Australian Government
Department of Health

phn
An Australian Government Initiative

Primary Health Networks Core Funding

Primary Health Networks After Hours Funding

Activity Work Plan 2016-2018

- Annual Plan 2016-2018
- Annual Operational and Flexible Funding Streams Budget 2016-2017
- After Hours Budget 2016-2017

Nepean Blue Mountains

When submitting this Activity Work Plan 2016-2018 to the Department of Health, the PHN must ensure that all internal clearances have been obtained and has been endorsed by the CEO.

The Activity Work Plan must be lodged to Chris Macdonald via email chris.macdonald@health.gov.au on or before 6 May 2016

Introduction

Overview

The key objectives of Primary Health Networks (PHN) are:

- Increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- Improving coordination of care to ensure patients receive the right care in the right place at the right time.

Each PHN must make informed choices about how best to use its resources to achieve these objectives.

Together with the PHN Needs Assessment and the PHN Performance Framework, PHNs will outline activities and describe measurable performance indicators to provide the Australian Government and the Australian public with visibility as to the activities of each PHN.

This document, the Activity Work Plan template, captures those activities.

This Activity Work Plan covers the period from 1 July 2016 to 30 June 2018. To assist with PHN planning, each activity nominated in this work plan can be proposed for a period of 12 months or 24 months. Regardless of the proposed duration for each activity, the Department of Health will still require the submission of a new or updated Activity Work Plan for 2017-18.

The Activity Work Plan template has the following parts:

1. The Core Funding Annual Plan 2016-2018 which will provide:
    a) The strategic vision of each PHN.
    b) A description of planned activities funded by the flexible funding stream under the Schedule – Primary Health Networks Core Funding.
    c) A description of planned general practice support activities funded by the operational funding stream under the Schedule – Primary Health Networks Core Funding.

2. The indicative Core Operational and Flexible Funding Streams Budget for 2016-2017.

3. The After Hours Primary Care Funding Annual Plan 2016-2017 which will provide:
    a) The strategic vision of each PHN for achieving the After Hours key objectives.
    b) A description of planned activities funded under the Schedule – Primary Health Networks After Hours Primary Care Funding.

4. The indicative Budget for After Hours Primary Care funding stream for 2016-2017.

Annual Plan 2016-2018

Annual plans for 2016-2018 must:

- provide a coherent guide for PHNs to demonstrate to their communities, general practices, health service organisations, state and territory health services and the Commonwealth Government, what the PHN is going to achieve (through performance indicator targets) and how the PHN plans to achieve these targets;
- be developed in consultation with local communities, Clinical Councils, Community Advisory Committees, state/territory governments and Local Hospital Networks as appropriate; and

- articulate a set of activities that each PHN will undertake, using the PHN Needs Assessment as evidence, as well as identifying clear and measurable performance indicators and targets to demonstrate improvements.

Activity Planning

The PHN Needs Assessment will identify local priorities which in turn will inform and guide the activities nominated for action in the 2016-2018 Annual Plan. PHNs need to ensure the activities identified in the annual plan also correspond with the PHN Objectives; the actions identified in Section 1.2 of the PHN Programme Guidelines (p. 7); the PHN key priorities; and/or the national headline performance indicators.

PHNs are encouraged to consider opportunities for new models of care within the primary care system, such as the patient-centred care models and acute care collaborations. Consideration should be given to how the PHN plans to work together and potentially combine resources, with other private and public organisations to implement innovative service delivery and models of care. Development of care pathways will be paramount to streamlining patient care and improving the quality of care and health outcomes.

Primary Health Networks After Hours Funding

From 2016-17, PHNs will have greater flexibility to commission programme specific services, having completed needs assessments for their regions and associated population health planning. PHNs are funded to address gaps in after hours service provision and improve service integration within their PHN region. Item B.3 of the After Hours Funding Schedule may assist in the preparation of the After Hours components of your Activity Work Plan (pages 12-15 of this document).

Measuring Improvements to the Health System

National headline performance indicators, as outlined in the PHN Performance Framework, represent the Australian Government's national health priorities.

PHNs will identify local performance indicators to demonstrate improvements resulting from the activities they undertake. These will be reported through the six and twelve month reports and published as outlined in the PHN Performance Framework.

Activity Work Plan Reporting Period and Public Accessibility

The Activity Work Plan will cover the period 1 July 2016 to 30 June 2018. A review of the Activity Work Plan will be undertaken in 2017 and resubmitted as required under Item F.22 of the PHN Core Funding Agreement between the Commonwealth and all Primary Health Networks.

Once approved, the Annual Plan component must be made available by the PHN on their website as soon as practicable. The Annual Plan component will also be made available on the Department of Health's website (under the PHN webpage). Sensitive content identified by the PHN will be excluded, subject to the agreement of the Department.

It is important to note that while planning may continue following submission of the Activity Work Plan, PHNs can plan but must not execute contracts for any part of the funding related to this Activity Work Plan until it is approved by the Department.

Further information

The following may assist in the preparation of your Activity Work Plan:

- Clause 3, Financial Provisions of the Standard Funding Agreement;
- Item B.3 of Schedule: Primary Health Networks After Hours Funding;

- Item B.4 of Schedule: Primary Health Networks Core Funding;
- PHN Needs Assessment Guide;
- PHN Performance Framework; and
- Primary Health Networks Grant Programme Guidelines.

Please contact your Grants Officer if you are having any difficulties completing this document.

1. (a) Strategic Vision

Nepean Blue Mountains PHN's current strategic vision

The Nepean Blue Mountains PHN is a not for profit organisation that works to improve health for the communities of Blue Mountains, Hawkesbury, Lithgow and Penrith.

We do this by working with and providing support to General Practice, other primary health care providers and the many health and non-health stakeholders across the region.

Our Vision

Improved health for the people in our community.

Our Mission

Empower local general practice and other healthcare professionals to achieve high quality, accessible and integrated primary healthcare that meets the needs of our community.

Our Values

Respect ~ Ethical Practice ~ Quality ~ Collaboration ~ Continuous Improvement

Guiding Principles

The guiding principles for our work are:

- A continuing effective relationship between a patient and their preferred primary care provider.
- A care model that ensures people receive the right care in the right place at the right time.
- Joined up health care to enable a smooth, optimal health journey for patients.
- High quality, sustainable health services.
- A focus on those at risk of poor health outcomes.

1. (b) Planned activities funded by the flexible funding stream under the Schedule – Primary Health Networks Core Funding

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Proposed Activities	
Priority Area	**1. Chronic and Preventable Conditions** The needs assessment identifies high and increasing prevalence of diabetes, high rates of death for cardiovascular disease compared to 8 metro PHNs, 29% of persons in NBM region reported in 2011-12 as obese and 35% as overweight with one in five people reported as obese and one in three people reported as overweight in 2014. Respiratory disease was the third leading cause of death in the NBM population and COPD is the leading cause of potentially preventable hospitalisations during 2011-12.
Activity Title / Reference	**1.1 Chronic care collaborative**
Description of Activity	Chronic and preventable conditions with the highest prevalence in the NBM region including COPD, Diabetes, cardiovascular disease, overweight and obesity are addressed. The formation of a chronic and preventable conditions collaborative will focus on quality improvement measures that support the implementation of improved care coordination for these conditions. Existing systems and services within general practices and across primary care will be utilised to support sustainability. A cohort of general practices will work closely to form the collaborative and co-design a pilot model that will be tested over the two year period. The collaborative will be supported by governance and guidelines developed by GPs, specialists and allied health.
Collaboration	Improvement Foundation General Practice Allied Health Specialists NBM Local Health District Diabetes Australia Lung Foundation University of Sydney Clinical School National Heart Foundation Universities (TBA)
Indigenous Specific	No
Duration	Two year period (2016-2018) commencing July 2016 with review in 12 months

Coverage	All regions within the NBM
Commissioning approach	Commissioned
Data source	MBS data NBM PEN Clinical Audit Tool will extract data from participating general practices to provide baseline and monitoring reports of quality improvement in service provision

Proposed Activities	
Priority Area	**1. Chronic and Preventable Conditions** The needs assessment identifies childhood immunisation rates as below national targets for some postcode groups within specific LGAs in the NBM region.
Activity Title / Reference	**1.2 Addressing variation In Childhood Immunisation Rates in hard to reach populations**
Description of Activity	The activity aims to understand decision making of vaccine-hesitant parents in low-coverage populations in the Blue Mountains LGA and the role complimentary medicine practitioners may have in addressing challenges to immunisation uptake. Aim: To work with the university and LHD partners to support research and novel approaches to increase childhood immunisation rates in particular sections of the Blue Mountains LGA. Background: There are postcodes in the Mid-Upper Blue Mountains where vaccine-hesitancy rates as measured by Conscientious Objector rates are higher than the NSW average and local childhood immunisation coverage rates are lower when compared to surrounding postcodes and LGAs. Objectives are to: 1. Use a qualitative study and other research methodology to expand on an earlier pilot survey indicating there may be a link between vaccine-hesitancy and complimentary medicine use in parents living in the Upper Blue Mountains

	2. Determine if there is a role for local Complimentary Practitioners to help meet the challenges of low vaccination rates 3. Share the results of our research with other PHNs who have areas of low childhood immunisation coverage rates These objectives are aligned to the following NBMPHN objectives and outcomes: • Planning, purchasing and commissioning services- Facilitate health promotion and disease prevention programs through primary health care and in partnership with the Local Health District to enable better health for our community, • Stakeholder relationships engagements - Build and support effective relationships with health and non-health stakeholders to achieve mutual goals. The activity will • Purchase research services from our university partners to best leverage the combined resources from university and NBMLHD partners • Build on a previous pilot research to potentially identify novel partners with whom the challenges of vaccine-hesitancy may be addressed
Collaboration	NBMLHD, NBMPHN, University of Technology Sydney, University of Sydney (National Centre of Immunology and Research Surveillance) The partners will continue to work together to steer the project and leverage/pool resources as they become available
Indigenous Specific	No
Duration	Two year period (2016-2018) commencing July 2016 with review in 12 months
Coverage	Targeted region of the Blue Mountains LGA
Commissioning approach	Commissioned
Data source	Research as conducted by the university partners

Proposed Activities	
Priority Area	**2. Older Persons** The needs assessment identifies influenza and pneumonia hospitalisation rates, variation in microbial prescribing rates, prevalence and cost of chronic pain, variation in prescribing of Opioids. The needs assessment also identifies the needs of ageing population, increasing pressure on general practice to coordinate services for older persons, increasing prevalence of chronic pain, support and services for older persons in the general practice and in the home
Activity Title / Reference	**2.1 Keeping older persons out of hospital through targeted approaches to primary care coordination**
Description of Activity	A range of targeted activities in primary care supported through the governance framework of an older persons care consortium. The consortium will address comprehensive care coordination needs of older persons to prevent hospital presentations and admissions including: • Implementing process pathways to support development of **Advance Care Directives** for older persons residing in RACFs in the Blue Mountains • Implementing process pathways of best practice **therapeutic management of antimicrobials, pain and poly pharmacy** in older people. The specific activities will be co-designed by key stakeholders with the aim of developing systems and models of care around best practice prescribing of opioids, other pain management medications and avoidance of poly pharmacy. • **Falls prevention** strategies for vulnerable, older persons with a focus on identification of high risk and implementation of risk assessment tools and systems in general practice to support intervention. • Increasing the **immunisations of older people for pneumonia and influenza** to reduce the risk of vaccine preventable hospital presentations and admissions and potential use of antimicrobials
Collaboration	General Practice Specialists – Pain Pharmacy Allied Health – occupational therapists, physiotherapists

	RACFs NBM LHD – Aged Care and Emergency departments National Prescribing Service Other NGOs as identified
Indigenous Specific	No
Duration	Two year period (2016-2018) commencing July 2016 with review in 12 months
Coverage	All regions in the NBM PHN but targeting specific activities in regions by priority of need e.g. Advance Care Directives in the Blue Mountains RACFs
Commissioning approach	Commissioned
Data source	MBS National non-admitted patient emergency department care database

Proposed Activities	
Priority Area	**3. Demographic and cultural factors influencing health status** The needs assessment for Aboriginal people inclusive of inequitable access to optimal care for Aboriginal people living in the region , readmission and leaving hospital against advice issues, high proportion of Aboriginal people living in NBM region, young and growing population, socioeconomic status, high incidence of risk factors in chronic conditions, low immunisation rates of Aboriginal children, high prevalence of smoking, higher rates of hospitalisation attributed to alcohol and other conditions including suicide, trauma and poisoning, higher rates of potentially preventable hospitalisations, high proportion of low birth weights and perinatal mortality, lower life expectancy The needs assessment of CALD communities inclusive of readmission rates within 28 days of discharge, diversity of high CALD needs, high prevalence of chronic disease with high number of presentations to ED for Samoan community, Syrian refugees complex mental health issues and child disability issues, access to mental health for CALD youth

Activity Title / Reference	**3.1 Capacity building with local health care providers**
Description of Activity	1. The capacity of suitable organisations within the primary care space to support the delivery of services specific to Aboriginal people is not fully understood across the NBM region. Where it is known, limitations with business models inhibit the capacity of such organisations to become viable contenders in the commissioning arena. A fuller review of the capacity and capability will be undertaken to identify suitable interventions in the first half of the reporting period with a view to building capacity to support organisations to undertake commissioning activities by the second half of the reporting period. 2. CALD and Refugee populations, as patients of primary care, are sometimes not culturally supported in sensitive and appropriate ways by health care providers The cultural competencies of health care providers in the regions to manage CALD and Refugees is not fully known. Activities will be undertaken to explore this further and provide support to build cultural competence capacity, particularly in the Penrith LGA where a refugee population increase has been predicted
Collaboration	General Practice NBM Local Health District Multicultural Unit NSW Centre for Refugee Health Western Sydney University Consumer groups
Indigenous Specific	No
Duration	Two year period (2016-2018) commencing July 2016 with review in 12 months
Coverage	NBM region
Commissioning approach	Commissioned
Data source	NBM data collection National non-admitted patient emergency department care database

Proposed Activities	
Priority Area	**4. Access to health services** The needs assessment identifies difficulty with accessing services and inadequate health transport options, general practice workforce shortages, high levels of general practice workforce attrition due to ageing, inadequate data to support regional planning and inadequate coverage for afterhours general practice
Activity Title / Reference	**4.1 Supporting and increasing access to local primary health workforce**
Description of Activity	4.1.1. A viable **health workforce** is essential to support community access to primary health services. The primary health workforce face consistent demands relating to current and predicated shortages due to population growth, workforce attrition, after hours needs and demographic factors. Sustainability and growth of the health workforce requires regular attention in addressing unmet service needs and innovative ideas to attract and retain health clinicians. Health workforce retention and development has been identified as a priority over the next two years. This activity will continue to build on the current workforce support program provided by the NBMPHN with the employment of a part-time officer to support attraction and retention of primary care clinicians to the area and monitoring of areas of particular need. It will also seek to commission new health services to meet unmet service needs i.e. using RDN funding or other models Example activities include: • Provide general practices with a GP vacancy referral service • Actively assist general practitioners to apply for and gain the requisite legal and regulatory status to commence work in our region. • Support retention of existing GP workforce through provision of local timely, topical professional development and networking activities. • Analysis and documentation of workforce distribution to establish a baseline. Consideration will then be given to address those gaps, through commissioning and facilitating the co-location of compatible health services and providers. • Actively seek to commission new health services to meet unmet service needs. i.e. in areas where there is a market failure.

	• Work with GP Synergy (GPET organisation) to promote and monitor registrar placements in the NBM region • Scope the viability of conducting a workforce census to establish primary care workforce capacity for NBM region; monitor trends such as aging general practice workforce, after hours services and impact of new general practitioner placement process; identify localised gaps in workforce capacity 4.1.2 **Emergency management** throughout the region and primary care's response is a critical aspect of access to health services in times of critical incidents. The NBMPHN will continue to work with General Practice and other stakeholders to implement and support primary care role in emergencies and pandemics. 4.1.3 **Work with stakeholders to develop solutions to address transport to primary health services** Inadequate transport has been identified by consumers as one of the major barriers in the NBM region to access health care services. The PHN will support the mapping and communication of transport options to health services and work with key stakeholders to identify solutions to improve access to health services across the region
Collaboration	Opportunities to establish new services under the Rural Doctors Network Outreach programs will be sought, particularly to increase service provision to the outlying areas of Lithgow, Hawkesbury and the Katoomba area. Collaboration with the Local Health District clinical services and other relevant agencies to meet service gaps will continue over the next two years e.g. provision of diabetes care in the Lithgow LGA. GP Synergy – GP registrar placements. RACGP – Emergency management NBM Local Health District Emergency Management Committee General Practice

	Local health transport agencies and other relevant service providers Local councils where relevant
Indigenous Specific	NO
Duration	Two year period (2016-2018) commencing July 2016 with review in 12 months
Coverage	NBM region
Commissioning approach	Approach to market and or direct engagement will occur with particular focus on continuing currently commissioned services that are meeting local health needs.
Data source	National Health Workforce Data Set NBM data collection

Proposed Activities	
Priority Area	**5. Cancer Care** The needs assessment identifies preventable cancer deaths projected for 2016, lower than state average for cervical screening in Penrith.
Activity Title / Reference	**5.1 Increasing cervical screening participation in the Penrith Local Government Area (LGA).**
Description of Activity	Aim of the activity: This activity will work in partnership with General Practices and other key stakeholders in Penrith postcode areas 2760 and 2750, currently with the lowest cervical screening participation rates in the region, to co-design interventions to increase cervical screening participation. These will be based on best practice, organisation of primary health care with a preventive health focus, and with consideration of the new National cervical screening Renewal program (to commence 1st May 2017). How the activity will address the priority: The cervical screening participation rate for eligible women 20-69 years in the Penrith LGA in 2013-14 was 50.4%, the lowest screening rate compared to other

	NBMPHN LGAs and the entire NBMPHN region (54.5%), and was lower than the NSW state average (57.7%). A coordinated approach to the organisation of primary care including for the early detection and treatment of chronic disease including cancer is recommended by national guidelines. Target population cohort: This activity will target women living in the Penrith LGA in NBMPHN region. This activity aligns with PHN objectives to: • Increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and • Improve coordination of care to ensure patients receive the right care in the right place at the right time. This activity aligns to the following national health priority area: • Population health This activity aligns with the following national headline indicator: • Cancer screening rates (cervical cancer)
Collaboration	This activity will be implemented with other stakeholders and organisations including: • General Practices in Penrith LGA • University partners • Women's Health non-government organisations • Cancer Institute NSW • Nepean Blue Mountains Local Health District public health unit
Indigenous Specific	NO
Duration	Two year period (2016-2018) commencing July 2016 with review in 12 months
Coverage	Coverage of this activity will be the Penrith Local Government Area.
Commissioning approach	Commissioned
Data source	Data source: Cervical screening – NSW Pap Test Register and NSW Ministry of Health (SAPHARI)

	Indicator 1 will be sourced from the NSW Pap Test register (NSW state data set). [1.] The Cancer Institute NSW collects cervical screening participation data on a continuous basis and reports biennial cervical screening participation data to NSW PHNs on request. Cervical screening participation data for the period May 2015-April 2017 will not be available until Feb-Mar 2018. [2] The national cervical screening Renewal program will commence on 1st May 2017. It is currently unclear what type of cervical screening participation data will be available under the Renewal program through the new National cervical screening register and the time period it will first report data for.

Proposed Activities	
Priority Area	**5. Cancer Care** The needs assessment inclusive of preventable cancer deaths projected for 2016, identifies the NBM regions as lower than state average for bowel screening in Penrith and Hawkesbury LGAs.
Activity Title / Reference	**5.2 Increasing bowel screening participation with a focus on men with low participation rates.**
Description of Activity	Aim of the activity: This activity will work in partnership with General Practices, men's health organisations and Western Sydney University to co-design interventions to increase bowel screening participation in the Penrith and Hawkesbury LGAs, with a focus on men in the 50-54 year age group who currently have significantly lower screening rates. How the activity will address the priority: The bowel screening participation rate for eligible men and women 50-74 years in the Penrith and Hawkesbury LGAs in 2013-14 was 29.4% and 30.3% respectively, the lower screening rate LGAs compared to other LGAs in the entire NBMPHN region (31.2%) and lower than the NSW state average (32.8%). Further, the bowel screening participation rate in NBMPHN region was lower for males compared to females for every 5-year age strata between 50-69 years and was as low as 22.8% for 50-54 year males between 2013-14 *(Source: Australian Institute of Health and Welfare).* This activity will draw upon existing services and community-supports for men to raise awareness amongst men of the importance of bowel screening. It will also support men to participate in the National bowel screening program, and visit their General Practitioner to discuss bowel screening.

	Target population cohort: This activity will target men living in the Penrith and Hawkesbury LGAs in NBMPHN region. This activity aligns with PHN objectives to: • increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and • improve coordination of care to ensure patients receive the right care in the right place at the right time. This activity aligns to the following national health priority area: • population health This activity aligns with the following national headline indicator: • cancer screening rates (bowel cancer)
Collaboration	This activity will be implemented with other stakeholders and organisations including: • General Practices in the Penrith and Hawkesbury LGAs • Western Sydney University • Cancer Institute NSW • Local men's health non-government organisations • Nepean Blue Mountains Local Health District public health unit • Penrith and Hawkesbury City Councils
Indigenous Specific	NO
Duration	Two year period (2016-2018) commencing July 2016 with review in 12 months
Coverage	Coverage of this activity will be the Penrith and Hawkesbury Local Government Areas.
Commissioning approach	Commissioned
Data source	Data sources: Indicator 1: National Bowel Cancer Screening Program (National data set), reported by the Australian Institute of Health and Welfare.

	[1,2] The National Bowel Cancer Screening Program (NBCSP) collects bowel screening participation data on a continuous basis. Bowel screening biennial participation data is reported by the Australian Institute of Health and Welfare on an annual basis in December, with cancer screening participation data for the previous two-year (biennial) period. Is it not currently known whether biennial bowel screening participation data can be made available by the NBCSP for biennial time-periods other than January to December. There is a minimum 9-month time lag from the time of collection to the time of public reporting for bowel-screening participation data. Therefore, should data for the July 2015-June 2017 biennial period not be available, this data will not be available to inform NBM PHN's September Twelve month performance report to the Department and Local Performance Indicators 1 and 2 will need to be removed from this annual plan.

Proposed Activities	
Priority Area	**5. Cancer Care** The needs assessment inclusive of preventable cancer deaths projected for 2016, as having lower than state average for breast screening in Lithgow LGA for ATSI and CALD in the Blue Mountains LGA
Activity Title / Reference	**5.3 Increasing breast screening participation with a focus on low screening regions**
Description of Activity	Aim of the activity: **5.3.1 Aboriginal women in the Lithgow LGA** This activity will commission a local agency / local Aboriginal agency to work with the local community to increase breast screening participation among women in Lithgow. A particular focus of the activity will be to target Aboriginal women, and to link women participating in breast screening with access to and support by their primary healthcare provider. The approach will identify enablers and foster a culture-centred, community ownership and empowerment approach aimed to increase breast screening participation, in particular by Aboriginal women living in the Lithgow LGA. How the activity will address the priority: The breast screening participation rate for eligible women 50-69 years in the Lithgow LGA in 2013-14 was 40.3%, the lowest screening rate compared to other NBMPHN LGAs and the entire NBMPHN region (44.7%), and lower than the NSW state average (50.9%). Further, the breast screening participation rate among Aboriginal women in the Lithgow LGA

	was less than half the NSW state average for breast screening participation among Aboriginal women (15.8% vs. 36.3%). Community engagement strategies based on empowerment approaches have been effective in promoting participation in preventive health behaviours among Aboriginal women in rural Australian communities. In addition Aboriginal women have qualitatively been found to seek a culture-centred approach to cancer care and treatment from healthcare providers which honours and accommodates their cultural needs. Target population cohort: This activity will target all women, in particular Aboriginal women living in the Lithgow LGA in NBMPHN region. **5.3.2 CALD women in the Blue Mountains LGA** Women from a CALD background residing in the Blue Mountains LGA breast screening rate is 31.9% compared to the NSW State average of 44.8%. The activity will aim to reach these women through a primary care and community intervention strategy. This activity aligns with PHN objectives to: • Increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and • Improve coordination of care to ensure patients receive the right care in the right place at the right time. This activity aligns to the following national health priority area: • Population health This activity aligns with the following national headline indicator: • Cancer screening rates (breast cancer)
Collaboration	This activity will be implemented with other stakeholders and organisations including: • The local Aboriginal community in Lithgow • Local Aboriginal organisations / agencies in Lithgow or surrounding areas • Local CALD communities in the Blue Mountains

	• General Practices in Lithgow and Blue Mountains LGA • Westmead Breast Cancer Institute (Westmead BCI operate the NSW BreastScreen service in Western Sydney and Nepean Blue Mountains region) • Nepean Blue Mountains Local Health District
Indigenous Specific	YES
Duration	Two year period (2016-2018) commencing July 2016 with review in 12 months
Coverage	Coverage of this activity will be the Lithgow Local Government Area.
Commissioning approach	Commissioned
Data source	Data source: BreastScreen NSW – BreastScreen NSW Information System and NSW Ministry of Health (SAPHARI) Indicator 1 will be sourced from the BreastScreen NSW register (NSW state data set). [1,2] BreastScreen NSW collect breast screening participation data on a continuous basis. Breast screening biennial participation data are reported to NSW PHNs by the Cancer Institute NSW on an annual basis in December, with cancer screening participation data for the previous two-year (biennial) period. Note that screening participation data have a minimum 10-month time-lag from the time of collection to the time of public reporting. Therefore, data for the July 2015-June 2017 biennial period may not available until mid-2018. BreastScreen participation data for the period July 2016-June 2018 will not be available until mid-2019.

Proposed Activities	
Priority Area	**6. Health Service Integration** This activity refers to gaps in access to health pathways for clinical care identified throughout the needs assessment.

Activity Title / Reference	**6.1 Facilitating Health Service Integration through Health Pathways**
Description of Activity	Aim: to support the integration of health care services through collaborative development of localised clinical and referral health pathways Objectives are to: 4. Develop health pathways prioritised by NBMPHN needs assessment 5. facilitate access of pathways through online access 6. establish and embed pathway use through targeted education and promotion to general practice and allied health The "Health Pathways" tool is used by 7 NSW metropolitan PHNs and 2 bordering PHNs to build integrated clinical and referral pathways. Hence, it is broadly accepted by neighbouring general practices and acute health services, well-established in the NSW/Australian setting and is well-placed to support shared pathways. The NBMPHN and NBMLHD intend to combine resources to purchase the "Health Pathways" software and also to share ongoing, online technical support. Other strategies to establish strong integration activities include shared recruitment opportunities (health planner and Health Pathways coordinator) and shared responsibility for clinical input into the development and prioritising of Health Pathways. Specifically the following activities will occur • Health Pathways will be purchased • The coordinator, clinical leads and clinical editors will be recruited • Pathways will be prioritised and health workgroups established to develop/localise the pathways • General practice and allied health will be supported to use the developed "live" clinical and referral pathways
Collaboration	NBMLHD and NBMPHN – shared funding of Health Pathways, ongoing online technical support and recruitment of key staff. Shared priority setting of health pathway development through shared local health planning and local needs assessments.

	Specialists, GPs, Allied Health –shared development and localisation of clinical and referral pathways through working groups
Indigenous Specific	No Although some of the developed pathways will be localised to specifically support local Aboriginal needs
Duration	Two year period (2016-2018) commencing July 2016 with review in 12 months
Coverage	Across NBMPHN region
Commissioning approach	Commissioned
Data source	Data source – live NBM Health Pathways website National non-admitted patient emergency department care database

Planned core activities funded by the operational funding stream under the Schedule – Primary Health Networks Core Funding

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Operational funding stream

1. General Practice Support

General practice support activities	
Activity Title / Reference	**OP 1. Building quality data systems for quality improvement and Practice sustainability**
Description of Activity	**AIM**: Support uptake and active usage of quality data systems for improved patient care, population health planning, and optimum business modelling. Objectives 1. To provide and support the implementation of PEN CS suite of Clinical Audit Software tools for all eligible General Practices across the region, in order to facilitate capture and interrogation of quality data sets for improving their organisations health efficiencies and improved patient outcomes 2. To support Practice knowledge of their patient population needs, areas for improvement and point of care solutions for prevention and management activities 3. To provide primary data sources at a regional level to drive evidence based quality improvement initiatives across the PHN boundary and service planning The Practice Support team will facilitate the development of general practice capacity to optimise the usage of both CAT4 and Top Bar to drive patient management improvement initiatives at a Practice level and organisational business efficiencies, leading to Practice sustainability. De-identified data provided by Practices to the PHN via the PATCAT tool will support evidenced based population health planning and quality improvement activities for better health outcomes at a macro and meso level. This activity will be critical to improving efficiencies and effectiveness of primary care services within PHN boundary.

	Several Practice Support activities over the next 2 years will be driven by the utilisation of the Pen CS tools including accreditation support, immunisation, cancer screening, chronic and preventable conditions management, e health and the development of the heath care home model.
Collaboration	The rollout of the PEN CS suite of software tools in General Practice will be supported also by PEN organisation with training and IT services provided to the PHN and General Practice staff.
Duration	Two year period (2016-2018) commencing July 2016 with review in 12 months (Training and implementation of the tool will commence in 2016 with a one-year contract provided by PEN CS. It is expected to be renewed in 2017 and will run until the end of the PHN funding period in 2018)
Coverage	All computerised Practices across the NBMPHN will be offered access to PEN CS tools and corresponding Practice Support.
General practice support activities	
Activity Title / Reference	**OP. 2. Building Capability and Capacity in General Practice for managing chronic disease**
Description of Activity	**AIM**: To improve General Practice adherence to evidenced based management of chronic and preventable conditions and support the development of optimum business models and team based approaches for increased capacity Objectives 1. To support the utilisation of the CAT4/Topbar in General Practice to identify sub optimal care for patients with chronic and preventable conditions (including diabetes, COPD, CHF, CKD, overweight and obesity) and implement processes to improve care management

	2. To support Practice staff with education and training to improve disease management 3. To support Practices in business modelling techniques to build capacity 4. To support GP and Allied Health Professional connectivity for improved team based care 5. To embed HealthPathways in General Practice as a key clinical decision support tool Practice Support staff will work with Practices to implement data cleansing systems and appropriate data capture to ensure data quality is apparent. Practices will be supported to review patient profiles according to chronic and preventable conditions clinical parameters, best practice guidelines for management, medication management profiles, cycles of care standards, and relevant MBS items such as GP Management Plans, TCA, HMRs, Health assessments, vaccinations, NBMPHN will collect de-identified data at Practice and at regional level to reflect on management practices and areas for education and training. Subsequent education sessions will be held throughout 2016-18 aligned to the key chronic and preventable condition areas noted above. This will include upskilling in the use of HealthPathways. Additional training will be provided to review optimum MBS billing opportunities in line with evidenced based best practice to support development of business models for improved team based care. In order to build team based care, Practice Nurses aligned to areas of high diabetes prevalence and or poor patient accessibility for Diabetes Education services would be supported by NBMPHN to undertake COMDIAB training. Practice Support Staff will promote and encourage adoption of HealthPathways as a quality Clinical Decision Support tool for appropriate management and referral pathways.

	The above activities have been designed to support the PHN objectives with areas of focus aligned to our priority health needs.
Collaboration	In order to effectively implement this activity NBMPHN will collaborate with the NBM LHD and Diabetes NSW and the Lung Foundation to support education and training of Practice staff, including Practice Nurses. Business modelling activities will be supported by utilisation of Primary Health Care Consultants to deliver a series of workshops in conjunction with Clinical Management up-skilling. Collaboration with the NBMLHD will also be critical to the development and rollout of HealthPathways in areas of chronic disease, which will be embedded in all Practice Support activities.
Duration	Two year period (2016-2018) commencing July 2016 with review in 12 months
Coverage	All computerised Practices across the NBMPHN will be offered access to PEN CS tools and corresponding Practice Support. Education and training will be offered to all Practices in the areas of chronic conditions listed above.
General practice support activities	
Activity Title / Reference	**OP 3. Building quality Practices across the Region**
Description of Activity	**AIM**: To increase the number of Practices achieving accreditation across the region Objectives 1. To support Practices to understand accreditation standards (including revised standards) across the PHN 2. Develop collaborative plans with Practices to work towards accreditation 3. Support the uptake of the PEN CS software tools in all eligible Practices

	4. Encourage the uptake of accreditation through exploration of SIP and PIP benefits Practice Support staff will work with all Practices to encourage uptake of clinical software systems and PEN CS tools. For Practices who are accredited staff will train Practice staff to monitor key accreditation parameters and ensure they are captured on a regular basis. For non-accredited Practices Practice Support staff will encourage the uptake of the PEN CS tool and provide basic modelling around opportunities for SIP and PIP payments to highlight the benefits of accreditation. Practice Support staff will work closely with Practice Managers, and the NBMPHN will facilitate networking opportunities to influence uptake of accreditation. Additional training will be provided to review optimum MBS billing opportunities in line with evidenced based best practice for improved business modelling. This activity is the cornerstone for ensuring the NBMPHN has extensive coverage of quality primary care practices providing effect and efficient medical services across the area.
Collaboration	NBMPHN will work in collaboration with the NBM LHD for delivery of education and training needs as required for Practices
Duration	Two year period (2016-2018) commencing July 2016 with review in 12 months
Coverage	All Practices across the PHN boundary
General practice support activities	
Activity Title / Reference	**OP. 4. Building better communication across service providers and patients**

Description of Activity	AIM: To increase the number of Practices across the NBMPHN participating in digital health activities and uploading quality shared health summaries for their patients Objectives 1. To support Practices to register and implement digital health programs including MHR, secure messaging, and electronic discharge communications 2. To support Practices to ensure patient data is recorded accurately and coded appropriately for shared Health Summary uploads 3. Encourage GPs to upload quality shared health summaries for their patients 4. To support Allied Health organisations and Pharmacy to register and implement digital health programs for improved connectivity to General Practice and acute services, and improved continuity of care for patients Practice Support staff will work with all Practices to encourage uptake of clinical software systems compliant with Digital health program requirements. Practice Support staff will also work with Practices to support data cleansing and appropriate data coding to ensure patient health summaries are current and of high quality. Education and training will be provided by staff in Practice but also as part of CPD activities, leveraging off changes to e PIP incentive payments. Practice Support staff will assist Practices to develop reports for e health uploads in support of claiming e pip payments. The PHN will work in collaboration with HealthLink to support Practices to receive appropriate electronic discharge summaries. The Digital Health Advisory Board will be continued to guide activities to support Digital Health programs in General Practice.

	PHN will undertake broad scale mapping of allied health organisations and pharmacies to identify and implement Digital Health strategies and activities. Access to timely discharge information through E discharge summaries will support efficiencies in medical service delivery also whilst secure messaging and effective utilisation of the MHR will support continuity and co-ordination of care.
Collaboration	NBMPHN will work in collaboration with the NBM LHD, HealthLink, and the Digital Health Unit (inc NeHTA) and key primary Care Health Providers to guide Digital Health activities and support delivery in Primary Care.
Duration	Two year period (2016-2018) commencing July 2016 with review in 12 months
Coverage	All Practices across the PHN boundary and eligible AHP and Pharmacists.
General practice support activities	
Activity Title / Reference	**OP. 5. System approach to Prevention**
Description of Activity	**AIM**: To increase immunisation rates and cancer screening rates in General Practice Objectives 1. To increase utilisation of the PEN CS software tools to drive accurate data capture and reporting of screening rates and immunisation rates 2. To increase utilisation of TOPBAR within the Practice Clinical Software system to support opportunistic screening and immunisations 3. To increase utilisation of CAT4 to identify gaps in screening and immunisation for Practice patients and drive strategies for timely recall and reminders

	4. Drive strategies from the PHN and Public Health Unit from practice and regional data collation Practice Support Staff will support Practice adoption and utilisation of the PEN CS software tools in Practice and through CPD education events to drive Practice based strategies and activities to improve screening and immunisation rates. CPD events will be conducted to train practices in immunisation schedule changes, cold chain management, breast, bowel and cervical screening requirements. Practice Support staff will promote HealthPathways for Clinical Decision Support and referral pathways for screening and appropriate management. Practice Support staff and PHN will partner with PHU to implement ongoing campaigns to encourage increased immunisation rates. The PHN will provide ongoing reports to Practices based on de-identified aggregated data to highlight trends, and benchmark Practices against State rates.
Collaboration	NBMPHN will work in collaboration with the NBM LHD Public Health Unit to support education and training activities. PHN will also work with the Cancer Institute and local cancer services for education and referral services.
Duration	Two year period (2016-2018) commencing July 2016 with review in 12 months
Coverage	All Practices across the PHN boundary

General practice support activities	
Activity Title / Reference	**OP. 6. Continuing Professional Development for Primary Care providers**

Description of Activity	AIM: To facilitate high quality CPD for primary care providers across the region The PHN will deliver regular, accredited continuing professional development (CPD) activities to GPs and other primary healthcare providers, on topics that relate to the PHN's objectives and activity plan.
Collaboration	The Local Health District will partner with NBMPHN by providing their staff to deliver CPD activities. NBMPHN will collaborate with external training providers to deliver quality education
Duration	Two year period (2016-2018) commencing July 2016 with review in 12 months
Coverage	Entire PHN region. Delivery of activities in local areas as appropriate.

2(a) Strategic Vision for After Hours Funding

NBM After Hours Strategic Vision

The NBMPHN After -Hours Program will continue to provide afterhours services to the residents of the Hawkesbury, Nepean, Blue Mountains and Lithgow LGA areas. Our success to date has occurred through strong partnerships with the Nepean Blue Mountains LHD (NBMLHD), Hawkesbury Hospital, several deputising services, select GP Practices and pharmacies. Due to the geographic spread of our region and areas of workforce shortages, timely access to services remain a challenge. Our partnership with the NBMLHD has facilitated the co-location of After Hours GP services at the emergency department which was essential due 'market failure' to deliver AH services over the last several years. The NBMPHN will continue to leverage off our partnerships and strengthen service areas which are effective and efficient in providing services and build new partnerships for addressing service gaps.

Our future goal in 2016-18 is to **facilitate** the provision of after-hours services for residents of the NBMPHN area in order to:

- Negate presentation to ED for low-acuity type conditions (Cat 4 and Cat 5) that can be managed by a GP, and
- Reduce unnecessary use of ambulance services to transport patients to acute services.
- Ensure after hours care is timely

Our strategic approach over the next two years to provide effective and efficient services to our community and address service gaps include:

- Facilitate the provision of after-hours services across the entire region and re-design any direct delivery services in areas of market failure to ensure optimum access and utilisation.
- Explore and facilitate the availability of After-hours pharmacy services co-located with GP after hours services in areas of need
- Improve timely access to RACF from after -hours deputizing services through bonus payment structures
- Improve Consumer awareness of these services and health literacy through community forums, flyers and targeted group presentations

3(b) Planned activities funded by the Primary Health Network Schedule for After Hours Funding

Proposed Activities	
After Hours Priority Area	**Priority 1. After hours General Practice services for all regions**
After Hours Activity Title / Reference	AH 1.1 Increase after hours service coverage in the Hawkesbury LGA
Description of After Hours Activity	Aim: Increase availability of After- hours services in the outer metro / rural region of Hawkesbury. Objectives: • To support the Hawkesbury After Hours Service (not eligible for PIP payments) by providing funding for reception staff and promotion. • To facilitate an After Hours Alliance/committee to bring together relevant services in the Hawkesbury region (such as acute, ambulance, local doctor network, aged care provides, pharmacists) to improve appropriate After Hours care in the region. This will include working to develop agreed referral processes and protocols, supporting appropriate use of after-hours services, improved integration and coordination across the geographical region.
Collaboration	NBMPHN will work with the existing GP After Hours service, Hawkesbury District Hospital, ambulance, local doctor network, aged care providers and pharmacists
Duration	01 JULY 2016 – 30 JUNE 2017 (pending ongoing funding)
Coverage	NEPEAN, BLUE MOUNTAINS, HAWKESBURY, LITHGOW
Commissioning approach	Commissioned
Data source	MBS After-hours Item numbers claimed over year 1 of operation Patient satisfaction survey collected on site.

Proposed Activities	
After Hours Priority Area	**Priority 2. After hours General Practice service for Nepean**
After Hours Activity Title / Reference	AH 2.1 Re-design of service model for the Nepean After Hours GP Clinic
Description of After Hours Activity	Aim: 1. Continue availability of after-hour GP services in Penrith, in close proximity to Nepean ED Objectives: • Develop a service model to capitalise on the workforce currently providing service (employed by Wentworth Healthcare) at the Nepean After Hours GP Clinic (not eligible for PIP payments) co-located at Nepean Hospital ED or in close proximity The NBMPHN will continue to support the provision of the After- hours GP clinic at Nepean hospital, whilst undertaking a feasibility review of the existing service model, and redesign to align with a commissioning approach. Scope may include review of current location as well as opportunities to re-locate this service in an area of close proximity. Initial activities will include consultation with current workforce, hospital staff, consumers and GP Network organisations. As this service was established due to 'market failure' in the Penrith area, this issue may still exist. Following consultation, a working group will be established to scope new models of service delivery which may include: • Commissioned service located at the hospital with supportive funding offered by PHN to support establishment of a management framework and governance arrangement, promotion, and workforce transitional support • Commissioned service at new location by accredited or non -accredited practice. Funding would support establishment and promotion costs and possible workforce transition incentives • Commission multiple providers across Penrith to provide services, with grant funding to support promotion and possible workforce transition incentives
Collaboration	NBMPHN will work with NBMLHD, General Practices in the Penrith region, Nepean GP Network

Duration	1 JULY 2016 – 30 JUNE 2017
Coverage	NEPEAN LGA
Commissioning approach	Commissioned
Data source	MBS After-hours Item numbers claimed over year 1 of operation Patient satisfaction survey collected on site. Bureau of Health Information - Report on Cat 4 and Cat 5 presentations of Nepean Hospital ED, per year, commencing commissioned after-hours service

Proposed Activities	
After Hours Priority Area	**Priority 3. Medical deputising Services and RACFs**
After Hours Activity Title / Reference	AH 1.3 Enhance service provision of Medical Deputising Services (MDS) in RACFs in the regions
Description of After Hours Activity	Aim: Increase effectiveness and efficiency of After- hours services delivered by Medical Deputising Services to RACFs Objectives: • To continue MDS service coverage across the region and improve timeliness of After- hours- care by them to residents of RACFs The NBMPHN will continue to support MDS service contracts across the region with work further scoping of implementing a performance payment structure to the MDS providing services to RACFs, for timely access; < 2 hr from call out time. This will encourage MDSs to strive for more efficient time frames to deliver care and in turn contribute to decreased ED presentations for cat 4 and 5 from RACFs.
Collaboration	NBMPHN will work with all the MDSs in the regions
Duration	1 JULY 2016 – 30 JUNE 2017
Coverage	NEPEAN, BLUE MOUNTAINS, HAWKESBURY

Commissioning approach	Commissioned
Data source	Six-monthly reports on call out times from the MDSs over year 1 of operation. RACF satisfaction survey collected on site

Proposed Activities	
After Hours Priority Area	**Priority 4. After hours Pharmacy with co-located GP services**
After Hours Activity Title / Reference	AH 1.4 Explore supporting extended after-hours operating times for Pharmacies in the regions
Description of After Hours Activity	Aim: Increase number of Pharmacies to provide after-hours extended times to coincide with the opening hours of General Practices, in co-located premises where possible Objectives: • To support **Pharmacies** to extend their opening hours during after-hours periods, to coincide with General Practices who currently offer after-hours services in co-located or nearby After Hours GP Practices Current contract with 24 hr pharmacy in Penrith will be renewed with NBMPHN undertaking a feasibility model review of targeted pharmacies who are able to extend their opening hours during after-hours periods.
Collaboration	NBMPHN will work with all the Pharmacies in the regions
Duration	1 JULY 2016 – 30 JUNE 2017
Coverage	NEPEAN, BLUE MOUNTAINS, HAWKESBURY, LITHGOW
Commissioning approach	Commissioned
Data source	Six-monthly reports from Pharmacies over year 1 of operation

Proposed Activities	
After Hours Priority Area	**Priority 5. Consumer awareness and health literacy**
After Hours Activity Title / Reference	AH 1.6 Provide community awareness and health literacy programs for After Hours services and usage
Description of After Hours Activity	Aim: Increase community awareness and health literacy in the region for appropriate ED and After hours usage Objectives: • Develop local resources for consumers at low literacy reading levels for community awareness of After Hours services and ED usage • Engage consumer networks across the region to disseminate resources and provide peer education The NBMPHN will initially consult with local community groups to develop resources for low literacy consumers and those of specific cultural backgrounds. NBMPHN will distribute resources through established local networks and specific cultural groups. A Train the Trainer program for Peer education will be developed and implemented through community networks. Ongoing awareness and education will be provided through General Practices, pharmacies and the ED departments across the region.
Collaboration	NBMPHN will work with its communication team, Aboriginal health team, mental health team, GPs, NBMLHD, community service providers, consumers, government departments and community networks.
Duration	1 JULY 2016 – 30 JUNE 2017
Coverage	NEPEAN, BLUE MOUNTAINS, HAWKESBURY, LITHGOW
Commissioning approach	Commissioned
Data source	Reports from Commissioned Community Groups