Implementation Plan for the Healthy Children initiative

NATIONAL PARTNERSHIP AGREEMENT ON PREVENTIVE HEALTH

NOTE: The Australian Government may publish all or components of this jurisdictional implementation plan, following initial consultation with the jurisdiction, without notice in public documents pertaining to the National Partnership Agreement.

PRELIMINARIES

1. This Implementation Plan is created subject to the provisions of the National Partnership Agreement on Preventive Health and should be read in conjunction with that Agreement. The objective in the National Partnership is to address the rising prevalence of lifestyle related chronic diseases, by:

   1.1 laying the foundations for healthy behaviours in the daily lives of Australians through social marketing efforts and the national roll out of programs supporting healthy lifestyles; and

   1.2 supporting these programs and the subsequent evolution of policy with the enabling infrastructure for evidence-based policy design and coordinated implementation.

   The measures funded through this Agreement include provisions for the particular needs of socio-economically disadvantaged Australians, and vulnerable groups.

2. The Healthy Children initiative provides funding to support implementation of healthy lifestyle programs in childhood settings across Australia.

3. Under the Healthy Children initiative jurisdictions are responsible for developing programs that may include a range of different activities. Some of these activities may be grouped according to similarities.

4. The National Partnership Agreement for Preventative Health Healthy Children Scoping Statement and Guiding Policy Principles is at Attachment A and includes definition of children and other parameters.

TERMS OF THIS IMPLEMENTATION PLAN

5. This Implementation Plan will commence as soon as it is agreed between the Commonwealth of Australia, represented by the Minister for Health and Ageing, and the State of Queensland, represented by the Deputy Premier (known as the Parties to this Implementation Plan).

6. This Implementation Plan may be varied by written agreement between authorised delegates.

7. This Implementation Plan will cease on completion of the specified program, including the acceptance of final performance program reporting and processing of final payments against performance benchmarks specified in this Implementation Plan.

8. Either Party may terminate this agreement by providing *30 days* notice in writing. Where this Implementation Plan is terminated, the Commonwealth's liability to make payments to the State is limited to payments associated with performance benchmarks achieved by the State by the date of effect of termination of this Implementation Plan.

9. The parties to this Implementation Plan do not intend any of the provisions to be legally enforceable. However, that does not lessen the parties' commitment to this Implementation Plan.

FINANCIAL ARRANGEMENTS

10. The maximum possible financial contribution to be provided by the Commonwealth for the Healthy Children initiative is $66.68m. Payments will be structured as 50 percent facilitation and 50 percent reward. The reward payments are conditional on achievement against performance benchmarks specified in the National Partnership.

11. Facilitation payments will be payable in accordance with Table 1 from July 2011 to 2014 in accordance with the National Partnership. All payments are exclusive of GST.

Table 1: Facilitation and Reward Payment Schedule ($ million)

Facilitation Payment	Due date	Amount
(i) Facilitation payment	July 2011	$6.65m
(ii) Facilitation payment	July 2012	$13.3m
(iii) Facilitation payment	July 2013	$6.61m
(iv) Facilitation payment	July 2014	$6.79m
Reward Payment *	Due date	Amount
(v) Reward payment	2013-2014	$13.34m
(vi) Reward payment	2014-2015	$20m

* note the actual amount of reward payment is conditional on assessment of achievement against performance benchmarks as set out in the National Partnership

12. Any Commonwealth financial contribution payable will be processed by the Commonwealth Treasury and paid to the State Treasury in accordance with the payment arrangements set out in Schedule D of the *Intergovernmental Agreement on Federal Financial Relations*.

Overall Budget

13. The overall program budget (exclusive of GST) is set out in Table 2.

Table 2: Overall program budget ($ million)

Expenditure item	Year 1	Year 2	Year 3	Year 4	Total
Pre-school setting	1,055,000	1,165,000	1,265,000	1,395,000	***4,880,000***
School setting	2,412,540	4,218,683	2,754,555	2,585,330	***11,971,108***
Family and community setting	3,180,460	7,913,317	2,589,445	2,806,670	***16,489,892***
TOTAL	$6,648,000	$13,297,000	$6,609,000	$6,787,000	***$33,341,000***
NPA contributions	*$6,648,000*	*$13,297,000*	*$6,609,000*	*$6,787,000*	***$33,341,000***

14. Having regard to the estimated costs of program and associated activities specified in the overall program budget, the State will not be required to pay a refund to the Commonwealth if the actual cost of the program is less than the agreed estimated cost. Similarly, the State bears all risk should the costs of the program and/or a project(s) exceeds the estimated costs. The Parties acknowledge that this arrangement provides the maximum incentive for the State to deliver projects cost-effectively and efficiently.

PROGRAM OVERVIEW AND OBJECTIVE

15. The objective of the Healthy Children program is to reduce the risk of chronic disease by reducing the prevalence of overweight and obesity, improving nutrition and increasing levels of physical activity in children and young people, through implementation of a range of initiatives across a variety of settings in Queensland.

The strategies in the Queensland Healthy Children Initiative have been informed by evidence from the international and national literature regarding the success and sustainability of nutrition and physical activity promotion programs for children and young people. Key success factors include:

- Implementation of multi-component programs that both:
    - Provide healthy physical and social environments to support healthy lifestyles including safe places and spaces for physical activity, both incidental and planned e.g. provision of bike paths, playgrounds, playing fields etc; increased access to healthy food and drinks and decreased access to high-energy nutrient-poor food and drinks; and
    - Provide consistent evidence-based information to parents, carers and children, consistent with the National Health and Medical Research Council's dietary guidelines and national physical activity guidelines;

- Well established project planning and implementation to ensure the identified needs and interests of children are met and using a participatory approach to planning;
- Effective and consistent communication of the aims and purpose of the project to help build positive engagement;
- Recognition of the role of the family and community and involvement in key activities;
- Reaching children in a range of settings and locations, including child-care centres, schools, community groups etc;
- Reaching infants, parents and carers as early as possible; and
- Monitoring and evaluating all program components during program planning and implementation.

The Queensland Healthy Children Initiative should be seen in the context of significant activities to improve the nutrition and physical activity of all Queenslanders. All of the strategies form part of a comprehensive program to improve the nutrition, physical activity and healthy weight status of children and young people in Queensland and link with a broad suite of activities already underway or planned by Queensland Health and key partners.

Queensland has had a strong focus on promoting healthy eating, physical activity and healthy weight, particularly since the Premier's Obesity Summit in May 2006. Queensland Health is lead agency for this work and since 2002 has increased investment in recurrent funding to recruit specialised staff to deliver evidence-based nutrition and physical activity promotion initiatives. These projects target all key sections of the population, including children and young people.

The framework for the program response focusing on children and young people was outlined in Queensland's *Eat Well Be Active Healthy Kids for Life Action Plan 2005-2008* and included over 100 cross agency initiatives under two domains: reaching kids where it counts and supporting parents and carers. Leading up to, during and following the Queensland Premier's Obesity Summit in 2006 a range of options to promote healthy weight, particularly for children and young people, was sought from expert academics, NGOs and key stakeholders, and assessed and applied to help develop the work plan of the Premier's Eat Well Be Active taskforce.

The *Eat Well Be Active* frameworks have since been superseded by the Target Delivery Plans under the 'Healthy' component of the Queensland Government's *Toward Q2: Tomorrow's Queensland,* launched in September 2008. This Q2 Healthy Queensland target to reduce the prevalence of obesity, smoking, heavy drinking and unsafe sun exposure by one third by 2020 is consistent with the NPAPH (with the exception of unsafe sun exposure).

The Queensland Government's strategy to achieve the Q2 Healthy targets involves four priority actions. Examples of how work towards these priority actions also contributes to achieving the targets under the NPAPH Healthy Children initiatives include:

- Creating supportive environments – investing in action to create supportive physical and social environments that encourage healthy behaviour by making the healthy choice the easy choice. Approaches targeting children include provision of: parks, cycle paths, shade, planning guidelines for local government and healthier food choices in various settings, including child care centres, school and sporting clubs.
- Supporting community-based programs – investing in appropriate and targeted programs to encourage and support Queenslanders to live healthy lives. Approaches targeting children include school TravelSmart, outside school hours care programs and relevant activities under school-based and community child health nurse programs.

- Influencing social norms and culture – investing in actions which positively influence social norms and culture to support healthy behaviour choices, including ensuring that messages are based on evidence, personalised to meet the needs of target audiences and supported by information, programs and services. Approaches targeting children include: development of Your Guide to the First 12 months information booklet provided to all Queensland mothers on the birth of their baby, and provision of range of nutrition and physical activity information brochures consistent with national guidelines.

- Measuring and evaluating activity to identify what works – investing in appropriate monitoring and evaluation data and indicators at the individual, community and population level to inform planning, resource development and service delivery, such as the Healthy Kids Queensland survey conducted in 2006, which has been used to help develop and target intervention projects.

Strategies in the Queensland Healthy Children Initiative have been developed to meet identified gaps in current program approaches and expand on previous and current successful initiatives. Mapping exercises, previous needs and gap analysis and consultation with other jurisdictions to identify opportunities for action have been repeated in the formulation of the Queensland Healthy Children initiative. The breadth of strategies included in the Queensland Healthy Children initiative will support a range of partner organisations to add value to the multi-faceted components of Queensland's current promotion of healthy weight, nutrition and physical activity in children. The targeted spread of activities under the initiative is considered more likely to be effective than a smaller number of programs with a bigger investment in each.

Where relevant, there has been consultation with other jurisdictions to avoid duplication, expedite program design and maximise sharing of resources. For example, to foster efficiencies, in developing a family-focused management program for overweight and obese children, NSW was consulted on effective service delivery models, procurement processes and potential partnerships, and Queensland Health is also in discussion with NSW Health regarding provision of telephone/coaching services.

Strategies include a mix of universal and targeted approaches to improve nutrition, physical activity and healthy weight in children and young people. Strategies to reach disadvantaged, and rural and remote populations also form part of this approach.

Strategies aim to support healthy choices and behaviours in the places where children live, study, learn and play. Components include settings-based initiatives (playgroups, childcare, schools, and outside school hours care services), skills and/or knowledge development and education, healthy lifestyle programs, and supportive environment initiatives.

16. Queensland Healthy Children Initiative is inclusive of the following activities:

    a) Pre-school settings

    b) School settings

    c) Family and community settings

17. The senior contact officer for this program is the Executive Director, Preventative Health Directorate, Division of the Chief Health Officer, ph (07) 3328 9833.

18. **Activity: Healthy Children Initiative – pre-school setting**

19. **Overview:**

The pre-school setting activity is comprised of the following strategies:

1. **Healthy eating and physical activity in early childhood settings** will support the roll out of the new National Healthy Eating and Physical Activity Guidelines for Early Childhood Settings across the state. Activities will include development of additional educational resources for both staff and families, and provision of professional development for relevant staff.

2. **Have Fun – Be Healthy for supported playgroups** is a targeted initiative to extend the Have Fun – Be Healthy program across Queensland. Supported Playgroups focus on families from identified high risk groups, including young parent, low income, Indigenous and culturally and linguistically diverse families. These playgroups are facilitated by a coordinator who works with families for three to 12 months to develop the skills required for them to run their playgroup independently. Coordinators may also assist parents by providing parenting information and referrals to other family services. The *Have Fun – Be Healthy* program will deliver healthy cooking and physical play sessions to supported playgroups.

20. **Outputs:**

Outputs	**Quantity**	**Quality**	**Timeframe**
Conduct tender processes and appoint external providers	• Establish service agreements	Roles and responsibilities clearly defined	By July 2011
Develop training materials and support resources	• Resources quantities will be decided with Queensland Health, and reference and planning groups	Resources are consistent with the Healthy Eating and Physical Activity Guidelines for Early Childhood Settings and relevant to stakeholder needs, including low literacy and Indigenous groups	By December 2011
Implement training and workshops and supporting resources	• Deliver training/workshop sessions across Queensland to staff in early childhood education and care and supported playgroup settings	Training is relevant to stakeholder needs and accessible to all staff including those in rural and remote locations	Jan 2012 – June 2015
Conduct evaluation	Undertake evaluation of: • Resources • Support • Policy and menu reviews • Training • Workshops	Evaluation of services, resources, training and parental/carer knowledge and behaviour modification	Jan 2012 – June 2015

21. Outcomes:

Short term	Medium term	Long term
Increased access by Queensland early childhood services and supported playgroups and their communities to evidence-based information about nutrition, physical activity and screen time (e.g. television/computer) and resources to support this (June 2015).	Increased awareness and knowledge of healthy eating and physical activity by parents and carers (June 2015). Increased access to healthy food and drinks, opportunities to be physically active and decreased screen time by children attending early childhood services and supported playgroups (June 2015). Increased awareness and knowledge of national guidelines by early childhood services staff (June 2015). Increased awareness and ability of early childhood staff to apply practical strategies to support parents to encourage healthy eating and physical activity with their children (June 2015). Increased number of early childhood services meeting the National Quality Standard Area 2.2 Children's Health and Safety (June 2015).	Increased fruit and vegetable consumption of young children attending early childhood services and supported playgroups. Decreased consumption of unhealthy foods by young children attending early childhood services and supported play groups. Increased physical activity levels of young children attending early childhood services and supported playgroups. Decreased exposure to screen time by young children attending early childhood services and supported playgroups. Increased rates of healthy weight in young children attending early childhood services and supported play groups.

22. Rationale:

The early years are a critical period for establishing healthy eating and physical activity behaviours in children. Nutritious food and regular physical activity support the normal growth and development of children and reduce the risk of developing chronic lifestyle diseases including obesity.

The 2007-2008 National Health Survey[1] showed that there has been a steady increase in overweight and obese children in Australia since 1995, with the 2007 Australian National Children's Nutrition and Physical Activity Survey of children aged 2 – 16 years finding that 17% were overweight and six per cent were obese. The Healthy Kids Queensland Survey[2] found that 16.7% of boys and 19.7% of girls in grade one were either overweight or obese.

The National Healthy Eating and Physical Activity Guidelines for Early Childhood Settings (the Guidelines) form part of the Commonwealth Government's Plan for Early Childhood and Plan for Tackling Obesity.[3] This activity will appoint regional health staff focused on early childhood settings to assist in a coordinated approach to the promotion and support of the Guidelines at the local level.

[1] Australian Bureau of Statistics. National Health Survey: Summary of Results, 2007-2008. Canberra: Australian Bureau of Statistics. Cat. No. 4264.0.
[2] Abbott RA, Macdonald D, Stubbs CO, Lee AJ, Harper C, Davies PSW. Healthy Kids Queensland Survey 2006 – Full Report. Queensland Health. Brisbane; 2008.
[3] http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-early-childhood-nutrition-index (accessed July 2010).

There is a clear link between increased rates of obesity and low income, multi-ethnic, immigrant and Indigenous communities (WHO 2007)[4]; many of these groups attend supported playgroups throughout Queensland. This activity will provide additional assistance to supported playgroups through interactive workshops, and will also provide resources to remain within the community to support healthy eating and physical activity.

23. **Contribution to performance benchmarks:**

This activity will contribute to the performance benchmarks under the National Partnership by adopting strategies that focus on:

- Increasing assess to healthy food and drinks by infants and children attending early childhood education and care (ECEC) settings and supported playgroups (SP).
- Increasing physical activity opportunities for infants and children attending ECEC settings and SP.
- Decreasing exposure to screen time by infants and children attending ECEC settings and SP.

24. **Policy consistency:**

These strategies will contribute to the achievement of both national and state policies and priorities of promoting good health and reducing the burden of chronic disease, including Council of Australian Governments' (COAG) Australian Better Health Initiative, the National Preventative Health Strategy and the Queensland Government's Toward Q2: Tomorrow's Queensland. See Attachment B for further details.

25. **Target group(s):**

The target groups for this activity include:

- Early childhood education and care staff at centres, supported playgroups, family day care, preschools and playgroups in addition to family services which have contact with children and their families (e.g. early years centres and family hubs).
- Parents, carers and families.

26. **Stakeholder engagement:**

Achievement of chronic disease prevention performance benchmarks will require a high degree of collaboration and coordination of effort across the Queensland Government, in partnership with the non-government sector. A wide range of stakeholders have been consulted during the development of the Queensland Healthy Children Implementation Plan and will continue to provide strategic direction, advice and support during the implementation of the 'pre-schools setting' activity.

Key stakeholders include: Queensland Health, Office for Early Childhood Education and Care, Department of Education and Training, Department of Communities (Sport and Recreation Services), Department of Education, Employment and Workplace Relations, Professional Support Coordinators Queensland, Indigenous Professional Support Unit, early childhood services and supported playgroup facilitators, regional staff and community stakeholders, and parents, carers and children attending early childhood services and supported playgroups.

A range of strategies will be employed to engage stakeholders and may include establishment of project reference and planning groups, delivery of professional development and training, marketing and promotion activities, and distribution of practical resources.

[4] World Health Organisation. The world health report 2007 – A safer future: global public health security in the 21st century. Geneva: World Health Organisation; 2007.

27. Risk identification and management:

Risk	Level	Possible mitigation strategies	Responsibility
Not engaging appropriately skilled providers	Low	• Robust tender processes • Clear governance, deliverables and performance criteria	Queensland Health External providers
Not engaging sector in training	Low	• Utilise existing strong professional support networks	External providers Planning groups
Poor training and workshop quality	Low	• Evaluation of training sessions and facilitators against performance criteria • Training DVDs will guide and support workshop content	External providers with Queensland Health and planning groups
Poor sector satisfaction with factsheets, resources and training	Low	• Development processes to include collaboration with key stakeholders and focus testing	External providers with Queensland Health

28. Evaluation:

Evaluation type	Measure	Proposed methodology	Timing
Process	• Increased access by early childhood services and supported playgroups to nutrition, physical activity and screen time information and resources	Collation of data on: • Number of resources distributed • Number of training sessions/workshops and participants • Evaluation of training sessions/workshops • Audit of support agency services	January 2012-June 2015
Impact	• Increased proportion of ECEC services meeting National Quality guidelines and having policies consistent with the Guidelines	• Review of national rating system for Queensland services • ECEC sector census	Baseline (June – Dec 2011) and review (Jan -June 2015) Annual review
	• Increased awareness and confidence of early childhood and supported playgroup staff to support parents to encourage healthy eating, physical activity and reduced screen time	• Online survey	Baseline (Mar/Apr 2010) and review (Mar/Apr 2015)
	• Increased knowledge about healthy eating, physical activity and screen time and introduction of practical strategies by parents and carers	• Parent/carer survey	Jan 2012-June 2015 (before and after training/workshops)
Outcome	• Increased physical activity levels • Increased fruit and vegetable consumption • Decreased unhealthy food consumption • Reduced screen time exposure	• Longitudinal survey in random sample of targeted services • Surveys with parents/carers three months after supported playgroup interventions	Baseline (June – Dec 2011) and review (Jan -June 2015) Jan 2012-June 2015

29. **Infrastructure:**

The service agreements with external providers will cover the infrastructure required to complete these projects.

30. **Implementation schedule:**

Table 3: Implementation schedule

Deliverable and milestone	Due date
Service agreements finalised	July 2011
Project plans completed	August 2011
Parent/carer fact sheets developed	September 2011
Training manual/DVDs developed	December 2011
Online resources developed	December 2012
State-wide training and workshops completed	Jan 2012-June 2015
Evaluation completed	June 2015

31. **Activity budget:**

Table 4: Activity project budget

Budget	Year 1	Year 2	Year 3	Year 4	Total
TOTAL	$1,055,000	$1,165,000	$1,265,000	$1,395,000	$4,880,000

32. **Activity: Healthy Children Initiative – school setting**

33. **Overview:**

The school setting activity is comprised of the following six strategies:

1. The **Physical Activity and Nutrition in Outside School Hours (PANOSH) program** will update existing resources and conduct training for Outside School Hours Care (OSHC) services to align with the revised National Health and Medical Research Council Dietary Guidelines for Children and Adolescents in Australia and the new National Quality Framework for Early Childhood Education and Care.

2. The **Smart Moves Physical Activity Facilitator program** will support teachers and schools to increase physical activity participation levels of school children through the Queensland Department of Education and Training's Smart Moves Physical Activity Programs in Queensland State Schools, consistent with recommendations arising from recent evaluation of the program.

3. **Strengthening the implementation of Smart Choices Healthy Food and Drink Supply Strategy for Queensland Schools (Smart Choices)** will enhance action to implement the recommendations of the Smart Choices evaluation. Additional support will be delivered through statewide workshops; video conferences; resource development; support for curriculum strategies; assistance with school community engagement; harmonisation with the National Healthy School Canteen guidelines; and ongoing contact and support.

4. **Holiday cooking for high school students** will deliver cooking programs to high school students attending state schools through an external provider. The programs will target young people in priority population groups at school who do not currently study subjects that involve cooking or food preparation.

5. **Healthy Active School Travel program** is a tiered, action-learning initiative integrating Queensland local governments and primary schools, designed to encourage and increase school active transport.

6. **A Targeted Physical Activity Outreach program** will increase physical activity participation in 267 Queensland schools in Indigenous, socio-economically disadvantaged, and isolated rural and remote communities in 2012-13.

34. **Outputs:**

Outputs	Quantity	Quality	Timeframe
Appoint external providers and new Queensland Government staff	• Establish service agreements	Roles and responsibilities clearly defined	By July 2011
Program and contract management	• All externally contracted strategies	Involvement of governance groups	2011-2015
Appoint staff as required in out-year funding of projects	• Establish service agreements	Roles and responsibilities clearly defined	2012-2015
Develop and disseminate resources, supporting materials and websites	• Resources are sufficient to provide coverage to schools across the state • Resources will be developed in hard copy and electronic version	Resources are relevant to the needs of stakeholders, including being informative, of appropriate content and level, and appealing	2011-2015

		Resources link in with relevant standards, curriculum and national guidelines	
Conduct training e.g. workshops and videoconferences	• Training and workshops are conducted across the state, including in rural and remote areas • Training will be conducted through face-to-face, online and multimedia methods	Training is relevant to the needs of stakeholders including being informative, of appropriate content and level, and appealing	2011-2015
Implement strategies	• Service agreements set requirements for minimum number of programs to be conducted in rural areas, disadvantaged areas, and areas with high Aboriginal and Torres Strait Islander populations	Conduct pilot programs if required and expand after evaluation and review	2011-2015
Work with stakeholders to conduct targeted communication, advertising and recruitment campaigns	• Establish links with key contacts in each education region and school-based youth health nurses/health promotion workers across the state • Establish project planning and reference groups	Queensland Government support external providers and own staff where possible Consult with Queensland Health as required to ensure consistent healthy messages are delivered through programs	2011-2015
Evaluate strategies	• Process, impact and outcome evaluation measures will be conducted as appropriate for each strategy	Queensland Government to provide advice about evaluation frameworks and expectations of evaluation	By June 2015

35. **Outcomes:**

Activities	**Short term outcomes by June 2012 and June 2013**	**Medium term outcomes by June 2013 and beyond**	**Long term outcomes by June 2015 and beyond**
Update the PANOSH resources, and develop and deliver training to outside school hours care providers across Queensland. Physical Activity Facilitators provide workshops, material, strategies and resources to schools. Increased physical activity opportunities for targeted disadvantaged schools. Local healthy active school travel interventions are implemented.	Trained and skilled workforce to support and increase children's knowledge, attitudes, skills and abilities regarding health, nutrition and physical well being. Increased quality and quantity of physical activity provision to required levels, confidence of classroom teachers, and planning and leadership around physical activity. Improved knowledge and attitudes towards active travel in school communities, and commitment and action to	Changes in food prepared and provided, and increase in physical activity provided to children attending outside school hours care. Increased quality and quantity of physical activity provision to required levels, confidence of classroom teachers, and planning and leadership around physical activity. Improved knowledge and attitudes towards active travel in school communities, and commitment and action to	Increased fruit and vegetable consumption in Queensland children. Increased consumption of foods consistent with the dietary guidelines in Queensland children. Increased physical activity levels in Queensland children. Reduced prevalence of overweight and obesity in Queensland children.

	active travel by local governments	active travel by local governments.	
Implementation of Smart Choices is strengthened by implementation of a suite of activities and development of resources.	Increased supply of healthy food and drink across all aspects of the school environment.	Increased supply of healthy food and drink across all aspects of the school environment.	
Cooking program for high school students is delivered across the state including in rural and disadvantaged areas.	Increased number of high school students participating in cooking activities and improvement in related skills and knowledge.	Improved number and quality of meals prepared and consumed by students, and positive changes in attitudes towards cooking and healthy eating.	

36. **Rationale:**

The Healthy Kids Queensland Survey 2006 conducted anthropometric, dietary and physical activity assessments to provide important data for planning, implementing and evaluating initiatives to improve the health of young Queenslanders.[5] Overall, 21.1% of Queensland children aged five to 17 were overweight or obese. The prevalence of overweight and obesity generally increased with age, but the highest prevalence was observed among year five girls. Compared with survey results from 1985, there were more children who were overweight, the overweight children experienced more central obesity, and there were more extremely obese children.[6]

The survey found that few children consumed diets consistent with the National Health and Medical Research Council's Dietary Guidelines for Children and Adolescents in Australia.[7] Intakes of fruit, vegetables and milk products were generally less than recommended, while intakes of 'extra foods' such as soft drinks and snacks were more than recommended, especially among the older children.

The proportion of energy intakes derived from fat and saturated fat was above the amounts recommended in the dietary guidelines. Dietary quality was also observed to decrease with age. One in 20 year one boys and girls had diets inadequate in calcium; this increased to one in two boys and six in seven girls in the oldest age group. In addition, iron intake was low in about 10% of older girls.

International targets recommend 12,000 steps per day for girls and 15,000 steps per day for boys. In Queensland, only 27% of year one boys and 42% of year one girls met these targets. This increased to 40% and 53% for year five boys and girls, respectively. Despite the absence of a target for older children, the year 10 age group averaged the lowest number of daily steps. Screen time was observed to increase with age; year 10 students spent an average of three to four hours every day using a variety of media.[5]

A range of different approaches are required to address the public health priority of childhood obesity, and to improve children's health through better nutrition and physical activity. In Queensland, the key initiatives to promote healthy eating, physical activity and healthy weight in school-aged children

[5] Abbott RA, Macdonald D, Stubbs CO, Lee AJ, Harper C, Davies PSW. Healthy Kids Queensland Survey 2006 – Full Report. Queensland Health. Brisbane; 2008.
[6] Queensland Health. The Health of Queenslanders 2008: Prevention of Chronic Disease. Second Report of the Chief Health Officer Queensland, Queensland Health. Brisbane; 2008.
[7] National Health and Medical Research Council. Food for Health – Dietary Guidelines for Children and Adolescents. Commonwealth of Australia. Canberra; 2003.

include the health and physical education key learning area of the curriculum (years 1-9 essential learnings and standards), Smart Choices Healthy Food and Drink Supply Strategy for Queensland Schools and Smart Moves Physical Activity Programs in Queensland State Schools. These interventions are implemented across multiple sectors, including Queensland Department of Education and Training, Queensland Health and non-government organisations.

The six approaches in the school setting proposed as part of the National Partnership Agreement on Preventative Health Healthy Children will complement existing and planned investment in Queensland schools to address nutrition, physical activity and healthy weight in children and young people.

37. **Contribution to performance benchmarks:**

This activity will contribute to the performance benchmarks under the National Partnership by adopting strategies that focus on:

- Increasing healthy eating among children, particularly fruit and vegetable consumption.
- Improving the food preparation and cooking skills of young people, particularly for fruit, vegetables and healthy meals.
- Increasing awareness of the link between chronic disease and lifestyle risk factors, particularly poor nutrition, physical inactivity and unhealthy weight.
- Increasing appreciation of why everyday physical activity across the school curriculum and through active transport can contribute significantly to overall physical activity levels.
- Improving the food supply and increasing physical activity for children attending outside school hours care.
- Improving positive attitudes towards healthy eating, physical activity and achieving a healthy weight.
- Increasing the number of children who are a healthy weight.

38. **Policy consistency:**

These strategies will contribute to the achievement of both national and state policies and priorities of promoting good health and reducing the burden of chronic disease, including Council of Australian Governments' (COAG) Australian Better Health Initiative, the National Preventative Health Strategy and the Queensland Government's Toward Q2: Tomorrow's Queensland. See Attachment B for further details.

39. **Target group(s):**

The main target groups for this activity include:

- Primary and high school students.
- Primary and high school teachers.
- Outside school hours care staff and children that attend outside school hours care.
- School principals, parents and citizens' associations, and tuckshop convenors, staff and volunteers.
- Schools within specified local governments areas.

40. **Stakeholder engagement:**

Achievement of chronic disease prevention performance benchmarks will require a high degree of collaboration and coordination of effort across the Queensland Government, in partnership with the non-government sector. A wide range of stakeholders have been consulted during the development of the Queensland Healthy Children Implementation Plan and will continue to provide strategic direction, advice and support during the implementation of the 'schools setting' activity.

Key stakeholders include: Queensland Health, Department of Education and Training, Department of Communities (Sport and Recreation Services), Department of Transport and Main Roads, sector representatives working with schools (e.g. outside school hours care peak body and employers), nutrition organisations and physical activity providers, primary and secondary schools, existing reference groups (e.g. Smart Choices implementation reference group), and local governments.

A range of strategies will be employed to engage stakeholders and may include project reference and planning groups, professional development and training, advertising and promotion through schools and sector representatives, regular meetings and communications, and practical resources.

41. Risk identification and management:

Risk	Level	Possible mitigation strategies	Responsibility
Not engaging appropriately skilled providers	Low	• Robust tender processes • Clear governance, deliverables and performance criteria	Queensland Government External providers
Staff cannot be recruited or high turnover	Medium	• Ensure position description and performance criteria are clearly articulated • Extend recruitment zones and amend recruitment targets • Extend recruitment zones and amend recruitment targets	Queensland Government External providers
Not meeting proposed program budgets	Medium	• Establish service agreements with key stakeholders • Establish regular reporting mechanisms and governance structure • Expand or decrease target audience reach	Queensland Government External providers
Not engaging sector in training and identifying target groups for strategy implementation	Low	• Utilise existing strong professional support networks • Staff to be employed in relevant government departments in addition to non-government organisations	Queensland Government External providers Planning groups
Poor training and workshop quality	Low	• Evaluate training sessions and facilitators against performance criteria • Resources will be provided to support workshop content	Queensland Government External providers Planning groups
Poor quality and satisfaction rates with resources and materials	Low	• Development processes to include collaboration with key stakeholders and focus testing	Queensland Government External providers Planning groups
Parent resistance to strategies	Low	• Involvement of the whole school community in building knowledge of the benefits of strategies	Queensland Government External providers
Adverse effects to students through activities e.g. injury	Low	• Adherence to supervision and safety standards • External providers to demonstrate commit to safety of participants	Queensland Government External providers
Poor dispute resolution	Medium	• Establish issues management processes within project management framework	Queensland Government External providers Planning groups

42. Evaluation:

Evaluation type	Measure	Proposed methodology	Timing
Process	• Staff, project and contract management	• Matching reporting outcomes with services agreements	July 2011-June 2015
	• Access to resources • Attendance at training • Access to resources and training by schools and students in rural and remote areas, disadvantaged areas and high Indigenous populations	• Number of resources distributed • Number of training sessions held and participation rates • Website use • Geographic and demographic analysis of access to resources and training	
	• Relevance of resources and training to needs of schools, teachers, students and service providers • Satisfaction with resources, training and programs	• Feedback on resources and training sessions/workshops	
Impact	*Strategy 1* • Increased proportion of OSHC services with nutrition and physical activity policies • Increased access to healthy food and drink for children attending OSHC services • Increased proportion of OSHC services plan daily, play-based activities for children of all age groups	• Assessment of random sample of OSHC services	Baseline conducted: Jan-June 2011 Follow-up conducted: Jan-June 2013 and Jan-June 2015
	Strategy 2 • Physical activity in phase 1 and 2 schools compared to non-intervention school	• Use accelerometers/pedometers in subset of students	2012-2015
	• Student satisfaction with activities organised by teachers	• Pre- and post-intervention survey	2012-2015
	• Confidence, competency, knowledge and attitudes of teachers related to physical activity	• Pre- and post-intervention surveys	2012-2015
	• Parent awareness of school physical activity programs and implications of the strategy	• Computer assisted telephone interview survey on subset of parents	2011-2015
	• Assess policy dose of Phase 1 and 2 intervention	• Review and compare impact measures for Phase 1 and 2 schools	2015
	Strategy 3 • Increased support for Smart Choices and sustained positive attitudes in Queensland school communities • Increased access to healthy food and drink options by children in Queensland schools	• Selection of evaluation tool/s across regions including: o Email, phone and web-based surveys o Student and parent focus groups o Principals' surveys	2011-2015 (annually)
	Strategy 4 • Improvement in participants' basic cooking and food preparation skills, nutrition knowledge and confidence to prepare foods	• Pre- and post-program questionnaires	Ongoing throughout program with data reported
	• Positive changes in participants'	• Competency-based assessment	

	attitudes to cooking and healthy eating		2012, 2013, 2014, 2015
	Strategy 5 • Estimate active transport levels in representative target schools • Parent and student knowledge towards active transport and strategy initiatives • Teacher and principal knowledge and attitudes to active transport and strategy initiatives • Assess policy dose of intervention in targeted areas	• Pre- and post-intervention data collection • Pre- and post-intervention survey • Pre- and post-intervention survey • Monitor changes at school and local government level and integration of the policy	2011-2015 2011-2015 2011-2015 2011-2015
	Strategy 6 • Survey of daily physical activity capability in schools • Participant fitness levels • Confidence, competency, knowledge and attitudes of teachers	• Pre/post survey • Pre/post beep test • Pre/post school staff survey	2012-1013
Outcome	• Increased fruit and vegetable consumption among Queensland children • Increased physical activity levels among Queensland children • Reduced consumption of energy-dense nutrient-poor foods among Queensland children	Combination of methods, which may include: • Statewide computer assisted telephone interview survey • Random sample of children attending OSHC services and follow up • Subset of students across education regions (who will be school age during entire 4 year period) assessed periodically • Subset of cooking program participants followed up 6-12 months after program	Baseline conducted: Jan-June 2011 Follow-up conducted: 2012-2015 2010-2015
	• Student satisfaction with daily physical activity organised by teachers • Confidence and competency of schools and teachers to support quality physical activity in schools	• Monitor changes in Schools Opinion Survey across all age groups • Monitor changes in annual Smart Moves Principal and Schools Opinion Surveys	2010-2015

43. **Infrastructure:**

The service agreements with external providers will cover the infrastructure required to complete these projects, including administrative, management, travel and equipment costs. For some projects, external providers will be expected to provide the required human resource and administrative infrastructure.

Existing school infrastructure will be utilised, such as kitchens and cooking equipment, outside schools hours care and physical activity equipment. Some schools may need to undertake minor infrastructure improvements such as the provision of bike racks. However, this will not constitute more than five per cent of funding.

44. **Implementation schedule:**

Table 3: Implementation schedule

Deliverable and milestone	Due date
Service agreements finalised	July 2011
Project plans completed	August 2011
Staff recruited	Ongoing throughout 2011-2015
Physical Activity and Nutrition in Outside School Hours resources, website and training developed and implemented	2011-2015
Physical activity facilitator Phase 1 implemented	2011-2014
Physical activity facilitator Phase 2 implemented	2013-2015
Smart Choices videoconferences, workshops and resources developed and delivered	2011-2015
Cooking program piloted and evaluated	2011-2012
Cooking program expanded across the state	2012-2015
Healthy Active School Travel intervention implemented and online resources developed and published (round 1)	2011-2014
Healthy Active School Travel intervention implemented and online resources developed and published (round 2)	2012-2014
Jump Rope for Heart Outreach Program implemented	2012-2013
Evaluation of all strategies completed	June 2015

45. **Activity budget:**

Table 4: Activity project budget

Budget	Year 1	Year 2	Year 3	Year 4	Total
TOTAL	$2,412,540	$4,218,683	$2,754,555	$2,585,330	$11,971,108

46. **Activity: Healthy Children Initiative – family and community setting**

47. **Overview:**

The family and community setting activity is comprised of the following eight strategies:

1. **Food for Sport – Implementation and Support** will involve an external provider supporting Queensland sporting clubs to implement the Queensland Government's Food for Sport: Food and Drink Supply Guidelines for Queensland Sporting Clubs. The activity will include an accreditation or incentive system supported by the provision of workshops, materials and resources.

2. **Community Partnerships Grants** will provide funding to support the development and delivery of nutrition and physical activity programs at the local level. Successful projects will develop partnerships within the community to provide sustainable opportunities for Queenslanders to lead active lifestyles and adopt healthy eating patterns. The program will also encourage new community-based approaches for the development and delivery of physical activity and healthy eating initiatives, and enhance and build on successful initiatives to date.

3. **TRIM Kids** will tender for an external provider to work in collaboration with Queensland Health to deliver a family-focused management program for overweight and obese Queensland children aged 7-13 years. A number of delivery methods are possible, and may involve children and their parents/carers, or parents/carers only. The external provider will develop the program and provide support with delivery, recruitment and evaluation.

4. **Healthy Culturally and Linguistically Diverse (CALD) Children** will deliver healthy eating and physical activity messages to Pacific Islander parents to reinforce health messages for the whole family. The program will be delivered by Multicultural Community Health Workers. The primary delivery mode will be group sessions, and multicultural media will also be engaged.

5. **Age-Paced Parenting Information System – Small Talk** is a universal, cost-effective strategy that focuses on prevention and early intervention to encourage healthy behaviours among infants, young children and their families. This activity will adapt and extend a pilot of the Small Talk newsletter series, and will increase health promotion messages including nutrition, physical activity and healthy weight, and extend editions to support the antenatal period and 1-3 year age groups. Implementation be embedded within a new, universal health home visiting trial and other local health services within a high need area in south-east Queensland.

6. **Promoting Healthier Kids in Queensland** is a one-day training workshop that aims to increase the capacity of health and other professionals working with children to apply the key messages of the national physical activity recommendations and the new NHMRC dietary guidelines. Participants may include but not be limited to general practitioners, medical specialists, nurses, allied health professionals, Aboriginal and Torres Strait Islander health workers, School-Based Youth Health Nurses, child health workers, and education and community sector professionals. The workshops will help to ensure that consistent and accurate messages are delivered to children and young people and their parents, carers and other family members. Workshops will also provide details of activities targeting children and young people implemented under the NPAPH Healthy Children Initiative, and other activities run by Queensland Health and key partners.

7. **Healthy Kids Queensland Household Pack** will be targeted towards the parents and carers of children and young people with a focus on nutrition, physical activity and healthy weight. The self-help pack will be distributed to all Queensland households with children. The pack will assist children and young people to eat well and be more active through inclusion of evidence-based information, practical tips, and promotion of services and other activities funded under the NPAPH.

8. **Healthy Kids Queensland Local Activity Kit and Website** will be developed to meet a gap in the coordination of information, resources and practical tools for primary tier service providers and other Queensland professionals related to nutrition, physical activity and healthy weight services, activities and information for children and young people. The resources will build on existing materials developed in Queensland and other states, and will be consistent with national guidelines and recommendations.

48. **Outputs:**

Outputs	Quantity	Quality	Timeframe
Appoint external providers and new Queensland Government staff	• Establish service agreements	Roles and responsibilities clearly defined	By July 2011
Program and contract management	• All externally contracted strategies	Involvement of governance groups	2011-2015
Appoint staff as required in out-year funding of projects	• Establish service agreements	Roles and responsibilities clearly defined	2012-2015
Provide funding to local level partnership projects	• Maximum funding guidelines will apply • Number of projects funded will depend on number and quality of applications	Risk assessment approach will be utilised Projects will be consistent with outcome priorities	2011-2015
Develop and disseminate resources, supporting materials and websites	• Resources are sufficient to provide coverage to family and community-based settings across the state • Resources will be available in hard copy and electronic version	Resources are relevant to the needs of stakeholders, including being informative, of appropriate content and level, and appealing Resources link in with relevant standards and national guidelines	2011-2015
Conduct training and provide support e.g. workshops and advice	• Training conducted across the state, including in rural and remote areas • Training will be conducted through face-to-face, online and multimedia methods • Support will be available through variety of methods e.g. phone, email, website	Training is relevant to the needs of stakeholders including being informative, of appropriate content and level, and appealing Training and support links with relevant standards and national guidelines	2011-2015
Implement strategies	• Service agreements set requirements for minimum number of programs to be conducted in rural areas, disadvantaged areas, and areas with high Aboriginal and Torres Strait Islander populations	Conduct pilot programs if required and expand after evaluation and review	2011-2015
Work with stakeholders to conduct targeted communication, advertising and recruitment campaigns	• Establish links with key contacts in professional networks, peak bodies, and community networks • Establish project planning and reference groups	Queensland Government support external providers and own staff where possible	2011-2015
Evaluate strategies	• Process, impact and outcome evaluation measures will be conducted as appropriate for each	Queensland Government to provide advice about evaluation frameworks and expectations of evaluation	By June 2015

	strategy		

49. Outcomes:

Activities	**Short term outcomes by June 2012 and June 2013**	**Medium term outcomes by June 2013 and beyond**	**Long term outcomes by June 2015 and beyond**
Development of support package (training, resources, advice) for sporting clubs to improve provision of healthy food.	Increased access by sporting clubs to nutrition resources and training, and increased supply of healthy food and drinks.	Increased proportion of sporting club providing healthy food and drink choices that are accessed by children.	Increased fruit and vegetable consumption in Queensland children. Increased consumption of diets consistent with the dietary guidelines in Queensland children.
Providing funding to community partnerships for initiatives that support healthy eating and physical activity.	Increased access to services and supportive environments; target groups report increased ability to continue with new behaviours.	Target groups sustain improved physical activity and healthy eating, and community partnerships sustained 12 months after project completion.	Increased physical activity levels in Queensland children. Reduced prevalence of overweight and obesity in Queensland children.
Family-focused childhood obesity management programs delivered.	Programs run across the state and target areas of high disadvantage and high population density.	Programs run across the state and target areas of high disadvantage and high population density.	
Culturally tailored health promotion and messages in multicultural media.	Increased engagement with multicultural communities and media, and new resources developed.	Increased confidence to deliver culturally tailored health promotion; and increased awareness among communities about healthy eating and physical activity.	
Deliver information about healthy eating, physical activity and healthy weight to pregnant women and new parents.	Evidence-based messages provided to pregnant women and new mothers and their families.	Improvements in optimal infant feeding, breastfeeding and exposure of infants to range of healthy food and active movement experiences.	
Deliver workshops and develop website and local activity kit targeting Queensland professionals working with children and their carers.	Evidence-based nutrition and physical activity information and practical tools provided to professionals working with children and young people and their carers.	Increased nutrition and physical activity knowledge, skills and capacity among Queensland professionals, confidence to facilitate related programs, and referrals to appropriate programs.	

50. Rationale:

Health behaviours formed during childhood will often extend into adulthood. The prevention of chronic disease requires implementation of interventions that directly impact children and young people, in conjunction with broader interventions aimed at the whole population.[8]

The Healthy Kids Queensland Survey 2006 conducted anthropometric, dietary and physical activity assessments to provide important data for planning, developing and implementing initiatives to improve the health of young Queenslanders. In 2006, 19.5% of boys and 22.7% of girls aged 5-17 were overweight or obese. The prevalence of overweight and obesity generally increased with age, however the highest prevalence was observed among year five girls. Compared with survey results from 1985, there were more children who were overweight, the overweight children experienced more central obesity, and there were more extremely obese children.[9]

The survey found that few children consumed diets consistent with the National Health and Medical Research Council's Dietary Guidelines for Australian Children and Adolescents.[10] Intakes of fruit, vegetables and milk products were generally less than recommended, while intakes of 'extra foods' such as soft drinks and snacks were more than recommended, especially among the older children. The proportion of energy intakes derived from fat and saturated fat were above the amounts recommended in the dietary guidelines. Dietary quality was also observed to decrease with age. One in 20 year one boys and girls had diets inadequate in calcium; this increased to one in two boys and six in seven girls in the oldest age group. In addition, iron intake was low in about 10% of older girls.

International targets recommend 12,000 steps per day for girls and 15,000 steps per day for boys. In Queensland, only 27% of year one boys and 42% of year one girls met these targets. This increased to 40% and 53% for year five boys and girls, respectively. Despite the absence of a target for older children, the year 10 age group averaged the lowest number of daily steps. Screen time was observed to increase with age; year 10 students spent an average of three to four hours every day using a variety of media.

The eight approaches in the family and community setting activity proposed as part of the National Partnership Agreement on Preventative Health Healthy Children will complement existing and planned investment in Queensland to address nutrition, physical activity and healthy weight in children and young people. This mix of targeted and universal strategies will reach children and young people and their families through a range of settings including:

- Sporting clubs: combining participation in organised sport with the supply of healthier food and drink choices to enhance the supportiveness of the environment for adopting healthy lifestyles.

- Local communities: building the capacity of communities to mobilise resources and facilitating partnerships to improve health through better nutrition and physical activity; and providing a coordinated approach to programs that address management of childhood obesity.

- Culturally and linguistically diverse communities: providing culturally tailored health promotion and a dedicated multicultural workforce.

- Early childhood settings: delivering information about nutrition, physical activity and healthy weight to pregnant mothers and new parents.

- Health, education and community settings: ensuring Queensland professionals promote consistent and evidence-based nutrition and physical activity messages, have access to resources

[8] Queensland Health. The Health of Queenslanders 2008: Prevention of Chronic Disease. Second Report of the Chief Health Officer Queensland, Queensland Health. Brisbane; 2008.
[9] Abbott RA, Macdonald D, Mackinnon L, Stubbs CO, Lee AJ, Harper C, Davies PSW. Healthy Kids Queensland Survey 2006 – Summary Report. Queensland Health. Brisbane; 2007.
[10] National Health and Medical Research Council. Food for Health – Dietary Guidelines for Children and Adolescents. Commonwealth of Australia. Canberra; 2003.

and practical tools to support this work, and promote activities targeted towards children and young people including those funded under the NPAPH.

- Households: delivering a self-help pack with a focus on nutrition, physical activity and healthy weight.

51. **Contribution to performance benchmarks:**

This activity will contribute to the performance benchmarks under the National Partnership by adopting strategies that focus on:

- Increasing healthy eating among children, including increased fruit and vegetable consumption and decreased consumption of extra foods.
- Increasing the number of children who are a healthy weight.
- Increasing physical activity in children and reducing sedentary behaviours.
- Delivering consistent healthy messages that increase awareness of the link between chronic disease and lifestyle risk factors (poor nutrition, physical inactivity and unhealthy weight).
- Creating supportive environments for physical activity and healthy eating.
- Increasing positive attitudes towards healthy eating (particularly fruit and vegetables), physical activity and healthy body weight.
- Increasing confidence in achieving daily physical activity and healthy weight and appreciation of the consequent significant benefits.
- Enhancing optimal introduction of solids, fruit and vegetable consumption and physical activity and movement opportunities for infants and young children.
- Providing information to Queensland professionals to assist children and young people, and their parents, carers and other family members to eat healthily, be more active and achieve and maintain healthy growth and weight.
- Providing information to all Queensland households with children to support parents and carers to assist children and young people to eat well and be more active.

52. **Policy consistency:**

These strategies will contribute to the achievement of both national and state policies and priorities of promoting good health and reducing the burden of chronic disease, including Council of Australian Governments' (COAG) Australian Better Health Initiative, the National Preventative Health Strategy and the Queensland Government's Toward Q2: Tomorrow's Queensland. See Attachment B for further details.

53. **Target group(s):**

The target groups for this activity include:

- Parents and carers of children and young people.
- Sporting clubs and associations that cater for junior competitors.
- Children, family and community settings including: Aboriginal and Torres Strait Islander people, culturally and linguistically diverse groups, rural and remote communities, low income communities, and children with disabilities.
- Children aged 7-13 years who are overweight or obese and their parents/carers.
- Pacific Islander children and their parents/carers.
- Pregnant women, parents of infants and young children, and their families.
- Primary and middle school children in Aboriginal and Torres Strait Islander communities, disadvantaged areas, and isolated rural and remote communities.

- Professionals working with children and young people, including those in the education, health, community, sports and justice settings across the government and non-government sectors.

54. **Stakeholder engagement:**

Achievement of chronic disease prevention performance benchmarks will require a high degree of collaboration and coordination of effort across the Queensland Government, in partnership with the non-government sector. A wide range of stakeholders have been consulted during the development of the Queensland Healthy Children Implementation Plan and will continue to provide strategic direction, advice and support during the implementation of the 'family and community setting' activity.

Key stakeholders include: Queensland Health, Department of Education and Training, Department of Communities (Sport and Recreation Services), Department of Transport and Main Roads, Local Government Association of Queensland, Queensland peak sporting bodies, Queensland junior sporting clubs, Queensland Aboriginal and Islander Council, Ethnic Communities Council Queensland, external providers of nutrition, physical activity and healthy weight services, primary health care staff, Queensland families, and professionals working with children in the health, community and education sectors.

A range of strategies will be employed to engage stakeholders and may include consultation, project reference and planning groups, professional development and training, regular communication, and practical resources.

55. **Risk identification and management:**

Risk	Level	Possible mitigation strategies	Responsibility
Not engaging appropriately skilled providers	Low	• Robust tender processes • Clear governance, deliverables and performance criteria	Queensland Government
Staff cannot be recruited or high turnover	Medium	• Ensure position description and performance criteria are clearly articulated • Extend recruitment zones and amend recruitment targets	Queensland Government External providers
Not meeting proposed program budgets	Medium	• Establish service agreements with key stakeholders • Establish regular reporting mechanisms and governance structure • Expand or decrease target audience reach	Queensland Government External providers
Inability to identify specific target groups for activity implementation	Low	• Utilise strong professional support networks, peak bodies and community networks • Staff to be employed in relevant government departments in addition to non-government organisations	Queensland Government External providers Planning groups
Low demand for activity	Low	• Extensive consultation to determine specific needs and engage with relevant stakeholders • Program communication and marketing	Queensland Government External providers Project planning groups
Grants program over-subscribed with applications	Medium	• Set yearly priorities for funding to limit application pool	Queensland Government Project planning groups

Poor training and workshop quality	Low	• Evaluate training sessions and facilitators against performance criteria • Provide resources to support workshop content	Queensland Government External providers Planning groups
Poor quality and satisfaction rates of resources and materials	Low	• Development processes to include collaboration with key stakeholders and focus testing • Formative evaluations to be incorporated into review of resources and materials	Queensland Government External providers Planning groups
Poor dispute resolution	Medium	• Establish risk register and mitigation strategies • Establish issues management processes within project management framework	Queensland Government External providers Planning groups

56. **Evaluation:**

Evaluation type	**Measure**	**Proposed methodology**	**Timing**
Process	• Staff, project and contract management	• Matching reporting outcomes with service agreements	July 2011-June 2015
	• Access to resources • Attendance at training • Access to resources and training by services in rural and remote areas, disadvantaged areas and high Indigenous populations	• Number of resources distributed • Number of training sessions held and participation rates • Website use • Geographic and demographic analysis of access to resources and training	
	• Relevance of resources and training to needs of services in family and community settings • Satisfaction with resources, training and programs	• Feedback on resources and training sessions/workshops	
Impact	*Strategy 1* • Number of sporting clubs achieving accreditation or incentive standards • Increased access to healthy food and drink options at sporting clubs	• Quantitative data collection by service provider • Random sample of sporting clubs	Annually Baseline: Jan-June 2011
	Strategy 2 • Improved levels of physical activity and healthy eating in target groups • Sustained community partnerships and institutionalisation of project outcomes	• Mandatory project completion reports	Annually
	Strategy 3 • Behaviour change in participants that supports healthier lifestyles • Increased self-esteem and confidence of children and families	• Quantitative data collection • Pre and post-program questionnaire	Ongoing with data reported annually

	Strategy 4 • Increased in awareness of lifestyle modification needs for children and evidence of lifestyle modification *Strategy 5* • Awareness and knowledge related to nutrition, physical activity and healthy weight • Satisfaction and usage *Strategies 6 and 8* • Improvements in knowledge of national guidelines and confidence to impart these • Increased awareness of programs for children and young people to improve nutrition and physical activity and confidence to make referrals *Strategy 7* • Provision of evidence-based and credible information that is readily available to parents and carers	• Pre- and post-program surveys • Questionnaire to all recipients • Pre- and post-program questionnaires • Number of resources distributed	Baseline by June 2012 and Follow-up: 2012-2015 Commencing 2012; ongoing 2012-2014 2012
Outcome	• Increased fruit and vegetable consumption among Queensland children • Increased physical activity levels among Queensland children • Increased prevalence of healthy weight among Queensland children • Reduced consumption of energy-dense nutrient-poor foods among Queensland children • Increased use of national nutrition and physical activity guidelines by Queensland professionals working with children and young people • Increased knowledge about healthy eating, physical activity and healthy weight by Queensland parents and carers and introduction of practical strategies	Combination of methods, which may include: • Statewide computer assisted telephone interview survey • Random sample of children attending sporting clubs • Invitation to TRIM kids participants for three, six and 12 month follow-up and yearly thereafter • Annual questionnaire to cohort of Small Talk recipients • Subset of participants followed up six months after workshop • Surveys with parents/carers and feedback via post-return postcards	Baseline conducted: Jan-June 2011 Follow-up conducted: 2012-2015 2013 2012

57. **Infrastructure:**

This activity aims to build on existing administrative, physical and operational infrastructure wherever possible. The budget allocated will cover additional infrastructure required to complete project including staffing and resources.

58. **Implementation schedule:**

Table 3: Implementation schedule

Deliverable and milestone	Due date
Service agreements finalised	July 2011
Project plans completed	August 2011
Staff recruited	Ongoing throughout 2011-2015
Food for Sport accreditation or incentive system, supporting resources, and training and support strategy developed and implemented	2012-2015
Community partnership grants projects approved and funded, and completed and acquitted	2011-2015
TRIM kids program implemented	2011-2015
Healthy CALD kids module developed and delivered	2011-2015
Small Talk resource delivered and available online, and training provided	2012-2015
Promoting Healthier Kids in Queensland workshops piloted and delivered	2011-2013
Healthy Kids Queensland household pack developed, piloted and disseminated	2011-2012
Healthy Kids Queensland local activity kit and website developed and disseminated	2012-2013
Evaluation of all strategies completed	June 2015

59. **Activity budget:**

Table 4: Activity project budget

Expenditure item	Year 1	Year 2	Year 3	Year 4	Total
TOTAL	$3,180,460	$7,913,317	$2,589,445	$2,806,670	***$16,489,892***

ROLES AND RESPONSIBILITIES

Role of the Commonwealth

60. The Commonwealth is responsible for reviewing the State's performance against the program and activity outputs and outcomes specified in this Implementation Plan and providing any consequential financial contribution to the State for that performance.

Role of the State

61. The State is responsible for all aspects of program implementation.

62. The State agrees to participate in the Healthies Steering Committee or other national participation requirements convened by the Commonwealth to monitor and oversee the implementation of the initiative, if relevant.

PERFORMANCE REPORTING

63. The State will provide performance reports to the Commonwealth to demonstrate its achievement against the following performance benchmarks as appropriate to the initiative at 30 June 2013 and 31 December 2014:

    a) Increase in proportion of children at unhealthy weight held at less than five per cent from baseline for each state by 2013; proportion of children at healthy weight returned to baseline level by 2015.

    b) Increase in mean number of daily serves of fruits and vegetables consumed by children by at least 0.2 for fruits and 0.5 for vegetables from baseline for each State by 2013; 0.6 for fruits and 1.5 for vegetables by 2015.

    c) Increase in proportion of children participating in at least 60 minutes of moderate physical activity every day from baseline for each State by five per cent by 2013; by 15 per cent by 2015.

    d) Increase in proportion of adults at unhealthy weight held at less than five per cent from baseline for each state by 2013; proportion of adults at healthy weight returned to baseline level by 2015.

    e) Increase in mean number of daily serves of fruits and vegetables consumed by adults by at least 0.2 for fruits and 0.5 for vegetables from baseline for each state by 2013; 0.6 for fruits and 1.5 for vegetables from baseline by 2015.

    f) Increase in proportion of adults participating in at least 30 minutes of moderate physical activity on five or more days of the week of 5 per cent from baseline for each state by 2013; 15 per cent from baseline by 2015.

    g) Reduction in state baseline for proportion of adults smoking daily commensurate with a two percentage point reduction in smoking from 2007 national baseline by 2011; 3.5 percentage point reduction from 2007 national baseline by 2013.

64. The requirements of performance reports will be mutually agreed following confirmation of the specifications for measuring performance benchmarks by the Australian Health Minister's Conference.

65. The performance reports are due within two months of the end of the relevant period.

ATTACHMENT A

National Partnership Agreement on Preventive Health

HEALTHY CHILDREN

Scoping Statement and Guiding Policy Principles

PART 1: INTRODUCTION AND OVERVIEW

1.1 Purpose

This document, developed in consultation with states and territories, is designed to provide guidance in developing jurisdictional implementation plans and support a consistent approach to the implementation of the Healthy Children initiative under the National Partnership Agreement on Preventive Health (NPAPH).

1.2 Objectives

The objective of the NPAPH is to reduce the risk of chronic disease by reducing the prevalence of overweight and obesity, improving nutrition and increasing levels of physical activity in adults, children and young people through the implementation of programs in various settings. The NPAPH provides funding for:

- settings based interventions in pre-schools, schools, workplaces and communities to support behavioural changes in the social contexts of everyday lives and focusing on improving poor nutrition, and increasing physical inactivity. For adults also focusing on smoking cessation and reducing harmful and hazardous alcohol consumption;
- social marketing for adults aimed at reducing obesity and tobacco use; and
- the enabling infrastructure to monitor and evaluate progress made by these interventions, including the National Preventive Health Agency and research fund.

1.3 Outputs

To realise these objectives, the Healthy Children initiative will fund states and territories to deliver a range of programs:

a) building on existing efforts currently in place, while adapting them to suit demographic and other factors in play at various sites;
b) covering physical activity, healthy eating, primary and secondary prevention;

c) in settings such as child care centres, pre-schools, schools, multi-disciplinary service sites, and children and family centres; and

d) including family based interventions, settings based interventions, environmental strategies in and around schools, and breastfeeding support interventions.

1.4 Evidence Base

The interim results of the Australian Bureau of Statistics *National Health Survey 2007-08* show the proportion of combined overweight or obese children aged 5 -17 years increased from 20.8 per cent in 1995 to 24.9 per cent in 2007-08.[11] Further, results from the 2007 *Australian National Children's Nutrition and Physical Activity Survey* indicate that:

- the proportion of children meeting the guidelines for fruit intake (1-3 serves per day depending on age group and gender) declines with age (61 per cent for 4-8 year olds, 51 per cent for 9-13 year olds and 1- 2 per cent for 14-16 year olds); and
- the proportion of children meeting the guidelines for vegetable intake (2-4 serves per day depending on age group and gender) decreases with age (22 per cent for 4-8 year olds, 14 per cent for 9-13 year olds and 5 per cent for 14-16 year olds).[12]

Key factors emerging from the international and national literature that can determine the success and sustainability of health promotion programs suitable for children and young people include:

- *Well established project planning and implementation* ensures the identified needs and interests of children are met. A participatory approach to planning the program structure and content involving the key influencers in children's lives is beneficial.
- *Recognition of the role of the family and community and involvement in key activities.*
- *A focus on good nutrition and physical activity.*
- *Structural support for healthy lifestyles* including safe places and spaces for physical activity and increased access to healthy food.
- *Effective and consistent communication* of the aims and purpose of the program to build positive engagement.
- *Multi-component programs* can ensure a variety of behavioural risk factors, issues and strategies are addressed to engage greater numbers of children and young people with different preferences and health needs and ensure lasting change.
- *Monitoring and evaluation* of all program components should be established during program planning and inception.

PART 2: HEALTHY CHILDREN

Terminology, Scoping Statement and Guiding Policy Principles

2.1 Terminology

For the purposes of the Healthy Children initiative in the NPAPH, the following terms are defined:

Access and equity is about ensuring that individuals, families and populations are not further disadvantaged in a health and social sense through the programs and activities delivered as part of the NPAPH. It requires consideration of a range of factors that can impact on access to, reach of and

[11] Australian Bureau of Statistics (2009); National Health Survey 2007-08 – Summary of results, Canberra

[12] Australian National University (2007); Children's Nutrition and Physical Activity Survey – Fact Sheet – Key Findings 2007, Canberra

appropriateness of programs for certain populations, removing or reducing barriers to health and access to health-based activities. Programs must support equity of outcomes for all by increasing opportunities and removing or reducing barriers for participation. There are a number of interacting factors that must be considered in addressing access and equity, for example:

- the size of the organisation or setting and relative capacity to access, take up, participate in and/or be reached by programs and implement programs;
- consideration of the characteristics of children and young people, and their families at both a group and individual level including gender, cultural and linguistic background, Aboriginal and Torres Strait Islanders, people with a disability, physical location and socio-economic status. These factors should be considered in program design, delivery and evaluation;
- equity of outcome that considers all the elements above in relation to the outcomes for individuals (for example, were there organisations and individuals who experienced better results than others in the same cohort); and
- elements outlined in the Australian Government's *Social Inclusion Toolkit.*[13]

Children, for the purposes of this initiative, are defined as children and young people from birth to 16 years of age. Young people between the ages of 16 and 18 years are included in the definition of children if they are not participating in higher education as this setting is best addressed by the Healthy Communities and Healthy Workers initiatives.

Healthy living programs, in the context of this initiative, are those programs that cover physical activity and healthy eating. The use of the term 'program(s)' is inclusive of activities targeting individuals, groups of individuals and of activities that are of an organisational wide, enabling or capacity building nature. This may include policy enhancement, system change and minor supporting infrastructure improvements directly related to the implementation in the specific setting that are made to facilitate and support the health of children and young people and associated with behavioural change. The following language will be used to describe the hierarchy of elements of the NPAPH:

1. NPAPH initiatives, such as Healthy Children;
2. jurisdictional programs (i.e., state and territory programs or activities implemented according to an agreed plan); and
3. activities within jurisdictional programs; local government programs or pilot programs..

Primary and secondary prevention definitions are drawn from *The Language of Prevention*, National Public Health Partnership (2006)[14] and in the context of the Healthy Children initiative mean:

- *Primary prevention* - limiting the incidence of disease and disability in the population by measures that eliminate or reduce causes or determinants of departure from good health, control exposure to risk and promote factors that are protective of good health; and
- *Secondary prevention* – reduction of progression of disease through early detection, usually by screening at an asymptomatic stage, and early intervention.

Quality assurance framework, accreditation and standards or other relevant material are already in place and/or currently being developed by the Australian Government under the NPAPH. Programs and program providers will be encouraged to have regards to relevant accreditation processes in order to receive funding under the initiative from jurisdictions.

[13] www.socialinclusion.gov.au/Documents/SIToolKit.pdf
[14] National Public Health Partnership (2006), *The Language of Prevention,* Melbourne.

2.2 Scope

Consistent with the objectives and expected outcomes of the NPAPH, the policy scope for the Healthy Children initiative is summarised below:

2.2.1 The focus of the initiative is the prevention of lifestyle related chronic disease through addressing the modifiable lifestyle risk factors of poor nutrition and physical inactivity through sustained behaviour change for children and young people.

2.2.2 The primary target group is children and young people and program funding should be directed to these groups taking into account the key role and involvement of the family, particularly parents. Setting based initiatives may involve making the environment more supportive of healthy lifestyles. For example, food and physical activity policies, training of relevant health professionals, curriculum development and activities that target children and their families directly or indirectly through a child care or school setting, and child behaviours through combined parent/child interventions.

2.2.3 Substantial built environment or infrastructure improvements are beyond the scope of the NPAPH and this initiative.

2.2.4 Mental health is not included as a performance benchmark under the NPAPH. While programs may have a mental health element, this should not be the sole focus of the program.

2.2.5 Programs should ensure a positive body image is promoted and that emphasis is on a healthy lifestyle. This should involve consideration of the target audience for programs and individuals and groups who may be vulnerable to forming a negative body image. For example, programs that target groups such as teenage girls may need different support and messages than programs for very young children or for primary school aged children.

2.2.6 Programs should focus on preventive health activities and the promotion of healthy behaviour. Programs with a tertiary management focus (i.e., the clinical management of existing chronic conditions) are not within the preventive scope of this initiative. However, individuals already participating in tertiary treatment programs are not to be excluded. Note that only preventive programs may attract funding.

2.2.7 New and innovative programs can be implemented where gaps exist for children and young people, and their families, or existing programs can be adapted or extended to suit demographic and other factors.

2.2.8 Programs can be delivered in settings such as child care centres, pre-schools, schools, multi-disciplinary service sites, children and family centres and potentially other less formal settings such as play groups or youth sporting groups.

2.2.9 Programs may take the form of settings based initiatives, strategies in and around schools and early childhood settings, and breastfeeding support interventions. Programs must focus on delivery of activities within the defined setting. Delivery of program activities exclusively in the home is not within the scope of the initiative.

2.2.10 Programs should actively support breastfeeding, where relevant.

2.3 Policy Principles

General

2.2.1 Programs under the initiative should be focused on primary and secondary prevention.

2.2.2 Funding for programs should be invested in:

- significant enhancements or expansions to existing program(s) that have already demonstrated they are efficacious;
- new programs that have demonstrated efficacy elsewhere that are directly translatable to the initiative setting;
- programs that can demonstrate significant innovation and/or promise from initial results, but lack formal evidence to demonstrate effectiveness; and/or
- programs that have a high likelihood of being sustainable beyond the funding received under this initiative (should the program be effective and there is a demonstrated continuing need).

2.2.3 Programs should reflect the requirements of the Australian Government's *Social Inclusion Toolkit*.

2.2.4 Access and equity in terms of both access to programs and equity of outcomes as a result of participation in programs must be a key consideration.

2.2.5 Participation in-NPAPH programs is voluntary. However, the voluntary participation requirement does not override specifications of existing or new setting-based legislative requirements or policies (e.g., food supply, curriculum, and requirements for physical activity).

2.2.6 Programs and associated evaluations should not further stigmatise obesity and other applicable health conditions and behaviours and should promote a positive body image. Programs should also consider the potential for any negative body image messages and have appropriate management strategies in place.

2.2.7 Measures must be in place to protect the privacy of individuals as appropriate. Programs must comply with applicable legislation in relation to consent to collect personal and health information and the use, access, storage and disclosure of this information.

2.2.8 Program providers may be expected to comply with specified requirements, including quality assurance frameworks, standards or other guidance in existence or currently being developed under the NPAPH.

2.2.9 Programs should be developed and implemented in consideration of relevant local enablers and barriers (i.e. appropriate stakeholder consultation and support, infrastructure issues and different industry and workforce requirements).

2.2.10 Funding under the initiative may be used to extend existing programs or create new programs. However, the duplication of funding already allocated at a state and territory level, or by an organisation should not be permitted.

2.2.11 Programs will not be funded if they support, promote or utilise sponsorship of food or beverage products considered to be high in sugar, salt and saturated fat, or of tobacco and/or alcohol or promote sedentary behaviour.

2.2.12 Consistency and complementarity with programs already in place should be considered. An assessment of possible efficiencies and effectiveness should be undertaken that recognises activities in other settings (i.e. the community and workplaces).

2.2.13 Programs should have monitoring systems in place to ensure they are capable of reporting in an accurate and timely way on the achievement of program outputs in accordance with performance monitoring and evaluation requirements under the NPAPH.

2.2.14 Programs should have mechanisms in place for continuous quality improvement. Monitoring and evaluation arrangements should, where possible, be developed to help facilitate evaluation at a national level.

And specifically for the Healthy Children initiative

2.2.15 Programs that have a clinical risk assessment component should have identified clear and appropriate referral pathways in place that include complementary support activities that aim to address and lead to a reduction in identified lifestyle risk factors.

2.2.16 Programs should emphasise the importance of healthy lifestyles, good nutrition and regular physical activity and should include a comprehensive mix of interventions. This includes both universal approaches and targeted interventions for children and young people who may be at high risk of overweight/obesity, physical inactivity and/or have poor nutrition.

2.2.17 Consideration should be given to populations of children and young people at higher risk of overweight or obesity, physical inactivity and/or poor nutrition, in particular socioeconomically disadvantaged populations and Aboriginal and Torres Strait Islander communities.

2.2.18 Programs should complement existing effective programs and policies for children and young people.

2.2.19 Programs should explicitly support breastfeeding where relevant.

2.2.20 Programs should comply with requirements for working with children and young people in each state and territory.

2.2.21 Programs must be safe and appropriate for children and young people and their parents and families.

ATTACHMENT B

Policy consistency for the Queensland Healthy Children Implementation Plan (pre-school, school and family and community settings):

In July 2006, the Council of Australian Governments (COAG) agreed that all governments would commence implementation of a four-year, $500 million national program called the Australian Better Health Initiative (ABHI). This identified five priority areas for action to help shift the focus of the Australian health care system towards promoting good health and reducing the burden of chronic disease. Through the broader national health reform context, there has been further repositioning and refocusing of effort on primary prevention activities known to be effective. The National Preventive Health Strategy released in September 2009 identifies communities, schools and workplaces as priority settings for intervention to address unhealthy lifestyle behaviours.

The National Partnership Agreement on Preventive Health (NPAPH), signed by COAG in December 2008, provides for collaborative action and practical funding, infrastructure and implementation support to enable an increased collective 'dose' of primary prevention effort across the country. The scoping statement and guiding policy principles framework of the Healthy Children output area of the NPAPH is outlined in Attachment A. The NPAPH also expands and builds on ABHI commitments for chronic disease prevention.

These national efforts have been augmented and complemented by long-term state-level commitments to preventive health strategies addressing chronic disease risk factors, such as the Queensland Government's first action plan for healthy weight, *Eat Well Be Active Healthy Kids for Life Action Plan 2005-2008.* There has also been increased investment in recurrent funding to recruit specialised staff to deliver evidence-based nutrition and physical activity promotion initiatives.

The announcement of *Toward Q2: Tomorrow's Queensland* in August 2008 reinforced the importance of preventive health strategies in making Queenslanders Australia's healthiest people by 2020. The Queensland Government has set a target to cut by one third obesity, smoking, heavy drinking and unsafe sun exposure by 2020. This approach of prioritising the primary prevention of chronic disease is consistent with the NPAPH (with the exception of unsafe sun exposure). These collective state-based commitments include a focus across the key settings for children, workplaces and communities and have ensured Queensland's readiness for the augmented national chronic disease prevention effort under the NPAPH.

This activity is consistent with the objectives of the National Healthy Children Initiative and the Guiding Principles for the Initiative (appendix A) in the following ways:

- Proposes a variety of settings-based interventions including those based in schools and school communities.
- Focuses on activities to reduce the prevalence of overweight and obesity, improve nutrition and increase levels of physical activity of children and young people in Queensland.
- Focuses on primary and secondary prevention.
- Provides funding for initiatives that:
    - enhance and expand existing programs that have already demonstrated efficacy
    - demonstrate significant innovation and/or promise from initial results and build on similar programs in comparable settings, but lack formal evidence to demonstrate effectiveness
    - demonstrate efficacy elsewhere and are directly translatable to the initiative setting, meet a service gap, and will add to the evidence base through formal evaluation

  - have a high likelihood of being sustainable beyond the funding received under this initiative (should the program be effective and there is a demonstrated continuing need), and meets a service gap
  - demonstrate significant innovation and/or promise from initial results, but lack formal evidence to demonstrate effectiveness at medium term outcome level.

- Reflects the requirements of the Australian Government's *Social Inclusion Toolkit*.
- Addresses access and equity in terms of both access to programs and equity of outcomes as a result of participation.
- Participation will be voluntary.
- Will not further stigmatise obesity and other applicable health conditions and behaviours and will promote a positive body image.
- Protects the privacy of individuals and complies with applicable legislation.
- Requires providers to comply with specified requirements, including quality assurance frameworks and standards.
- Will be developed and implemented in consideration of relevant local enablers and barriers.
- Uses funding to extend existing programs or create new programs, but does not duplicate funding already allocated at a state and territory level, or provided by an organisation.
- Will not support, promote or utilise sponsorship of food or beverage products considered to be high in sugar, salt and saturated fat, or of tobacco and/or alcohol or promote sedentary behaviour.
- Will be consistent and complementary with programs already in place.
- Has monitoring systems in place to ensure accurate and timely reporting.
- Has mechanisms in place for continuous quality improvement.
- Contains a clinical risk assessment component, and will identify clear and appropriate referral pathways that include complementary support activities that aim to address and lead to a reduction in identified lifestyle risk factors.
- Emphasises the importance of healthy lifestyles, good nutrition and regular physical activity and includes a comprehensive mix of interventions.
- Considers populations of children and young people at higher risk of overweight or obesity, physical inactivity and/or poor nutrition, in particular socioeconomically disadvantaged populations and Aboriginal and Torres Strait Islander communities.
- Complements existing effective programs and policies for children and young people.
- Explicitly supports breastfeeding where relevant.
- Complies with requirements for working with children and young people in each state and territory.
- Will be safe and appropriate for children and young people and their parents and families.