Australian Government
Department of Health

phn
An Australian Government Initiative

Activity Work Plan 2018-2019:

Core Funding

General Practice Support Funding

After Hours Funding

Nepean Blue Mountains

Please follow the below steps (and the instruction sheet) for completing your Activity Work Plan (AWP) template for 2018-19:

1. **Core Operational and Flexible Funding** 2018-2019 has three parts:
    a) Provide a link to the strategic vision published on your website.
    b) Complete the table of planned activities funded by the *Core Flexible Funding Stream* under the Schedule – Primary Health Networks Core Funding (including description of any Health Systems Improvement (HSI) activity to support delivery of commissioned activity).
    c) Complete the table of planned activities funded by the C*ore Operational Funding Stream: HSI*[1] under the Schedule – Primary Health Networks Core Funding and planned activities under the Schedule – **General Practice Support Funding**[2].

2. Attach indicative Budget for Core Operational and Flexible Funding Streams for 2018-2019 using the template provided.

3. Attach the indicative Budget for General Practice Support for 2018-19 using the template provided.

[1] HSI Funding is provided to enable PHNs to undertake a broad range of activities to assist the integration and coordination of health services in their regions, including through population health planning, system integration, stakeholder engagement and support to general practice. HSI activities will also support the PHN in commissioning of health services in its region.

[2] Planned activities under the Schedule - General Practice Support Funding have been combined with the HSI activities to lessen the reporting burden on PHNs.

4. **After Hours Primary Health Care Funding** 2018-2019 has two parts:
    a) Provide strategic vision for how your PHN aims to achieve the After Hours key objectives.
    b) Complete the table of planned activities funded under the Schedule – Primary Health Networks After Hours Primary Health Care Funding.

5. Attach the indicative Budget for After Hours Primary Health Care for 2018-2019 using the template provided.

When submitting this Activity Work Plan 2018-2019 to the Department of Health, the PHN must ensure that all internal clearances have been obtained and that it has been endorsed by the CEO.

The Activity Work Plan must be lodged to your Program Officer via email on or before four (4) weeks after the execution of the Core Schedule Deed of Variation.

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.

This Activity Work Plan covers the period from **1 July 2018 to 30 June 2019.**

1. (a) Strategic Vision for PHN

Please provide a link to your organisation's strategic vision published on your website.

Strategic Vision

1. (b) Planned PHN activities

Core Flexible Funding Stream 2018-19

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. CF 1)	**CF1: Improve care for patients with Chronic Conditions** **1.1 Commission COPD Primary Care Collaborative** **1.2 Commission Pulmonary Rehabilitation Service in the Hawkesbury LGA** **1.3 Co-design and commission appropriate pain management services** **1.4 Explore a CVD Primary Care Collective**
Existing, Modified, or New Activity	1.1 & 1.3 are modified activity from the 2016-18 AWP. Refer to NP1.pg.3 1.2 & 1.4 are new focus areas
Program Key Priority Area	Other (please provide details) Chronic Conditions Health system integration across primary, secondary and acute care sectors addressing chronic conditions care (respiratory and cardiovascular)and pain management pathways
Needs Assessment Priority Area (e.g. 1, 2, 3)	Section 4 - Pages 116, 125 , 126
Aim of Activity	The **aim** of this activity is to increase access to appropriate care and services for people with the chronic conditions of COPD, Cardiovascular Disease and chronic pain. **Rationale:** These three conditions were identified as priorities in our region and further rational can be found in our needs assessment. In summary: COPD remains the leading cause of potentially preventable hospitalisations (PPH) in the Nepean Blue Mountains (NBM) region with a 6.0 day average length of stay in (2015/16). NBM region remains the highest among metropolitan regions in NSW with COPD presentations, at a rate of 308 per 100,000 people. Further analysis of PPH rates due to COPD highlight variation across the region with the highest

	in the Hawkesbury (467), Richmond-Windsor (433) and St Marys (402) per 100,000. In addition, average length of stay was significantly higher in the Hawkesbury region at 7.8 days. This compares to Penrith (6.2 days), Blue Mountains (5.0 days) and Lithgow-Mudgee (4.8 days). A joint effort remains between the NBM Local Health District (LHD) and the NBMPHN to continue to enhance clinical care, care coordination and self-management for patients with COPD across the care continuum. In this case further consultation with the public/private partnership service provider for the Hawkesbury LGA, St John of God, has indicated that augmenting the provision of a pulmonary rehabilitation service will provide an innovative approach to address gaps in current service provision and reduce length of stay for patients admitted to Hawkesbury hospital. In NSW around 1 in 5 people experience chronic pain. Primary care interventions to impact chronic pain management include prompt and targeted care, screening and appropriate referral, multimodal therapies including cognitive based programs and high intensity instead of low intensity care processes. Specifically within the NBM region, there is a lack of community based chronic pain programs and poor management of chronic pain for older persons, particularly those waiting for services /surgery. In 2011, cardiovascular diseases accounted for 15% of the total disease burden in Australia and the leading cause of death in the NBM region. This resulted in 629 deaths which represented 32.1% of all deaths in the region. Circulatory disease was the leading cause of death for females in the NBM region in 2015 and the second leading cause of death in males. In 2014-15, there were 645 deaths at a rate of 174.9 per 100,000 persons; this was significantly higher than the death rate due to circulatory disease in NSW (155.7 per 100,000 persons). In 2014-15, cardiovascular disease death rates were significantly higher for NBM males and females compared to the NSW population and was the highest among the eight metropolitan PHN regions.
Description of Activity	**1.1 Commission a COPD Primary Care Collaborative** This activity will build upon the successful implementation of a **COPD Primary Care Collaborative** through a targeted direct commissioning of up to 21 general practices, to reach an estimated 1,366, or 9% of patients with a diagnosis of COPD in the NBM region.

	A specialist service provider skilled in the development and delivery of primary care quality improvement will be commissioned to work with the participating general practices. Support for consumers with COPD through provision of a Lungs in Action support group, will also be commissioned in parallel to develop their self-management skills in the LGA of highest need i.e. the Hawkesbury. Results from the successful COPD collaborative conducted in 2017-18 FY over a 9 month wave period indicated the following changes: • An increase in access to spirometry for patients with COPD from 17% (July 17) to 33% (Mar 18) indicates 164 more patients were recorded as having a spirometry. • An increase in patients with a GP Management Plan for COPD from 54% (July 17) to 59% (Mar 18) indicates 90 more patients were recorded as having a GPMP who otherwise did not have one. • An increase in the percentage and number of patients who have been recorded as having a Pneumococcal vaccination from 38% (July 17) to 42% (Mar 18) indicates 74 more patients, who are considered at risk, were vaccinated against pneumococcal pneumonia, a potentially preventable hospitalisation. Spirometry, GPMP and up to date Pneumococcal vaccination are all indicators of best practice care for patients with a diagnosis COPD. The continuation of the quality improvement COPD collaborative will provide more patients with COPD, who have increased risk of potentially preventable hospitalisation, greater access to best practice quality care. Commissioning with general practice will be through an EOI. All computerised General Practices are eligible to apply. They will respond to set criteria in the EOI. Successful applicants will sign an agreement with WHL which outlines activities they will be required to implement for COPD patients. Practices are required to demonstrate improved service delivery for COPD patients. This includes increased access to spirometry for COPD patients. A specialist service provider, the Improvement Foundation, will be directly commissioned to work with these general practices to achieve improvement in the health outcomes of their COPD diagnosed patient populations. It is estimated over 1000 patients will receive care directly through this commissioned service activity. Any support required from NBMPHN staff is funded through HIS and not via flexible funding.

	As identified in our plan, this addresses a population health gap identified in the needs assessment. COPD is the largest potentially preventative hospitalisation condition in the NBM region. Support for consumers with COPD through provision of a Lungs in Action patient support group, will also continue to be commissioned (commissioned last FY through a targeted approach) to support patients to develop their self-management skills in the LGA of highest need i.e. the Hawkesbury. **1.2 Commission a Pulmonary Rehabilitation Service in the Hawkesbury LGA** The commissioning of a pulmonary rehabilitation service in partnership with St John of God Health Service for the Hawkesbury LGA. Co-design will be a feature of this commissioning activity in conjunction with general practitioners and St John of God. This will provide access to pulmonary rehabilitation for Hawkesbury residents where currently no service exists and will address a service gap. A pulmonary rehabilitation service that will support patients diagnosed with COPD in the Hawkesbury will be commissioned through a direct targeted approach and co-design with St John of God Health Service in the Hawkesbury – the most appropriate service provider in this region to host the service. The detail of this service will be determined as part of the commissioning process however it is likely the commissioned provider will employ a specialist and allied health provider to deliver the service directly to patients who currently have no access to pulmonary rehab in the Hawkesbury region. **1.3 Co-design and commission appropriate pain management services** This activity will work closely with the NBM Local Health District Pain Clinic and other service providers to co-design referral pathways and commissioning appropriate services that will support GPs with a broader range of options to manage their patients with chronic pain. A pain management service for patients will be commissioned. The commissioning approach will include co-design with primary care providers and key stakeholder, an open market/EOI process and contracting with the successful tenderer to provide direct patient care and management for people with chronic pain. The service will work closely with general practice as a direct referral source. This addresses a service gap in our region.

	This is a direct patient service and therefore is not suitable to be funded from HSI. As with all commissioned services integration with existing health services is essential to avoid further siloing of the health sector and fragmentation of patient care and the patient journey. **1.4 Explore a Cardiovascular Disease Primary Care Collective** This activity will explore opportunities and implement initiatives through general practice to increase access for patients with a diagnosed cardiovascular condition that improves health outcomes. The University of Sydney will be commissioned to provide an intervention and evaluation in General Practice to improve care for people with CHD with the aim of: i. reducing the rate of unplanned CVD hospitalisations and major adverse cardiovascular events at 24 months in patients with CHD and; ii. increasing the proportion of patients who are achieving national targets for risk factors (cholesterol, blood pressure, smoking) and have an active Chronic Disease Management (CDM) plan
Target population cohort	Patients with a diagnosis of COPD and CVD within participating general practices in the NBM region. Patients with a diagnosis of chronic pain within the NBM region.
Consultation - HSI Component	Intensive consultation during the initial stages of developing the COPD activity in the 2016-18 plan developed the current successful model of implementation. These initial consultations have consolidated working relationships and provided a platform for ongoing key stakeholder engagement necessary for successful implementation of the activity. Consultation for this activity will be ongoing, principally through key stakeholder participation in a chronic conditions governance committee and the COPD primary care collaborative inclusive of: • Secondary respiratory services and community health services of the NBM LHD and St John of God Health Services • Consumers representatives from consumer support groups • Primary care – General practitioners and practice nurses • Primary care – Allied health providers • Peak bodies including the Lung Foundation • Quality Improvement primary care service developers - The Improvement Foundation Consultation will also form a part of the commissioning process with general practice.

	Intensive consultation with key stakeholders, including the Local Health District, Western Sydney University and primary care practitioners has already occurred to commence scoping of pain management services and needs. This will continue as a part of the co-design process until services are developed. Consultation has occurred through the development of CVD related health pathways with secondary and primary care clinicians. Prioritisation to increase focus on the management of CVD through the primary care setting was identified as a factor in reducing preventable hospitalisations.
Collaboration - HSI Component	**Allied Health** – private practitioners for clinical advice and local knowledge **General Practices** – GPs and practice nurses for clinical advice and local knowledge and as a potential commissioned service provider **NBM Local Health District Pain Clinic** - overarching responsibility for public health service provision across the NBM region. **Nepean Blue Mountains Local Health District** – overarching responsibility for public health service provision across the NBM region **Pharmacists** - clinical advice and local knowledge and their role in chronic pain management and education of consumers **Puffers and Wheezers consumer support group** – consumer support advice **St John of God Health Service** – potential service provider **The George Institute for Global Health -** expert advice in cardiovascular care **The Improvement Foundation** – expert advice and knowledge in quality improvement methodology implementation with general practice. Potential commissioned service provider. **The Lung Foundation** – expert advice in respiratory care The Lung Foundation auspice '**Lungs in Action' consumer self-management education service** provider – advice and knowledge in consumer support and education. Potential commissioned service provider

	Western Sydney Pain Centre (Penrith) – clinical advice and local knowledge through multidisciplinary team
HSI Component – Other	Staff funded through HSI will support this activity to ensure appropriate project management and coordination. This includes planning and service design, ongoing consultation, stakeholder engagement, contract management of commissioned service contracts, monitoring, evaluation and reporting. Population health planning, data analytics and system integration will require support from Health Systems Improvement.
Indigenous Specific	No
Duration	**Start 01 July 2018 – Completion 30 June 2019** **01 July - 30 Sep 2018**: Phase 1 Tendering, co-design, planning With participating primary care providers **01 Oct 2018 - 31 May 2019**: Phase 2 Implementation and monitoring Implementation of the activities with participating primary care providers **01 Jun - 30 Jun 2019**: Phase 3 Completion and evaluation Completion of activities and evaluation of results
Coverage	The activity will cover the four local government areas across the NBM region including Penrith, Blue Mountains, Hawkesbury and Lithgow.
Commissioning method (if known)	Full commissioning of participating general practices Full commissioning of a specialist quality improvement service provider Full commissioning of a consumer support education service provider Co-commissioning of pulmonary rehabilitation service with St John of God Health Service Full commissioning with the preferred pain management service provider with co-design a strong feature of this process.
Decommissioning	Not applicable

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. CF 1)	**CF2: Improving care for patients impacted by lifestyle factors and cancer** **3.1. Overweight and obesity** **3.2 Cancer risk for bowel, breast and cervical cancer** **3.3 Smoking in the Aboriginal and Torres Strait Islander population**
Existing, Modified, or New Activity	This is a modified activity from the 2016-18 AWP. NP.2 pg. 9
Program Key Priority Area	Population Health Health system improvement and innovation that significantly redesigns a service to address overweight and obesity.
Needs Assessment Priority Area (eg. 1, 2, 3)	Pg. 128 – Overweight and obesity Pg. 158 – Cancer screening Pgs.157-158 – Aboriginal and Torres Strait Islander Health
Aim of Activity	This activity will **aim** to support primary care providers to address regional population health factors that affect the health outcomes of their patients including overweight and obesity; breast, cervical and bowel cancer; and smoking rates in Aboriginal and Torres Strait Islander population. **Rationale:** **Overweight and obesity** With 30% of adults in the NBM region reported to be obese and 31% of people overweight in 2017, rates of obesity in the NBM region are significantly higher than in NSW. High body mass has also been attributed to 5.8% of deaths in the region. Regional variability in obesity rates also indicated that the highest rates of obesity are in Lithgow and Penrith. The projected prevalence rate of obesity is increasing in the NBM region at a faster rate than in NSW. **Cancer screening** The National screening programs for breast, cervical and bowel cancer all aim to reduce illness and death from cancer through early detection and prevention of the disease. Regular screening is recommended as the best protection against each cancer. In 2016-17, participation in the National

	breast (52.1% vs 55.9%), cervical (48.7% vs. 53.2%) and bowel cancer (36.6% vs. 37.8%) screening programs by age-eligible persons was lower in the NBM region compared with NSW. Regional variation in screening participation also highlights areas of lowest screening participation in the NBM region, including Lithgow (breast screening 46.3%), Penrith (cervical screening 48.1%) and Penrith (bowel screening 34.3%). **Smoking rates** In 2015, the prevalence of smoking among Aboriginal adults in NSW was 34.9%. This was higher than the prevalence of smoking among all adults in the NBM region (11.6%) and in NSW (13.5%). *Cancer Institute NSW. Reporting for Better Cancer Outcomes Performance Report 2016: Nepean Blue Mountains Primary Health Network*
Description of Activity	This activity will work closely with primary care and key stakeholders to develop systems and services through a quality improvement framework and collaborative partnerships with service providers and research institutions to co-design innovative solutions. Commissioning of General Practices to enhance services to support people with overweight and obesity / cancer risk / smoking in the Aboriginal and Torres Strait Islander population will occur via EOI. These focus areas address population health gaps identified in the needs assessment. Practices will respond to specific criteria. Co-design is an important component of the commissioning process to implement innovative approaches to working with key service providers and patients. Any support required by NBMPHN staff will be funded via HSI funding stream or non-DoH funding sources if available. The activity will focus on three key population health issues of high priority in the NBM region as follows: 3.1 **Overweight and obesity:** Explore opportunities and implement commissioned initiatives for general practice to manage their overweight and obese patients through innovative solutions that will contribute towards addressing the growing prevalence rates in the NBM region.

	General practices in lower socioeconomic regions will be targeted to test a model suitable for people from lower socioeconomic backgrounds. This involves a combination of mHealth (an app) and telephone coaching provided to overweight and obese patients to assist them to improve their diet, increase physical activity they undertake and generally improve their health. Practice nurses will deliver the intervention through a process where individuals are assessed, receive advice and assistance to set behavioural goals using the App, navigate referral to evidence based preventive programs and maintain their behaviour change. 3.2 **Cancer screening for bowel, breast and cervical cancer:** Commissioned General Practices will be supported to increase the screening rates of their patients who are never screened, or under screened, to participate in bowel, breast and cervical cancer screening. The activity will be underpinned by a quality improvement framework that will continue to develop the general practice systems that support ongoing management of population health screening for cancer. Consultations with key stakeholders who influence the integration of screening results with general practice clinical systems will also continue so that systems integration issues can be addressed. 3.3 **Smoking cessation in Aboriginal and Torres Strait Islander people** Commissioned General Practices will identify and support their Aboriginal and Torres Strait Islander patients who are smokers to quit smoking through the Aboriginal Quitline. The activity will be underpinned by the implementation of a quality improvement framework that will support the ongoing management of these patients. The commissioning approach as described above also includes a formal agreement with participating general practices to undertake activities that either improve cancer screening rates or improve referral to the Aboriginal Quitline.
Target population cohort	Patient populations within primary care affected by population health issues including Aboriginal and Torres Strait Islander people.
Consultation - HSI Component	Consultation has already occurred with key stakeholders and will continue as a part of the activity implementation.
Collaboration - HSI Component	**Overweight and obesity:**

	• Nepean Blue Mountains Local Health District - Family obesity assessment and management service • Universities e.g. University of Sydney - Charles Perkins Institute / University of NSW • General practitioners • Aboriginal Quitline – behavioural intervention **Cancer screening:** • General Practitioners: Clinical advice and local knowledge; • Consumers: local knowledge and experience of screening and access; • Western Sydney University: evaluation of initiative to date and report to inform further initiatives; • Breast Screen NSW: service access and screening population statistics. **Smoking cessation:** Cancer Council – advice and expertise in cancer outcomes related to smoking cessation • Cancer Institute NSW Smoking Cessation Collaboration - clinical and tobacco control knowledge, advice and expertise • Community Pharmacist - clinical expertise, pharmacological including NRT expertise and local knowledge • General Practitioners - clinical and local knowledge • Local Community Service Providers – local Aboriginal Community knowledge • Tobacco Control Expert - clinical and tobacco control knowledge, advice and expertise
HSI Component – Other	Staff funded through HSI will support this activity to ensure appropriate project management and coordination. This includes planning and service design, ongoing consultation and integration, stakeholder engagement, contract management of commissioned service contracts, monitoring, evaluation and reporting.
Indigenous Specific	Yes – in part, the smoking cessation component is targeting Aboriginal and Torres Strait Islander people
Duration	**Commencement 01 July 2018 – completion 30 June 2019** **01 July - 30 Sep 2018**: Phase 1 Tendering, co-design, planning With participating primary care providers to participate in the trial. **01 Oct 2018 - 31 May 2019**: Phase 2 Implementation and monitoring Implementation of the trail with participating general practices

	01 Jun - 30 Jun 2019: Phase 3 Completion and evaluation Completion of trial and evaluation of results
Coverage	The activity will cover the whole of the NBM region.
Commissioning method (if known)	Full commissioning of primary care participants with co-design a strong feature of this process.
Decommissioning	Not applicable

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. CF 1)	**CF3: Supporting older persons and vulnerable populations to remain out of hospital during Winter**
Existing, Modified, or New Activity	This is a modified activity of the AWP 2016-18. NP4 pg.17
Program Key Priority Area	Population Health Health system integration across primary, secondary and acute care sectors addressing potentially preventable hospitalisations
Needs Assessment Priority Area (eg. 1, 2, 3)	Pg. 123
Aim of Activity	The **aim** of this activity is to work with General Practice and Residential Aged Care Facilities to reduce the risk of potentially preventable hospitalisations for their most vulnerable, at risk patients over the winter period. Concurrently, a specialist service provider skilled in the development and delivery of primary care quality improvement activities will be commissioned to work with the participating general practices.
Description of Activity	General Practices will be commissioned to address the rate of vulnerable and older people within their practice population presenting / representing to hospital during the winter season in 2019. These high risk patients will be managed by the practice to remain well and out of hospital, where appropriate, during winter. In parallel, there will be an enhancement of the 2018 Influenza Immunisation in RACF's pilot program, which will increase the number of RACF residents receiving the influenza immunisation. This will

	include the capacity building of Registered Nurses with immunisation accreditation and RACF's driving their own immunisation program. Commissioning with general practice will be through an EOI. They will respond to set criteria in the EOI. Successful applicants will sign an agreement with WHL which outlines activities they will be required to implement for vulnerable patients e.g. implement sick day plans for patients with chronic conditions at high risk of hospitalisation. The Improvement Foundation will be directly commissioned to work with these general practices. RACFs will be commissioned to provide immunisation clinics for RACF residents, increasing access for these patients to immunisation (which is low), with the aim of reducing illness and risk of hospitalisation in winter; and increasing herd immunity.
Target population cohort	Aged residents of RACFs and vulnerable and older general practice patient populations who are at high risk of hospitalisation (including representation) during the winter season.
Consultation - HSI Component	Consultation for the development of this model has already occurred broadly with key stakeholders. A co-design workshop with key stakeholders will follow to support the implementation of a model of service delivery for the winter season 2019.
Collaboration - HSI Component	**Nepean Blue Mountains Local Health District** – overarching responsibility for public health service provision across the NBM region **St John of God - Hawkesbury Hospital** (private /public partnership with NBMLHD) - target population supporting development and implementation of health pathways **General Practitioners** within the Penrith and Hawkesbury LGA – clinical advice and local knowledge **NSW Ambulance** – clinical advice on emergency transport and onsite support for hospital avoidance **Improvement Foundation** - expert advice and knowledge in quality improvement methodology implementation with general practice. Potential commissioned service provider **RACFs –** participation in an in-house immunisation program for residents and staff within the facilities
HSI Component – Other	Staff funded through HSI will support this activity to ensure appropriate project management and coordination. This includes planning and service design, ongoing consultation and integration,

	stakeholder engagement, contract management of commissioned service contracts, monitoring, evaluation and reporting.
Indigenous Specific	No
Duration	**Commencing 01 July 2018 with continued implementation to 30 June 2019** **01 July - 30 Sep 2018**: Phase 1 Tendering, co-design and planning **01 Oct 2018 – 15 Jun 2019**: Phase 2 Implementation and monitoring **15 Jun – 30 Jun 2019**: Phase 3 Completion and evaluation
Coverage	The activity will focus on the Penrith and Hawkesbury LGAs. The RACFs component will cover all LGAs.
Commissioning method (if known)	Full commissioning with the preferred provider with co-design a strong feature of this process.
Decommissioning	Not applicable

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. CF 1)	**CF4: Meeting a Community Need - Developing End of Life Pathways**
Existing, Modified, or New Activity	This is a modified activity of the 2016-18 AWP. NP. 4 pg. 17
Program Key Priority Area	Other (please provide details) Palliative Care Integration of primary, secondary and acute care services with community support providers to improve access to end of life care within the community, preventing unplanned hospital presentations at end of life.
Needs Assessment Priority Area (eg. 1, 2, 3)	Page 139.
Aim of Activity	The **aim** of this activity is to improve access to community resources at end of life to reduce unplanned hospital presentations, admissions and reduced length of stay. This will be achieved through:

	1. Increasing capacity within general practice, tertiary services and community settings to undertake end of life care planning discussions with patients leading to the upload of an advanced care directive into the patients individual My Health Record and; 2. Improving access for people at end of life to networks and resources available within the community. This will be achieved through the development of referral pathways assisted by 'Community Connectors' within the Blue Mountains LGA, working with General Practices to identify people at end of life and to assist people to remain supported in their place of choice. **Rationale:** Consultations held as part of the End of Life in the NBM Region Report in 2017, highlighted that EoLC discussions often commence at a time of crisis rather than through advance care planning practices. In addition the NBM region has limited end of life care resources with poor coordination of end of life care leading to: • Advance Care Plans often being completed far too late and EoLC discussions commencing at a time of crisis; • Delays in patient care, or potentially preventable hospital admissions; • Lack of understanding and knowledge of resources and referral pathways for people at end of life; • Stress for patients and families when a loved one is at end of life due to lack of support; Deaths per year in the NBM region is expected to increase from 1,900 in 2015 to 1,969 by 2030. Estimates of the need for end of life care (EoLC), based upon modelling of mortality data and underlying cause of death codes (ICD10 codes) predicts that the number of individuals in the NBM region needing EoLC will increase from 1,370 in 2015 to 1,420 in 2030.
Description of Activity	• Provide education and capacity building opportunities for general practices including Practice Nurses and General Practitioners on the development of advance care planning and behavioural interviewing in primary care to increase the awareness and skills in working with patients to develop end of life care plans; • Developing formalised referral pathways which will be embedded into HealthPathways enabling general practitioners across the Blue Mountains to access resources within the community broader than the pilot participating practices. • Community/health connectors will work with identified people at end of life within the participating general practices to refer and connect people to community resources for support through identified referral pathways enabling people to remain in their preferred setting (home).

	• Consumer capacity building through the community connectors to develop advance care plans and upload these into MHR to enable clinician access to the patient's end of life plan. Groundswell will be commissioned to provide this service. The direct commissioning approach was determined after extensive planning and service design work undertaking in 2017-18 FY to identify suitable providers. Community connectors will support patients who are at end of life to be better supported through community resources and pathways of care. A regional approach will be taken in the upper Blue Mountains to develop the end of life health care neighbourhood as part of this service. This will include general practices, allied health, hospitals and other community and health service providers and ensures the new service provides and promotes a sustainable and integrated health care model.
Target population cohort	People with chronic conditions and people at the end of their life.
Consultation - HSI Component	Consultation occurred in 2017 through the End of Life Care mapping project and work is currently being undertaken to identify networks, community resources and referral pathways to underpin this work. NBMPHN has an End of Life Care Key Leaders group which provides governance to this project
Collaboration - HSI Component	**Blue Mountains City Council**: Older Persons Coordinator – participation in the EoL Key Leaders Group and community engagement – local community knowledge. Director **Groundswell** - participation in the EoL Key Leaders Group and project lead/commissioned service provider. **General Practices** – engaged in community connector activities and implementation **General Practitioner** - participation in the EoL Key Leaders Group, clinical and local knowledge. **Nepean Blue Mountains Local Health District** Clinical Nurse Specialist Palliative and Supportive Care Nepean Hospital - participation in the EoL Key Leaders Group and champion in tertiary care for advance care planning discussions - clinical and local knowledge. Community Palliative Care Nurses – participation in the EoL Key Leaders Group - clinical and local knowledge

	Director of Palliative and Supportive Care Nepean Hospital - participation in the EoL Key Leaders Group and champion in tertiary care for advance care planning discussions – clinical and local knowledge. **Uniting Care RACF's** - Nurse Practitioner Palliative and Supportive Care – participation in the EoL Key Leaders Group - clinical and local knowledge. **Western Sydney University** – evaluation of the model.
HSI Component – Other	Staff funded through HSI will support this activity to ensure appropriate project management and coordination. This includes planning and service design, ongoing consultation, stakeholder engagement, contract management of commissioned service contracts, monitoring, evaluation and reporting.
Indigenous Specific	No
Duration	**01 July 2018-30 June 2019** **01 July - 30 Sep 2018**: Phase 1 Tendering and planning **01 Oct 2018 - 31 May 2019**: Phase 2 Implementation and monitoring Delivery of the service by the successful tenderer **01 Jun – 30 Jun 2019**: Phase 3 Completion and evaluation Completion of service provision and evaluation of results Consideration of the continuation of the service based on evaluation results
Coverage	The activity will cover the Blue Mountains LGA.
Commissioning method (if known)	Full commissioning with the preferred provider with co-design a strong feature of this process.
Decommissioning	Not applicable

1.

(c) Planned PHN activities

– Core Operational Funding Stream: Health Systems Improvement 2018-19

– General Practice Support Funding 2018-19

Please complete this table for Core Operational Funding Stream b) Health Systems Improvement (HSI)[3] and planned activities under the General Practice Support Funding Schedule only. Stream a) Corporate Governance, should not be included. Do not include HSI activities previously specified in 1. (b) Planned PHN activities – Core Flexible Funding 2018-19.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. HSI or GPS)	**HSI 1: Health planning, integration and commissioning systems**
HSI/GPS Priority Area	Population Health Planning
Existing, Modified, or New Activity	This is an **existing** activity within core operational funding previously supported by core
Aim of Activity	This activity **aims** to facilitate the development of integrated health care across the region through the outcomes of the PHN commissioning cycle, and other initiatives including the development of health pathways. **Rationale:** Opportunities to facilitate integration of health services across the region will arise from the process of identifying and prioritising health and service needs, followed by the commissioning of services to meet these needs. Activities such as Health Pathways will further enhance opportunities to identify gaps in service provision and support the co-design of care pathways that integrate primary, community and acute care services for improved patient outcomes and reduced risk of potentially preventable hospitalisations.
Description of Activity	The commissioning cycle is an iterative process that includes the development of an annual regional needs assessment encompassing the identification and prioritisation of local health and service needs

	that result in the subsequent commissioning of services. The ongoing monitoring and evaluation of the commissioned services is an integral part of the cycle. In parallel, Health Pathways will continue to be developed through a collaborative process between primary care and secondary care specialists. The development of Health Pathways also contribute towards the identification of service needs and the localisation of integrated care service pathways.
Supporting the primary health care sector	Evidenced based information around the NBM populations health needs will support appropriate planning for commissioning of health services. Appropriate and or additional services will augment the existing primary care sector and increase access to health care overall for people within the NBM region.
Collaboration	Quantitative and qualitative data will be derived from collaboration with key stakeholders at a local and national level. These include peak health organisations, local health service providers including public (Local Health District) and private services and the contribution of local consumers.
Duration	**01 July 2018 – 30 June 2019.** An iterative process throughout the year that will consist of the following key milestones: **01 July 2018 - 30 Jun 2019**: Ongoing qualitative and quantitative data collection and planning for commissioned services. Ongoing development of Health Pathways **Mid Nov 2018**: updated needs assessment developed **Mid Nov 2018 - 30 Jun 2019** : monitoring and evaluation of previous commissioned services and planning for new commissioning services for 2019-20 FY AWP
Coverage	This covers the whole of the NBM region.
Expected Outcome	An up to date regional needs assessment will be developed. As an integral part of the commissioning cycle, the updated needs assessment will be used to plan, procure, monitor and evaluate services to respond to prioritised health needs of the region. Health services will be commissioned using best practice processes. Health Pathways will be developed and available on the NBM Health Pathways website that continue to support the identification of needs and develop localised care pathways.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. HSI or GPS)	**HSI 2: Stakeholder engagement and promotion**
HSI/GPS Priority Area	Other (please specify) Collaboration & Stakeholder engagement
Existing, Modified, or New Activity	This is an existing activity previously supported by core
Aim of Activity	The activity will **aim** to engage with Primary Healthcare providers, secondary specialists, consumers and other health care and non-health care organisations to inform and shape health care priorities and improvements in the region and the work of the PHN. In addition it will support awareness of and access to health information and services coordinated through the PHN. **Rationale:** Strong engagement with key stakeholders and consumers will contribute to the delivery of high quality, accessible and integrated primary care services across the NBM region. The NBM region consists of four LGAs that are disparate in both population demographics and health service provision, including interface between primary care and the local hospitals. Consultation with both providers and consumers of primary care services at a regional level is essential in ensuring local needs are identified and planned services are appropriate to meet local needs. Key stakeholders include primary care clinicians - General Practitioners, Allied Health Professionals, Practice Nurses, Primary Care Staff, secondary care specialists, consumers, other health care and non-health care organisations. The role of consumers as a key contributor, is critical to understanding the patient health care journey and where the PHN can support the development of services that address gaps and needs. Primary care providers inform the PHN from a granular service level and through their intimate knowledge of the primary care service provision across the region. Other health care and non-health care organisations may also impact or influence the development and or delivery of services e.g. local councils, peak bodies. Consumers in our region indicate navigation of the health system and access to health services a challenge.

	An informed community will be better equipped to navigate their health care journey if they are provided with current information about health conditions and services available within the NBM region. In parallel health care providers similarly will gain from the provision of information regularly disseminated that keeps them up to date so they can better assist people in their care to access the right services, at the right time and in the right place.
Description of Activity	Consultation with key stakeholders will occur through a regular, formalised process throughout the year and will be contributory towards the needs assessment, prioritisation planning and co-design of targeted commissioned services. This will be delivered through formal board advisory committees including: • Consumer Advisory Committee • GP Advisory Committee • Clinical Council • Allied Health Advisory Committee These committees will provide advice to NBMPHN Management and the Wentworth Healthcare Board. The Consumer Advisory Committee is a joint committee of the NBMPHN and NBMLHD to facilitate better service integration. In addition, Clinical Advisors, program advisory committees and peer-to-peer networking opportunities will support the development and implementation of initiatives. Where appropriate, formal partnership arrangements will be implemented with health and non-health care organisations to strengthen relationships and facilitate a commitment with working together. Expanding engagement with health care professionals and consumers beyond committees will facilitate a wider contribution from a broader audience. It will also provide a mechanism to promote important information, support an enhanced understanding of needs and provide greater perspective of how to tailor initiatives to meet needs. Facilitating access to professional and consumer information, networks, resources and education opportunities through a number of mediums including websites, social media, local media and broad casting, electronic and hard copy newsletters and literature, and interactive mobile friendly navigation tools.

Supporting the primary health care sector	Formal engagement with primary care providers, consumers, secondary specialists, non-health care organisations at a regional level provides a conduit for local health service needs, at a regional level, to be addressed.
Collaboration	Primary care clinicians – General Practitioners and Allied Health professionals NBMLHD media and communications Local media and marketing organisations
Duration	01 July 2018 – 30 June 2019
Coverage	This covers the whole of the NBM region
Expected Outcome	Relationships with the key stakeholders will assist in supporting the development, maintenance and strengthening of quality health care within the NBM region. Patients in the local region will be able to access high quality and accessible primary health care services at the right time and in the right place.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. HSI or GPS)	**HSI 3: Support the development of a skilled and sustainable local primary healthcare workforce** 3.1 Provide and promote continuing professional development opportunities for primary care clinicians. 3.2 Provide workforce support to primary healthcare providers to attract and retain providers (including registrars) working in the NBM region and identify opportunities to commission services to meet un-met gaps. 3.3 Facilitate the development of culturally competent primary health care services. 3.4 Maintain primary care disaster response preparedness.
HSI/GPS Priority Area	Other (please specify) Health Workforce
Existing, Modified, or New Activity	This is an existing but modified activity that relates to NP 6 from 2016-18 AWP Flexible

Aim of Activity	The **aim** of this activity is to support the development of a skilled and sustainable primary care workforce that is accessible to health consumers throughout the region. **Rationale:** Retaining a viable primary care workforce and enabling their access to professional resources, cultural competency, clinical and business optimisation skills development and networking opportunities is critical in maintaining and building their capacity to support the primary health care needs of consumers throughout the region. Regional geographic, economic and social disparities influence recruitment and retention of a skilled workforce. These are further compounded by the classification in a number of areas as being a 'district of GP workforce shortage'; a high rate of predicted retirement/attrition of the existing workforce over the next five years; and a growth in burgeoning After Hours needs. Attention to the workforce needs of the region will support patients to receive the right care in the right place at the right time. In addition, the geography of our region puts communities at risk of natural disasters such as floods and bushfires as well as extreme weather conditions. Learnings from the devastating 2013 Blue Mountains bushfires show the important role of general practice in disaster preparedness and response. It is important that the region is prepared to respond and work will continue to maintain this.
Description of Activity	The local primary care workforce will be supported through: 1. Facilitating access to professional networks, resources and education opportunities. 2. Orientating new GPs and GP Registrars to assist with their transition to the region. 3. Identifying and addressing primary health workforce gaps including strategies to support attraction and retention of healthcare providers. 4. Commissioning specialist and allied health outreach services, in areas of workforce market failure, facilitated through the NSW Rural Doctors Network's (NSWRDN) Outreach program. 5. Partnering with the NSW RDN to develop a regional health workforce plan for the Lithgow LGA, to address known barriers to accessing primary healthcare. 6. Maintaining a skilled GP and primary care nurse workforce to assist in the event of an emergency or disaster within the NBM region. This could relate to a flood, bushfire or extreme weather condition or pandemics. 7. Building capacity of the primary care workforce in cultural competent practices through the delivery of cultural competency training both face to face and online. Cultural support is provided to practices on a regular basis to reinforce cultural safety within primary care.

	DoH have advised that staffing costs associated with the commissioning process can be funded from HIS (and are not to be funded from Flexible Funding). Funding in HIS under HSI3 supports staff to address workforce issues in the NBM region. This includes identifying and co-designing solutions to address workforce issues. Where opportunities allow, funding to pay for a specialist or allied health contracted service to meet an identified gap will be sourced through the NSW Rural Doctors Network (NSWRDN) Outreach program. Such patient services are not proposed to be funded from HIS funding.
Supporting the primary health care sector	This activity will maintain and develop the primary care workforce skills and sustainability to meet the NBM regions primary health care needs.
Collaboration	• **GP Synergy**, the regional GP training organisation to monitor and support the allocation of registrars to work in the region. • **Nepean Blue Mountains Local Health District** to host services such as the school-based paediatric speech pathology clinic and coordinate disaster planning. • **NSW Rural Doctors Network** to provide direct assistance in the recruitment and retention of health professionals working in the rural areas of this PHN e.g. the Lithgow LGA. • **Primary care clinicians** including GPs, practice nurses and allied health professionals • **Providers of continuing professional development including the RACGP** • **Providers of cultural competency skills attainment**
Duration	01 July 2018 – 30 June 2019
Coverage	Entire NBM PHN region
Expected Outcome	Patients in the local region will be able to access high quality and accessible primary health care services at the right time and in the right place.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. HSI or GPS)	**GPS 1 Supporting general practice through a culture of quality improvement and outcomes focus** 1.1 Engaging general practice in the principles of quality improvement and the use of data quality systems to improve health care outcomes for patients.

	1.2 Supporting general practice to implement models of care that reflect best practice including accreditation, immunisation and chronic conditions management. 1.3 Increasing the adoption of digital health systems and technologies to improve patient care and communication.
HSI/GPS Priority Area	General Practice Support
Existing, Modified, or New Activity	This is an existing activity that relates to OP1 in the AWP 2016-18
Aim of Activity	This activity **aims** to support and empower general practice so that they are able to deliver high quality, accessible and integrated primary health care to the people of the NBM region. **Rationale:** Facilitating the development of primary care data sources at a regional level will drive evidence based quality improvement initiatives across the NBM region and contribute towards informing the needs assessment and service planning, particularly for chronic and preventable conditions. Improvements in the quality of data at a practice level will support improvements in health care outcomes for patients, business efficiencies and longer term Practice sustainability. The Safety and quality Commissions National General Practice Accreditation Scheme provides a quality and safety measure that supports the delivery of primary care. Maintaining and increasing the number of general practices that meet these standards throughout the NBM region will contribute towards improving the quality of care, patient experience and health outcomes. While childhood immunisations rates in the NBM region increased between 2013-14 and 2016-17 for 1 year olds (from 89.9% to 94.4%), 5 year olds (from 93.3% to 94.7%), and were above the national average (1 year olds, 93.8%; 5 year olds, 93.5%), regional variation highlights local areas within the NBM region which continue to under-perform national averages. In 2016-17, local areas of under-performance included the Blue Mountains SA3 (1 year olds, 92.1%; 5 year olds, 91.8%); St Marys SA3 (1 year olds, 93.3%) and Hawkesbury SA3 (5 year olds, 92.7%). In addition, despite recent improvements between 2014-15 and 2015-16, immunisation rates against HPV in the NBM region remained lower than the national average for girls (77.4% vs. 80.1%) and boys (71.2% vs. 74.1%). It is vital that NBMPHN continues to work closely with general practices and local communities in our region to strengthen participation in childhood, adolescent and adult immunisations.

	The development of digital health systems and technologies is essential to drive improvements in patient care and communications that will prevent potentially preventable hospitalisations across the region. The NBM region has the foundation of a 98% coverage of consumers registered with My Health Record. Sustaining awareness, adoption and meaningful use of digital health systems and technologies with health care providers will continue drive improvements in patient care and communication across the NBM region.
Description of Activity	1.1 Engaging general practice in the principles of quality improvement and the use of data quality systems to improve health care outcomes for patients: • Support uptake and active utilisation of quality data systems that influence practice population health planning and optimum business modelling. • Facilitate the capture and analysis of practice data to support continuous quality improvement, practice population health planning and optimum business modelling. • Support the identification and uptake of point of care solutions for prevention and management activities including chronic conditions and After Hours access e.g. PIP, MBS. 1.2 Supporting general practice to implement models of care that reflect best practice including accreditation, immunisation and chronic conditions management: • Support Practices to maintain or undertake Accreditation (RACGP 5th Ed Standards). • Support General Practices with implementation of immunisation best practice. • Support General Practice with the systematic management of chronic conditions. • Disseminate relevant up to date information and best practice guidelines/models to general practice to support patient care. 1.3 Increasing the adoption of digital health systems and technologies to improve patient care and communication: • Provide targeted and tailored support to assist in the change and adoption use of My Health Record and other digital systems and technologies to all eligible health care providers.
Supporting the primary health care sector	This activity will focus on supporting general practices and health care providers to deliver high quality and accessible healthcare to patients through the application of data quality systems, quality care standards and the meaningful use of digital health systems.
Collaboration	Primary care providers, in particular general practices, across the entire NBM region

Duration	01 June 2018 – 30 June 2019
Coverage	Health care providers, in particular general practices, across the NBM region
Expected Outcome	This activity is will aim to have the following outcomes, including: • General practices will utilise data to drive quality care for their patients. • Accredited practices will deliver improvements in patient safety, quality of care and patient experience and outcomes. • Rates of childhood immunisation in the region meet or exceed national targets. • Patients with chronic conditions are managed through systematic approaches. • The increased uptake and meaningful use of digital health systems will improve patient care and communication.

4. (a) Strategic Vision for After Hours Funding

The overall vision for NBMPHN's After Hours funding is to facilitate access to effective primary health care services and resources in the After Hours period for GP style presentations that cannot wait until the next day. Additionally to improve access for Residents of Residential Aged Care Facilitates (RACFs) to GPs across the region and to build the capacity and capability of General Practitioners to support the delivery of emergency care and anticipatory care planning so as to reduce the number of inappropriate ED presentations in the After Hours period.

Improved access to primary healthcare may contribute to a reduction in the number of potentially avoidable presentations at hospital emergency departments in the After Hours period. To achieve this, NBMPHN intends to commission After Hours clinics, a medical deputising service and a 24/7 community pharmacy, while also raising community awareness and health literacy on accessing After Hours primary care services and improving primary care access for RACF's in the region.

NBMPHN will continue to develop tailored solutions for each local government area. Due to GP workforce shortages, population maldistribution and the changing demographics of the GP workforce, it is not viable to have a 'one size fits all' approach. Given the achievements of the Hawkesbury After Hours GP Clinic and the Penrith After Hours Doctors clinic, NBMPHN will continue to commission these services in 2018-19. The National Home Doctors Service will be commissioned to extend its coverage into the lower Blue Mountains area. Lithgow and parts of the Blue Mountains and Hawkesbury LGAs do not have the population density to sustain a medical deputising service (commissioned or otherwise), so the focus in these regions will be on working with existing general practices to provide After Hours coverage, while at the same time educating the community on how to access telephone and online health advice.

A broad scale community awareness campaign will aim to improve health literacy in low socio-economic and CALD populations. This will be achieved through a multi-layered community awareness campaign that will promote the range of face-to-face, telephone and online services and resources. The campaign will have a health literacy focus and aimed at those with lower literacy levels.

4. (b) Planned PHN Activities

– After Hours Primary Health Care Funding 2018-19

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. AH 1)	**AH 1: Commission After Hours Primary Care Clinics**
Existing, Modified, or New Activity	Existing Activity - After Hours AWP 2016-18 Priority 1. After hours Primary Care clinics across the region.
Needs Assessment Priority Area (eg. 1, 2, 3)	Pages. 148-152.
Aim of Activity	The aim of this activity is to support general practices and other health care providers to deliver suitable After Hours access to people in the NBM region.
Description of Activity	1. Maintain the existing walk-in After Hours Doctor clinics and extension of hours of GP clinic. Commission the continued operation of the After Hours Clinics in Hawkesbury and Penrith, and the continued extension of hours for a GP clinic in Lithgow. NBMPHN will work closely with each service to monitor service usage and facilitate improvements in patient access, adoption of digital health technology, workforce development and integration with other services e.g. hospital emergency departments, After Hours pharmacies and general practices. 2. Improve integration and coordination between primary and tertiary After Hours services in the Penrith region. NBMPHN will convene a stakeholder forum of primary care services, NSW Ambulance and Nepean Hospital's emergency department in the Penrith LGA. The intended purpose is to promote utilisation of existing services, patient care pathways and to consider strategies for reducing pressure on hospital emergency departments.
Target population cohort	Adults aged 16-44 year olds and children 0-15. In this region, these groups are known to have the highest number of presentations to ED for non-urgent or semi-urgent care in the After Hours period; CALD populations.

Consultation	A consultation forum will be held with various stakeholders in the Penrith LGA, to improve communication and service linkages. Key stakeholders to be invited are: • General Practitioners • Local Health District (Health Planning & Emergency Departments) • Penrith After Hours Doctors • 24 hour Pharmacy • NSW Ambulance – planned • Medical Deputising Services • Residential Aged Care Facilities
Collaboration	St John of God providers of the Hawkesbury District Health Service (Hawkesbury Hospital): The HDHS host the Hawkesbury After Hours GP Clinic (HAHGC) within their community health centre. The Emergency Department (ED) works closely with the HAHGC regarding clinical governance, access to medical imaging. GP Clinical Advisor: Engaged to provide guidance and clinical governance for the Hawkesbury After Hours GP Clinic. Nepean Blue Mountains Local Health District: Work with Health Planning and emergency department to: Improve communication and integration between the hospital and the After Hours clinic; and Consider evaluation methods to determine the impact of the clinic in reducing inappropriate emergency department presentation.
Indigenous Specific	No
Duration	1 July 2018 to 30 June 2019
Coverage	Penrith, Hawkesbury and Lithgow LGAs
Commissioning method (if relevant)	Fully commissioned services.
Decommissioning	Not applicable

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. AH 1)	**AH 2: Commission Home Doctor Visiting Services**
Existing, Modified, or New Activity	Existing: After Hours AWP 2016-18 Priority 2. Home visiting services and targeted populations in need
Needs Assessment Priority Area (eg. 1, 2, 3)	Pages 148-152.
Aim of Activity	The **aim** of this activity is to Increase the availability and accessibility of home visiting services delivered either by regular GPs or a Medical Deputising Service (MDS), in areas where gaps exist.
Description of Activity	Incentivise Medical Deputising Services to extend their coverage into areas where it would otherwise be commercially unviable. Reduce inappropriate emergency department presentations during the After Hours period by working with general practices to promote the uptake and utilisation of local After Hours arrangements, through the After Hours Practice Incentive Program. Commission a MDS to extend its existing coverage to the lower Blue Mountains region, where known After Hours service gaps exist. SWMDS has previously been commissioned by NBMPHN to extend its commercial services into geographically isolated areas in the Hawkesbury region. A review by the PHN in April 2018 considered the service not to be value for money and therefore was decommissioned at the end of 2017-18 and not re-commissioned in 2018-19. Due to SWMDS's own commercial interests, they will continue to provide the service in all areas of the Hawkesbury region. This will allow General Practices to continue to utilise the service as an MDS. The performance of this service is not under the control of the PHN and not part of our AWP.
Target population cohort	RACFs residents and older persons living at home. Adults aged 16-44 year olds and children 0-15. In this region, these groups are known to have the highest number of presentations to ED for non-urgent or semi-urgent care in the After Hours period; CALD populations.
Consultation	Consultation occurred with key stakeholders including After Hours providers; general practices, RACF's and the local health district in 2017. Building on this work consultation with these groups will continue to ensure utilisation in After Hours periods.

Collaboration	National Home Doctors Service will be commissioned to extend its MDS coverage in this region. Collaboration with Sydney West Medical Deputising Service regarding After Hours home visiting in the Hawkesbury LGA.
Indigenous Specific	No
Duration	1 July 2018 to 30 June 2019
Coverage	Lower Blue Mountains (for commissioned Medical Deputising Service). Entire region for the practice incentive program support.
Commissioning method (if relevant)	Fully commissioned
Decommissioning	Sydney West Medical Deputising Service will be de-commissioned, due to lack of value for money and variable accessibility of service. Sydney West Medical Deputising Service will remain as a service provider in the area (unfunded by NBMPHN), enabling General Practices to maintain their formal agreements for MDS services.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. AH 1)	**AH 3: Commission 24 hour After Hours Pharmacy**
Existing, Modified, or New Activity	Existing: After Hours AWP 2016-18 Priority 3. After hours Pharmacy aligned with GP services where possible
Needs Assessment Priority Area (eg. 1, 2, 3)	Pages. 148-152.
Aim of Activity	The **aim** of this activity is to provide 24 hours access to pharmacy services, including health advice from a pharmacist, within proximity of Nepean Hospital and the Penrith After Hours Doctors clinic. **Rationale:** Provision of an After Hours pharmacy in the Penrith LGA will support a reduction in inappropriate emergency department presentations during the After Hours period. This will be facilitated through increased access to medication dispensing for patients prescribed through the After Hours GP clinic

	and the Nepean Hospital emergency department. Additionally, minor and self-limiting conditions can also often be supported through a Pharmacy, freeing up general practitioners and emergency departments to manage the more serious and urgent cases in the After Hours period.
Description of Activity	1. Re-commission an existing pharmacy to extend its opening hours to provide 24 hour coverage, seven days a week. 2. Promote the availability of the 24 hours pharmacy and other extended hours pharmacies in the area as part of a broader After Hours consumer awareness campaign.
Target population cohort	Adults aged 16-44 year olds and children 0-15. In this region, these groups are known to have the highest number of presentations to ED for non-urgent or semi-urgent care in the After Hours period; CALD populations.
Consultation	Consultation process is planned with the 24 hour pharmacy, Penrith GP After Hours clinic and Nepean Hospital Emergency Department.
Collaboration	Following on from consultation with the above services, a collaborative project to improve integration is anticipated.
Indigenous Specific	No
Duration	1 July 2018 to 30 June 2019
Coverage	Penrith LGA and adjoining areas.
Commissioning method (if relevant)	Direct approach. Re-commissioning.
Decommissioning	N/A

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. AH 1)	**AH 4: Addressing the After Hours service needs of consumers**
Existing, Modified, or New Activity	New

Needs Assessment Priority Area (eg. 1, 2, 3)	Pages 148-152.
Aim of Activity	The **aim** of this activity is to engage with consumers across the region to gain a better understanding of their awareness, concerns, needs and gaps in accessing After Hours primary care services. **Rationale:** Improved patient awareness and experience of After Hours primary care services will impact on reducing inappropriate presentations to hospital emergency departments during the After Hours period. Informed consumers are able to better manage their own health conditions, know when to seek help, and know where to seek appropriate care in the After Hours period.
Description of Activity	1. Raise awareness of the available After Hours primary care services. 2. Increase health literacy and community awareness of appropriate use of primary care and emergency department care as well as alternate options for care. 3. Promote appropriate use of general practitioners, other primary care services, emergency departments and alternate options for care amongst targeted CALD communities. 4. Scope opportunities to use validated tools to measure the patient experience of access to After Hours primary care services. Promotion of the 24 hr pharmacy by the PHN is considered to be within the guidelines as this pharmacy is the only pharmacy in the region which provides 24 hr coverage. Promotion will be via a PHN driven website which includes a link to the National Health Services Directory to enable consumers to find any pharmacy which is open in their area in the after-hours period (including the 24 hr pharmacy).
Target population cohort	Adults aged 16-44 year olds and children 0-15. In this region, these groups are known to have the highest number of presentations to ED for non-urgent or semi-urgent care in the After Hours period; CALD populations. Older persons, CALD populations and people with chronic conditions.
Consultation	Joint NBMPHN and NBM LHD Consumer Advisory Committee will be consulted regarding consumer perspectives. NSW Health Agency for Clinical Innovation (ACI)

Collaboration	Nepean Blue Mountains Local Health District Multicultural Health Unit - will be consulted to contribute to identifying the CALD groups to target; how best to reach them and assist with launching a community awareness campaign to targeted populations. St John of God -Hawkesbury District Health Service and local multicultural agencies in the Hawkesbury LGA - will be consulted to support the launch and dissemination of a community awareness campaign. NSW Health ACI - to scope opportunity and relevancy of the work that ACI have been undertaking with PREM's and PROM's. After Hours Primary Care Service Providers throughout the region – will be consulted to assist with identifying needs and co-design of appropriate services in targeted areas. NBMPHN Consumer Advisory Committee – will be consulted to assist with identifying needs and co-design of appropriate After Hours services across the region.
Indigenous Specific	No
Duration	**01 July 2018-30 June 2019** **01 July - 30 August 2018**: Phase 1 Consultation, planning, co-design and commissioning **01 Sept 2018 - 30 Nov 2018**: Phase 2 Development of communication package **01 Dec 2018– 31 May 2019**: Campaign Implementation **01 Jun 2019 – 30 June 2019**: Completion, Review and evaluation
Coverage	Whole of region
Commissioning method (if relevant)	Direct Commissioning
Decommissioning	N/A

Activity Title / Reference (eg. AH 1)	**AH 5: Building Capability and Capacity of General Practitioners**
Existing, Modified, or New Activity	New

Needs Assessment Priority Area (eg. 1, 2, 3)	Pages 148-152.
Aim of Activity	This activity **aims** to increase the capacity and capability of General Practitioners to support the delivery of emergency care and anticipatory care planning so that GP style presentations to emergency departments can be avoided. **Rationale:** Developing GPs' knowledge, skills and confidence in responding to medical emergencies and patient self-management care planning will better support patients to self-manage their conditions and reduce their need for urgent or emergency services during After Hours periods.
Description of Activity	The PHN will provide opportunities for GPs to undertake credentialed training in the areas of managing clinical medical emergencies, as well as developing anticipatory care plans. A credentialed training organisation will be engaged by the PHN to deliver a Clinical Emergency Management training program to approximately 50 GPs in the region, with a focus on non VR GPs working either in day time or after-hours practices. This is a 1 day course designed to build knowledge skills and confidence when responding to medical emergencies. A credentialed training organisation will be engaged by the PHN to deliver training in the area of care planning for patients with chronic disease to approximately 50 day-time GPs. This training is designed to build capacity in GPs to work with chronic disease patients to discuss and create self –care and team care plans to prevent potentially unnecessary presentation to ED.
Target population cohort	Older persons and people with chronic conditions requiring primary health care services in the After Hours period.
Consultation	Local Health District – consultation to identify primary care referrers to the emergency department for GP style presentations. Consult with emergency departments to identify the nature of inappropriate referrals.
Collaboration	With appropriate training providers and General Practice
Indigenous Specific	No
Duration	1 July – December 31, 2018 – planning and design 1 January to 31 May 2019 – delivery of GP training

	01 Jun – 30 June 2019: completion, review and evaluation
Coverage	Whole of region
Commissioning method (if relevant)	The design and delivery of the training will be commissioned to a suitable training provider.
Decommissioning	N/A

Activity Title / Reference (eg. AH 1)	**AH 6: Increasing GP Access in Residential Aged Care Facilities**
Existing, Modified, or New Activity	New
Needs Assessment Priority Area (eg. 1, 2, 3)	Pages 148-152.
Aim of Activity	The **aim** of this activity is to improve access for Residents of Residential Aged Care Facilitates (RACFs) to GPs across the region to reduce the likelihood of ambulance callouts and inappropriate ED presentations in the After Hours period.
Description of Activity	The PHN will consult with GPs and RACFs to develop a strategy for improving and increasing access to general practitioners for RACF residents. A co-design workshop will be held with key stakeholders to explore current barriers, opportunities and potential service models for improving access to GP's for residents of RACFs. This activity links to After Hours care by ensuring residents within RACFs are supported by clearly defined pathways of care for each resident during the after-hours period. Examples include 'sick day' plans, advance care plans, GP Ambulance Authorised care plans and chronic conditions management plans. In order to achieve this it is critical to engage GPs who are actively involved within RACFs to co-design an approach that engages with all key stakeholders to reduce the likelihood of potentially preventable hospitalisations in the after-hours period.
Target population cohort	Older persons and people with chronic conditions.
Consultation	A forum will be convened with the following stakeholders: Nepean Blue Mountains Local Health District

	General Practitioners who routinely provide services to RACFs RACFs Ambulance NSW NBMPHN Older Persons Care Consortium
Collaboration	NBMPHN will seek to co-design a service model with RACFs and the GP workforce.
Indigenous Specific	No
Duration	**01 July 2018 - 30 June 2019** 1 July 2018 - 30 Nov 2018: Phase 1 Tendering and planning and co-design 01 Dec 2018 – 31 May 2019: Phase 2 Implementation and monitoring of initiative 01 Jun – 30 Jun 2019: Phase 3 Completion and evaluation
Coverage	Whole of region
Commissioning method (if relevant)	Commissioning GP workforce will be considered, once scoping phase has been undertaken.
Decommissioning	N/A