Australian Government
Department of Health

phn
An Australian Government Initiative

Updated Activity Work Plan 2016-2018: Core Funding

Nepean Blue Mountains

Overview

This Activity Work Plan is an update to the 2016-18 Activity Work Plan submitted to the Department in May 2016.

1. (a) Strategic Vision

Nepean Blue Mountains PHNs 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 general practice and other healthcare professionals to deliver 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.

Main changes to the 2017-18 Activity Work Plan:

The Activity Work Plan 2017-18 Core Flexible and Operational remains much the same with the only main variant being the expansion of one original broad activity previously captured under **NP 1. Chronic and preventable conditions in the 2016-17 Activity Plan.**

There are now 2 activities within under this area including:

NP 1. Chronic and preventable conditions - COPD Collaborative and

NP 2. Chronic conditions – Overweight and Obesity: Increasing awareness of management options in primary care.

1. (b) Planned PHN activities – Core Flexible Funding 2016-18

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. NP 1)	**NP 1. Chronic and preventable conditions - COPD Collaborative**
Existing, Modified, or New Activity	This is an existing activity, modified to focus on COPD
Program Key Priority Area	System Integration
Needs Assessment Priority Area (eg. 1, 2, 3)	Section 4: Opportunities, Priorities and options Chronic and preventable conditions – COPD Pg. 109 Section 2: Outcomes of the health needs analysis Priority Theme: Chronic and preventable conditions COPD Pgs. 14-15 / Potentially Preventable hospitalisations pgs.18.19
Description of Activity	Chronic and preventable conditions have the highest prevalence in the NBM region including COPD, Diabetes, cardiovascular disease, overweight and obesity. In Australia in 2003, COPD has been estimated to have accounted for 2.9% of the burden of disease. In 2011-12 within the NBM region, COPD accounted for 46% of the local burden of disease with 970 hospitalisations (481 male and 498 female patients) and a trend being significantly higher than NSW COPD hospitalisation rates overall. COPD was also the leading cause of potentially preventable hospitalisations in the NBM region accounting for 970 hospital admissions with an average length of stay (ALOS) of 6.1 bed days equating to a total of 5,917 bed days. A joint effort between the NBMLHD and the NBMPHN to enhance care coordination and improve self-management across the care continuum could potentially reduce the growth in COPD-related ED presentations and subsequent hospital admissions. As such COPD will be the first chronic condition addressed. The aim will be to contribute towards a potential reduction in the average length of hospital stay for patients with COPD by 30 June 2018. The formation of a 'Chronic and preventable conditions collaborative – COPD' encompassing primary, secondary and acute care clinicians will focus on an integrated approach to both mapping the gaps and co-designing effective and sustainable interventions based on quality improvement measures that support the implementation of improved pathways of care for patients with COPD across the care continuum.

	Existing systems and services within general practices and across secondary and acute care will be explored through the collaborative to develop improved access to services and support sustainability and to services. A Governance framework will facilitate the approach and a link to HealthPathways will support integration and development of consistent local clinical guidelines The potential to apply the same model to other chronic conditions in the future will also be evaluated. Partnering with the Local Health District and other private providers and key stakeholders who support patients with COPD in the region will be an integral component of the collaborative. Objectives include: 1. Primary, secondary and acute care clinicians form a chronic care collaborative to address the care coordination needs of patients with COPD within the NBM region. 2. Gaps in service provision are identified and interventions are co-designed to improve the quality of care coordination and referral processes for patients with COPD 3. Localised clinical guidelines on the management and referral options for COPD are clearly articulated and communicated to all health care clinicians within the NBM region. 4. Services are commissioned to support improved care coordination of patients with COPD within the NBM region
Target population cohort	Patients diagnosed with COPD who are a part of the general practice population participating in the collaborative.
Consultation	**Development stage:** Consultation with the NBM Local Health District Health Planning Department to identify updates from the original needs assessment data sets and plans for the Nepean Hospital upgrade. Consultation with the NBM Local Health District and NBM PHN Boards and Executives to gain bilateral strategic agreement for a shared implementation of a collaborative model addressing COPD. Consultation with the NBM Local Health District Department of Respiratory Medicine to map existing systems and services and gain operational commitment to participate in the implementation of the collaborative model.

	Consultation with the NBM Local Health District Emergency Department to map existing systems and services via ED for COPD patients and gain operational commitment to participate in the implement of the collaborative model. Consultation with the Hawkesbury Hospital to map existing systems and services and gain both strategic and operational agreement to participate in the implementation of the COPD collaborative. Consultation with private Respiratory Specialists and Allied Health to map existing service pathways and gain commitment to participate in the implementation of the collaborative model. Consultation with general practice representative to identify concepts for a collaborative model implementation, with a focus on aspects of quality improvement. Consultation with Consumer groups representative of COPD to support the development of best practice care-coordination from a local perspective. Consultation with the Lung Foundation and the Improvement Foundation to determine potential participation and commissioning activities. Consultation with Private Health Funds to determine potential participation. Consultation with potential University partners to support a formalised evaluation process. **Implementation stage:** Engagement with general practices across the region to support participation in the COPD collaborative model through commissioning. Engagement with all stakeholders involved through a formalised governance structure to support oversight of the implementation and evaluation of the model.
Collaboration	General Practice Private Allied Health Private Respiratory Specialists NBM Local Health District Health Planning NBM Local Health District Department of Respiratory Medicine NBM Local Health District Department of Emergency Medicine

	Hawkesbury Hospital (Part /private public partnership) The Lung Foundation of Australia The Improvement Foundation University partners (TBA) for the purposes of evaluation Consumers Private Health Funds
Indigenous Specific	No
Duration	1. **Planning stage:** 01 Jul 2016 to 30 Jun 2017 • Consultation activities include gaining of partnership commitments, mapping of service gaps and development of a collaborative COPD model through co-design • Formation of the chronic care collaborative governance structure • Targeted commissioning/procurement with key stakeholders who will support the implementation of the co-design model • Development of the evaluation framework 2. **Implementation stage:** 01 Jul 2017 to 30 Jun 2018 • Targeted commissioning with general practices and key stakeholders involved in the implementation of the co-design model and subsequent commencement of service delivery to patients • Monitoring of implementation model • Commencement of the evaluation process
Coverage	The activity will aim to cover the four local government areas across the region including Penrith, Blue Mountains, Hawkesbury and Lithgow. Outcomes of potential coverage will be determined by participation of general practice.
Commissioning method (if relevant)	There will be two parts to the commissioning of services: **Part one** – **Model design:** The development of the chronic care COPD collaborative and the subsequent implementation model for general practice will involve a direct engagement and

	targeted procurement of services available from key stakeholders identified to support the co-design and implementation process. **Part two – General practice participation:** A targeted approach to the commissioning of general practices will result in service delivery to patients with COPD through implementing the model of chronic care developed through the COPD collaborative.
Approach to market	A targeted approach to market / direct engagement / EOI will be used to either procure or commission suitable providers
Decommissioning	NA

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. NP 1)	**NP 2. Chronic conditions – Overweight and Obesity: Increasing awareness of management options in primary care**
Existing, Modified, or New Activity	This is a new activity
Program Key Priority Area	Population Health
Needs Assessment Priority Area (eg. 1, 2, 3)	Section 4: Opportunities, Priorities and options Pgs. 116, 117, 118 Chronic and preventable conditions- Overweight and Obesity Section 2: Outcomes of the health needs analysis Pgs. 12, 13. Obesity and overweight prevalence
Description of Activity	As General practitioners (GPs) play pivotal roles in the delivery and coordination of primary health care in Australia with 84% of the population seeing a GP at least once in the previous year and obesity comprising 27% of total presentations (AIHW, 2014). GPs have an important role in encouraging of lifestyle interventions that support a reduction in overweight and obesity. Practice nurses also play a role in coaching , coordinating care and documenting obesity measures consistently with National Health and Medical Research Council (NHMRC, 2013) guideline recommendations. This activity will aim to increase awareness with general practice staff of the NHMRC guideline recommendations on the management and referral of overweight and obese patients.

	Linkages to existing and newly developed services that support obesity and overweight management will also be developed and promoted with primary care.
Target population cohort	Primary Care
Consultation	Stakeholder engagement and consultation activities will include discussions, meetings, formalised networking with key stakeholder in overweight and obesity to support guidance on the implementation of activities. There is a focus on general practice engagement.
.Collaboration	General Practice Private Allied Health Private Respiratory Specialists NBM Local Health District Health Planning NBM Local Health District Department of Endocrine Medicine Hawkesbury Hospital (Part /private public partnership) University partners – UNSW Centre for Obesity Management and Prevention Research Excellence in Primary Health Care (COMPaRE-PHC)
Indigenous Specific	No
Duration	01 Jul 2017- 30 Jun 2018
Coverage	All four Local Government Areas of Penrith, Blue Mountains, Hawkesbury and Lithgow within the NBM region.
Commissioning method (if relevant)	Education and training of primary care will be a commissioned activity.
Approach to market	Direct engagement of a suitable provider will be employed.
Decommissioning	Outline any decommissioning arising from the activity and potential implications. NA

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. NP 1)	**NP 3. Chronic and preventable conditions - Addressing variation In Childhood Immunisation Rates in hard to reach populations**
Existing, Modified, or New Activity	This is an existing activity for the period 2016-18
Program Key Priority Area	Population Health
Needs Assessment Priority Area (eg. 1, 2, 3)	Section 4: Opportunities, Priorities and options Pgs. 121, 122 Immunisation Below Target Childhood Immunisation Rates For NBMPHN Section 2: Outcomes of the health needs analysis – Pgs. 19.20, 21 Chronic and preventable conditions. Childhood Immunisation Prevalence.
Description of Activity	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. This leads to low Blue Mountains SA3 childhood immunisation rates compared to surrounding SA3s such as Lithgow or Penrith: Blue Mountains SA3 2014-2015 • 1yr 87.9% • 2yr 83.6% • 5yr 90.2% Understanding the decision making of vaccine-hesitant parents in low-coverage populations in the Blue Mountains LGA, and the role that complementary medicine practitioners may have in addressing challenges to immunisation uptake, will contribute toward improved outcomes in vaccination rates in these target areas. The aim is to work with university and LHD partners to support research and novel approaches to increase childhood immunisation rates in particular sections of the Blue Mountains LGA. PHN will partner with Public Health Unit to implement ongoing campaigns to encourage increased immunisation rates, minimise vaccine wastage in the region and provide education events. In

	addition we will work to ensure that immunisation registers in primary care are aligned to the national register. 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. • Support national immunisation targets Objectives include: 1. Apply a qualitative study and other research methodology to expand on an earlier pilot survey indicating a potential link between vaccine-hesitancy and complementary medicine use in parents living in the Upper Blue Mountains. 2. Determine if there is a role for local Complementary Practitioners to assist addressing the challenges of low vaccination rates. 3. Share the results of our research with other PHNs with similar areas of low childhood immunisation coverage rates. 4. Improvement in recorded immunisation rates
Target population cohort	Conscientious objectors (vaccine hesitancy) residing in the Blue Mountains NSW affecting children 0-5 yrs.
Consultation	Consultation with the NBM Local Health District Population Health Department and the Health Planning Department consolidate the need to address the reason for low vaccination rates within pockets of the Blue Mountains LGA. Consultation with general practices within the affected region provides opportunities for health promotion and further evidence of vaccination management for the target population group. Consultation with local complementary practitioners will assist in identifying alternate options available that may attract vaccine hesitant groups. Consultation with key University partners involved in the research project. The partnership is formalised through a partnership contract and the relationships are maintained through a regular governance forum to monitor progress of the project.
Collaboration	NBM Local Health District Department of Population Health

	University of Technology Sydney University of Sydney (National Centre of Immunology and Research Surveillance)
Indigenous Specific	No
Duration	1. **Year 1**: 01 Jul 2016 to 30 Jun 2017 An evidence-based qualitative research report is received from University partners which supports, or otherwise, potential partnerships with CAM practitioners to increase childhood immunisation rates during the reporting period 01 Jul 2016 - 30 Jun 2017 A publication/abstract draft is completed on the report within the by 30 Jun 2017. 2. **Year 2**: 01 Jul 2017 to 30 Jun 2018 Results of the research findings are shared - a publication/abstract is accepted within the 2017-2018 reporting period.
Coverage	The activity will aim to cover the Blue Mountains local government area
Commissioning method (if relevant)	Direct engagement and procurement of services with University partners
Approach to market	A targeted approach to procurement of services through direct engagement with University partners will be used.
Decommissioning	NA

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. NP 1)	**NP 4. Older Persons - Keeping older persons out of hospital through targeted approaches to primary care coordination**
Existing, Modified, or New Activity	This is an existing activity for the period 2016-18
Program Key Priority Area	Aged Care

Needs Assessment Priority Area (eg. 1, 2, 3)	Section 4: Opportunities, Priorities and options Pgs. 113. 114.115 Chronic and preventable conditions. Pneumonia-Influenza, Chronic Pain Pgs. 123,124.125. Older Persons. Section 2: Outcomes of the health needs analysis Pgs. 22, 23. Older Persons
Description of Activity	There are a number of factors that lead to older people presenting or being admitted to hospital, which could be supported through the care delivered by their GP. These include management of poly pharmacy, management of chronic pain (opioid specific), prevention of falls and vaccine preventable conditions (pneumonia and influenza). Once an older person presents or is admitted to hospital their wishes are not always clearly articulated. These can be addressed through the development of advance care directives, accessible through the My Health Record or otherwise to treating clinicians. Additionally maintaining linkages and broad promotion of palliative care services throughout the region assists primary care clinicians with the coordination of end-of-life care. Clearly articulated management and referral options for the care of rapidly declining older persons within the region are also not easily accessible or broadly disseminated to primary care. The aim of this activity is to work within the governance framework of the older person's care consortium; a formal partnership arrangement of key stakeholders with an active involvement in the care of older persons across the region. The older persons care consortium will address the areas of need as described above. The governance framework of this model facilitates a co-design approach to addressing sustainable interventions. These will contribute towards avoidable hospital presentations and admission of older persons through improvements in care coordination within primary care. Objectives include: 1. Primary care clinicians are better informed of choices with referral and management options for older persons with rapidly declining health. 2. Primary care clinicians have improved access to older persons wishes for end of life management and options for end-of-life care. 3. Interventions are developed through co-design that will contribute towards reducing the risk of specific causes of presentation and admission of older persons to hospital within the region.

Target population cohort	Older persons aged over 65 years residing within the Nepean Blue Mountains region.
Consultation	The older persons care consortium provides a governance and consultative framework for a formal partnership arrangement of key stakeholders with an active involvement in the care of older persons across the region. Outside of the consortium, consultation will occur with stakeholders in relation to the prioritised needs identified to action.
Collaboration	General Practice Private Allied Health and Pharmacy NBM Local Health District Health Planning NBM Local Health District Department of Population Health NBM Local Health District Department of Geriatrics NBM Local Health District Department of Emergency Medicine Hawkesbury Hospital (Part /private public partnership) NSW Ambulance Residential Aged Care Facilities NSW Health Agency for Clinical Innovation – Building partnerships framework National Prescribing Service Consumers
Indigenous Specific	No
Duration	1. **Year 1**: 01 Jul 2016 to 30 Jun 2017 The older persons care consortiums co-design a process pathway to address the acute needs of the rapidly declining older person in the Penrith LGA. The process pathways is made available to all clinicians in the NBM region via a mobile friendly website The older persons care consortium prioritise commissioning activities to address the identified needs including the management of poly pharmacy, the management of chronic pain (opioid specific),

	prevention of falls, vaccine preventable conditions (pneumonia and influenza) and increased access to Advance Care directives Linkages and broad promotion of palliative care services throughout the region continues. 2. **Year 2**: 01 Jul 2017 to 30 Jun 2018 Prioritised activities either commissioned or process pathways are redesigned to provide better solutions. Linkages and broad promotion of palliative care services throughout the region continues.
Coverage	Year one of the key activity, the development of the process pathways will cover the Penrith LGA with broad promotion of palliative care services covering all four LGAs within the region i.e. Penrith, Blue Mountains, Hawkesbury and Lithgow LGAs. Year two of the activity will aim to cover all four LGAs in the region i.e. Penrith, Blue Mountains, Hawkesbury and Lithgow LGAs.
Commissioning method (if relevant)	Parts of the activity, particularly in year 2, will be commissioned through either a direct engagement or an EOI process.
Approach to market	A targeted approach to market / direct engagement / EOI will be used to either procure or commission suitable providers.
Decommissioning	NA

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. NP 1)	**NP 5. Demographic and cultural factors influencing health status - Capacity building with local health care providers**
Existing, Modified, or New Activity	This is an existing activity for the period 2016-18
Program Key Priority Area	Indigenous Health Population Health

	CALD and Refugee communities
Needs Assessment Priority Area (eg. 1, 2, 3)	Section 4: Opportunities, Priorities and options Pgs. 132 - 138. Demographic and cultural factors influencing health status Section 2: Outcomes of the health needs analysis Pgs. 40 – 54. Cultural and demographic factors influencing health status
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 with the aim of identifying 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. In addition it is essential that the NBMPHN continues to build strong cultural capacity to support the commissioning of Aboriginal health across the region particularly as it moves from a direct service delivery model for Aboriginal health to a commissioned model.. An Aboriginal reconciliation action plan will be developed in 2017 to formalise existing practice and intention to support Aboriginal people and communities in health service delivery, and to further build capacity to meet community needs. 2. CALD and Refugee populations,, are sometimes not appropriately culturally supported by primary health care providers. The cultural competencies of primary health care providers in the regions to manage CALD and Refugees is not fully known. The aim will be to undertake activities 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. Examples of activities include: • Researching the mental health and other health needs of Syrian and Iraqi migrants and refugees and existing capacity of health services to address those needs (Western Sydney University partnership) • Evaluating a pilot intervention using community coaches and facilitators on reducing the impact of diabetes and its complications in the greater Western Sydney Samoan Community (Western Sydney University partnership)

	• Joining the multicultural governance committee of the NBM Local Health District (a key stakeholder in this area) • Researching barriers and identify strategies with CALD community access to Mental Health services (Nepean Migrant Access and Western Sydney University partnership) • Developing a plan for building cultural competency of general practices to respond to newly arrived refugees. Objectives include: 1. There is an increased understanding of the local Aboriginal health provider landscape that will enable effective planning of activities to support capacity building of eligible contenders for commissioning across the region. 2. The cultural capacity of the PHN to support the commissioning of Aboriginal Health across the region is enhanced. 2. Increased cultural competency of local primary care clinicians will enhance quality of care provided to CALD and refugee populations within the region.
Target population cohort	Aboriginal and Torres Strait people within the Nepean Blue Mountains region CALD and Refugee populations within the Nepean Blue Mountains region General Practice Aboriginal Community Controlled organisations
Consultation	Consultation and networking with key stakeholders will identify measures suitable to support the development of interventions in the first year. Further consultation, networking, formalised partnerships and co-design where appropriate will support the implementation and or commissioning of interventions.
Collaboration	General Practice NBM Local Health District Aboriginal Health Department NBM Local Health District Multicultural Health Department Nepean Migrant Access Aboriginal consumers

	CALD and Refugee consumers Aboriginal Community Controlled Organisations University partners (Western Sydney University)
Indigenous Specific	Yes
Duration	This is an existing activity for the period 2016-18
Coverage	All four Local Government Areas of Penrith, Blue Mountains, Hawkesbury and Lithgow
Commissioning method (if relevant)	A targeted EOI followed by an RFP process will be implemented. Co-design may be implemented if gaps are identified with EOI due to reduced capacity and or capability of Aboriginal Community Controlled organisations. This will form part of the capacity building solution.
Approach to market	Direct engagement will use used to procure services where applicable
Decommissioning	This activity relates to the commissioning of the Integrated Team Care Program. The ITC plan identifies fully the extent of commissioning activities.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. NP 1)	**NP 6. Access to health services - Supporting and increasing access to local primary health workforce**
Existing, Modified, or New Activity	This is an existing activity 2016-18
Program Key Priority Area	Health Workforce
Needs Assessment Priority Area (eg. 1, 2, 3)	Section 4: Opportunities, Priorities and options Pgs. 139 - 142. Access to health services Section 2: Outcomes of the health needs analysis Pgs. 34 - 39. Access to health services
Description of Activity	1. A viable **health workforce** is essential to support community access to primary health services. The primary health workforce faces consistent demands relating to current and predicted 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. The aim of this activity will be to 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 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. 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 Objectives include: 1. There will be an increase in a sustainable primary health care workforce for the region 2. GP assistance is available at emergency evacuation centre in the events of local/regional emergencies and pandemics 3. Protocols and a governance framework are developed to support the rostering of GPs to emergency evacuation centres in the event of a regional emergency or disaster. 4. The availability of information for health transport options in each LGA improves access for consumers to local health services
Target population cohort	General Practice Workforce Allied Health Workforce Consumers
Consultation	**Health Workforce** Consultation activities include discussions, formalised meetings and establishment of networks with key stakeholders to map the gaps and identify viable solutions. A continuation of already established working relationships i.e. Rural Doctors Network, will help facilitate more opportunities to address workforce enhancement. Establishment of new relationship will need to occur with the new GPET and University partners to facilitate further opportunities for workforce enhancement and research and evaluation. **Emergency Management** Consultation for the development of emergency management will rely on both existing i.e. RACGP and new relationships with sectors of the Local Health District and to support the development of localised policy and procedures that support the role of GPs in emergency management **Health Transport** Similarly the development of health transport options will involve a large amount of consultation with key transport stakeholders to define existing transport options to access health services across the region.

Collaboration	General Practice – GPs, GP Registrars, Practice Nurses, Practice Administrators Private Allied Health and Pharmacy NBM Local Health District Health Planning Department NBM Local Health District Population Health Department NBM Local Health District Emergency Management Committee Hawkesbury Hospital (Part /private public partnership) GP Synergy (GPET organisation) University partners Health Transport agencies across the region Rural Doctors Network Local Councils of Penrith, Blue Mountains, Hawkesbury and Lithgow RACGP Consumers
Indigenous Specific	No
Duration	**01 Jul 2016 - 30 Jun 2017** Health Workforce • Continuing to build on the activities that focus on supporting attraction and retention of primary care clinicians to the area and monitoring trends in workforce capacity and capability to support planning • Continuing to monitor areas of need and commission new health services to meet unmet service needs i.e. using RDN funding or other models • Establishing a relationship with the new GPET (GP Synergy) that support Registrar placements within the NBM region. • Continuing to support provision of local timely, topical professional development and networking activities

	• Conducting a workforce census to establish primary care workforce capacity and capability for NBM region. Emergency Management • Working with GPs and the RACGP to support the development of policies and procedures that identify the role of the GP in local emergencies and pandemics Health Transport • Further mapping the local health transport options across the region and making this information in an accessible format to health care providers and consumers **01 Jul 2017 - 30 Jun 2018** Workforce • A continuation of the previous years workforce attraction and retention activities and monitoring trends in workforce capacity and capability – putting plans into action where viable i.e. commissioning RDN services or other models • Continuing to work with the new regional GPET (GP Synergy) to promote and monitor registrar placements within the NBM region • Continuing to support provision of local timely, topical professional development and networking activities • Following up on the outcomes of the workforce census to support development of capability and capacity for the NBM region. Emergency Management • Implementing a localisation of the developed policies and procedures that support the role of the GP in local emergencies and pandemics i.e. working with the Local Health District Health Transport • Updating the local health transport options information and making it available in a more user friendly mobile application of the website

Coverage	All four local government areas with the region including Penrith, Blue Mountains, Hawkesbury and Lithgow.
Commissioning method (if relevant)	The workforce elements of the activity will be commissioned where appropriate including enhancement opportunities through the Rural Doctors Network and workforce census of primary care through a consultant.
Approach to market	Approach to market and or direct engagement will occur with specific focus on continuing currently commissioned services that are meeting local health needs including the following RDN funded commissioned services: • Paediatric Specialist Outreach Clinic in Lithgow • Speech Pathology Service in Portland (Lithgow) • Access to paediatric ENT consultations and surgery (Aboriginal Health (Lithgow) • Delivery of a multidisciplinary diabetes clinic (Windsor)
Decommissioning	NA

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. NP 1)	**NP 7. Cancer care - Increasing cervical screening participation in the Penrith Local Government Area (LGA).**
Existing, Modified, or New Activity	This is an existing activity 2016-18
Program Key Priority Area	Population Health – Cancer prevention
Needs Assessment Priority Area (eg. 1, 2, 3)	Section 4: Opportunities, Priorities and options Pgs. 148 – 151 Cervical cancer screening Section 2: Outcomes of the health needs analysis Pgs. 30 - 33 Cancer care
Description of Activity	The implementation of best practice approaches in primary care will support prevention and early intervention of cervical cancer and contribute towards increased cervical cancer screening rates within the Penrith LGA.

	This activity will aim to 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. 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 co-design approach will be taken with key stakeholders in the region to develop interventions that contribute towards increasing cervical screening participation rates through primary care. These will be based on developing best practice systems in primary health care with a preventive focus of early detection and intervention, and implementation of the new National cervical screening Renewal program (to commence 1st May 2017)
Target population cohort	Women aged 20 - 69 yrs. residing in the Penrith Local Government Area General Practices within the Penrith Local Government Area
Consultation	Stakeholder engagement and consultation activities will include discussions, meetings, formalised networking and the establishment of a cancer screening expert reference group to support guidance on the implementation of activities. There is a focus on general practice engagement.
Collaboration	General Practice NSW Cancer Institute NGO Womens Health Services within the Penrith LGA Private Pathology Providers NBM Local Health District Health Planning NBM Local Health District Department of Population Health NBM Local Health District Health Promotion – Sexual Health University partners (Western Sydney University) for the purposes of evaluation Consumers - Women
Indigenous Specific	No

Duration	**01 Jul 2016 - 30 Jun 2017: Planning** • Identifying service gaps and needs • Establishing relationships with key stakeholders • Establishing an expert reference group • Co-designing a model of implementation with input from the expert reference group • Implement the model through a commissioning process with general practice • Defining evaluation needs and partnering with WSU University • Establishing a network with other PHNs in NSW tasked with the same objective **01 Jul 2017 - 30 Jun 2018: Implementation** • Continue to support commissioned activities with General Practice • Evaluating and reporting on the outcomes in partnership with WSU University
Coverage	Penrith Local Government Area.
Commissioning method (if relevant)	Substantial parts of the activity – the pilot model with general practice - will be commissioned. The research and evaluation component will be commissioned.
Approach to market	Procurement through direct engagement and an EOI process for commissioning of different activities will be employed.
Decommissioning	NA

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. NP 1)	**NP 8. Cancer care - Increasing bowel screening participation with a focus on men with low participation rates.**
Existing, Modified, or New Activity	This is an existing activity 2016-18
Program Key Priority Area	Population Health – Cancer prevention
Needs Assessment Priority Area (eg. 1, 2, 3)	Section 4: Opportunities, Priorities and options Pgs. 151-156 Bowel cancer screening Section 2: Outcomes of the health needs analysis Pgs. 30 - 33 Cancer care

Description of Activity	The implementation of health promotion interventions within the community setting and the application of best practice approaches in primary care will support prevention and early intervention of bowel cancer and contribute towards increased bowel cancer screening rates across the region 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 aim to work in partnership with General Practices, men's health organisations and Western Sydney University to co-design interventions that will contribute towards increasing bowel screening participation rates 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. The activities will draw upon existing services and community-supports for men to raise awareness of the importance of bowel screening, participation in the National bowel screening program and linking with a General Practitioner.
Target population cohort	Men 50 – 74 years residing in the Nepean and Hawkesbury Local Government Areas General Practices within the Nepean and Hawkesbury Local Government Areas
Consultation	Stakeholder engagement and consultation activities will include discussions, meetings, formalised networking and the establishment of a cancer screening expert reference group to support guidance on the implementation of activities. There is a focus on consumer engagement within the community setting and general practice engagement.
Collaboration	General Practice NSW Cancer Institute NGO Mens' Community Groups within the Penrith and Hawkesbury LGAs Private Pathology Providers

	NBM Local Health District Health Planning NBM Local Health District Department of Population Health University partners (Western Sydney University) for the purposes of evaluation Consumers – Men and their partners
Indigenous Specific	No
Duration	**01 Jul 2016 - 30 Jun 2017: Planning** • Identifying service gaps and needs • Establishing relationships with key stakeholders • Establishing an expert reference group • Co-designing a model of implementation with input from the expert reference group • Commission services • Defining evaluation needs and partnering with WSU University • Establishing a network with other PHNs in NSW tasked with the same objective **01 Jul 2017 - 30 Jun 2018: Implementation** • Commissioning process with general practice • Evaluating and reporting on the outcomes in partnership with WSU University
Coverage	Penrith and Hawkesbury Local Government Areas
Commissioning method (if relevant)	Substantial parts of the activity – the pilot model with general practice - will be commissioned. The research and evaluation component will be commissioned. Community engagement activities will be commissioned.
Approach to market	Procurement through direct engagement and an EOI process for commissioning of different activities will be employed.
Decommissioning	NA

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. NP 1)	**NP 9. Cancer care - Increasing breast screening participation with a focus on low screening regions.**
Existing, Modified, or New Activity	This is an existing activity 2016-18
Program Key Priority Area	Population Health – Cancer prevention Indigenous Health – Aboriginal Women
Needs Assessment Priority Area (eg. 1, 2, 3)	Section 4: Opportunities, Priorities and options Pgs. 144 – 148 Breast cancer screening Section 2: Outcomes of the health needs analysis Pgs. 30 - 33 Cancer care
Description of Activity	The implementation of health promotion interventions within community settings and the application of best practice approaches in primary care, will support prevention and early intervention of breast cancer and contribute towards increased breast cancer screening rates across the region for low screening populations, including Aboriginal women in the Lithgow and CALD women in Blue Mountains LGAs. Aboriginal women in the Lithgow LGA • 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. This activity will commission a local Aboriginal agency to work with the local community to encourage breast screening participation amongst Aboriginal women in Lithgow. A particular focus of the activity will be to link Aboriginal women participating in breast screening to their primary care provider. The approach will aim to identify enablers and foster a culture-centred, community ownership and empowerment that contributes towards increasing Aboriginal womens breast screening participation rates in the Lithgow LGA.

	CALD women in the Blue Mountains LGA • Women from a CALD background residing in the Blue Mountains LGA have breast screening rates of 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 engagement intervention strategies.
Target population cohort	Aboriginal women in the Lithgow Local Government Area CALD women in the Blue Mountains Local Government Area
Consultation	Stakeholder engagement and consultation activities will include discussions, meetings, formalised networking and the establishment of a cancer screening expert reference group to support guidance on the implementation of activities. There is a focus on consumer engagement within the Aboriginal community setting, CALD community networks and general practice engagement.
Collaboration	General Practice NSW Cancer Institute Breast Screen NSW Aboriginal Community Groups within the Lithgow LGA CALD Community Networks within the Blue Mountains LGA Private Medical Imaging Providers NBM Local Health District Health Planning NBM Local Health District Department of Population Health NBM Local Health District Multicultural Health NGO Multicultural Organisations University partners (Western Sydney University) for the purposes of evaluation Consumers – Aboriginal and CALD women
Indigenous Specific	Yes
Duration	**01 Jul 2016 - 30 Jun 2017: Planning**

	• Identifying service gaps and needs • Establishing relationships with key stakeholders • Establishing an expert reference group • Co-designing a model of implementation with input from the expert reference group • Implement commissioning process with an Aboriginal Consultant • Defining evaluation needs and partnering with WSU University • Establishing a network with other PHNs in NSW tasked with the same objective **01 Jul 2017 - 30 Jun 2018: Implementation** • Continued commissioning Evaluating and reporting on the outcomes in partnership with WSU University
Coverage	Lithgow Local Government Area Blue Mountains Local Government Area
Commissioning method (if relevant)	Substantial parts of the activity – the community engagement with Aboriginal women will be commissioned. The research and evaluation component will be commissioned.
Approach to market	Procurement through direct engagement for commissioning of Aboriginal Community engagement and CALD Community engagement will be employed.
Decommissioning	NA

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. NP 1)	**NP 10. Health Service Integration - Facilitating Health Service Integration through HealthPathways**
Existing, Modified, or New Activity	This is an existing activity 2016-18
Program Key Priority Area	Other – Health Service Integration
Needs Assessment Priority Area (eg. 1, 2, 3)	Section 4: Opportunities, Priorities and options Pgs. 103 – 109 Integration Framework. The opportunities are also reflected throughout most sections

	Section 2: Outcomes of the health needs analysis Pgs. 18, 19 Potentially preventable hospitalisations. The needs are also reflected throughout most sections This activity refers to many gaps within the needs assessment specifically relating to access to health pathways for clinical care, which often result in potentially avoidable hospitalisations. It is viewed as a key integration enabler with the Local Health District and local Specialist clinicians to support potentially preventable hospitalisations.
Description of Activity	The development of HealthPathways will support integrated approaches to service redesign and planning whilst improving immediate access to localised clinical guidelines and referral options which will contribute towards reducing avoidable hospital presentations and admissions across the NBM region. 'HealthPathways' is a well-established model within the Australian health care setting that supports the development of integrated clinical care and referral pathways. It has been implemented in 9 of 15 NSW Local Health Districts and PHNs, including 7 metropolitan and 2 neighbouring PHNs. HealthPathways has wide acceptance overall and particularly within our neighbouring regions where a number of pathways encompass our region and will be shared due to the broad remit of some NSW Health Services e.g. Renal Services HealthPathways will aim to support a better patient journey across the Nepean Blue Mountains region through the development of jointly agreed clinical guidelines and referral processes across the health sectors that enhance pathways of patient care. The collaborative approach undertaken across primary, secondary and acute care, as a part of the development of health pathways, will also aim to foster the integration of health care services where appropriate. The NBM PHN and NBM Local Health District will jointly share resources and responsibilities to implement HealthPathways through the following key actions: • Establishing a shared governance model including the contribution of clinical leads from primary, acute and secondary health sectors • Recruiting a joint implementation manager position to rollout and manage the HealthPathways program • Establishing a reference group to help guide the implementation and to prioritise the first 50 HealthPathways to be developed

	• Communicating the HealthPathways model to primary and acute and secondary care clinicians
Target population cohort	General Practitioners Private Allied Health Local Health District Clinicians
Consultation	Stakeholder engagement and consultation activities will include discussions, meetings, formalised orientations and networking events and the establishment of a Steering Committee to support program governance
Collaboration	General Practice Private Allied Health Private Specialists NBM Local Health District Board and Executive NBM Local Health District Health Planning NBM Local Health District Department of Emergency Medicine Hawkesbury Hospital (Part /private public partnership) Streamliners New Zealand
Indigenous Specific	No
Duration	**2016- 2017** • Governance model developed • Staff employed • Launch of Orientation to Health Pathways for LHD and Primary care clinicians **2017-2018** • Co-design of HealthPathways • Launch of live HealthPathways site providing regional wide access

Coverage	All four Local Government Areas of Penrith, Blue Mountains, Hawkesbury and Lithgow within the NBM region.
Commissioning method (if relevant)	Part of the activity will be commissioned – the licensing agreement with Streamliners New Zealand sole custodians of the HealthPathways online tool and platform)
Approach to market	Direct engagement of Streamliners New Zealand, sole custodians of the HealthPathways licence (online tool and platform).
Decommissioning	NA

1. (c) Planned PHN activities – Core Operational Funding 2016-18

Proposed general practice support activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. OP 1)	**OP 1. Building quality data systems for quality improvement and Practice sustainability**
Existing, Modified, or New Activity	Existing
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 including chronic disease and cancer screening activities described under flexible plan.

	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.
Supporting the primary health care sector	This activity will focus on supporting Primary Health sector and specifically General Practice to improve Practice systems, clinical management and population health monitoring.
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	Training and implementation of the tool will commence in 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.
Expected Outcome	This activity will aim to improve both effectiveness and efficiencies of primary health services as it will be aligned to several supportive initiatives of the PHN to improve patient health outcomes within each practice, population health across the region and business opportunities for optimum Practice Models
General practice support activities	
Activity Title / Reference (eg. OP 1)	**OP. 2. Building Capability and Capacity in General Practice for managing chronic disease**

Existing, Modified, or New Activity	Existing
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.
Supporting the primary health care sector	This activity will focus on supporting Primary Health sector and specifically General Practice to improve clinical management systems, processes and chronic disease management.
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	This activity will run from 2016-18.
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.
Expected Outcome	This activity is expected to have several outcomes, including: • Improved patient care • Improvement in clinical parameters and secondary prevention • Improvements in utilisation of appropriate MBS items and subsequent improvements in continuity of care • Reduced potentially preventable hospitalisations • Improvement in organisation processes and quality care Improvement in appropriate referral patterns for supporting patients receiving the right care, at the right time and right place
General practice support activities	

Activity Title / Reference (eg. OP 1)	**OP 3. Building quality Practices across the Region**
Existing, Modified, or New Activity	Existing
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.
Supporting the primary health care sector	This activity is focussed on supporting the primary health care sector to build quality general practices and maintain quality standards.
Collaboration	NBMPHN will work in collaboration with the NBM LHD for delivery of education and training needs as required for Practices
Duration	This activity will run from 2016-18.

Coverage	All Practices across the PHN boundary
Expected Outcome	This activity is expected to have several outcomes, including: • Increase in quality Practices across the PHN • Improvement in quality data capture • Increased opportunity to drive education and training in prevention activities • Improvement in organisation processes and quality care • Greater uptake of digital health and hence improved continuity of care for patients
General practice support activities	
Activity Title / Reference (eg. OP 1)	**OP. 4. Building better communication across service providers and patients**
Existing, Modified, or New Activity	Existing
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.
Supporting the primary health care sector	This activity will support the entire primary health care sector to build greater connectivity to ensure improved 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	This activity will run from 2016-18.
Coverage	All Practices across the PHN boundary and eligible AHP and Pharmacists.
Expected Outcome	This activity is expected to have several outcomes, including: • Increased connectivity between health providers, patients and hospital services. • Improvement in quality data capture • Increased uptake of accreditation and e pip initiatives • More timely access to health services Greater continuity of care for patients

General practice support activities	
Activity Title / Reference (eg. OP 1)	**OP. 5. System approach to Prevention**
Existing, Modified, or New Activity	Existing
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. Practice Support staff will promote HealthPathways for Clinical Decision Support and referral pathways for screening and appropriate management. The PHN will provide ongoing reports to Practices based on de-identified aggregated data to highlight trends, and benchmark Practices against State rates.
Supporting the primary health care sector	This activity will support increase knowledge and understanding of health prevention strategies within primary care. It will also aim to establish and nurture linkages with the Local Health District to further strengthen Primary Care capacity and capability to undertake prevention activities.

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	This activity will run from 2016-18.
Coverage	All Practices across the PHN boundary
Expected Outcome	This activity is expected to have several outcomes, including: • Improved system for identifying gaps in patient prevention activities • Improved systems for recalling and reminding patients in a proactive manner • Improvement in quality data capture • Improvement in accreditation requirements • Improved systems for targeting population cohorts and regional variation
General practice support activities	
Activity Title / Reference (eg. OP 1)	**OP. 6. Continuing Professional Development for Primary Care providers**
Existing, Modified, or New Activity	Existing
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 not elsewhere funded under other specific program activities.
Supporting the primary health care sector	This activity will support the entire Primary Health sector as education and training will be both discipline driven and integrated across primary care clinicians.
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	1 July 2016 to 30 June 2018

Coverage	Entire PHN region. Delivery of activities in local areas as appropriate.
Expected Outcome	At least 32 education events are conducted Evaluations of CPD event indicated at least 80% overall satisfaction rating by attendees

1. (d) Activities submitted in the 2016-18 AWP which will no longer be delivered under the Core Schedule

2. Nil