care facilities (if there are family members who are the primary carers already living in the area), and clients who use the dental services include people who live outside of this catchment area (as part of Government policy).

The main communities in the north of the catchment are Drysdale/Clifton Springs, Portarlington, Indented Head, and St Leonards; and in the south, Queenscliff/Point Lonsdale, and Barwon Heads/Ocean Grove (Figure 1.1).

Figure 1.1 BCH Catchment Area



1.6 BCH current service mix

The existing BCH model has two major program streams: Residential Aged Care and Primary Care and related services. Appendix 2 provides detail of the current levels of funding received for these programs. Appendix 3 provides information about the current utilisation of primary care service delivery sites for these programs.

Primary Care Program

The primary care service delivery arrangements of BCH are complex, with services provided at the Community Health Centres adapting to shifting patterns of demand, funding opportunities and staff changes.

The following information highlights the major primary care service elements and should be considered as a broad conceptualisation. The aim is to identify the primary care service range.

Allied Health

BCH allied health services encompass the full range of services traditionally identified with community health services. These include physiotherapy, occupational therapy, podiatry (divided into footcare and podiatry services), dietetics, speech pathology, social work, psychology, youth health and youth work.

SWITCH data for the first quarter of 2003/04 has been factored to provide a typical full year service profile for BCH allied health services (Table 1.1). An estimated annual total of 6500 clients are supported by community health primary care services, 15250 contacts are made and 26,250 hours of service provided.¹ Services experiencing significant demand pressures are podiatry (waiting list approximately 3 months), speech pathology (7-8 weeks), and occupational therapy (up to 4 weeks).

Table 1.1 BCH Primary Care Service Utilisation (First Quarter 2003/04)

Activity	Contacts		Contact hours		Total clients seen	
	Number	%	Number	%	Number	%
Primary care nursing	1957	51.33	1646.5	25	895	55
Podiatry	450	11.8	464.75	7	285	17.57
Physiotherapy	312	8.18	263	4	94	5.8
Dietetics	185	4.85	218.42	3.3	94	5.8
Occupational therapy	230	6	507	7.69	101	6.22
Speech pathology	304	7.97	428.8	6.5	66	4
Health promotion	228	6	2749	41.8	54	3.3
Counselling	146	3.83	285	4.3	33	2
Total quarter	3812	100	6562.47	100	1622	100
Full year equivalent			21886			
			Target			

SWITCH data: 1 July 2003 – 30 Sept 2003.

¹ Full year data estimates rounded to nearest 100

Social Support

Social support (also known as Adult Day Activity within BCH (Community Health program funded and called Planned Activity Groups in the HACC Program) is a socialisation and respite program mainly for the frail aged and people with dementia. It forms a significant program stream within the existing BCH model. A significant transport service is linked to this program.

This support program is provided from Queenscliff, Drysdale and Portarlington CHC's. A service has previously been offered at the Ocean Grove Community Health Centre. There were 150 aged clients receiving service as at June 2002, including 75 at Queenscliff (2 sessions of 10, three sessions of 20 and one session of 15 per week), 25 at Drysdale (1 session of 20 and one session of 10) and 50 at Portarlington (1 session of 20, one session of 10 and two sessions of 15) plus a ladies outing group which is not centre based². Sixteen sessions per week have been reduced to 11, with the possibility of further consolidation, to improve service efficiency.

Home Nursing

Home nursing (also termed District Nursing) is a significant program that includes both general nursing and specialist nursing (including diabetes education, wound care, continence support, palliative care, hospice care, hospital in the home, early obstetric care).

The home nursing service located at Queenscliff Community Health Centre has a Bellarine Peninsula catchment, with the majority of service demand linked to areas with higher numbers of older people. In 2001/02 it supported 1151 clients and provided 21230 occasions of service. Nearly half (47%) are from the HACC target group, 11% are veterans and **18% midwifery clients**, with the remaining 24% including TAC, **post acute**, Linkages, **Hospital in the Home**, **Rehabilitation in the Home**, **palliative care** and program funded clients. There is no waiting list, however referrals can only be accepted on weekdays, and early discharge from hospitals is increasing the demand on this service. **(The services noted in bold font are provided by BCH through a sub-contracted arrangement with Barwon Health).**

Health Promotion and Health Education

Health promotion is provided under a multi disciplinary approach and not a separate program. It is included as an activity undertaken by appropriate disciplines according to need. An annual planning process is undertaken to identify the range of health promotion activity to be undertaken for the coming year. There are some exceptions depending on project funding availability. The Primary Care Manager currently provides coordination for several of the initiatives.

Community Development

Community development is a small program within the total model (one part time worker), but the philosophy is integrated within the service range and included in programs such as the Well Women's Clinic and group activities facilitated by BCH.

² Some clients attend more than one ADA session.

Maternal and Child Health

BCH Maternal and Child Health services are a minor component of the model. BCH provides the service on behalf of the Borough of Queenscliffe at the Queenscliff Community Health Centre, with the City of Greater Geelong providing the service from other BCH service sites.

Dental

A public dental service located at Queenscliff CHC for pensioners and Health Care Card holders is a significant and highly valued component of the BCH model.

In 2001/2002 the dental service treated 1183 patients who visited on 2703 occasions to receive 6489 treatments. The top six locations of service users were: Ocean Grove (24%), Portarlington (12%), St Leonards (9%), Point Lonsdale (7%) and Barwon Heads (5%) and Queenscliff (5%). Of the remainder, 30% come from other parts of the Bellarine Peninsula and 7% come from elsewhere. Almost one third of patients (29%) come from Ocean Grove/Barwon Heads but the service is located in Queenscliff. There is currently a 20 month waiting list for service.

Medical 'sub-program'

A medical practice is located within the Queenscliff Community Health Centre. It is a private practice of five general practitioners (full time and part time) that is fully integrated into the community health service and shares all services. It incorporates a nursing clinic and functions in full collaboration with the allied health services. This service is one of the defining strengths of the BCH model and extends the service range and service integration beyond that of many other Community Health Services.

The general practice service located at the Queenscliff Community Health Centre is the largest BCH related service. In 2001/02 it had an active client caseload of 9885 patients and provided 34,251 consultations. Its primary catchment is the Pt Lonsdale and Queenscliff area with secondary catchments extending to Barwon Heads/Ocean Grove, with lesser numbers from other Bellarine Peninsula localities.

Delivered Meals

BCH is the service provider for delivered meals in the Borough of Queenscliffe. Volunteers deliver approximately 14000 meals a year (1100 to 1200 per month) to 150 clients. Meals services on the remainder of the Bellarine Peninsula are provided by the City of Greater Geelong, however BCH provides delivery points for these services from the Drysdale and Ocean Grove sites.

Volunteers

The community support and volunteer structure is a significant part of the BCH model. Over 700 volunteers provide support at all service centres and across all program areas, including administration.

There are three Local Advisory Groups and a Residential Care committee that serve as the link between the Board, staff and the community. There are also three fundraising Auxiliaries.

Support Programs

A range of significant support services are also a component of the model. These include administration, food services coordination, program development, quality improvement program and accreditation, occupational health and safety and reception services.

Accreditation

BCH primary care programs undergo QICSA accreditation each three years. This external accreditation process will be undertaken again in February 2004.

For an analysis of waiting lists and demand for primary care services as at October 2003, refer to Appendix 4.

Residential Aged Care Program

The Residential Aged Care program stream consists of the management and operation of three Commonwealth funded low care residential aged care facilities and Independent Living Units.

The facilities are:

Point Lonsdale:

- Coorabin Hostel (40 beds, located adjacent to the Queenscliff Community Health Centre site). There is also an unfunded family support unit suite on site.
- Eric Tolliday Independent Living Units (16 units located adjacent to Coorabin)
- Sims Lodge (a 22 bed dementia unit located less than 1 kilometre from Coorabin, which will be sold in 2004 and the residents moved to the new re-developed ANH).

Portarlinton

- Ann Nichol House (30 bed low care facility. 30 additional bed licences have been obtained to expand the service to 60 beds. This facility is located on a separate site to the Portarlinton Community Health Centre).

Each of BCH aged care facilities attained full three-year accreditation in September 2003, achieving all 44 standards set by the Commonwealth Aged Care Standards Agency.

1.7 Change in level and mix of services over the past five years

The demographic profile of the Bellarine Peninsula is changing and the move towards retirement living to coastal locations is emerging as a significant national phenomena (refer to Part 2 of this report). Health and community services policy is responding accordingly, with a significant redefinition of services towards more integrated and flexible methods of service provision. The trend towards community care for BCH commenced with the formation of the Queenscliff CHC in 1972. Home based and community based care is becoming a predominant theme as a result of the government HACC policy directions which commenced in 1986. This trend

challenges traditional models and there is an increasing blurring and overlapping of services. Just as the "hospital" concept is moving to a vertically integrated "health services" model, so the traditional understanding "community health centre" is challenged to consider its role for the future as a community-based primary care service³.

BCH has responded to the changing need over the past five years by providing services in response to those with higher and more complex demand for services. As opportunities have arisen internally through staff departures, identification of gaps in service provision to meet changing needs has resulted in a reorientation of recruitment of staff with skills to meet the needs. Community members being prepared to contribute small amounts for services provided to keep service levels up in higher demand service areas. Concurrently external opportunities have been taken when available, for example submitting for and receiving increased funding in some areas, forming partnerships with other local and regional health and community care providers and to meet changing and un- met needs. Examples of the important partnerships are detail in Part 3 on pages 27-28.

1.8 The current BCH primary care model in perspective

The salient features of the current model for planning purposes include:

- In contrast to other community health services, BCH has two major components: primary care and residential aged care. Each service functions relatively independently, but both sectors have a major influence of future planning decisions. The aged residential service has a high proportion of low dependency clients (19% RCS 7 & 8). The presence of an integrated medical practice on the Queenscliff site also provides a relatively unique service dimension. The medical practice is the largest service of all those provided and it also has a significant effect on service planning.
- The public dental service also provides a significant service dimension to the model
- The model currently functions in a "hub and spoke" manner. This has raised the question for BCH to consider the appropriateness of this approach for the future and the balance of services provided at each site.
- The model includes one hub, three service centres and one access centre. The appropriateness of this model has been considered to be inappropriate and so a revised model has been confirmed for adoption. This decision will directly inform future capital planning.
- The role of the service centres in each community needs to be seen from a community development perspective. The sites provide a base for both primary care service delivery and a focus for a range of activities community activities.

³ The recent release of the Department of Human Services discussion paper *Towards a Community Health Policy Framework* identifies possible themes to guide future development.

- The primary care model is based on an integrated service approach, as opposed to a “team approach”. There is one integrated service for each type of primary care, with limited placements of staff at the service centre sites. Most activity is currently generated from the hub at Pt Lonsdale.
- The social support (ADA) service accounts for a significant proportion of staff EFT and budget but it is directed at a smaller number of clients than several other primary care services.
- There is a comprehensive range of allied and related services and this provides an opportunity for multi-disciplinary practice.
- Podiatry and the footcare service have a high profile relative to other allied health services.
- There is limited emphasis on youth programs
- Home nursing is a very significant component of the current model, and the balance of home based and community based services is an issue for consideration.
- Community participation in the service is a major element of the BCH model, with over 700 volunteers directly supporting the service.

Part 2: Service Planning Considerations

2.1 Demographics of the Bellarine Peninsula

This information is summarised from the BCH Primary Care Service Model Review undertaken by Jack Sach in 2002.

Whilst a detailed analysis of the demographic characteristics of the population assists service planning, the main requirement for strategic planning is to understand the age structure and distribution of the population.

The data presented in this report has been specifically selected for planning purposes. There is a particular need to provide a context to inform key planning questions, such as:

- Are service delivery points best linked to where people live?
- Is the number of service delivery points appropriate?
- Is the size of service centres appropriate to their catchments?
- Is the demand from the localities across the Bellarine Peninsula likely to change?
- Is the service range appropriate to the likely needs of the identified demographic?

Summary of key demographic features

The salient demographic features of the Bellarine Peninsula that influence service planning decisions include the following:

- The total population is approximately 32,526
- There are significant communities on both the north and south of the Peninsula -47% of The population in the north Peninsula and 53% in the south
- Ocean Grove/Barwon Heads and Drysdale/Clifton Springs are the largest communities
- The largest concentrations of both younger and older people are in Ocean Grove/Barwon Heads and Drysdale/Clifton Springs
- There is a high proportion of older people (19% over 65 years)
- The following communities have very high proportions of older people: Indented Head 35%, Point Lonsdale 35%, St Leonards 34% and Portarlington 32%.
- The Bellarine Peninsula population is growing at twice the rate of Victoria and Geelong
- The highest growth rate is occurring in the 45 to 59 age cohort
- An increase in the “young active aged” population (55-64 years) is expected to become significant over the next 10 years, and thereafter the 65-74 aged group
- The over 80 years age group is growing very rapidly (4%, 160 persons per annum).

Population Growth

The population of the Bellarine Peninsula (Census year 2001) is 32,526. It increased by 2997 over 1996, which represent a growth rate of 2.0% per annum. This compares to the following annual growth rates over the same period: Australia 1.0%, Victoria 1.0%, Melbourne 1.0% and City of Greater Geelong 1.0%, and illustrates increasing attraction of coastal communities near capital cities (Table 2.1).

Table 2.1 Bellarine Peninsula population compared to other areas

Area	Population		Growth rate (% pa)	
	1996	2001	1991-96	1996-2001
Australia	17,972,400	18,972,400	+1.0%	+1.0%
Victoria	4,437,500	4,645,000	+1.0%	+1.0%
Melbourne	3,138,100	3,366,500	+1.0%	+1.0%
City of Greater Geelong*	175,409	184,331	+1.0%	+1.0%
Queenscliffe Borough	3,193	3,078	+0.4%	-0.7%
Bellarine Peninsula**	29,519	32,526	N/a	+2.0%
Surf Coast Shire	16,714	19,629	+3.4%	+3.3%
Golden Plains Shire	13,158	14,319	+0.3%	+1.7%
Total Geelong Region	208,744	221,357	+0.6%	+1.2%

Please note:

* Includes Bellarine Peninsula

** Excludes overseas visitors on Bellarine Peninsula on census night

Source:

ABS Census of Population and Housing

Population location

Within the Bellarine Peninsula 48% live in localities on the south Peninsula (Queenscliff, Point Lonsdale, Ocean Grove and Barwon Heads) and 42% in localities on the north Peninsula (Drysdale, Clifton Springs, Portarlinton, Indented Head, St Leonards) and 10% are dispersed over a wide in rural area of the Bellarine Peninsula (Table 2.2).

Table 2.2 Bellarine Peninsula population distribution

Locality	Persons		Per Cent	
	1996	2001	1996	2001
North Peninsula towns	12130	13574	41.1%	41.7%
South Peninsula towns	14383	15604	48.7%	48.0%
Rural Bellarine Peninsula	3006	3348	10.2%	10.3%
Total	29519	32526	100%	100%

The largest population concentrations are at Ocean Grove/Barwon Heads (12,522) in the south and Drysdale/Clifton Springs (8,949) in the north (Table 2.3). Overall, there are nine distinct communities on the Bellarine Peninsula, plus the rural areas.

Table 2.3 Bellarine Peninsula population by locality

Locality	Persons			Per cent	
	1996	2001	Change	1996	2001
Drysdale	1452	1729	277	4.9%	5.3%
Clifton Springs	6645	7220	575	22.5%	22.2%
Portarlinton	2338	2690	352	7.9%	8.3%
Indented Head	448	583	135	1.5%	1.8%
St Leonards	1247	1352	105	4.2%	4.2%
Point Lonsdale	1101	1127	26	3.7%	3.5%
Queenscliff	2068	1955	-113	7.0%	6.0%
Ocean Grove	9089	9972	883	30.8%	30.7%
Barwon Heads	2125	2550	425	7.2%	7.8%
Rural Bellarine	3006	3348	342	10.2%	10.3%
Total	29519	32526	3007	100%	100%

Please note:
Excludes overseas visitors

Age distribution

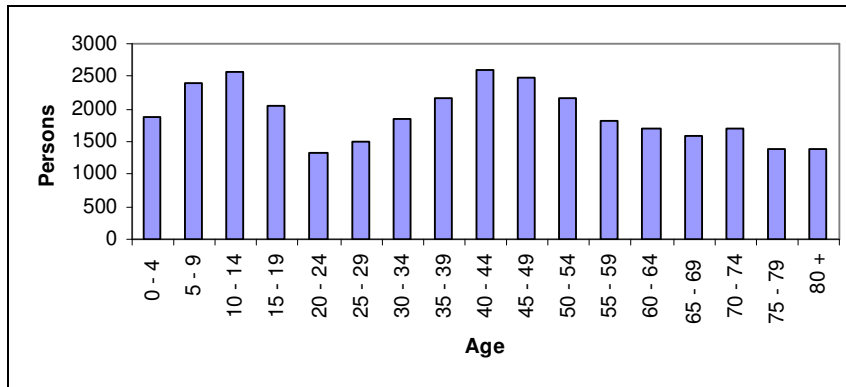
Most of the population growth is occurring in the over 45-59 year age group (Table 2.4, Figure 2.2). This cohort accounted for 60% of the Bellarine Peninsula population growth that occurred between 1996 and 2001 and is a portent of the future demand for services from the “active aged” over the next 10 years.

Table 2.4 Bellarine Peninsula population by age group

Age group	Persons			Per cent	
	1996	2001	Change	1996	2001
0-4	2157	1887	-270	7.3%	5.8%
5-9	2400	2404	4	8.1%	7.4%
10-14	2317	2556	239	7.9%	7.9%
15-19	1833	2045	212	6.2%	6.3%
20-24	1320	1316	-4	4.5%	4.0%
25-29	1435	1502	67	4.9%	4.6%
30-34	1972	1842	-130	6.7%	5.7%
35-39	2374	2160	-214	8.0%	6.6%
40-44	2404	2593	189	8.1%	8.0%
45-49	1902	2482	580	6.4%	7.6%
50-54	1432	2151	719	4.9%	6.6%
55-59	1304	1819	515	4.4%	5.6%
60-64	1399	1706	307	4.8%	5.2%
65-69	1613	1599	-14	5.5%	4.9%
70-74	1517	1696	179	5.1%	5.2%
75-79	978	1373	395	3.3%	4.2%
80+	1154	1395	241	3.9%	4.3%
Total	29511	32526	3015	100%	100%

Please note:
Excludes overseas visitors

Figure 2.2 Bellarine Peninsula population age structure 2001



Older people

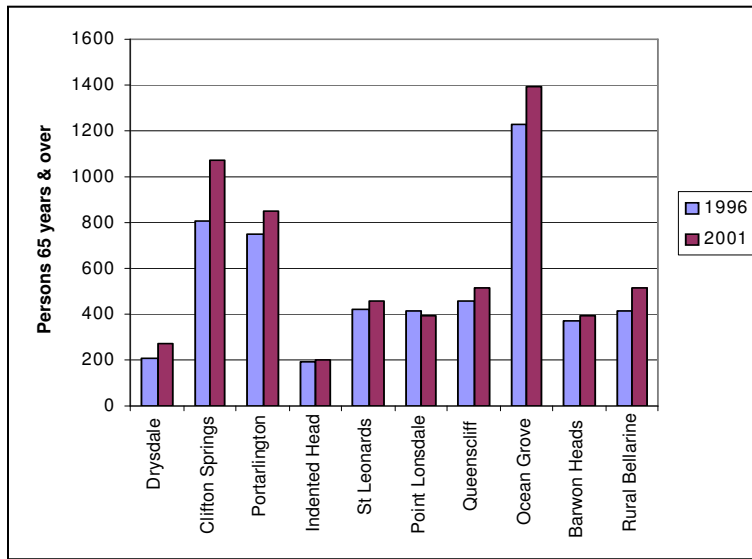
The aged population of the Bellarine Peninsula accounts for 18.6% of the total. It increased 15.2% between 1996 and 2001 and is growing at 3.0% per annum compared to 2.0% for the Bellarine population as a whole. The over 80 years age group, a significant user of services, is growing at 4% per annum, double that of the overall population. Each year between 1996 and 2001, an additional 160 persons over 80 years was added to the 1996 base of 1154 persons (Table 2.5).

Table 2.5 Bellarine Peninsula aged population

Age group	Persons		
	1996	2001	Change
65-69	1613	1599	-14
70-74	1517	1696	179
75-79	978	1373	395
80-84	684	797	113
85-89	333	427	94
90-94	112	149	37
95-99	19	16	-3
100 and over	6	6	0
Total	5262	6063	801

The aged population is distributed across the Bellarine Peninsula, with concentrations in the Clifton Springs/Drysdale (1346) and Ocean Grove/Barwon Heads (1786). These areas accounted for two thirds of the growth in the aged population between 1996 and 2001 (Figure 2.3).

Figure 2.3 Bellarine Peninsula aged population 1996, 2001



Young people

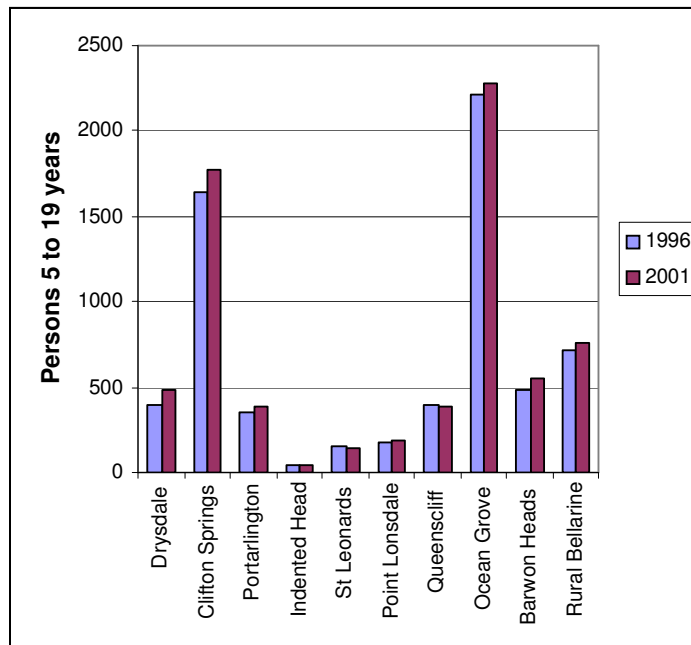
The Bellarine Peninsula youth population (5 to 19 years) is growing at 1.4% per annum (91 persons a year). There are significant concentrations of younger people in Clifton Springs/Drysdale (2259) and Ocean Grove/Barwon Heads (2839) (Table 2.6, Figure 2.4).

Table 2.6 Bellarine Peninsula youth population by locality (5-19 years)

Locality	Persons		
	1996	2001	Change
Drysdale	392	486	94
Clifton Springs	1640	1773	133
Portarlington	352	384	32
Indented Head	39	46	7
St Leonards	152	139	-13
Point Lonsdale	177	190	13
Queenscliff	392	383	-9
Ocean Grove	2214	2285	71
Barwon Heads	481	554	73
Rural Bellarine	711	765	54
Total	6550	7005	455

Please note:
Excludes overseas visitors

Figure 2.4 Bellarine Peninsula youth population 1996, 2001



The Sach Primary Care Service Model Review (2002) provides more detail about age breakdowns in each of the towns on the Bellarine Peninsula.

2.2 Socioeconomic status

The catchment area of BCH includes the following postcode areas:

- 3222 Drysdale/Clifton Springs
- 3223 Portarlington/Indented Head/St Leonards
- 3225 Queenscliff/Point Lonsdale
- 3226 Ocean Grove/Collendina
- 3227 Barwon Heads

A proportion of the rural areas of the Bellarine Peninsula are covered by postcode 3221, however this postcode contains large areas outside of the BCH catchment, hence it has been left out of the following assessment of relative socioeconomic status of localities within the BCH catchment area.

In 1999 the Jesuit Social Services released a paper, *Unequal in Life*, which measured relative disadvantage of every postcode in Victoria and New South Wales. These rankings were developed based on the following indicators:

- Unemployment
- Low income
- Low birth weight
- Child abuse
- Early school leavers
- Emergency assistance
- Psychiatric hospital admissions

- Court convictions
- Child injuries
- Unskilled workers
- Court defendants

The ranking system used results in a score, where 0 is average, negative scores indicate relative disadvantage and positive scores indicate relative advantage. A rank is also provided, with 1 being the state's most disadvantaged postcode, and 622 being the least disadvantaged postcode. The Bellarine Peninsula postcodes scores and ranks are in Table 2.7.

Table 2.7 Bellarine Peninsula relative disadvantage by postcode

Postcode	Relative score	Rank
3222	0.62842	442
3223	-1.48849	42
3225	0.59167	436
3226	-0.50020	205
3227	-0.6458	288

This data indicates that the localities of Portarlington, Indented Head and St Leonards are significantly disadvantaged compared to the rest of the Peninsula and indeed much of Victoria.

As the Jesuit report is almost five years old, 2001 data was also sourced from the Towns In Time dataset for a number of socioeconomic status indicators (Table 2.8).

Table 2.8 Selected socioeconomic indicators for the Bellarine Peninsula

Postcode	% income in lowest quartile	% income in highest quartile	Unemployment rate
3222	28.3%	17.3%	6.6%
3223	46.2%	7.5%	14.3%
3225	32.2%	17.6%	5.3%
3226	26.6%	21.2%	6.5%
3227	27.0%	19.3%	5.8%

This data confirms the rankings in the Jesuit report, that postcode 3223 is the most disadvantaged locality on the Bellarine Peninsula.

One potential factor that is not taken into account in the socioeconomic data presented in this section is the issue of people who are asset rich and cash poor. This phenomenon is potentially a real issue on the Bellarine Peninsula, where a significant proportion of the large aged population in all townships owns real property that is increasing in value, but their income week to week is very low.

2.3 Service utilisation

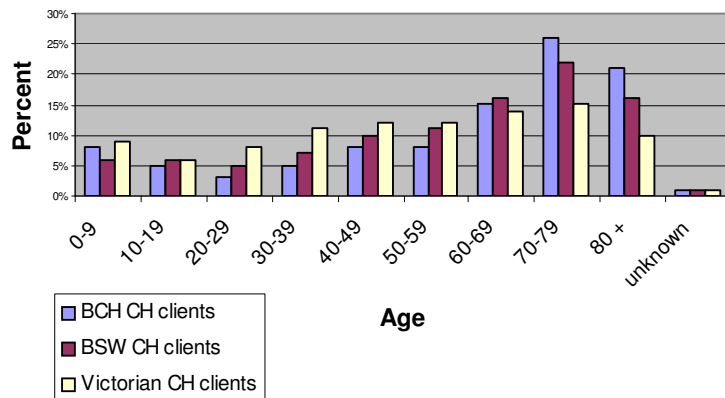
In common with many Community Health Services that receive funds across a range of programs there is no uniform, client data set encompassing all services provided by BCH. Reporting systems (such as SWITCH and the HACC Minimum Data Set) are being progressively refined, but there is only limited data on the services provided

from separate service sites. Despite these difficulties, BCH has undertaken a review of some of the characteristics of the HACC and other State funded Primary Care (including Community Health) clients who receive services from BCH.

Age of BCH clients

One key feature identified from this analysis is that BCH Community Health program funded clients are generally older than those across the state (Figure 2.5).

Figure 2.5 Age structure of BCH Community Health program clients



Please note:

17.2% of Victorians are aged 60+, compared to 41.3% of Victorian CH clients, 55% of BSW region CH clients, and 63% of BCH CH clients.

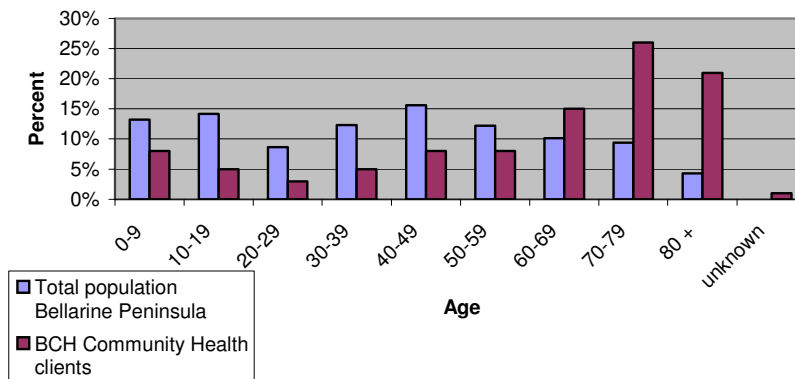
There are limitations associated with comparing data sourced from two different financial years.

Data Source

BCH CH clients: BCH 2002-2003 registered clients report
 BSW region and Victorian CH clients: Community Health Plan Data Sets 2003 (2001-2002 Registered Clients Database)

This feature of BCH Community Health clients is also demonstrated when their age profile is compared with the age profile of all residents of the Bellarine Peninsula (Figure 2.6).

Figure 2.6 Age structure of BCH Community Health program clients compared to all Bellarine Peninsula residents.



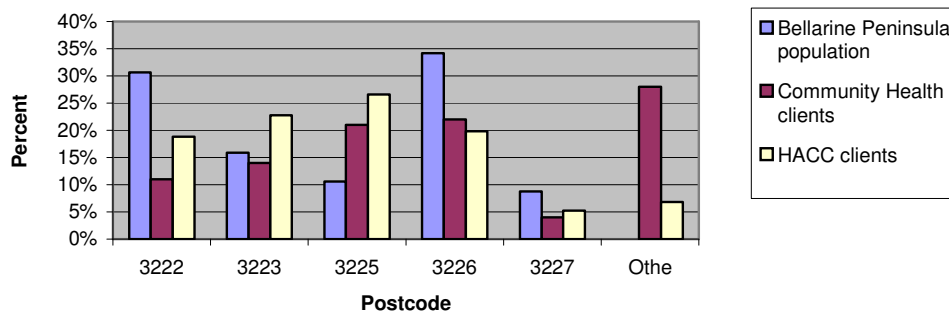
As is to be expected, the age profile of clients of BCH’s second significant program, Home and Community Care (HACC), is strongly skewed to the older age groups, given these people form the target group for this program.

When considering the aged structure of BCH Primary Care (including Community Health Program funded) and HACC funded program clients together, this demonstrates that the vast majority of funds received by BCH for community based service delivery are currently expended on older populations.

Location of BCH clients

A greater proportion of both Community Health (21%) and HACC program (27%) services are delivered to people who live in postcode 3225 (Queenscliff/Point Lonsdale) compared to the proportion of the Bellarine Peninsula population who live in this area (11%) (Figure 2.7). This possibly reflects the fact that the main campus of BCH is located in Point Lonsdale, clients attend the Community Health funded clinic attached to the medical practice (and see the nurse), and that there are significant transport problems on the Bellarine Peninsula.

Figure 2.7 Location of BCH clients compared to location of Bellarine Peninsula residents



Access to services not provided by BCH for Bellarine Peninsula residents

Bellarine Peninsula residents access mental health services at a lesser rate than regional or state averages. Of those Bellarine Peninsula residents who do access mental health services, there are proportionally more males aged 24-44 than regional and state averages. Bellarine Peninsula residents accessing mental health services are also more likely to have been diagnosed with a mood affective disorder or schizophrenia, and to be accessing Adult Continuing Care services than regional and state averages.

Bellarine Peninsula residents access drug and alcohol services at a similar rate to other Victorians, with the exception of people aged between 19-29 and 50-59, who are accessing services at a greater rate than state averages. Actual numbers of people living on the Bellarine Peninsula accessing drug and alcohol services are very small, therefore analysis of drug and alcohol service usage can only be undertaken with caution.

Anecdotal evidence indicates that some residents of the Bellarine Peninsula who require mental health services and drug and alcohol services have difficulty accessing regional services. This difficulty in accessing services is compounded by the lack of transport options on the Peninsula.

Use of acute hospital services by residents of the Bellarine Peninsula

An analysis of Victorian Admitted Episodes Dataset (VAED) data shows that patterns of hospital use by residents of the Bellarine Peninsula for all conditions are not greater than regional averages, which is a positive statistic. One area of concern is in the 60-69 year old age group, whose usage rate has been significantly higher than regional averages, however this has reduced significantly over the past three years.

A subset of the VAED data, the Ambulatory Care Sensitive Conditions (ACSC) dataset, is of greater relevance to service planning for community based services. This dataset records admissions to hospital for conditions that could be avoided with appropriate management in the community, for example diabetes, asthma, cellulitis, chronic cardiac failure, dental conditions. When people are admitted to hospital for these conditions, it can indicate lack of access to community-based services.

There are three measures of ACSC admissions that, if all elevated, indicate that there is an elevated admission pattern for these conditions (Figure 2.8). These three measures are:

- ACSC admissions as a percentage of total admissions
- ACSC WIES (expenditure) as a percentage of total WIES
- ACSC bed days as a percentage of all bed days

Figure 2.8 ACSC summary data for Bellarine Peninsula residents

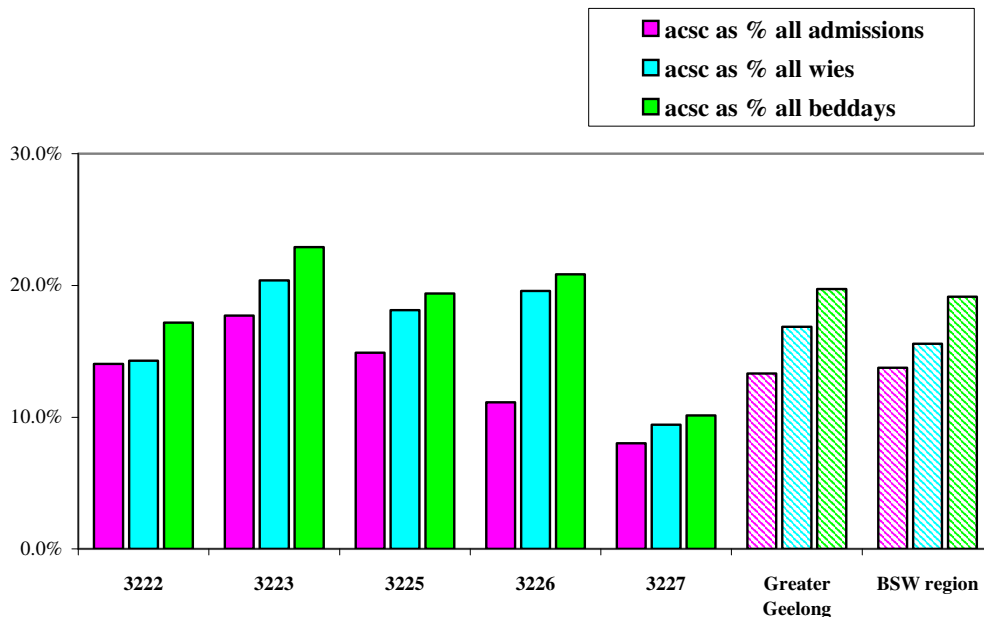


Figure 2.8 demonstrates that all three measures are elevated compared to local and regional averages in postcode 3223 (Portarlington/Indented Head/St Leonards). Of the 17 ACSCs, postcode 3223 is elevated in 13. Table 2.9 shows which conditions are elevated in the five Bellarine Peninsula postcodes.

Table 2.9 ACSC summary for the Bellarine Peninsula by postcode

ACSC	3222	3223	3225	3226	3227
Asthma					
Chronic cardiac failure					
Diabetes complications					
Chronic obstructive pulmonary disease					
Angina					
Iron deficiency					
Hypertension					
Dehydration					
Pyelonephritis					
Ulcers					
Cellulitis					
Pelvic					
Ear, nose, throat infections					
Dental					
Convulsions					
Gangrene					
Flu					

Key

Higher than Greater Geelong and BSW region
Higher than Greater Geelong only

2.4 Service planning considerations

The demographic, socioeconomic and service utilisation data presented in this section, when considered together, identify the following issues that should be considered in refining the BCH service model:

- There are significant youth and older age group cohorts on the Bellarine Peninsula, however the bulk of service is delivered to older people. This may be entirely appropriate due to the prevalence of illness and disability in older populations. However a specialised youth counselling service has been identified by BCH as a future need (strategic objective) to be located at Ocean Grove CHC.
- A significant proportion of the BCH client primary care target group that use BCH allied health services fall within the HACC target group guidelines. However the majority of these clients are provided with services through the Community Health Program funded DHS grants (with very limited HACC funds - 0.7 EFT allied health). This funding through the Community Health program is historically based.

- People from Queenscliff and Point Lonsdale are accessing services at a higher level than are people who live in other areas on the Bellarine Peninsula. This possibly reflects the location of the BCH service hub in this area, making it more accessible to those living nearby, the age group of the population, the medical clinic integrated into the CHC and the ownership the community has of its CHC.
- People who live in Portarlington/Indented Head/St Leonards are not accessing services at a rate that is proportional to the percentage of the Bellarine Peninsula residents that live in this area. People living in this area are relatively more disadvantaged than people living in other areas on the Peninsula. There is the potential that these two factors are linked.
- People living in Portarlington/Indented Head/St Leonards are being admitted to hospital on more occasions for ACSCs than people living in other areas on the Bellarine Peninsula, the City of Greater Geelong, and the Barwon-South Western Region. This may indicate that these people are not accessing timely community based services.
- The pattern of ACSC admissions for residents across the Bellarine Peninsula provides an opportunity to target community-based services to try to deal with the conditions that are showing elevated admission levels. Health promotion programs in particular are well placed to respond to these conditions in the community setting.

Part 3: Future directions for BCH

3.1 Background

A strategic review of the total organisation to develop a future model to address increasing and changing demands and needs undertaken in 2002 has provided BCH with the blueprint to move towards an appropriate model for the future. In this review, BCH has looked at:

- The business we do (the services BCH provides)
- The way we do business (the method of delivering services), and
- Where we do it (the locations and required facilities).

3.2 BCH primary care service model

The primary care model for BCH seeks to “develop the best integrated and means of delivering services across the Bellarine Peninsula” (*BCH Strategic Plan 2001-2004 objective*).

The model is a response to several key factors:

- It incorporates a broad view of health that seeks to strengthen the role of local communities in building healthier social and physical lifestyles. It endorses the 1996 Ottawa Charter that identifies health promotion to include building public health policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services. In particular it acknowledges the needs of each township on the Bellarine Peninsula as a community. The model also aims to provide the appropriate *scale* of response to each community and avoids a unidimensional “one size fits all” approach.
- It provides a Bellarine –specific vision that it is pragmatic, affordable and achievable for the medium (5 –7 year) term.
- It takes into account the relatively unique structure of an urban/coastal community that is both adjacent to a regional city and sufficiently close to a major capital city to attract both young families seeking affordable lifestyles and retirees. It responds to the rapid population growth and its distribution across nine distinct localities.
- It seeks to use pragmatic innovation to achieve service development.

Principle and Objectives

‘**A whole of community approach**’ is the principle that underpins the strategic directions and objectives. Therefore:

- Service planning will take account of opportunities to work with the whole of the Bellarine community to understand health needs and to develop a community health strategy recognising that the communities in the different townships have different needs.
- Support will be provided to people to help them take responsibility for their health at both an individual and collective level.
- Planning and delivery of community health services will be undertaken in collaboration with a range of providers.

The objectives of BCH are:

Integrated service delivery where opportunities exist

The emphasis is on the needs of individuals and the community and not on services defined by funding streams. Services may be provided in association with others and across funding sectors. Dementia services, for example, will support both residential and community clients.

Supporting communities

The objective is to provide a basis for community development by providing services and facilitating opportunities to participate in fulfilling activity.

Optimal access to services

Service planning seeks to optimise access, within resource availability. Frequently used services will be delivered locally; less frequently used services requiring larger service catchments will be provided at a district level; and infrequently used and home-based services will be planned on whole-of-area basis.

Wider scope of services

There will be a stronger emphasis on health promotion, preventative health services (including gerodentics), management of chronic conditions, rehabilitation, youth counselling and community development.

Core business

The identification of the BCH core business is identified to focus strategic planning decision making and not to limit service development.

The core business structure is based on four main *service themes*:

- Improving health status: disease prevention and health promotion
- Rehabilitation: assisting recovery following a medical or physical event
- Maintenance of function: assisting community members to optimise their physical abilities, including management of chronic conditions

- Well-being: counselling and assistance and support to optimise well-being, particularly for people with limited resources, and to build community capacity.

The core business of BCH is:

- Allied health services: physiotherapy, occupational therapy, speech therapy, dietetics, podiatry/footcare
- Community development
- Counselling: social work, psychology
- Health promotion and disease prevention: community health nursing, community development
- Home nursing: including home-based palliative care
- Public dental services
- Rehabilitation: maintenance and restorative
- Social support: activity and support for aged and disabled.
- Integrated private medical services
- Residential aged care: incorporating ageing in place

All of these services currently exist in some form. However the core business in the new model will extend the range of some services or modify the manner in which they are delivered, described below. These extensions clearly link to the demographic characteristics and service utilisation patterns described in Part 2.

Health promotion/disease prevention

With population growth and in particular growth in the “active aged group”, health promotion, illness prevention and disease management will be afforded a clear profile in the core business of BCH. The BCH primary care model will optimise its resources and organise staff allocations in such a manner as to target specific needs and expand develop both specific initiatives in both health promotion and management of chronic conditions. Commitment to the use of a community development approach at management level will be strengthened to drive this service development.

Rehabilitation

Rehabilitation currently encompasses individual consultations (such as physiotherapy, speech therapy) and group sessions (such as Weight Resistance Strengthening Training). The scope of these services will be extended to provide community based ambulatory sub-acute rehabilitation. Extended allied health rehabilitation professional capacity and dedicated community based rehabilitation facilities will be required for this new initiative.

The elements of the proposal include:

- Primary target users: orthopaedic and neurological sub-acute patients
- Services: assessment, time-limited treatment to optimise functional ability, independence and safety. Post-rehabilitation support would be provided in the form of maintenance level rehabilitation in centres close to home and home-based nursing support.

- Rehabilitation team: The Rehabilitation Program would function as a multi-disciplinary service use physiotherapy, occupational therapy, speech therapy, dietetic, podiatry, nursing and counselling staff. Subject to detailed program design, it is likely that an additional senior full time Physiotherapist (Rehabilitation Program Manager) and two Physiotherapy Assistants would be required to complement the existing allied health team.
- Service profile: Programs would be time-limited and individually case managed, based on functional performance evaluation. Maintenance rehabilitation and individual therapies would also continue to be provided at other BCH service centres as currently exists.

The proposal is consistent with the Department of Human Services' *Sub-Acute Strategic Directions* report (2001) and subsequent policy position.

Dental

The Primary Care Model provides for the establishment of a Gerodentic Service on the Bellarine Peninsula. The concept expands the existing community dental service from one chair to two and requires an additional dentist to be appointed. The existing dental nurse establishment will be retained. The service would provide a higher level of service delivery than currently exists, extend dental restorative procedures, extend the prosthodontics (denture) manufacturing output and provide for dental assessments for people living in residential care and deliver dental education.

This proposal is consistent with Department of Human Services Future Directions for Dental Health in Victoria and the (draft) Department of Human Services Gerodentic Clinic Draft Guidelines and Standards and Guidelines for Residential Aged Care Services: Oral and Dental Health.

Youth counselling

BCH will aim to establish a youth counselling service as part of its core business, whilst maintaining relationships with other services providing youth activity and support services. Youth counselling would encompass crisis counselling, support counselling (conflict, anger management, self esteem etc.) and group sessions to support youth development.

Social support program

The Adult Day Activity Program currently supports approximately 150 clients and has 7.68 EFT staff positions. It is the second highest cost program (following home nursing). Eleven sessions are currently provided each week across three centres (progressively rationalised from 16 sessions per week).

The Primary Care Model provides for the progressive re-design of this service as a Social Support Program, including the development of three levels of support:

- dementia specific day care (integrated with residential dementia care)
- frail aged/disabled support and
- non-centre based periodic programs.

Partnership with other health and community service providers

BCH already has both formal and informal agreements with Barwon Health, the two local governments within BCH catchment area, local GP's, local secondary college and other local and regional community providers and groups. These arrangements include:

- Barwon Health sub-contract to BCH to provide a range of post acute care services including: early obstetric care, palliative care, hospital in the home and post acute care, through BCH nursing and allied health team
- BCH provides the Maternal and Child Health Nursing and Meals on Wheels service for the Borough of Queenscliff
- BCH has a contract with local GP's who provide services through one of the CHC's
- BCH has a contract with a specialist neurologist who provides a weekly service through one of the CHC's.
- BCH has a contract with a private Dentist for 1 session per week
- BCH has an informal agreement with Open Family services who provide a full time Youth Outreach Worker.

BCH is a major partner in the Barwon Primary Care Forum (PCF) and is represented on the Barwon PCF steering committee and BCH is fully committed and involved in service coordination (SCOT) implementation across all services. BCH chairs the district Barwon PCF Area Alliance for Bellarine and this group has representation from a wide range of community providers including Ocean Grove Neighborhood Centre, GP Association Geelong, Ocean Grove Police, Geelong Ethnic Communities Council, Women's Health Network, local Church denominations, City of Greater Geelong, Borough of Queenscliff, Salvation Army and local schools. Examples of successful partnership projects include School Breakfast Programs, Multicultural Open Day, Youth Support programs, 10000 Steps Walking Program, Mens Health forum and Quality of Life Walk and Cycle Event.

Other collaborative activities BCH is involved in are:

- BCH CEO and management team/coordinators have recently held a joint planning session with the new General Manager of COGG Community and Recreation Services and the COGG relevant Managers, to identify and further develop partnerships on common areas of planning and service delivery. This includes identifying opportunities for capital infrastructure opportunities.
- BCH is represented on the recently formed COGG Bellarine Peninsula Recreation and Leisure Needs study project.
- BCH is a member of the Borough of Queenscliff Community Development Committee.

In the development phase of the BCH Service Plan, extensive consultation was undertaken with the community, other service providers and Regional DHS to identify emerging and changing need and demands.

BCH has had ongoing discussions with DHS in relation to the development of the Service Plan and discussed their involvement in contributing a regional facilitation role in discussing meeting some current unmet needs, currently being provided at a Regional level. Some examples include: post acute rehabilitation (ambulatory care), drug and alcohol services, adolescent mental health services.

BCH is aware that it cannot provide 'everything to everybody'. Partnerships are therefore critical to enhance the necessary care required for the Bellarine Community. BCH past history of working collaboratively for the benefit of the community will continue and be further developed, enabling the community's priority unmet needs to be partly or fully met.

Service delivery configuration

The BCH primary care model recognises that each service has a specific role and organises their delivery to provide the highest level of access to them for all community members.

The following levels of service are recognised:

- Area services: services delivered across the whole Peninsula.
- District services: services delivered to either the north or south Peninsula
- Local services: services provided for a specific community
- Integrated services: services that are linked to the BCH

Not all levels will be provided at all service centres. A district centre will deliver Area, District and local services, but the service range of one district centre will differ from that of the other. Services will be provided from service delivery centres across the Bellarine Peninsula according to the following configuration (Figure 3.1).

Figure 3.1 BCH service delivery configuration

	District centres		Local service centres		
Service level	Queenscliff (Southern hub)	Drysdale (Northern hub)	Ocean Grove	Portarlington	St Leonards
Area	Central admin. Home nursing OT Dementia services	Rehabilitation centre Dental Speech therapy Health promotion	Psychology Youth counselling		
District	Residential aged care Social support Allied health team	Social support Allied health team		Residential aged care	
Local	Physiotherapy Dietetics Podiatry/ footcare Community development	Physiotherapy Dietetics Podiatry/ footcare Community development	Physiotherapy Dietetics Podiatry/ footcare Community development	Physiotherapy Dietetics Podiatry/ footcare Community development	Physiotherapy Dietetics Podiatry/ footcare Community development
Integrated services	Medical M&CH	Program link to neighbourhood house		Medical Neighbourhood	Medical Neighbourhood

Queenscliff (the South Peninsula district centre)

Area services:

- Administrative services for all service centres. IT links to all sites.
- Home nursing and OT would use this centre as their base and deliver services across the Peninsula
- Dementia specific services. This would include dementia specific day care, and, dementia specific residential aged care (with a day care program)
- Residential aged care and Independent Living Units

District services:

- Social support program (intermediate level day care: frail aged)
- Allied health team: south Peninsula team base

Local services:

- Physiotherapy, dietetics, podiatry/footcare delivered to the Queenscliff/Point Lonsdale communities by the allied health team on a scheduled basis. Other allied health services according to need.

Integrated services:

- Base for services provided by other organisations or professionals. The Queenscliff medical practice and Queenscliff Maternal & Child Health Service would be core on-site services.

Drysdale (the North Peninsula district centre)

Area services:

- Rehabilitation centre: sub-acute rehabilitation service
- Dental services: relocated from Queenscliff to provide critical mass to Drysdale Centre. (Alternative: retain at Queenscliff.)
- Speech therapy: relocated from Queenscliff, also to provide critical mass to Drysdale centre. (Alternative: relocate dietetics service to Drysdale centre.)

District services:

- Social support program (intermediate level day care: frail aged)
- Allied health team: north Peninsula team base

Local services:

- Physiotherapy, dietetics, podiatry/footcare delivered to the Drysdale/Clifton Springs communities by the allied health team on a scheduled basis. Other allied health services according to need. A Community Development Worker(s) would be based at the centre.

Integrated services:

- Springdale Neighbourhood House is developing in a separate new facility. Related program planning and client care planning is proposed within the primary care model.

Ocean Grove

Area services:

- Psychology/youth counselling: The Ocean Grove Centre will be the base for counselling services, with a particular emphasis on youth.

Local services:

- Core local services would be provided on designated days (similar to existing arrangement). A Community Development Worker(s) would be based at the centre.

Integrated services:

- Program links to Ocean Grove Neighbourhood Centre to be fostered.

Portarlington

Area services:

- Residential aged care

Local services:

- Physiotherapy, dietetics, podiatry/footcare delivered to Portarlinton on a scheduled basis. Other allied health services according to need. A Community Development Worker would be based at the centre.

Integrated services:

- Integrated on-site general medical, community health, neighbourhood and residential services is preferred.

St Leonards

Local services:

- Physiotherapy, dietetics, podiatry/footcare delivered to St Leonards on a scheduled basis. A Community Development Worker would provide support on a scheduled basis.

Integrated services:

- Integrated on-site neighbourhood, community health and general medical service is preferred.

3.3 Recurrent funding issues linked to the service model

Increased, new or substitution of current funding and partnership with other health and community care providers will all be considered in the implementation of the change in Service Model.

Consideration will be given to the following funding sources for service enhancements:

Rehabilitation

Service substitution of some DHS Level 2 (inpatient) Rehabilitation funding, or, the allocation of Community Rehabilitation Centre program funding this innovative ambulatory program are both possible sources of funds. Partnership arrangements with Barwon Health in the short term and response to any new DHS sub-acute service funding opportunities for an ambulatory sub-acute service is the strategy that will be pursued.

Dental

DHS Dental Health Program funding for the gerodonic service, discussions have commenced. A submission will be made under the Community Dental Program or CDP Special Needs Projects for a second dentist.

Youth counselling

The model requires the appointment of a full time Youth Counsellor position. Service substitution opportunities from within existing budgets will be examined as a way to fund the proposed youth counselling service. (Existing family counselling and psychological counselling services will be retained).

Health promotion/health education

BCH will focus on key initiatives and target its resources accordingly. Core areas will include a focus on youth, targeted health promotion and chronic disease management.

A commitment at a management level will be a specific focus to a service wide community development approach to planning and service provision. This will provide a resource for program planning, development and delivery.

Social support program

Funding of this re-configured service will be progressively reviewed in conjunction with the facility development program. (State) Primary Care Program, any new DHS dementia service opportunities and (Commonwealth) Residential Care Program funding will be considered in conjunction to determine the optimal method of service delivery, particularly focussing on the dementia day care component. The need for additional funds is not anticipated in early stages of development.

General service development and population growth

Funding arrangements that reflect both the demographic structure of rapidly expanding coastal communities as retirement destinations and the costs associated with service delivery according to a multi-site model are factors that impact service delivery capacity. Adequate consideration of these factors in the provision of base funding will remain an issue for continued consideration.

Additional funding or collaborative partnerships with other providers and/or community groups will be required to achieve the revised service model. When opportunities arise to review existing program areas (as people leave positions), substitution may be considered, depending on service demand priorities.

3.4 Capital funding issues linked to the Primary Care service model

BCH is aware of the many competing demands for capital funding to address the myriad of capital funding unmet needs in the health sector. BCH is one of these organizations with unmet capital needs (one of the CHC's is 33 years old). However BCH is not seeking a primary health facilities redevelopment to be fully funded by State government.

It is critical however that BCH develops a strategic capital facilities plan so that BCH Board can identify the priority areas to meet demand and major occupational health and safety compliance requirements (requiring significant funding). BCH board can then identify from its own reserves and also seek other sources of funding to implement a staged capital funding program across the organization.

The Primary Care Service Model adopted by the BCH Board is linked to the six-year capital facility redevelopment as detailed in Appendix 5, and summarised as follows:

- Queenscliff: integrated community health/residential/community facility redevelopment. A feasibility study, followed by master planning should encompass three possible options.

- Drysdale: development of the existing centre to include a Rehabilitation Centre to service the Bellarine Peninsula and upgrading of the Centre to district status.
- Ocean Grove: internal layout modifications
- Portarlinton: integrated residential/community health/community centre development on the Ann Nichol House site
- St Leonards: support other providers to develop a community centre of which community health is one significant user

Should this facility development program not be implemented as planned, Appendix 5 describes the impact on the service model of a do-nothing option and a minor capital works option.

Funding of capital requirements for the BCH Residential Aged Care program are managed by BCH through a combination of use of reserves, fundraising, borrowings and seeking Commonwealth capital funding. For particular details about how the expansion of Ann Nichol House is to be funded, refer to the Ann Nichol House Redevelopment Proposal 2003.

Appendix 1

Current staffing arrangements

Funding is derived from a range of programs and this creates a complex arrangement with professionals from similar disciplines funded under different program streams. In this planning analysis, the staffing structure has been examined from a professional discipline and service function perspective to identify the staffing framework of the BCH model.

BCH has a staff establishment of 100.84 EFT positions encompassing 220 persons (Table 4.1).

The existing model may be described in several ways. The structure of the total BCH staff establishment is:

- Management and administration 15%
- Primary care workers 39%
- Residential care workers 46%

Table 4.1 BCH staff establishment

Category	Staff EFT	%
Management	3.89	3.85
Administration/reception	11.8	11.7
Dental	3	2.97
Allied health (CH + HACC)	10.38	10.29
Social support (ADA)	7.68	7.61
Home nursing + Palliative care	8.42	8.35
Community nursing	1.79	1.77
Clinic nursing	1.00	0.99
Other professional	2.36	2.34
Artisans	3.6	3.57
Aged Residential + food services	46.92	46.53
	100.84	100%

If the residential care component is removed, the primary care staffing model is revealed (Table 4.2). It indicates that home nursing (including palliative care), allied health and social support (ADA) are the three large program streams by staff EFT.

Table 4.2 BCH primary care staff establishment (including total management and administration)

Category	Staff EFT
Administration/reception	11.8
Home nursing + Palliative care	8.42
Allied health (CH + HACC)	10.38
Social support (ADA)	7.68
Management	3.89
Dental	3
Artisans	3.6
Community nursing	1.79
Other professional	2.36
Clinic nursing	1.00

Drilling further down into the data set to examine the allied health and related services component (Table 4.3) indicates the significance of podiatry and footcare services (2.51EFT), with the core allied health services each having a similar staff loading of around 1.0EFT. Other services have small staff establishments. Allied health services that employ several workers may have increased flexibility in the manner in which services are provided to the service centres. These include footcare and podiatry (7 clinicians), occupational therapy (a home based service) (3 clinicians), community health nursing and primary general care nursing (5 positions), dietetics (2 clinicians) and family counselling (2 clinicians).

Table 4.3 BCH allied health and related staff establishment

Category	Staff EFT
Podiatry	1.51
Foot care	1
Occupational therapy	1.55
Community health nursing	1.26
Speech therapy	1.00
Physiotherapy	1.63
Medical Clinic Nursing	1.00
Dietetics	0.88
Family counselling	0.63
Primary care general nursing	0.74
Psychology	0.72
Local initiatives workers	0.48
Maternal & Child Health (Q'ffe)	0.45
Youth health	0.42
	13.27

Appendix 2

Current funding levels

Total budget revenue from all sources, including fees was \$6.4mil in 2001-02. Departmental grants, clinic revenue and donations are shown in Table 4.4.

Table 4.4 BCH grants 2003-2004

Program area	Revenue
Residential aged care - Commonwealth	1,445 mil
Residential aged care (DHS)	194,000
HACC (DHS)	968,000
Community Health and other primary care (DHS)	1,496 mil
Clinic	200,000
Special purpose (Donations etc.)	342,000
Total	4.645 mil

Please note: does not include fee revenue

Some characteristics of the current BCH expenditure framework indicate that:

- Residential care and primary care have relatively similar expenditure weighting, but contrasting numbers of clients
- Within primary care services, community health nursing, home nursing, social support and dental services predominate
- Podiatry/footcare accounts for the largest allied health expenditure (53% more than the next largest allied health service [occupational therapy])
- There is a sound spread of expenditure across a wide range of services, thereby enabling BCH to provide a multidisciplinary service
- Expenditure on youth health programs is minimal.

Appendix 3

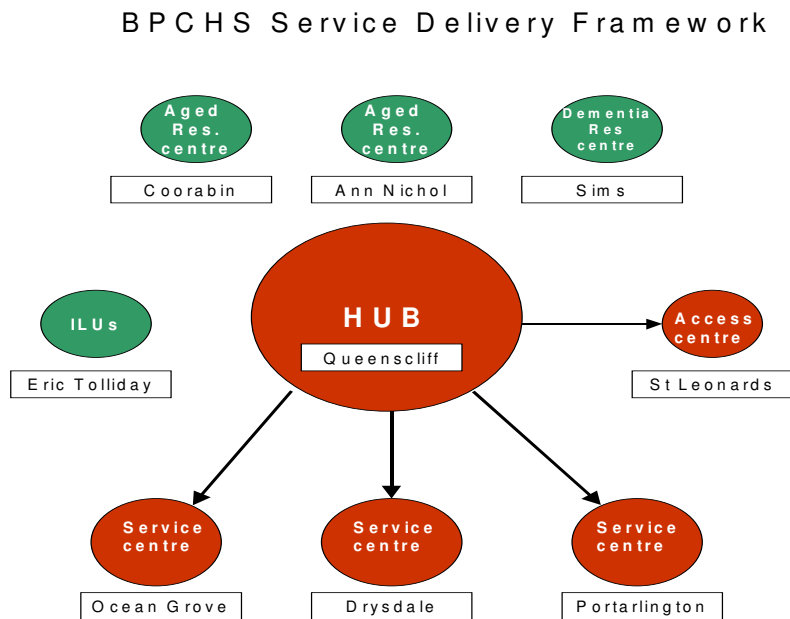
Current primary care site utilisation

Overview

The current BCH service delivery framework includes:

- A "hub and spoke" arrangement, (compared to other possible structural arrangements such as a "linked model" consisting of centres with a core set of services at each site)
- A central hub (that serves as both a service centre and a service distribution point), three service centres and one access centre.
- Three residential aged care components. These are largely independent of the primary care service system for direct service delivery (some allied health support exceptions) but receive program management and administrative support through the central hub. The ILUs are a relatively independent service.

Figure 4.1 BCH service delivery framework



OrgChartx2.ppt

Hub centre: Queenscliff Community Health Centre

The Queenscliff Community Health Centre (located in Pt Lonsdale) is the hub.

It incorporates the following functional elements that are unique to this site:

- Service management
- Central administration (personnel, finance)
- Home nursing service
- Dental service
- Integrated private medical service
- Most transport services
- Residential aged care.

It also includes allied elements found on other sites.

The site is also the base for significant in-home services including home nursing and occupational therapy. The Queenscliff site for most allied health services is the distribution centre to other sites. Thus the Queenscliff site may be perceived as providing a higher order service role. This arrangement has historic precedents rather than a planning basis.

Service centres: Ocean Grove, Drysdale, Portarlington

There are three facilities that provide a "service centre" role. The functional characteristics of a "service centre" include:

- No dedicated management function. Each centre has a Coordinator (part time) and receptionist (full time) but there is no in-take worker function. Whereas the Queenscliff site is a centre where clients may come to directly access a particular primary health service (such as doctors and dentists), the "service centres" are sites where clients come for allied health appointments or health related group activities.
- There are no medical or dental services (one exception - a general practitioner visits one morning a week)
- Primary care nursing is available for advice and referral
- A small number of clinicians may be based (or largely based) at these sites
- Allied health services are provided on a scheduled basis from Queenscliff (eg physiotherapy, dietetics, footcare/podiatry)
- Project work and community development may be based at these centres (eg community health nurses, youth project worker and community development worker)
- Social support (ADA) is a core function (two out of three sites)
- Group activity is also a core function (eg men's group, youth group, slimmers group, exercise group, young mothers, heart health program, low vision support group).

In addition co-located services (such as Maternal and Child Health services provided by the City of Greater Geelong) are based at these centres and visiting regional services use the facilities (eg Drug & Alcohol).

These sites also have a community development function and this serves as an important defining characteristic. In small communities where there are limited services, the community health centres on the Bellarine Peninsula are a focus of community activity, especially given that they are often the only community facility. A wide range of after hours meetings and activities occur at the centres ranging from ethnic group meetings, garden club, friendship group, tai chi, meditation, yoga classes and others.

The Queenscliff, Drysdale and Portarlington facilities were previously independent community health services and the Ocean Grove centre is a City of Greater Geelong owned facility that functions as a "one stop shop" for library, Council services⁴ and BCH community health.

Access centre: St Leonards

St Leonards Health Link is a service access centre. It operates from a small former bank and includes a consulting room, two work stations and waiting room/meeting room area. The service opens two mornings a week. Friends of the Health Link is a Local Advisory Committee to BCH.

The functional characteristics of this access centre include:

- Opens on a limited basis (2 mornings a week)
- No dedicated on-site staff positions
- Volunteers provide some service functions (eg reception)
- Advice and referral to BCH services provided
- Limited visiting services
- Base for group activity and community development activity

⁴ As of June 1 2002, Council services have been curtailed from Ocean Grove.

Appendix 4

Current demand for services

The Jack Sach review identifies significant changes in the demographics of the Bellarine Peninsula and this has resulted in an increased demand for services, both existing and new. The major changes relate to older people living longer and many young people/families now living in the community.

A review of the waiting list for most services over the last year has revealed the following:

Footcare – the average waiting period for the Footcare Nurse is 6 – 8 weeks. The demand for this service has remained high and constant and is predominantly utilised by the older population who either have physical difficulty reaching their feet, sight impairment or no carer to assist them with their footcare needs, to maintain quality of life. This service also greatly assists the Podiatry service, in that it can provide basic treatments, which then allows the Podiatry service to focus on more complex needs.

Podiatry – the average waiting period is 3 months. With the older population living longer, the demand continues to be very high. Many people who have diabetes use this service, due to the co morbidities associated with diabetes.

Occupational Therapy – the average waiting period is 3 – 4 weeks. The increasing focus on both Commonwealth & State government policy directions of maintaining people in their homes has a significant impact on OT services. There are many and constant assessments, which result in modifications to homes and the provision of aids. Also, with the continual pressure for inpatient hospital beds, significant numbers of people are discharged to home requiring intervention initiatives in place and this results in increased referrals to OT services.

District Nursing – whilst there is no waiting period of significance, referrals can only be accepted on weekdays and not on weekends, due to limited funding resources. A significant number of referrals originate from early discharge from hospitals and as per OT services, the pressure for hospital beds is relevant here also.

Physiotherapy – the average waiting period is 3 weeks. Both individual client appointments and group rehabilitation is a feature of Physiotherapy and the demand is constant with no ‘slack’ at all. There has been an increased focus on sub acute rehabilitation, which again relates to hospital bed demand.

Counselling – Social Work/Psychology – the average waiting period is 3 – 5 weeks and the focus is on family services, both with individuals and families. The demand is steadily increasing with an identified need for more specialised youth counselling. Resources are limited and no regional funding supports this service for the communities living on the Bellarine Peninsula. Client needs are often very complex.

Speech Pathology – the average waiting period is 7 – 8 weeks, although during April to December this can expand to 10 weeks. The demand is constant.

Women's Health – BCH offers a Well Women's Clinic, which has a varied focus including pap smears, breast self examination, menopause support, young women with intellectual conditions, birth control advice and the average waiting period is 4 weeks, with the increased focus on Women's Health policies.

This is a service also in strong demand because of the 'scarcity' of specific women's health medical centres.

Dietetics – the average waiting period is 3 weeks. As well as individual client appointments, the Dieticians conduct many group sessions across a range of needs. The Vic Government Health policy has a strong focus on nutrition in younger children, as this has been identified as an area of significant future importance. As a result of this there is an increasing demand for education in schools and the Dieticians provide a strong focus in this area. Diabetes is another area of significant focus because of the demographics of the Bellarine Peninsula community.

Dental – the waiting list is twofold, being 'cons' and 'pros'. Cons is 2.5 years and relates to checkups, hygiene and fillings. Pros is 3 years and relates to dentures. The change in demographics has identified an opportunity for a Gerodontics program, however this would require specific program funding from Dental Health Services Victoria (DHSV) which is not available at present.

Youth Health - the major focus for this service is counselling, support and education and situations are often in 'crisis mode', and therefore the waiting period is not of significance. However, resources are limited.

Maternal and Child Health – there is no waiting period of significance for this service, however, with the limited resources available, the MCHN puts in many more hours than she is remunerated for.

Unmet Demand for Services

The above analysis identifies that demand for all services is constant and high in some areas. The Jack Sach review identifies a number of recommendations that are aligned with the change in demographics. In terms of Primary Healthcare services these relate to Gerodontics, Youth Counselling, Sub Acute Rehabilitation and Health Promotion programs that are accessible to older people, isolated and financially disadvantaged people.

Gerodontics has been discussed above. There is no dedicated service for Youth counselling and with current resources as above, this is very limited. With the steady increase in the younger population, this is an area of strong need and recognition, with particular reference to social connectedness and isolation. There is an increasing and strong need for a dedicated Sub Acute Rehabilitation program as per above, however, resources are limited and dedicated program funding, along with partnerships with other relevant agencies would be required. All Health Promotion programs aim to provide equitable access, but could be further evaluated and enhanced.

Appendix 5

Facility development plan

Several options exist for capital works programming subject to capital availability, timing and feasibility investigations for each proposed project. The BCH Primary Care Model provides a do nothing option, a minimal capital works strategy option, and a preferred capital works option.

Do nothing option

Under the do nothing option the current level of service could be maintained, but the opportunity for service development and integration would be compromised.

Minimal capital works strategy

A minimal capital works strategy would include renovation of Queenscliff Community Health Centre to address building limitations. Under this scenario, there would be no change at Drysdale, Ocean Grove, Portarlington or St Leonards.

A similar level of service provision to that which currently exists could be maintained. However, the objective of providing “the best integrated model and means of delivering services across the Peninsula” would be compromised.

Preferred capital works model

The preferred capital works program would provide for the full implementation of the “whole of community” concepts and provide an exemplary primary care model illustrating a full integrated community, community health, ambulatory sub-acute and residential aged care service based on a multi-campus arrangement.

Queenscliff

Three facility development options will be investigated through master planning and feasibility study.

Option 1:

- Move the existing Community Health Service functions (including the medical practice) to an integrated community (neighbourhood)/community health/medical centre on the former Queenscliff High school site. The existing Point Lonsdale site would be redeveloped as an integrated residential/dementia care site by relocating Sims Lodge and developing a dementia care centre.
- Option 1 is subject to the possibility of the Borough of Queenscliffe Community Centre concept proceeding within one to two years.
- An integrated Queenscliff Community Centre on the former Queenscliff High School site could include:
 - community health and neighbourhood programs provided from same facility
 - medical practice

- significant multi-purpose room for use by the community health and community programs
- integrated reception and services areas
- integrated IT, financial administration and related services
- facility access 6 or 7 days a week, plus most evenings
- The Point Lonsdale site could be developed in the following manner:
 - Existing CHS facilities demolished (relocated to Queenscliff High School site).
 - Coorabin Aged Care Home and Eric Tolliday ILUs retained.
 - Dementia support centre for use by residents and community.

Option 2:

- Same as Option 1, but refurbish the existing Community Health Centre facility.

Drysdale

The existing facility would be upgraded to district centre status by extending onto vacant Council land to include a rehabilitation centre.

Subject to decisions relating to the relocation of some Area-wide services from Queenscliff to Drysdale, the existing facility would also require some internal modification (and possibly extension) to accommodate a 2 chair dental surgery and office space for speech therapy. Car parking would be extended.

Ocean Grove

The internal layout of the Council facility would be modified.

- Larger multi-purpose room (relocate kitchen and join two existing multi-purpose rooms).
- Rationalisation of use of existing combined staff office
- Relocation of adjacent library could be examined during the design process, as a possible future option.

Portarlington

An integrated facility would be developed on the Ann Nichol House site as a staged development. (Ann Nichol House extension [30 places] would form Stage 1).

Residential aged care, community health, medical and community (neighbourhood) services would be co-located within a master planned facility development.

St Leonards

BCH will work with the community to identify funding for an integrated community facility, of which community health would be one user, incorporating the following features:

- Primarily a community facility in which community health is one user.
- A multi-purpose facility of domestic scale and character built on Council land
- Rooms allocated for visiting community health services
- Medical practice incorporated into the design.

Figure 4.2 Summary of preferred capital works strategy

Site location	Facility development model
Queenscliff	Options (in priority order) 1 Residential services on Pt Lonsdale site & New Community health & community services on former high school site 2. <i>(lower cost option)</i> Refurbish existing CHS
Drysdale	Extend existing centre
Ocean Grove	Internal layout modifications
Portarlington	Integrated centre on Ann Nichol House site
St Leonards	Integrated centre on Council land

Staging of capital works

A capital works program could be extended over six years to include:

Years 1 to 3:

- Extension to Ann Nichol House (based on an integrated community facility design)
- Queenscliff Integrated Centre development
- Drysdale District Centre Development
- St Leonards Community Centre feasibility study (year 1) and construction (year 3).

Years 4 to 6:

- Portarlington Integrated Community Centre
- Ocean Grove facility modifications.

Figure 4.3 Preferred capital works timing

