NEPHU POPULATION HEALTH CATCHMENT PLANNING

WORKSHOP FINDINGS REPORT

STAGE 1: PHASE 4

FEBRUARY 2023

NEPHU NORTH EASTERN PUBLIC HEALTH UNIT

ACKNOWLEDGEMENTS

We acknowledge the traditional owners of the land on which we work and live. We pay our respects to elders past and present and extend that respect to all Aboriginal and Torres Strait Islander people.

We recognise, celebrate and respect Aboriginal and Torres Strait Islander people as the First Australians. We acknowledge their unique cultural and spiritual relationships to the land and waters, as we strive for equality and safety in health and wellbeing outcomes.

CONTRIBUTORS

NEPHU would like to acknowledge the contribution of the following teams in preparing this report:

- Public Health Integrated Planning and Programs
- Senior Leadership
- Communications

We would also like to thank the many stakeholders who contributed their time, knowledge and insights during the workshop.

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1. INTRODUCTION

1.1. BACKGROUND

The North Eastern Public Health Unit (NEPHU) is required by the Department of Health to develop a Population Health Catchment Plan by 30 June 2023. This plan will identify priorities for place-based primary and secondary prevention activity focused on preventable chronic disease and modifiable risk factors. As part of this process, NEPHU must identify two population health priorities for targeted collective effort in FY22-23.

During July to December 2022, NEPHU launched the first stage of the collaborative multi-sector stakeholder population health planning process to lay the foundations and evidence-base for developing a Population Health Promotion and Prevention Catchment Plan. Stage 1 of this planning process consisted of four phases:

1. **Desktop review** of the prevention landscape across the NEPHU catchment.
2. **Listening Lab Program** comprising interviews with internal and external stakeholders to capture reflections, opportunities and expectations.
3. **Population Health Profile** to generate a picture of the health and wellbeing needs and indicators of the NEPHU community.
4. **Multisector stakeholder workshop** to generate recommendations for two shared priorities moving forward for collective impact.

NEPHU delivered the online Population Health Catchment Planning Workshop on 15th December 2022. 54 stakeholders participated in the workshop, representing 33 multi-sector organisations from across the NEPHU catchment.

The purpose of this report is to document the findings of the NEPHU Population Health Catchment Planning Workshop (Stage 1, Phase 4). The findings of Stage 1 (Phases 1 – 4) will inform Stage 2 of the Population Health Catchment Planning Process.

1.2. WORKSHOP PURPOSE

To discuss the priority areas identified via earlier phases of the NEPHU Population Health Catchment Planning process and generate recommendations for two key priority areas for collective action within the current financial year.

2. METHOD

2.1. WORKSHOP DESIGN

A two and half -hour workshop was conducted on the 15th of December 2023. The workshop consisted of two parts (see Appendix 1 for full agenda):

1. **Context and evidence base**

   A series of presentations delivered by the NEPHU Leadership Team and the Executive Director of Policy and Programs, Public Health Division, Department of Health, summarising:

   - Departmental Catchment Planning requirements.
   - NEPHU's approach and work to date on catchment planning.
   - Key findings from NEPHU's Population Health Profile.

2. **Stakeholder consultation**

   A series of three interactive consultation activities that saw participants undertake both small and whole of group activities and report back on findings.

2.2. WORKSHOP PARTICIPATION

Key health promotion and prevention stakeholders from across the NEPHU catchment were invited to attend. A full list of stakeholders invited is shown in Appendix 2. Organisations were asked to register a maximum of two staff members, consisting of one leadership representative and one subject matter expert.

Organisations invited to participate and those that attended are listed in Table 1 below. One invitee was unable to attend but submitted a response to Activity 1 and Activity 3 outside of the workshop.

Table 1. Workshop participation by organisation type

Organisation type	Number of participants	Number of organisations represented	Number of organisations invited to participate
Community Health	20	11	13
Local Government	13	9	12
Department of Health/DFFH	5	3	5
Women's Health	4	2	2
Sexual Health	4	2	2
Aboriginal Controlled Community Health Organisations (ACCHO)	1	1	4
Primary Health Network	4	2	2
Tertiary Health Service	3	3	4
NEPHU	20	1	1
Total	74	34	45

2.3. PRE-WORKSHOP RESOURCES

To assist with enabling informed and meaningful participation in consultation activities, registered participants received a Briefing Pack prior to attending the workshop. The pack contained the NEPHU Population Health Catchment Planning Stage 1, Phases 1-3 Report with an accompanying Appendices document. Information included:

- Desktop review of the prevention landscape across the NEPHU catchment
- Listening Lab Program
- Population Health Profile.

2.4. INTERACTIVE CONSULTATION ACTIVITIES

Workshop participants engaged in three interactive consultation activities using the Mural platform (see Appendix 3 Workshop Mural Board) and moved between facilitated break out rooms and whole of group activities.

2.4.1. Activity 1: Exploring Priority Areas

In Activity 1, participants were placed into one of seven preassigned breakout rooms, with each room focusing on a single priority area (generated via Stage 1, Phases 1-3 findings) and asked to discuss the following questions:

- Q.1. What might shared effort and action look like?
- Q.2. (a). What is the rationale for choosing this priority for collective action?
- Q.2. (b). What is the rationale against choosing this priority?

Table 2. Priority areas allocated to each breakout room discussion:

Room	Priority area
1	Increasing active Living
2	Increasing healthy eating
3	Reducing injury
4	Reducing harmful alcohol and drug use
5	Improving sexual and reproductive health
6	Reducing tobacco related harm
7	Reducing preventable chronic disease

2.4.2. Activity 2: Key Priority Ranking

In Activity 2, participants were asked to vote on two priorities they felt NEPHU should focus on in the coming financial year. The top four selected priorities became the focus of discussion in Activity 3.

2.4.3. Activity 3: Towards Success Together

In Activity 3, participants were randomly allocated into one of four breakout rooms. Discussion within each room focused on one of the top four priority areas identified in Activity 2 (Table 3).

Participants responded to the following questions:

- Q.1. What would success in this priority area look like?
- Q.2. If collective action was to be undertaken in this priority area, would your organisation be a potential partner?

Table 3. Priority areas allocated to each breakout room discussion:

Room	Priority area
1	Improving sexual and reproductive health
2	Increasing active living
3	Increasing healthy eating
4	Reducing harmful alcohol and drug use

3. WORKSHOP FINDINGS

3.1. ACTIVITY 1: EXPLORING PRIORITY AREAS

3.1.1. Room 1: Increasing Active Living

Participants put forward a range of suggestions for shared effort and action, which have been grouped under the following five themes:

1. Advocacy and funding
2. Infrastructure and environment
3. Evaluation
4. Accessible and equitable systems and services
5. Partnerships and shared learning.

Details of the suggested actions can be found in Q1 of the table below, whilst Q2 findings document the rationale participants identified for and against choosing this priority area for collective action. Where a comment was made more than once on the Mural board, the number is shown in brackets.

Table 4. Activity 1: Exploring Priority Areas – Room 1: Increasing Active Living

Q1. What might shared effort and action look like?
Advocacy and funding

• Collective advocacy (x2) for example:
  ○ to the Department of Education and Training
  ○ to Public Transport Victoria
  ○ for improved active travel infrastructure
• Lobbying to reduce the cost of accessing physical activities (e.g., gyms) through Government subsidies
• Funding for structured opportunities to be active (outside normal business hours)

Infrastructure and environment
• Improved and well-linked up infrastructure to support active travel including increasing walkability (x3) • Improved and more coordinated policies • Targeting sporting leagues and state-based organisations to improve their offerings • Installation of ‘drop and stride’/ ‘park and walk’ zones for schools
Evaluation
• Shared impact measures to evaluate and monitor change • Clarity around what needs to be measured to show impact

Accessible and equitable system and services

- Greater availability, accessibility, affordability, quality, frequency and diversity, of group physical activities offered within communities
- Applying an intersectional lens to understanding barriers to participation e.g., gender, age, disability
- Improved health promotion regarding the benefits of physical activity

Partnerships and shared learning

- Focus on one or two actions that achieve increased activity e.g., incidental activity for a particular cohort
- Coordinate to avoid duplication and ensure role clarity
- Shared models and learning about what works
- Scale up existing models and projects that show strong outcomes
- Region-wide social marketing campaigns
- Collaborative, sustained, long-term, mutually reinforcing program of activity that reaches those most in need (dependent on local community needs)

Q2. The rationale for and against choosing this priority for collective action

FOR	AGAINST

• Data for physical inactivity and sedentary behaviour demonstrates need (x2)
• Substantive clinical evidence-base regarding wide-ranging health benefits of exercise
• Co-benefits for other health priorities. E.g., mental health, chronic disease, social connection, community engagement (x6)
• Can be more affordable and accessible than other priorities (depending on the activity)
• Specific benefits of collective action and a coordinated approach:
  ○ sustainability is more likely to be achieved
  ○ upstream approaches (e.g., leagues and state-based organisations) will be more effective than working with organisations at club-level
  ○ advocacy will be more effective (x2)
• Alignment with empowering communities/asset-based community development
• Can involve a large number of stakeholders. Multiple approaches are possible
	• Complexity of this area; there are lots of government departments and agencies involved
	• Barriers to increasing physical activity at individual level: being time poor (x2); lack of required skill level, cost of living; exercise is not usually a priority as not perceived as having immediate benefit
	• Significant difficulty in motivating individuals to undertake consistent and dramatic lifestyle changes

Final position: In support of recommending collective action on this priority area

3.1.2. Room 2: Increasing healthy eating

Participants put forward a range of suggestions for shared effort and action, which have been grouped under the following five themes:

1. Advocacy
2. Environments, infrastructure and food systems
3. Partnerships and networks
4. Evaluation
5. Community engagement and education.

Details of the suggested actions can be found in Q1 of the table below, whilst Q2 findings document the rationale participants identified for and against choosing this priority area for collective action. Where a comment was made more than once on the Mural board, the number is shown in brackets.

Table 5. Activity 1: Exploring Priority Areas – Room 2: Increasing healthy eating

Q1. What might shared effort and action look like?
Advocacy
• Advocacy to government departments to create regulatory and broad systems change rather than small, hard-to-achieve changes at a local level • Influence policy on advertising/media • Advocate for Vic Kids Eat Well to have increased follow through (as it is one-off process that is not currently sustained)
Environments, infrastructure and food systems
• Improved infrastructure • Working to directly address climate change in terms of local food systems • Increase stakeholder buy-in for the Achievement Program in relevant settings (x3)
Partnerships and networks
• Regional Communities of Practice for peer support and sharing findings • A Food Systems network for community health organisations (x2) • Combined effort with the VicHealth Council Partnership Program • Shared effort across an LGA to scale up project level action by single organisations, which is supported by policy • Innovation and new approaches; support provided to bring all areas of this work along
Evaluation
• Shared program logic including inputs from across the region and expected outputs • Shared measurement including the ability to combine impact and outcomes data

Community engagement and education

- Gain community ground swell so that communities want to see changes in environments (e.g., schools)
- Build community understanding about the influence that large corporations have on our food choices
- Communicating the impact of our collective food choices on the whole ecosystem (x2)
- Recognition of the need for education to start with young people to develop a healthy lifestyle
- A health literacy approach
- Take a size inclusive/weight neutral approach

Q2. The rationale for and against choosing this priority for collective action

FOR	AGAINST
• There are a range of co benefits e.g., climate, mental health, physical health and chronic disease reduction (x3) • Collective action is needed for such a big issue with so many drivers and influences; Whole of Food System work is lacking • A collective approach would enable innovative initiatives to be shared quickly, and greater ability to scale up effective approaches • This is a priority for many organisations working in health promotion; Existing work and knowledge can be leveraged and grown. • There are lots of supporting programs and infrastructure to draw on • A collective approach has greater potential to influence and inform Department of Education and Training on school canteen policy • The potential benefit of shared measurement (A Collective Impact approach to measurement); Universities have done some work in this area to help with measurement and evaluation	• There is a lot of work already underway in this space (need to ensure value is added) (x3) • Action in this space that doesn't include regulatory action at a government level isn't efficient • It's too hard for government to act because of political pressure from industry • Lack of support from government and Department of Education and Training (x2) • Risk of continued silo between health and education Using state wide approaches is not popular with many settings especially schools

Final position: In support of recommending collective action on this priority area

3.1.3. Room 3: Reducing injury in the community

Participants put forward a range of suggestions for shared effort and action, which have been grouped under the following six themes:

1. Needs and opportunity identification
2. Priority population focus
3. Partnerships and information sharing
4. Advocacy
5. Community engagement
6. Accessibility of services.

Details of the suggested actions can be found in Q1 of the table below, whilst Q2 findings document the rationale participants identified for and against choosing this priority area for collective action. Where a comment was made more than once on the Mural board, the number is shown in brackets.

Table 6. Activity 1: Exploring Priority Areas – Room 3: Reducing injury in the community

Q1. What might shared effort and action look like?
Needs and opportunity identification
• Defining scope. E.g., types of injuries • Identifying hotspots including specific injury types; shared data on which LGAs are hotspots • Mapping existing similar programs in this space • Evidence on what works in the prevention space
Priority population focus
• Identifying population groups at increased risk (x2) • Development of translated material that focuses on prevention of injuries
Partnerships and information sharing
• More communication between different organisations, well-established networks and forming a community of practice • Information sharing between organisations regarding training opportunities • Harnessing the strengths of different organisations. For example, providing specialised training tailored to priority populations • Defining roles in this space • Collaborative planning and priority setting • Small pilots in a limited range of settings • Opportunities to replicate and scale initiatives that have proven effective elsewhere
Advocacy
• Combined advocacy for changes at state and commonwealth level

Community engagement

- Community consultation
- Improving awareness with providers and the general community

Accessibility of services

- Clear service directories/referral pathways

Q2. The rationale for and against choosing this priority for collective action

FOR	AGAINST
• Injury is a significant problem for elderly populations yet aged care is often overlooked and underfunded • Data findings • Could start to build awareness for future action • Climate risk will increase a focus on this in the long term • Co-benefits to other priority areas like mental health and preventing violence against women	• It's not a priority area that many organisations are working in so opportunity for collective impact is limited (x2) • Long term action required (x3) • Causes of injury likely to be widespread, so there is no one-size-fits all solution • Limited understanding of the issues in community and services (x2) • Data presented indicates that there is lower need in this area compared with others • Only 28% of external stakeholder and 7% internal stakeholders recommended this as a priority (during NEPHU's Phase 2 consultation)

Final position: NOT in support of recommending collective action on this priority area

3.1.4. Room 4: Reducing harmful drug and alcohol use

Participants put forward a range of suggestions for shared effort and action, which have been grouped under the following four themes:

1. Advocacy
2. Accessible services
3. Targeted approaches, primary prevention and community engagement
4. Partnerships.

Details of the suggested actions can be found in Q1 of the table below, whilst Q2 findings document the rationale participants identified for and against choosing this priority area for collective action. Where a comment was made more than once on the Mural board, the number is shown in brackets.

Table 7. Activity 1: Exploring Priority Areas – Room 4: Reducing harmful drug and alcohol use

Q1. What might shared effort and action look like?
Advocacy
• Flexible local funding • Advocate for health lens rather than justice lens
Accessible services
• Service mapping including awareness of gaps • Enhanced service integration and coordination; pathways between services (including between prevention/support services and those that manage the consequences of harmful use) • Integrated service access
Targeted approaches, primary prevention and community engagement
• Solutions/interventions need to be nuanced to meet the needs of different communities to be effective (including NEPHU funded targeted local solutions). • Community engagement to ensure service users voices and experiences are central to service and program planning and evaluation • Focus on primary prevention
Partnerships
• An engaged, cross-sector working group (x2); collaboration is key; engagement of non-health groups such as Victoria Police and other agencies outside of health service delivery • Community of practice (x2) • Working collaboratively with local community health organisations • Strategic partnerships at a local level that result in co-designed initiatives • Applying Gender Impact Assessment (GIA) and gender lens to collective work

Q2. The rationale for and against choosing this priority for collective action	
FOR	**AGAINST**
• The burden of disease is huge; the issue has been exacerbated by COVID–19 and impacts disadvantaged communities and individuals the most • Behaviour change in this priority is slow and requires consistent attention, intervention and a prevention lens • Though it's everyone's problem, it is often seen as no one's priority. So, having it as a NEPHU priority could finally help get traction • Has direct links to all other priority areas (x3) • Huge public health and community safety issue in Yarra	• Can't think of one (x2) • More direct priorities such as reducing chronic disease may take precedence • There is no doubt this is a priority issue, however sexual and reproductive health (SRH) needs to be a priority • Lack of investment of resources from other key stakeholders • Lack of funding for community health organisations to deliver

Final position: In support of recommending collective action on this priority area

3.1.5. Room 5: Improving sexual and reproductive health

Participants put forward a range of suggestions for shared effort and action, which have been grouped under the following three themes:

1. Social determinants and priority populations focus
2. Secondary prevention and service access
3. Partnerships.

Details of the suggested actions can be found in Q1 of the table below, whilst Q2 findings document the rationale participants identified for and against choosing this priority area for collective action.

Table 8. Activity 1: Exploring Priority Areas – Room 5: Improving sexual and reproductive health

Q1. What might shared effort and action look like?
Social determinants and priority populations focus
• A focus on a social determinants approach; Recognise the intersection of health and other determinants • Prevention strategies expand upon understandings of SRH • Increasing health literacy (x2)
Secondary prevention and service access
• Focus should include secondary prevention (abortion access, STI testing and tracing, and other chronic issues relate to this priority) • Increasing service coordination regarding medical and surgical abortion • Inclusive service provision for priority populations, including LGBTIQ+
Partnerships
• Build the implementation of existing strategies; broaden existing partnerships (x2) enabling wide partnerships and a prevention approach • Potential for more health promotion work • Skills acquired by NEPHU through our work in contact tracing for COVID can be readily transferred to SRH. • Long term work but quick wins in this space

Q2. The rationale for and against choosing this priority for collective action	
FOR	**AGAINST**
• The burden of disease associated with SRH is significant, but not well understood or studied (STIs, maternity health, lack of abortion access, stigma and taboo, and chronic disease associated with SRH cancers and disease) • An opportune time for collaboration; opportunities for quick wins and long-term benefits • Limited action in this space in relation to prevention (x2); opportunity to scale up of existing work, and development of new and emerging work (x2) • Opportunity to build on SRH shared regional action plan and broaden existing partnerships (x2) • SRH is an issue very strongly identified by community, but rarely shows up in the data • Opportunity for more collaboration with community-controlled and community-led services • An opportunity to leverage NEPHU connections with tertiary services, General Practitioners and community organisations working in primary prevention	• There are already a lot of existing resources and programs in this area
Final position: In support of recommending collective action on this priority area	

3.1.6. Room 6: Reducing tobacco-related harm

Participants put forward a range of suggestions for shared effort and action which have been grouped under the following five themes:

1. Priority populations
2. Partnerships
3. Building the evidence-base for vaping
4. Accessible services and referral pathways
5. Advocacy and legislation.

Details of the suggested actions can be found in Q1 of the table below, whilst Q2 findings document the rationale participants identified for and against choosing this priority area for collective action.

Table 9. Activity 1: Exploring Priority Areas – Room 6: Reducing tobacco-related harm

Q1. What might shared effort and action look like?
Priority populations
• Target priority groups (x4) at greater risk of uptake and/or current use and tailor interventions for them (x2); co-design with priority populations • Focus on priority LGAs e.g., Whittlesea Council, Knox City Council and Darebin City Council • Education/prevention of vaping particularly for younger populations
Partnerships
• Support for and partnerships with ACCHOs • Partnerships with other higher-risk settings, e.g. prisons, public housing
Building the evidence base for vaping
• Strong focus on building the evidence-base around vaping, including impact of vaping in NEPHU catchment (x3) • What works to reduce uptake of e-cigarettes
Accessible services and referral pathways
• Service mapping and linking to existing services • Increased availability of and access to smoking cessation groups/services • Increase promotion and uptake of QUIT program; enhance referrals to QUIT program
Advocacy and legislation
• Submission into law reform committee to advocate for decriminalisation • Need for legislative and regulatory work in relation to e-cigarettes • Further bans on where you can smoke

Q2. The rationale for and against choosing this priority for collective action

FOR	AGAINST
• Intersections between tobacco-related harm and other health priorities/outcomes • Strong concern from community around vaping • High rates of vaping • Could be a good secondary priority that focuses on a smaller segment of the community, or particular LGAs, if the other priority is more of a population-wide priority • Lots of existing supports/research into tobacco harm, and State programs available to support this work is available (x2) • Opportunity to intervene relatively early to prevent downstream negative health outcomes • Real risk of losing gains from past tobacco control efforts which will have negative impact on health outcomes downstream	• Long term work is required to achieve outcomes in this space (i.e., beyond 2022/23) (x3) • Without strong action at a policy/legislative/national level, the potential impacts at a community level are limited (x3) • Except vaping, which is identified as a concern from community, this is not often identified as a key community priority • Population health data profile does not show a strong case for regional collaboration (higher than average in a few LGAs only) (x3) • Did not come up as a high priority for stakeholders in Phase 2 Consultation Report • Needs clear definition to identify opportunities for collective impact (versus selected agency involvement) and may take a while for people to get on board if not currently working in the space

Final position: NOT in support of recommending collective action on this priority area

3.1.7. Room 7: Reducing preventable chronic disease

Participants put forward a range of suggestions for shared effort and action, which have been grouped under the following four themes:

1. Accessible services and referral pathways
2. Advocacy
3. Partnerships and sharing resources
4. Settings-based approach.

Details of the suggested actions can be found in Q1 of the table below, whilst Q2 findings document the rationale participants identified for and against choosing this priority area for collective action.

Table 10. Activity 1: Exploring Priority Areas – Room 7: Reducing preventable chronic disease

Q1. What might shared effort and action look like?
Accessible services and referral pathways
• Address barriers to accessing prevention/treatment • Increase screening and access to primary health services • Improved two-way referral pathways from community to tertiary health and vice versa • Improving access to health information in a health literate context (x2) • Reduced emergency presentations and hospitalisations/reduced load on the tertiary system
Advocacy
• Advocacy for funding to meet requirements of collaborative care between primary and tertiary settings
Partnerships and sharing resources
• Localised partnerships and coordinated communications • Re-orienting health service by extending remit of trusted partners (e.g., surgeons and exercise promotion) • Focus on confirming a collective impact approach rather than addressing 'issues' • Shared resourcing across partners to deliver programs into community (x2) • Leveraging existing programs that can be immediately upscaled
Settings-based approach
• Community or settings engaged, and readiness evident • Embedding tertiary services in community settings

Q2. The rationale for and against choosing this priority for collective action	
FOR	**AGAINST**
• All of the other six domains work to reduce preventable chronic disease • Better outcomes are achieved through a collaborative approach (x2) • Interventions could be widely impactful (x2) • Enables the application of an intersectional lens to population issues • This priority needs population health focused action to reduce risk factors • Target communities where need is greatest • High rates of overweight and obesity • High rates of chronic disease in NEPHU catchment (x2) • Strong strategic alignment	• All of the other six domains work to reduce preventable chronic disease • Sits within Primary Health Network (PHN) remit • Lots of existing providers in this space • Very hard to demonstrate impact and outcomes (x2) • Can the effort be better placed in other priorities? • Needs to be combined with other priorities e.g., healthy eating and active living
Final position: NOT in support of recommending collective action on this priority area	

3.2. ACTIVITY 1: KEY FINDINGS

All virtual rooms identified partnerships as a central key theme. Partnerships encompassed sharing of resources, learnings and information. Advocacy emerged as the second most identified key theme in 6 of 7 rooms, particularly collective advocacy directed towards funding and legislative change.

Three key common themes for shared action emerged across several of the potential priority areas: the provision of accessible and equitable systems and services; a focus on priority populations; and evaluation. As such, it is noted that as NEPHU and our partners progress with work within the selected priority areas for collection action, the above themes are to be embedded in the design, implementation and evaluation of the body of work.

3.3. ACTIVITY 2: KEY PRIORITY RANKING

Workshop participants were asked to rank the seven priority areas by voting for their top two priority areas to be considered for collective action. Each participant was allocated two votes and was required to cast these to two different priorities (i.e. an individual could not allocate both their votes to a single priority).

The top four priorities were:

1. Improving sexual and reproductive health
2. Increasing active living
3. Reducing harmful drug and alcohol use
4. Increasing healthy eating.

The total number of votes cast in the vote was 86, which represented participation in the vote by 43 workshop participants. The ranking of all priorities as a result of the vote is shown in the table below.

Table 4. Key priority area ranking:

Priority area	Rank	Total votes
Improving sexual and reproductive health	1	22
Increasing active living	2	18
Reducing harmful drug and alcohol use	3	15
Increasing healthy eating	4	14
Reducing preventable chronic disease	5	13
Reducing tobacco related harm	6	3
Reducing injury in the community	7	1

3.4. ACTIVITY 3: TOWARDS SUCCESS TOGETHER

In this activity, participants were allocated to one of the four top priorities identified in Activity 2.

In breakout rooms, participants were first asked what success might look like for their allocated priority. Participant responses are summarised in Tables 11 – 14 below.

Participants were then asked to indicate their potential interest in partnering in each of the top four identified priority areas. Participant responses are summarised in Appendix 4, Tables 15 – 18.

3.4.1. Room 1: Improving sexual and reproductive health

Participants put forward a range of suggestions for what success might look like, which have been grouped under the following five themes:

1. Accessible and equitable services and systems
2. Priority populations focus
3. Partnerships
4. Advocacy
5. Capacity development.

Table 11. What success looks like: Improving sexual and reproductive health

What does success look like for this priority?
Accessible and equitable services and systems
• Improved information and service access; better availability of services (not solely centralised to metropolitan Melbourne) • Equitable access for northern metro region (there is no SRH Hub in the northern metropolitan region) • All population groups can access services • Improved rates of testing
Priority populations focus
• Taking a determinants approach • Designing targeted SRH interventions for priority groups including CALD communities, LGBTQI+ communities, Aboriginal and Torres Strait Islander people and young people; an equity lens is applied to achieve better outcomes • Recognition of non-traditional risk cohorts • Youth led co-design with young people • Understanding of population data is client-informed (i.e., are rates a true reflection of population prevalence) • Increased awareness, education and information regarding SRH including consent education for young people

Partnerships

- Clarity of role for stakeholders
- Developing partnerships to deliver initiatives and submissions
- Bolstering of shared effort through the involvement of additional sectors and partners in existing strategies
- Integration of SRH strategies, impacts and outcomes into non-SRH programs/services
- Shared data to inform evidence-based planning

Advocacy

- Joint advocacy for SRH hub in the north
- Joint federal budget submissions
- Improved funding to community-controlled organisations
- Improved longer-term funding

Capacity development

- Enhanced workforce capacity for primary prevention initiatives and those involved in all forms of service delivery

When asked to indicate their potential future interest in collective action, fourteen organisations from across various sectors indicated they could be a potential partner in improving sexual and reproductive health. These organisations are shown in Appendix 4, Table 15.

3.4.2. Room 2: Increasing active living

Participants put forward a range of suggestions for what success might look like, which have been grouped under the following five themes:

Participants proposed a range of suggestions for what success might look like, which have been grouped under the following five themes:

1. Accessible and equitable services and systems
2. Community engagement
3. Advocacy
4. Infrastructure and environment
5. Partnerships.

Table 12. What success looks like: Increasing active living

What does success look like for this priority?
Accessible and equitable services and systems
• Inclusive and accessible places for engaging in active living for all populations, especially those who are disadvantaged • Access to low-cost activities for active living • Communities choose active transport more often
Community engagement
• Value-based and strength-based key messaging is developed in different community languages • Multilingual education • Communities are engaged in the design of opportunities for increasing activity • Community services are engaged including community hubs in peri-urban centres and schools • Place-based ways to increase incidental exercise are identified; increased use of active transport, walking and cycling paths, Council leisure facilities, walking groups, community sport and passive recreation in parks, especially by people in the community who face barriers to access and participation
Advocacy
• Advocacy at local, regional and state-wide levels to increase active transport through supportive environments • Funding to design/codesign interventions for priority populations
Infrastructure and environment
• Walkability is improved • The building of infrastructure is influenced • Buy-in from sporting codes creates more inclusive recreational options

Partnerships

- Partnerships that are formed have a shared vision
- Key partners for communication are identified

When asked to indicate their potential future interest in collective action, 11 organisations (largely across local government and community health sectors) indicated they were a potential partner in increasing active living. These organisations are shown Appendix 4, Table 16.

3.4.3. Room 3: Reducing harmful drug and alcohol use

Participants put forward a range of suggestions for what success might look like, which have been grouped under the following four themes:

1. Strategic and theoretical approach
2. Accessible and equitable services and systems
3. Education and capacity building
4. Partnerships.

Table 13. What success looks like: Reducing harmful drug and alcohol use

What does success look like for this priority?
Strategic and theoretical approach
• Harm minimisation approach to alcohol and other drugs (AOD) • Health-based framework for addiction, not criminalisation • Improved social behaviour change strategies to target and change prevalent drinking culture • Upstream approaches with consideration to urban planning controls and liquor licencing • Recognising disease and mortality burden of prescription medication abuse • Greater understanding of the social determinants of AOD misuse and need for increased services
Accessible and equitable services and systems
• Better access to AOD services; increased and faster access to detox facilities • Better established and more streamlined referral pathways (x2) • Access to Drug/Pill testing • Better access to GPs for opioid replacement therapy (ORT) • Another medically supervised injecting room • Holistic referral pathways developed, centred on individual needs. E.g., Dual diagnosis versus alcohol and drug services
Education and capacity building
• Understanding of stigma and discrimination on the use of drugs and alcohol • Multidisciplinary training across services and sectors
Partnerships
• Collaboration with all sectors working in the space • Understanding what has/does and hasn't/doesn't work across the sector and leveraging off existing knowledge and programs

When asked to indicate their potential future interest in collective action, 14 organisations from cross various sectors indicated they were potentially interested in partnering to reduce harmful drug and alcohol use. These organisations are shown in Appendix 4, Table 17.

3.4.4. Room 4: Increasing healthy eating

Participants put forward a range of suggestions for what success might look like, which have been grouped under the following six themes:

1. Food systems and theoretical frameworks
2. Partnerships
3. Policy and legislation
4. Advocacy
5. Priority populations focus
6. Measurement.

Table 14. What success looks like: Increasing healthy eating

What does success look like for this priority?
Food systems and theoretical frameworks
• Design and implement sustainable food utilisation strategy such as urban farming • Upstream actions - working with suppliers and producers • Employing a determinants approach rather than a behavioural approach • Resisting the temptation for quick wins in relation to individual behaviour change • Systems change as well and focused interventions that engage community • Theoretical frameworks • Achievable actions readily implemented • Supported through a broader lens of reducing preventable chronic disease • Gender impact assessments are being applied to all work in healthy eating space, noting the highly gendered nature of healthy eating work and public discourse
Partnerships
• Engagement with multiple sectors e.g., supermarket, education • Commitment across partners and community • Agreed action plan with all schools • Builds on existing work within the catchment
Policy and legislation
• Requirements for food relief providers to provide nutritious food • Local policy change in organisational settings • Healthy Choices should be compulsory across Early Childhood Services, Schools, Sport and recreation facilities, Councils and Healthcare settings • All Councils legislated to have a food systems strategy and/or action plan • Minimal unhealthy sponsorship across Council owned facilities and sports fields

Advocacy

- Advocacy for food policies and plans within councils
- Healthy food retail recognition program
- Challenging bias present in medical profession which limits people's access to evidence-based care

Priority populations focus

- Specific action plans in place for different cultural groups in the community
- Access to healthy affordable food for socially disadvantaged individuals

Measurement

- Systems framework and measures are developed

When asked to indicate their potential future interest in collective action, 11 organisations from across various sectors indicated their potential interest in partnering to increase healthy eating. These organisations are shown in Appendix 4, Table 18.

A complete summary of potential partner organisations for the top four priority areas is shown in Appendix 5, Table 19.

3.5. SUMMARY OF KEY INSIGHTS

Participants ranked the Priority Areas by voting individually for their top two choices. The top four priority areas were:

1. Improving sexual and reproductive health (22 votes)
2. Increasing active living (18 votes)
3. Reducing harmful drug and alcohol use (15 votes)
4. Increasing healthy eating (14 votes).

These four areas will now be explored further in order to identify which two priority areas will be selected for collection action within the current financial year.

3.5.1. Improving sexual and reproductive health

Notably, participants envisioned that achieving success through a collective approach to improving sexual and reproductive health would include:

- Improved access to services in the northern metropolitan region
- Widening participation in existing regional strategies
- A focus on priority populations.

Drawing on Activity 1, participants presented a range of rationale in favour of choosing this priority, including a significant burden of disease that is poorly understood, limited prevention activity at the current time, and the potential to build on shared regional plans and expand existing partnerships.

Few arguments were put forward against choosing this priority.

3.5.2. Increasing active living

Achieving success through a collective approach to increasing active living was envisioned as:

- Including improved infrastructure for active transport, including increased walkability
- Inclusive, accessible and affordable spaces
- Opportunities for engaging in physical activity.

The engagement of communities and priority populations was recognised as key to success. Key rationale for selecting this priority included a demonstrated need based on data for physical inactivity, a substantive clinical base for the wide-ranging benefits of exercise, and co-benefits for mental health and climate change.

The argument against this priority included the complexity of government.

3.5.3. Reducing harmful drug and alcohol use

Achieving success through a collective approach to reducing harmful drug and alcohol use was envisioned to include:

- A harm minimisation approach
- health-based frameworks for addiction, rather than criminalization
- Better access to services, including detox facilities
- Streamlined referral pathways
- Action to reduce stigma.

Key rationale for selecting this priority included significant burden of disease, the need for prevention, links to other priority areas, and the potential for NEPHU leadership to be a catalyst for gaining traction in this priority area.

One rationale against choosing this priority was a lack of funding for community health organisations to deliver action in this area, and a lack of investment in resources from other key stakeholders.

3.5.4. Increasing healthy eating

Achieving success through a collective approach to increasing healthy eating was envisioned to include:

- Action towards sustainable food systems
- Strengthening of policy and legislation to support healthy eating
- Engagement with multiple sectors and commitment across partners and the community.

The large number of organisations already working in this priority area was considered to be a reason both for and against choosing this priority.

Other key reasons for choosing this priority included the broad range of benefits for chronic disease prevention, as well as co-benefits for mental health and climate health, the need for collective action to address such a significant issue with so many drivers, and the potential to develop shared measurement systems to evaluate the impact of collective work.

Additional reasons against choosing this priority included the potential for action to be ineffective unless supported by regulatory action at government level, industry pressures which make it difficult for government to act, and challenges in achieving effective action within schools, which are a key setting.

3.5.5. Summary of indicative partners for top four priorities

In Activity 3, participants also gave an initial indication of whether their organisation would be a potential partner in collective action for each of the top four priorities. The number of potential partners for each priority is shown below. It should be noted that this activity took place at the end of the workshop and not all participants were still present in the virtual room at the time.

- Improving sexual and reproductive health – 14
- Increasing active living – 11
- Reducing harmful drug and alcohol use – 14
- Increasing healthy eating – 11

The workshop has demonstrated clear rationale, multi-sectoral support and significant opportunity for collective action within each of the identified top four priority areas. In addition, many of the key action areas across these priorities align strongly with a potential role for NEPHU, which was identified during earlier phases in Stage 1 of the Catchment Planning process.

The workshop findings, including stakeholder ranking of priorities, support subsequent further assessment of the top four identified priority areas, in determining two priority areas for collective action in 2022-23.

4. CONCLUSION

Participation by stakeholders from 33 organisations across the catchment demonstrates significant commitment to collaboration and collective action with good multi-sector representation across all partners.

Findings relating to action and functions for success align with earlier phases of NEPHU's Catchment Planning Process, providing a deeper insight into stakeholders' appetite for collective impact and preferred priority areas for focus during NEPHU's foundational year.

Based on the workshop findings and Phases 1-3 of Stage 1, NEPHU will progress the planning process with a focus on the following four priority areas:

1. Improving sexual and reproductive health
2. Increasing active living
3. Increasing healthy eating
4. Reducing harm from alcohol and drug use.

In order to determine the final two priority areas for collective action NEPHU will progress the following timeline of activities:

Activity	Period
Undertake a data assessment of each of the four priority areas.	January – February
Establish and activate a NEPHU Catchment Plan Steering Committee to receive recommendations and play a key role in the determination of two priority areas for collective action (in addition to a broader function and terms of reference).	February
Seek endorsement from all relevant parties on the determination of two priority areas for collective action in 2022-2023 financial year.	February
Subsequently create two priority area working groups.	March
Use report findings in the drafting of the broader catchment plan.	January – March

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5. APPENDICES

APPENDIX 1: WORKSHOP AGENDA

Date: Thursday 15 December 2022

Time: 10:00am – 12:30pm

Location: Online via Microsoft Teams

Speakers:

- Maria Bubnic – Executive Director, Policy and Programs, Public Health Division, Department of Health
- Prof. Paul Johnson – Director NEPHU
- Joanne Kenny – Operations Director NEPHU
- Bridget Ruff – Senior Manager Public Health Integrated Planning and Programs NEPHU
- Johanna Mithen – Public Health Planning and Evaluation Lead NEPHU
- Aaron Osborne – Senior Epidemiologist NEPHU

Purpose:

To discuss the priority areas identified via earlier phases of the NEPHU Population Health Catchment Planning process and generate recommendations for two key priority areas for collective action within the current financial year.

Time	Item	Presenter/Facilitator
10:00-10:05am	Welcome, Acknowledgement of Country	Prof. Paul Johnson
10:05-10:10am	Purpose & Housekeeping	Prof. Paul Johnson
10:10- 10:25am	**Our Strategic Landscape** - Victorian Department of Health, Health Promotion and Prevention Commissioning Framework	Maria Bubnic
10:25- 10:55am	**Our Journey So Far** - Health Promotion and Prevention: • Our Planning Approach • Research and consultation findings • Population Health Profile • Utilising the evidence	Joanne Kenny Johanna Mithen Aaron Osborne Joanne Kenny
10:55-11:05am	Questions	
11:05 – 11:15	Break	

Time	Item	Presenter/Facilitator
11:15- 11:50pm	Interactive Consultation • Warm up • **Activity 1**: Exploring priority areas	Bridget Ruff Breakout Room Host
11:50– 11:55pm	• **Activity 2:** Key priority ranking	Bridget Ruff
11:55-12:20pm	• **Activity 3:** Towards success together	Bridget Ruff Breakout Room Host
12:20-12:25pm	Summation and Next Steps Participant Evaluation	Joanne Kenny
12:30pm	Close	Prof. Paul Johnson

APPENDIX 2: ORGANISATIONS INVITED TO ATTEND THE PLANNING WORKSHOP

Department of Health, Department of Families, Fairness and Housing

- Dept of Health North Region, Prevention and Population Health
- Dept of Health Eastern Region, Prevention and Population Health
- Dept of Health Public Health Reform, Policy & Programs
- Dept of Health Aboriginal Health and Wellbeing Division
- Dept of Families, Fairness and Housing Aboriginal Health and Engagement

Community Health

- Sunbury and Cobaw Community Health
- DPV Health
- healthAbility
- Banyule Community Health
- Your Community Health
- Access Health and Community
- Link Health and Community/Latrobe Community Health Service
- EACH
- Inspiro Health
- Eastern Health (Yarra Ranges)
- North Richmond Community Health
- Merri Health
- Cohealth (City of Yarra)

Local Government

- City of Hume
- City of Whittlesea
- Nillumbik Shire
- City of Banyule
- City of Darebin
- City of Whitehorse
- City of Manningham
- City of Boroondara
- City of Maroondah
- City of Knox
- Yarra Ranges Shire
- City of Yarra

Women's Health

- Women's Health in the North
- Women's Health East

Sexual Health

- Sexual Health Victoria
- Thorne Harbour Health

Aboriginal Community Controlled Health Organisations

- Victorian Aboriginal Health Service
- Victorian Aboriginal Community Controlled Health Organisation
- Victorian Aboriginal Child Care Agency
- Oonah Health and Community Services Aboriginal Corporation

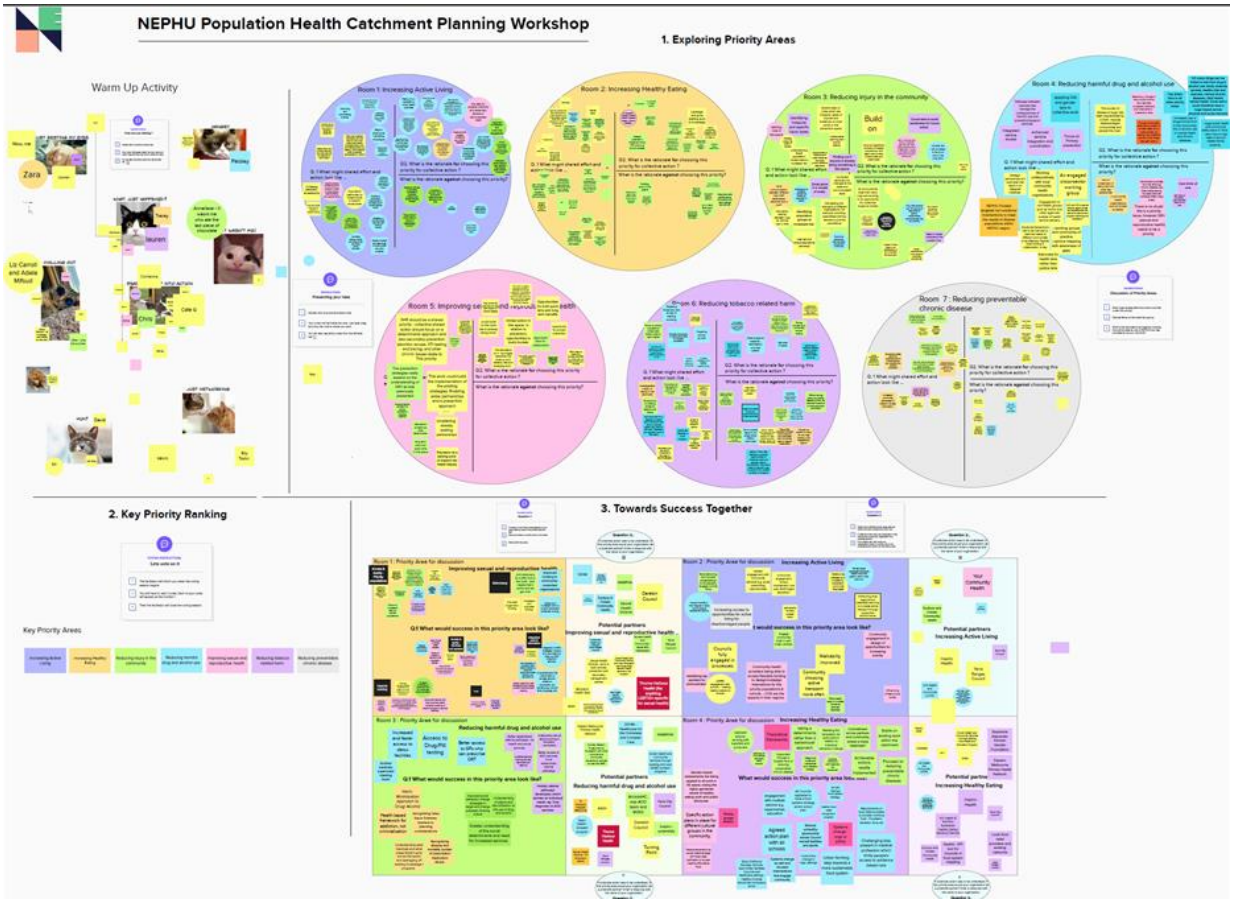
Primary Health Networks (PHNs)

- Eastern Melbourne PHN
- North Western Melbourne PHN

Tertiary Health Services

- Northern Health
- Austin Health
- Eastern Health
- St Vincent's Hospital

APPENDIX 3: MURAL BOARD



APPENDIX 4: POTENTIAL PARTNER ORGANISATIONS

Table 15. Organisations potentially willing to participate in collective action to improve sexual and reproductive health

Yarra Ranges Shire	City of Yarra	City of Whittlesea	City of Darebin
Sexual Health Victoria	Thorne Harbour Health	Women's Health in the North	Women's Health East
Sunbury and Cobaw Community Health	Merri Health	Access Health and Community	Oonah Health and Community Services Aboriginal Corporation
St. Vincent's Hospital Melbourne	North West Melbourne Primary Health Network		

Table 16. Organisations potentially willing to participate in collective action to increase active living

City of Whittlesea	City of Yarra	Yarra Ranges Shire	Link Health and Community	Inspiro Health
Your Community Health	Sunbury and Cobaw Community Health	Oonah Health and Community Services Aboriginal Corporation	Eastern Health (Yarra Ranges)	Merri Health
City of Whitehorse				

Table 17. Organisations potentially willing to participate in collective action to reduce harmful drug and alcohol use

City of Yarra	Yarra Ranges Shire	City of Darebin	Eastern Melbourne Primary Health Network	North West Melbourne Primary Health Network
St. Vincent's Hospital Melbourne	Sexual Health Victoria	Thorne Harbour Health	Oonah Health and Community Services Aboriginal Corporation	Access Health and Community
Merri Health	EACH	Inspiro Health	City of Whitehorse	

Table 18. Organisations potentially willing to participate in collective action to increase healthy eating

City of Yarra	Yarra Ranges Shire	Eastern Health (Yarra Ranges)	Eastern Melbourne Primary Health Network	Oonah Health and Community Services Aboriginal Corporation
Sunbury and Cobaw Community Health	Inspiro Health	Merri Health	Link Health and Community	EACH
City of Whitehorse				

APPENDIX 5 SUMMARY OF POTENTIAL PARTNERS ACROSS TOP FOUR PRIORITY AREAS

Table 19: Potential partners across the top four identified priority areas

Organisation	Improving sexual & reproductive health	Increasing active living	Reducing harmful drug and alcohol use	Increasing healthy eating
City of Whittlesea				
City of Darebin				
City of Yarra				
Yarra Ranges Shire				
City of Whitehorse				
Merri Health				
Access Health and Community				
Inspiro Health				
EACH				
Link Health and Community				
Sunbury and Cobaw Community Health				
Oonah Health and Community Services Aboriginal Corporation				
Your Community Health				
Eastern Health (Yarra Ranges)				
St. Vincent's Hospital Melbourne				
Eastern Melbourne PHN				
North West Melbourne PHN				
Sexual Health Victoria				
Thorne Harbour Health				
Women's Health East				
Women's Health in the North				
TOTAL	**14**	**11**	**14**	**11**