Australian Government
Department of Health

phn
An Australian Government Initiative

Updated Activity Work Plan 2016-2018:

Core Funding

After Hours Funding

The Activity Work Plan template has the following parts:

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

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

Perth South PHN

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

PHNs may attach an existing strategic vision statement. If the PHN does not have a strategic vision statement please outline, in no more than 500 words, an overview of the PHN's strategic vision for the 24 month period covering this Activity Work Plan that demonstrates how the PHN will achieve the key objectives of:

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

WA Primary Health Alliance (WAPHA) exists to facilitate a better health system for all Western Australians that achieves improved outcomes for patients and delivers better value to our community. WAPHA takes a whole of system approach that puts people and communities first.

The primary health care system in WA is fragmented and lacks strong, integrated general practitioner (GP) led care at its core. WAPHA is committed to addressing the many access barriers that exist for people trying to navigate the current system – particularly those at risk of poor health outcomes. These barriers contribute to more than 62,000 Western Australians presenting at hospital emergency departments each year, whose care would be best managed through a co-ordinated and responsive primary health care system. WAPHA is committed to enabling patients to stay well in the community.

In the 24 months of this Activity Work Plan, the PHN intends to demonstrate improvement in equity, efficiency and effectiveness of primary health care services and in better enabling patients to stay well in the community. The founding principles of this plan include:

- Transitioning from a programmatic based approach to supporting Comprehensive Primary Care where General Practitioners lead, and are central to the care team/model which is underpinned by the 10 building blocks of high performing primary care and the Quadruple aim.
- Helping people to understand and manage their own health by supporting them as partners in our health system.
- Reducing fragmented care by supporting the provision of person-centred, integrated and coordinated care for vulnerable and disadvantaged people in identified geographic priority locations.
- Place based health approach to commissioning whereby local activities are implemented to engage the community, social and health care providers, local government and other key stakeholders to knit together services to more effectively meet the needs of local citizens and work towards a shared agenda.
- Prioritising evidence-base, local relevance and evaluation.
- Building sustainable primary care workforce capacity that is tailored to the priority areas identified through the PHN Needs Assessment. and
- Co-designing and commissioning activities to promote local innovation from within primary care.

Our commissioning effort and resources are focussed on a small number of high impact activities that can demonstrate our success in facilitating changes to the health system. These changes will have improved health outcomes, deliver better value to the community and will meet one or more of the following five priority areas, identified through the Needs Assessments:

- Keeping people well in the community.

- People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs.
- Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage.
- System navigation and integration to help people get the right services at the right time and in the right place.
- Capable workforce tailored to these priorities.

It will be essential that WAPHA and the PHN build sustainable relationships across the health and social care systems that most effectively address the barriers impacting on the health care outcomes of people in metropolitan, regional, rural and remote Western Australia. WAPHA and the PHN will be responsive to the diversity of our communities.

Based on the services gaps and the priorities identified in the WA Primary Health Network Needs Assessments, and guided by local and Commonwealth strategic priorities, WAPHA will plan and commission for quality, cost effective and integrated services that are sustainable, evidence based and outcomes based. Engagement of clinicians and the community in the planning and commissioning of services will assist in identifying, and subsequently meeting, priority needs at regional level for the WA community.

The following will be key to the achievement of WAPHA's objectives:

- Establishing a sustainable commissioning capability.
- Increasing the system's capacity to support patients through non-hospital primary health care pathways.
- Fostering the authorising environment.
- Building an organisational culture that supports innovation, good governance and sustainability. and
- Using commissioning levers and enablers (such as digital health and workforce) to maximise integration and create efficiencies that improve effectiveness in clinical services delivery.

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Definitions applied

Clinical governance - the systems and processes that organisations use to audit care, train staff, obtain feedback from clients and manage clinical risk to ensure that the services provided are safe and good quality.

Co-design - where service users, providers and commissioners are equal partners in the design of systems and services that affect them.

Co-production - In practice, involves people who use services being consulted, included and working together from the start to the end of any things that affect them. (*Often used as the operational description of how co-design is achieved, but also gets used interchangeably).*

Collective impact - an approach that brings a range of organisations together to focus on an agreed common change agenda that results in long-lasting benefits.

CREMs – clinician reported experience measures.

Evidence based care - care that research has shown is effective in providing the desired result.

HealthPathways **-** an online management tool to assist general practitioners (GPs) provide consistent conditions-specific care and referrals. Each pathway provides GPs with up to date information about local referral pathways.

Multi-disciplinary team - A term used to describe a variety of different health professionals working together. (Also called inter-professional or interdisciplinary team).

Outcome based commissioning - planning and purchasing services based on **what** positive differences are made, over **how** they are done. This is a key concept in reforming our health services.

An example would be where a government replaces a block contract of 2000 counselling sessions a year, with a contract to deliver an agreed level of improvement in clinical outcomes for a group of people in a region, facilitating for people to receive the right treatment to meet their needs. Counselling might be the right answer in some cases, but probably in fewer cases than before, and most importantly that decision is directed much more by the outcomes that the patient wants.

Person centred care - when decisions about the way health care is designed and delivered puts the needs and interests of the person receiving the care first. (Also called Consumer Centric Care).

Place based approach - a way of addressing issues within a defined place, community or region in a systemic way.

PREMs - Patient reported experience measures.

Primary care - the first point of contact with health care provided in the community most commonly with a GP. Does not require an external referral at point of entry.

PROMs - Patient reported outcome measures.

Quadruple aim - is widely accepted as a compass to optimise health system performance. The Quadruple aim includes – enhancing patient experience, improving population health, reducing costs and improving healthcare provider experience and satisfaction.

Secondary care - care provided by a specialist often in a clinic or hospital requiring an external referral.

Shared care - care provided by a team of people in a coordinated way.

An example would be arrangements between a local hospital and GP for pregnancy care where some appointments are with the GP, and some are at the hospital.

Stepped care - A key concept in mental health. In this model the care is "stepped" up or down in intensity and scope, depending on the severity and complexity of the patient's needs, rather than care "dosing" according to diagnosis and service specification.

For example, someone suffering depression related to a specific incident in their life such as sickness or job loss, will require a different level of care to a person with long-term chronic depression or psychiatric conditions. With a stepped care approach, all patients with depression start with low intensity intervention, usually 'watchful waiting', as around half will recover spontaneously within 3 months. Progress is monitored by a mental health professional and only those who don't recover sufficiently move up to higher intensity intervention – which might involve guided self-help. There are two more levels or steps: brief one-on-one therapy. then for those still badly impacted by depression, longer-term psychotherapy and antidepressant medication.

Systems approach - a way of tackling issues by looking at all the services that exist and the connections between them and making changes that can affect the whole system rather than just individual parts within it.

Social determinants of health - the conditions within which people are born, develop, grow and age – they include social, economic, cultural and material factors surrounding people's lives, such as housing, education, availability of nutritional food, employment, social support, health care systems and secure early life.

Tertiary care - specialised care usually provided in hospital that usually requires referral from a primary or secondary care provider.

Wrap around care - this is a key concept within person centred care. The patient and their family form a partnership with their primary care provider team and other services "wrap around" this partnership as required.

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

Key Projects underpinning proposed activities

Mental Health, Alcohol and Other Drugs (AOD) Atlas of Western Australia (the Atlas) - The Atlas maps by primary function, all of the free to access mental health and AOD services in WA including their reach. Once completed (anticipated March 2017) the project will provide a planning tool that helps health commissioning organisations to understand current service availability by locality.

My Health Record project - My Health Record is a secure online summary of a person's health information, provided to all Australians by the Commonwealth Department of Health. The individual can control what goes into the record and who can access it. The My Health Recordmakes it possible for an individual to share their health information with a variety of healthcare services and providers such as GPs, hospitals and specialists. Everyone granted access to the record is able to see information about an individual's health condition, allergies, test results or medications depending on what the individual elects to share, and with whom. The benefits are significant – the electronic record is a convenient way for people to store all of their health information and also in reducing duplication and potential errors through health professionals having access to the right information all in one place.

HealthPathways – *HealthPathways* is an online system for General Practitioners (GPs) and primary health clinicians, accessed through an online portal. *HealthPathways* has been designed to be used at the point of care. It provides GPs and primary health clinicians with additional clinical information to support their assessment, treatment and management of individual patient's medical conditions, including referral processes to local specialists and services.

HealthPathways is central to the support that WA Primary Health Alliance (WAPHA) and the WA Primary Health Networks (PHNs) can provide to GPs and primary health clinicians. WAPHA administers *HealthPathways* in Western Australia. The PHNs' Primary Health Liaison Officers promote *HealthPathways*, and support GPs to implement and use the system in their practices to ensure people in Western Australia receive the right care, in the right place at the right time.

WAPHA works collaboratively with the State Government's Department of Health and the Area Health Services to set *HealthPathways* priorities and direction. Clinical pathways are selected for inclusion by a formal process based on the areas of greatest need.

Patient Opinion – WAPHA and WA PHNs will be supporting use of Patient Opinion[1] to promote the vital role of consumer feedback in service improvement. Through a license agreement with Patient Opinion the PHN aims to encourage service and patient use of the site to inform continuous quality improvement of WAPHA funded services. The PHN is prioritising use of the site in areas where the local area health service has already adopted and is using the site. This approach seeks to assist in joining up the different areas of the health system, supporting a consistent approach to patient feedback across the whole patient journey.

My Community Directory – My Community Directory is a directory of community services, accessibly online and available to download as a printable portable document format (pdf). This sophisticated platform meets the identified needs of both community and service providers. For community, the online directory is free to access and can be searched by location, empowering people to stay well in their community and access local services where possible. For service providers, the directory supports place-based collaboration and tools in the platform support the co-ordination and navigation of place-based care for consumers. By entering a partnership agreement with My Community Directory, WAPHA and the WA PHNs will also benefit from the service mapping and search data generated from the directory. This will support service planning and contribute to the assessment of community needs.

Primary Health Exchange - Primary Health Exchange is a website to support engagement with community and wider stakeholders in PHN activities. The PHNs will continue to use the site to maintain open and transparent communication with communities around commissioning activities, including consultation to inform needs assessment and to outline anticipated timeframes. The site will continue to be used as a central hub for information and as a key communication tool between PHN committees and service providers, with communities of practice continuing to be established to encourage learning and communication across providers. Data and analysis tools within the administration side of the site will continue to be used to monitor and evaluate levels, and the nature, of engagement from stakeholders and contribute to the evaluation of associated face to face engagement activities such as workshops and focus groups.

[1] Further information on Patient Opinion can be accessed at www.patientopinion.org.au

A note on the PHN's commissioning approach and performance management: the WAPHA Outcomes Framework

WAPHA intends to create impetus for providers to focus on positive health outcomes by commissioning for good outcomes, rather than focussing on levels of activity, where appropriate.

The purpose of this outcomes framework is to provide an approach for understanding whether the commissioning work being done by WAPHA over the three WA PHNs, is achieving its intended aims. It is not a means for monitoring or penalising providers, rather it provides a means for monitoring and evaluating our own work in commissioning appropriate services to meet our objectives.

Wherever possible and when appropriate, we will attempt to consult with the wider community (clinicians, providers, patients and community organisations) involved with our commissioned activities to determine the most meaningful outcomes and indicators to use.

Our Outcome Domains

WAPHA emphasises the following pillars in prioritising the activities of the PHNs in line with national priorities:

- Aboriginal Health.
- Mental Health.
- Ageing/Older people.
- Population Health (in particular chronic diseases).
- eHealth.
- Workforce.

National headline indicators have also been prescribed and defined by the Commonwealth which reflect the Australian Government priorities. These are:

- Potentially preventable hospitalisations.
- Childhood immunisation rates.
- Cancer screening rates (breast, bowel and cervical).
- Mental health treatment rates, with child and adolescent rates reported separately.

WAPHA has also outlined five outcome domains which align with the five priority areas determined by our health needs assessments. These outcome domains represent the system changes we intend to make within the primary health care space through our commissioning activities. Our outcome domains are:

1. Building capacity within the place.
2. Increasing accessibility and reducing inequity.
3. Providing care coordination: people receive the right care, in the right place at the right time.
4. Delivery of services with a person-centred approach.
5. Creation of locally sustainable health systems.

We invite our providers to adapt this framework to their own services, so they may build their capacity to monitor and evaluate themselves. No one knows their business better than themselves, so providers will be best placed to determine the outcomes which represent the achievement of their aims and the measures and indicators which best track their performance against those outcomes.

Approach taken to prioritising activities

In November 2016, the PHN produced a 'refresh' of the Baseline Needs Assessment Report produced in March 2016 (Phase 1). The updated Report (Phase 2) consolidates the key themes and issues of the region's population health and service provision needs. In addition, it takes an alternate approach that considers place-based unmet needs for residents in the southern suburbs of metropolitan Western Australia (WA).

While a broad range of health needs were identified within the community, key stakeholders were involved in a prioritisation process to agree high level priority needs. The following needs were determined:

- Keeping people well in the community.
- People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs.
- Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage.
- System navigation and integration to help people get the right services, at the right time and in the right place.
- Capable workforce tailored to these priorities.

These priority needs are guiding resource allocation in the commissioning process.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. NP 1)	**NP 1 – Enhanced Practice Support**
Existing, Modified, or New Activity	Modified activity (p9)
Program Key Priority Area	Other - system integration
Needs Assessment Priority Area (e.g. 1, 2, 3)	**1. Keeping people well in the community (p44).** • Strategies to keep people connected to primary health care – Nurse or Aboriginal Health Worker led care coordination and health coaching models for patients with chronic disease. – Telehealth, telemedicine and other resources to complement face to face health programs and to support education and self-management. • Strategies to enhance continuity of care – Promotion of My Health Record and Electronic Transfer of Care. – Additional *HealthPathways*. – Embedding data management systems to identify service gaps and GP business development opportunities. – Maximising GP use of care planning and other MBS items and incentive payments. – Supporting GPs to maximise existing incentives to provide care for vulnerable populations. – Partnerships with WA Department of Health, East Metropolitan Health Service (EMHS), South Metropolitan Health Service (SMHS), hospitals, General Practitioners (GPs) and key community health organisations to manage care transitions. – Agreements on processes for referrals, discharge summaries, care plans and emergency care attendance summaries. • Strategies to improve self-management – Self-management as a cornerstone of commissioning in chronic disease and mental health/AOD. – Accessible self-management services for major chronic disease and mental health conditions. – Supporting GPs to explore options to enhance self-management strategies. • Focus on place-based strategies – Multiple data sources are used to identify places of high need.

	– Communities and service providers are partners in developing services which address identified unmet needs in specific communities. **2. People with multiple morbidities especially chronic co-occurring physical conditions and mental health conditions and drug and alcohol treatment needs (p46).** • Strategies for integrated chronic care management – In conjunction with Area Health Services, explore options for joint planning and service development across regions to support integrated responses to chronic disease. – Specialist In-reach programs to GP practices for chronic conditions with high referrals rates. • Strategies to develop integrated care pathways in partnership with WA Department of Health, Area Health Services, GPs and other clinicians – Regionally and locally tailored *HealthPathways*. – Tailored practice support to enhance My Health Record take up, adoption of digital tracking programs and electronic discharge summaries. • Strategies to ensure chronic condition self-management principles are included in commissioning activities • Strategic partnerships and service agreements to achieve targeted co-commissioning and integrated delivery plans – Working collaboratively with other WA PHNs to maximise opportunities for integrated service development. **3. Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage (p48).** • Place-based planning and commissioning – Application of consistent methodology to determine the attributes of place that require change for better health outcomes. – Focusing on localities and populations within localities for targeted programs. – Investing in a range of programs in particular localities to achieve concerted change. • Mainstream transformation and cultural proficiency development – core and flexible funding

	• Specialist In reach programs to practices with high- prevalence conditions referrals using e.g. cardiovascular, endocrinology and respiratory. • Strategies to improve access to primary health care. **4. System navigation and integration to help people get the right services at the right time and in the right place (p48).** • Strategies which incorporate service integration, consortia approaches, person-centred support and system navigation – Practice-based Mental Health Nurse, care management models that assist people with complex conditions to navigate the system. – Supporting increased use of electronic discharge summaries. • Partnerships with GPs, WA Department of Health and Area Health Services to increase GPs' use of agreed referral pathways and processes, navigate the system and provide effective and timely management and referral – Promoting My Health Record. – Working with Area Health Services, Local Government Authorities and other local stakeholders to address coordination, integration and navigation in local communities. – Integrated Team Care specifically oriented to assisting Aboriginal people to navigate their way into and around the health system. • Digital solutions to improve system navigation and service integration - core and project funding – Promote My Health Record to provide service continuity. **5. Capable workforce tailored to these priorities (p49).** • Strategies to increase the capacity of GPs to implement care management plans – Integration of coordination programs into GP practices –Integrated Team Care (ITC) program. headspace program. Mental Health Nurse care management program. – WAGPET/WAPHA shared training. • Strategies to build the capacity of primary health services to provide culturally secure, accessible, accountable and responsive services to Aboriginal people

	• Contract services that use appropriately qualified staff to incorporate coordination, linkage and care management. • Develop strategies to increase the capacity of the Multi-disciplinary team to understand and implement the concept of person-centred wrap-around care coordination – Primary Health Liaison practice support program. – Chronic disease management programs (including risk reduction). – Specialist In reach programs to practices with high condition referrals.
Description of Activity	Building on our Comprehensive Primary Care (CPC) approach, our Enhanced Practice Support activity will be made available to all practices in the Perth South Primary Health Network (PHN), that are not involved in the PHN's CPC initiative. Using the PHN's CPC approach as a foundation for this activity, Enhanced Practice Support offers a number of CPC initiatives aligned with Bodenheimer's Building Blocks 1 to 4 (engaged leadership, data-driven quality improvement, patient engagement and team based care). These initiatives are designed to help to build the capacity and capability of the practice team, to respond to the Commonwealth's policy direction for primary care. This activity will focus on building the capacity and capability of participating practices to transition to sustainable business models, which are adaptive to changes in the health system, and improve coordination and continuity of care to ensure better health outcomes for patients with complex and chronic conditions. This activity will also play a pivotal role in addressing the priorities identified in the Needs Assessment, by improving the health of local communities. enhancing the patient experience. reducing health care costs and supporting health professionals. Enhanced Practice Support will offer: • Training and support in continuous improvement methodologies through the implementation of Plan, Do, Study, Act (PDSA) cycles. • A self-assessment tool, which will assist practices to understand their readiness for a patient centred medical home.

	• Support to continuously improve business and clinical systems and processes to optimise the performance of the practice. • Data management and support through a range of activities to practices which build capacity and capability of the practice team to better understand, manage and optimise data. • Information and support on the Commonwealth's primary health care policy including My Health Record and PIP re-design. • Practices will be informed/linked/involved with other PHN place based commissioned activities in the region, as relevant. This support is additional to the general practice support provided through the PHN's Core Operational funding for General Practice Support activities (i.e. OP1, OP3, OP4, OP5, OP6 and OP7).
Target population cohort	This activity will be offered to general practices not taking part in the CPC program. Patients with multiple chronic long term conditions who would benefit from coordinated, integrated team-care will be a priority target for this program.
Consultation	WAPHA and the PHN conducted a Naive Inquiry which was an exploratory study that sought General Practices' views and perceptions of the Patient Centred Medical Home (PCMH) models of care and their appropriateness in WA. The Inquiry also allowed WAPHA and the PHN to understand how practices currently manage their chronic and complex patients, and what they see as the optimal model of care. The study consisted of two stages: • Stage 1 Innovation Hub – brought together GPs to discuss the development and implement of the PCMH model and informed the development of the Naïve Inquiry and the framework for the PHN's PCMH model. • Stage 2 – Semi-structured interviews with a range of practice staff across 10 WA based general practices, conducted by GP interviewers. Consultation across both stages involved GPs, GP Registrars, Practice Mangers, Practice Nurses, receptions and representatives from Royal Australian College of General Practitioners (RACGP) WA and GP Education and Training (WAGPET). Outcomes from the Naïve Inquiry have informed the development of this activity.
Collaboration	The PHN will work with several key stakeholders including:

	• Royal Australian College of General Practitioners WA Faculty (RACGP) – played a key role in the Innovation Hub and continue to work with WAPHA and the PHN. • WA GP Education and Training (WAGPET) – played a lead role in the Naïve Inquiry and identified the GPs and practice staff to take part in the inquiry. WAPHA and the PHN's engagement with WAGPET and the GP registrars and GP supervisors continue to inform this activity. • AMA Council of General Practice (WA) – the PHN continues to update and engage with the Council. • General Practitioners in Perth South. • PHN's Community Engagement Committee – informed about and contributed to PCMH model. • PHN's Clinical Commissioning Committee – informed about and contributed to the PCMH model. • PHN Council – informed about and contributed to the PCMH model. • Private Health Insurers including Medibank Private and HBF – working collaboratively on and funding their members to participate in the CareFirst health coaching program. • Area Health Services and Hospitals – providing specialist support and advice to participating practices and primed to participate in integration activities between GP practices and hospitals. • Pharmacy Guild of Australia – WA Branch. • Pharmaceutical Society of Australia. • See NP1 for details of a naïve enquiry process with the Health Consumers' Council WA. • South Metropolitan Health Service. East Metropolitan Health Service. • Other allied health professionals and patients, family and carers and other WA PHNs.
Indigenous Specific	No
Duration	July 2017 – June 2018.
Coverage	General Practices across the PHN region
Commissioning method (if relevant)	Services/activities will be commissioned and/or procured based on the service requirements identified in collaboration with GPs and their practice/s and will be based on: • economies of scale. • scalability. • sustainability. This activity will be commissioned in part.
Approach to market	The following procurement approaches may be used to commission activities. • EOI

	• Direct engagement/single provider/third party contractors • Requests for tender
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$593,000
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Not applicable.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. NP 1)	**NP 2 – Chronic Disease Management**
Existing, Modified, or New Activity	Modified activity (p12)
Program Key Priority Area	Population Health
Needs Assessment Priority Area (e.g. 1, 2, 3)	**1. Keeping people well in the community (p44)** • Strategies to keep people connected to primary health care. • Strategies to enhance continuity of care. • Strategies to improve self-management. **2. People with multiple morbidities especially chronic co-occurring physical conditions and mental health conditions (p46)** • Strategies for integrated chronic care management. • Strategies to ensure chronic condition self-management principles are included in commissioning activities. • Strategic partnerships and service agreements to achieve targeted co-commissioning and integrated delivery plans. • Develop strategies and partnerships to address barriers and enablers to patient centred informed decision making and end-of-life care planning for patients with life limiting conditions. **3. Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage (p48)** • Mainstream transformation and cultural proficiency development. **4. System navigation and integration to help people get the right services at the right time and in the right place (p50)**

	• Partnerships with GPs, WA Department of Health and Area Health Services to increase GPs' use of agreed referral pathways and processes, navigate the system and provide effective and timely management and referral. • Digital solutions to improve system navigation and service integration. **5. Capable workforce tailored to these priorities (p51)** • Develop strategies to increase the capacity of the Multi-disciplinary team to understand and implement the concept of person-centred wrap-around care.
Description of Activity	The PHN will implement a number of activities to address the priorities identified in the needs assessment: • Targeted chronic disease management programs for high priority conditions. • Enhancing capacity in General Practice to support consumers to self-manage their conditions. • Collaboration with state health services to improve consumer pathways between acute care and primary care and minimise potentially preventable hospitalisations. **Chronic disease management programs** Respiratory conditions are one of the three highest Age Standardised Rate (ASR) of chronic conditions across the Perth South PHN region. The PHN, in collaboration with Perth North PHN, will implement a program to provide responsive care coordination and self-management support to consumers with chronic respiratory conditions across the Perth metro area, and in this way, support people to stay well in the community, minimise potentially preventable hospitalisations and improve health outcomes. The program aims to achieve: • Increased consumer capacity and confidence to manage their condition and other comorbidities • Increased capacity and confidence amongst GPs to support consumers with chronic respiratory conditions to self-manage their condition. • Better integrated systems between community and tertiary hospitals to ensure limited delays between diagnosis and community intervention. • Care coordination to enable smooth journeys of care from community through to tertiary and back to community.

	• Improve the advance care planning for consumers to manage exacerbations and transition to palliative care smoothly. • Integrated care between all sectors through regular communication and the use of My Health Record. This activity will integrate with other PHN activities including Comprehensive Primary Care, Care First, Integrated Team Care, Local Integrated Team Care, and *HealthPathways*. **Building capacity in General Practice** • See NP1 and the Innovation Activity Proposal - Comprehensive Primary Care. • The PHN and the *HealthPathways* team will work with GPs and Area Health Services to identify opportunities for capacity building and education for General Practice. These could include education days, increased access to specialist advice in General Practice and specialist in-reach. **Collaboration with state health services** The PHN will work with state health services to identify cohorts of consumers who frequently attend hospital due to exacerbation of a chronic condition which is potentially preventable. Options for collaboration include: • Primary care clinicians working within the hospital to identify consumers who would benefit from additional clinical support on discharge to enable them to stay well in the community. • Scoping opportunities for consumers to have rapid access to hospital services and stabilisation services with the aim of intervening early and minimising preventable hospital stays or reducing average length of stay. • PHN non-recurrent funding for a hospital liaison pharmacist to work in a hospital to review medication for patients with chronic and complex conditions to enable them to be discharged from hospital as soon as is clinically appropriate.
Target population cohort	Consumers with chronic conditions.
Consultation	The PHN has consulted the CCC and CEC. Consultation will take place with a range of stakeholders including WA Health, East Metropolitan Health Service, South Metropolitan Health Service and relevant peak bodies.

Collaboration	The PHN will work with GPs, peak bodies and local Health Services to scope and implement this activity.
Indigenous Specific	No
Duration	• Planning and consultation: - Modified respiratory conditions program Jan – April 2017. - GP capacity building and acute care collaborations February – May 2017. • Procurement: - Modified respiratory conditions program Feb – March 2017. - GP capacity building and acute care collaborations - to be confirmed following planning and consultation process. • Implementation and service delivery: - Respiratory conditions program June 2016 – June 2018 (changes to program from 1 April 2017). - GP capacity building and acute care collaborations - to be confirmed pending discussions with Area Health Services.
Coverage	The activity will be available across the PHN region, with a focus on the priority areas as identified in the needs assessment.
Commissioning method (if relevant)	Chronic disease management services for respiratory conditions will be commissioned in whole. Other activity will be scoped in partnership with local Health Services. It is expected that services will be commissioned in whole.
Approach to market	• Chronic disease management program for respiratory conditions – direct engagement. • GP capacity building – as outlined in NP1. • Acute care collaborations – approach to be agreed in partnership with local Health Services.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$631,174
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0

Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$650,000
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	To be confirmed

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. NP 1)	**NP 3 – Community-based integrated Pain Management**
Existing, Modified, or New Activity	Modified activity (p14)
Program Key Priority Area	Population Health
Needs Assessment Priority Area (e.g. 1, 2, 3)	**1. Keeping people well in the community (p44):** • Strategies to keep people connected to primary health care. • Strategies to enhance continuity of care. • Strategies to improve self-management. **2. People with multiple morbidities, especially chronic occurring physical conditions and mental health conditions (p45):** • Strategies for integrated chronic care management. • Strategies to develop integrated care pathways in partnership with WA Department of Health, Area Health Services, GPs and other clinicians. • Strategies to ensure chronic condition self-management principles are included in commissioning activities. - Chronic pain management programs. • Strategic partnerships and service agreements to achieve targeted co-commissioning and integrated delivery plans. • Develop strategies and partnerships to address barriers and enablers to patient centred informed decision making and end of life care planning for patients with life limiting conditions. **3. Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage (p48):** • Engagement with Aboriginal people to plan and design strategies that address localised priorities • Place-based planning and commissioning. • Mainstream transformation and cultural proficiency development. • Strategies to improve access to primary health care.

	• Continuous quality improvement through culturally appropriate, ethical and transparent evaluation of services to Aboriginal people.
Description of Activity	**Aim** This activity aims to provide improved access to, uptake of, and effectiveness of self-management options amongst consumers, and to enhance capacity in General Practice to support consumers to self-manage chronic pain. **Background** Existing community based pain management services in the Perth South region have experienced a range of issues including a high number of consumers who do not attend clinic sessions, and relatively low improvements in patient outcomes. It has also been identified that the existing services have limited availability and that alternative modes of delivery may be preferred for consumers who have mobility issues (due to their condition) and/or access issues (due to their location). There are currently no community based services in regional WA. **Activity** • Existing pain services which are currently funded by the PHN (Self-Training Educative Pain Sessions - STEPS) will continue to be funded to June 2018. • Between now and then, the PHN team will commission an accessible program to build capacity for GPs to better manage chronic pain in the community; and. build capacity for self-management amongst consumers. Options to be considered include: • Promotion of online modules for consumers via the pain*HEALTH* website https://painhealth.csse.uwa.edu.au/. • Education for GPs and practice staff. • Care coordination/navigation/coaching support from clinical staff to support consumers to better self-manage their condition. • Multi-disciplinary team care support.

	• Telehealth options for all of the above. We will also work with stakeholders to identify opportunities for integrating our community-based pain model with practices who are part of the Comprehensive Primary Care program.
Target population cohort	• Consumers with chronic pain. • GPs and other clinicians working with patients with chronic pain.
Consultation	• A *HealthPathways* pain management working group was held in November 2016 to initiate discussions about pain management referral pathways in WA. Attendees included GPs, allied health and pain specialists from across the WA health sector. • Further discussions will take place with this group, as well as with existing providers of community-based pain management services and other stakeholders. • Face to face and online consultation will take place with consumers with chronic pain to inform service development.
Collaboration	• Existing service providers – subject to consultation and planning process, may be involved in implementing new models of care. • Local Area Health Services and WA Department of Health Musculoskeletal Health Network – to ensure integration between community based services and hospital based services. • Perth North PHN and Country WA PHN – subject to outcome of consultation and planning, services may be co-commissioned with the other WA PHNs.
Indigenous Specific	No
Duration	Start date – July 2016 Completion date – June 2018 Key milestones: • Planning and consultation - July 2016 – April 2017 • Procurement of new service - April 2017 – June 2017 • Service delivery - Existing STEPS programs – June 2016 – July 2018

	- Newly commissioned services – June 2017 – July 2018 with the possibility of extension, subject to Government policy and funding
Coverage	Perth South PHN region
Commissioning method (if relevant)	This activity will be commissioned in full.
Approach to market	Subject to the outcomes of the planning and consultation phase, an approach to market is planned to be undertaken to procure new services from 01/07/17. • Options include direct engagement and restricted or open EOI..
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$337,500
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$300,000
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Not applicable.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. NP 1)	**NP 5 – Regionally tailored mental health services**
Existing, Modified, or New Activity	Modified
Program Key Priority Area	Mental Health
Needs Assessment Priority Area (e.g. 1, 2, 3)	1. Keeping people well in the community. 2. People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs. 3. Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage. 4. System navigation and integration to help people get the right services, at the right time and in the right place.
Description of Activity	This service provides evidence based short term counselling and care coordination to individuals with a broad range of mild to moderate mental health concerns[1]. Activities include group and individual education/information, clinical intervention and liaison and shared triage with the State Adult Mental Health Service[2]. Care coordination is an important aspect of this service ensuring each referred client is able to access a suitable service[3].
Target population cohort	People with a broad range of mild to moderate mental health concerns.
Consultation	This is a service continuity contract. Consultation is taking place with the existing provider to align the service with the PHN's Integrated Primary Mental Health approach.

[1] PHN Needs Assessment, priority 2: People with multiple morbidities especially chronic co-occurring physical conditions and mental health conditions, a. Commission models of integrated complex chronic care management incorporating proactive coordination and multi-disciplinary collaboration

[2] PHN Needs Assessment, priority 3 Services designed to meet the health of vulnerable and disadvantaged people including those of Aboriginal heritage, f. Develop strategies and partnerships to achieve targeted co-commissioning and integrated delivery plans with key service providers.

[3] PHN Needs Assessment, priority 2: People with multiple morbidities especially chronic co-occurring physical conditions and mental health conditions, c. Commission and implement strategies to ensure chronic condition self-management principles are included in care plans

Collaboration	This service links to the State Adult Mental Health Service and a shared care model exists and will be utilised including triage[4]. The PHN will work with the provider to align this service with the PHN's Integrated Primary Mental Health approach.
Indigenous Specific	No
Duration	July 2016 –June 2018. Service will be funded from PHN's Mental Health flexible funding from July 2017 – June 2018. Transition to PHN's Integrated Primary Mental Health approach will begin from 01/04/17.
Coverage	PHN Perth South region, focussing on the Peel region.
Commissioning method (if relevant)	The contract for this service provided by 360 health and Community will be extended until 30/06/18. It is anticipated that activities covered by this Service will be incorporated into and delivered under activities outlined in the PHN's Integrated Primary Mental Health activities.
Approach to market	Service continuity through direct engagement.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$360,000
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	
Funding from other sources	

[4] PHN Needs Assessment, priority 1: Keeping people well in the community, a. Work in partnerships with State and Area Health Services, hospitals and General Practitioners (GPs) to effectively manage the hospital-community interface.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. NP 1)	**NP 8 – Innovation and Capacity Building**
Existing, Modified, or New Activity	Modified activity (See p22)
Program Key Priority Area	System integration between primary and social care sectors.
Needs Assessment Priority Area (e.g. 1, 2, 3)	**1. Keeping people well in the community (p44):** • Strategies to keep people connected to primary health care. • Strategies to enhance continuity of care. • Strategies to improve self-management. • Focus on place-based strategies. • Communities and service providers are partners in developing services which address identified unmet needs in specific communities. **2. People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs (p46):** • Strategies for integrated chronic care management. • Strategies to develop integrated care pathways in partnership with WA Department of Health, Area Health Services, GPs and other clinicians. • Strategies to ensure chronic condition self-management principles are included in commissioning activities. • Strategic partnerships and service agreements to achieve targeted co-commissioning and integrated delivery plans. • Develop strategies and partnerships to address barriers and enablers to patient centred informed decision making and end-of-life care planning for patients with life limiting conditions. **3. Services designed to meet the health needs of vulnerable and disadvantaged people including those of Aboriginal heritage (p48):**

	• Engagement with Aboriginal people to plan and design strategies that address localised priorities.
	• Place-based planning and commissioning.
	• Mainstream transformation and cultural proficiency development.
	  - Aboriginal liaison and transitional care arrangements to support Aboriginal patients from regional and remote areas, in conjunction with Aboriginal Health Improvement Unit, GPs, AMSs, Area Health Services, other WA PHNs, and other key providers.
	  - Specialist In reach programs to practices with high - prevalence conditions referrals using e.g. cardiovascular, endocrinology and respiratory.
	• Continuous quality improvement through culturally appropriate, ethical and transparent evaluation of services to Aboriginal people.
	• Develop strategies and partnerships to improve access to after-hours primary health care for Aboriginal people and other disadvantaged people.
	• Strategies to improve access to primary health care.
	• Targeted primary health care for Aboriginal people; culturally diverse populations; people with mental illness; and displaced people.
	• Integrated Team Care (ITC) specifically oriented to link Aboriginal people with chronic conditions to culturally appropriate mainstream primary health care and Aboriginal Controlled Health Organisations (ACCHOs).
	
	4. System navigation and integration to help people get the right services, at the right time and in the right place (p50).
	
	• Strategies which incorporate service integration, consortia approaches, person-centred support and system navigation.
	• Partnerships with GPs, WA Department of Health and Area Health Services to increase GPs' use of agreed referral pathways and processes, navigate the system and provide effective and timely management and referral.
	• Evidence-informed strategies for system integration.
	• Digital solutions to improve system navigation and service integration.
	• Implement strategies which provide information about access to after-hours primary care.
	
	5. Capable workforce tailored to these priorities (p51):

	• Strategies to increase the capacity of GPs to implement care management plans. • Strategies to build the capacity of primary health services to provide culturally secure, accessible, accountable and responsive services to Aboriginal people. • Strategies to support the employment of Aboriginal people. • Develop strategies to increase the capacity of the Multi-disciplinary team to understand and implement the concept of person-centred wrap-around care coordination.
Description of Activity	Through this activity, PHN staff will proactively work with local stakeholders to identify opportunities for innovation and capacity building in line with PHN priorities. The budget will be allocated to one-off projects that: • aim to test innovative approaches to improving the delivery of primary care through working across health and social care systems/organisations. • support improved system integration, or meet other PHN priorities, by building local capacity. • enable collaboration between organisations that will result in sustainable improvements in line with PHN priorities. A provider will not receive more than one allocation from this fund in any one year. Some examples of potential projects include: • a grant could be used to fund a fixed-term project officer to undertake mapping of health and social care services for a particular cohort of people in a particular geographical area. This information could be used by those organisations to identify duplication and/or gaps in services which could be addressed by them through further collaboration. • PHN staff are proactively engaging with community members and stakeholders in priority areas (as identified in the needs assessment) and facilitating collaborations between organisations and individuals to test models and share knowledge and learnings. • PHN staff have met with a range of stakeholders in the Murray/Waroona area to discuss opportunities for building capacity in an area identified as a priority in the PHN's needs assessment. In addition to the possibility of providing some fixed-term funds to support local innovation, the PHN is playing a key role in bringing together local Aboriginal community members, local government, South Metropolitan Health Service, and local service providers to discuss local service needs and options.

	Projects will be selected using the following criteria: • Alignment with PHN priorities. • Community need and rationale. • Innovation. • Contribution to sustainable system change. • Organisational capacity and risk management. A first round of funding took place in 2016. Projects to be implemented from January 2017 in Perth South include • Development of the *client-centred integrated model of care* as the operational model for Youth Health Hub. It Involves a GP-supported model for mental, social and physical care, that aims to lead to systemic change in the delivery of complex care for young people. • The Nurse Led Clinic (NLC) to establish clinical pathways and coordinate services over a 12-month period. The focus of the NLC is to improve the physical health outcomes of people with a mental disorder and will connect tertiary mental health services with primary care services to engage clients who have or are at risk of developing co-morbid chronic disease. • Development of an enhanced navigation system to build upon the approach taken by other local networks and adapt it to the context of chronic disease and complex care management.
Target population cohort	This will vary depending on the project. Key target groups include • Vulnerable populations such as people with a mental illness and/or chronic disease. • Health and/or social care workforce who work with this population.
Consultation	The PHN will continue to consult with: • community members, service providers, local government, Area Health Services and other stakeholders. • PHN Clinical Commissioning and Community Engagement Committees, and PHN Council for feedback regarding the development of specific place-based projects.
Collaboration	Projects will be jointly implemented with local stakeholders including Area Health Services, State Government, and Local Government. Some projects may be jointly funded with other WA PHNs

Indigenous Specific	No
Duration	• Throughout the financial year. Projects will last up to 12 months. • Service provision for the first round of projects will start in January 2017.
Coverage	The activity will be implemented throughout Perth South PHN region, targeting priority LGAs as identified in the Needs Assessment. • Armadale. • Belmont. • Cockburn. • Fremantle. • Gosnells. • Kwinana. • Mandurah. • Murray. • Rockingham. • Waroona.
Commissioning method (if relevant)	Projects which address the PHN priorities will be proactively identified by PHN staff and reviewed regularly by PHN management with input from the Community Engagement Committee and the Clinical Commissioning Committee.
Approach to market	It is anticipated that funding will be allocated through a combination of direct engagement and through seeking Expressions of Interests from service providers wanting to test innovative projects in the market.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$454,905
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$0

Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Perth South PHN is in discussions with a collective impact partnership forum to co-commission an innovative project. If confirmed, they will be contributing $75,000.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. NP 1)	**NP 9 – Local Integrated Team Care (LITC)**
Existing, Modified, or New Activity	Modified activity (p25)
Program Key Priority Area	Population Health
Needs Assessment Priority Area (e.g. 1, 2, 3)	**1. Keeping people well in the community (p44).** • Focus on place based strategies - Communities and service providers are partners in developing services which address identified unmet needs in specific communities **2. People with multiple morbidities especially chronic co-occurring physical conditions, mental health conditions and drug and alcohol treatment needs (p46):** • Strategies for integrated chronic care management • Strategies to develop integrated care pathways in partnership with WA Department of Health, Area Health Services, GPs and other clinicians • Strategies to ensure chronic condition self-management principles are included in commissioning activities • Strategic partnerships and service agreements to achieve targeted co-commissioning and integrated delivery plans • Develop strategies and partnerships to address barriers and enablers to patient centred informed decision making and end-of-life care planning for patients with life limiting conditions **3. Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage (p48).** • Place-based planning and commissioning - Focusing on localities and populations within localities for targeted programs. - Investing in a range of programs in particular localities to achieve concerted change. • Strategies to improve access to primary health care - Targeted primary health care for Aboriginal people. culturally diverse populations. people with mental illness. displaced people.

	4. System navigation and integration to help people get the right services, at the right time and in the right place (p50).
	• Strategies which incorporate service integration, consortia approaches, person-centred support and system navigation.
	  - Practice-based Mental Health Nurse, care management models that assist people with complex conditions to navigate the system.
	• Partnerships with GPs, WA Department of Health and Area Health Services to increase GPs' use of agreed referral pathways and processes, navigate the system and provide effective and timely management and referral.
	  - Working with Area Health Services, Local Government Authorities and other local stakeholders to address coordination, integration and navigation in local communities.
	• Evidence-informed strategies for system integration
	  - Using small grants to test concepts. develop evidence for future service types or delivery.
	  - Demonstrate program effectiveness.
	
	5. Capable workforce tailored to these priorities (p51).
	• Strategies to build the capacity of primary health services to provide culturally secure, accessible, accountable and responsive services to Aboriginal people - flexible and program funding
	  - Contract services that use appropriately qualified staff to incorporate coordination, linkage and care management.

Description of Activity	LITC is a program approach that delivers place-based coordinated care to targeted vulnerable patient groups through a local network of providers, led by a lead agency. The aim of LITC is to deliver incremental and sustainable change that is responsive to the health needs of the target population. LITC is a key part of the PHN's plan to transition from the current single service, fragmented, episodic and output-focused systems funding to a co-ordinated outcome-based commissioning approach. The Perth South PHN LITC approach is intended to deliver wrap-around and co-ordinated care to support vulnerable and disadvantaged people to live well in their local community by accessing the right care in the right place at the right time.

	The PHN will commission partnerships or consortia of service providers to deliver primary care services which meet these desired outcomes: • Increased support to vulnerable and disadvantaged people with chronic diseases to ensure equitable access to primary health care that meets their needs. • Increased collaboration between organisations that provide treatment and support services to vulnerable and disadvantaged population groups and primary health care services with the aim of providing holistic, person centred care that meets the physical, social, psychological and emotional needs of the individual. • Increased capacity of primary health care providers to provide holistic, person centred primary health care services that meet the unique needs of the vulnerable and disadvantaged people. It is envisaged that, as a minimum, the proposed activity will include aspects of: 1. Care coordination to support primary health providers to ensure patients receive appropriate coordinated care at the right time and place by the right organisation/service. This includes: o Arranging and providing access to required services for patients. o Managing ongoing monitoring and feedback within the services. o Face to face liaison to integrate, support and assist in the implementation of the person's primary health care needs. 2. Health navigation and education to support vulnerable and disadvantaged people manage their health and understand the services available to meet their needs. This includes providing support and information to help people make informed decisions and work towards self-management of their health to improve their outcomes. LITC is a complementary approach to the Comprehensive Primary Care program and supports the needs of vulnerable populations, who do not have a regular primary health care provider or are not enrolled as a participant in the Comprehensive Primary Care program. Priority will be given to patients with complex chronic care needs who require Multi-disciplinary coordinated care in order to manage their chronic disease/s. Complementary PHN programs, including the Mental Health Atlas and *HealthPathways*, will be included within and are important to the design and implementation of this approach.

Target population cohort	Vulnerable and disadvantaged people that do not have access to primary health care that meets their needs.
Consultation	The PHN has consulted with a range of stakeholders including the CCC and CEC, the PHN Council and board and local Area Health Services.
Collaboration	• The EOI process prioritises partnerships and organisations working in consortia. • The PHN will work with GPs, NGOs, Area Health Services and others to integrate this program with existing services.
Indigenous Specific	No
Duration	April 2017 – June 2018 Milestones: • June – Dec 2016 – planning and consultation • Jan – Mar 2017 – procurement • April 2017 – services commence • June 2017 – June 2018 – monitoring and evaluation
Coverage	Priority areas have been identified through the PHN's needs assessment process. Responses to the EOI that propose to provide a service in the priority locations will be prioritised. Perth South – south east region: Armadale, Gosnells, Belmont Perth South – south west region: Kwinana, Rockingham, Fremantle, Cockburn, Mandurah, Murray, Waroona Priority will be given to avoiding duplication and filling current gaps, particularly in disadvantaged and hard to reach communities.
Commissioning method (if relevant)	Services will be commissioned in whole. The approach to market is being undertaken at the same time as other PHN activities (integrated mental health and alcohol and other drug treatment services for Aboriginal people and mainstream) to enhance opportunities for integration with those services.

	Further integration with other PHN activities, such as Comprehensive Primary Care will occur through the contract management approach. The PHN will work collaboratively with providers throughout the duration of the activity to facilitate adjustments as required to respond to the emerging needs of the target group.
Approach to market	The following procurement approaches will be used to commission LITC activities: • EOI • Direct engagement
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$700,000
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$700,000
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Nil

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. NP 1)	**NP 11 – Best practice in pharmacotherapy in General Practice**
Existing, Modified, or New Activity	New activity
Program Key Priority Area	Population Health
Needs Assessment Priority Area (e.g. 1, 2, 3)	**1. Keeping people well in the community** (p44) • **Strategies to keep people connected to primary health care** – Health Care Home stage one implementation –engaging with allied health providers. – Nurse or Aboriginal Health Worker led care coordination and health coaching models for patients with chronic disease. – Telehealth, telemedicine and other resources to complement face to face health programs and to support education and self-management. • **Strategies to enhance continuity of care** – Promotion of My Health Record and Electronic Transfer of Care. – Additional *HealthPathways*. – Embedding data management systems to identify service gaps. – Supporting GPs to maximise existing incentives to provide care for vulnerable populations. – Partnerships with WA Department of Health, East Metropolitan Health Service (EMHS), South Metropolitan Health Service (SMHS), hospitals, General Practitioners (GPs) and key community health organisations to manage care transitions. • **Strategies to improve self-management** – Self-management as a cornerstone of commissioning in chronic disease and mental health/AOD. – Supporting GPs to explore options to enhance self-management strategies. • **Focus on place-based strategies** – Communities and service providers are partners in developing services which address identified unmet needs in specific communities.

	2. People with multiple morbidities especially chronic co-occurring physical conditions and mental health conditions (p46) • **Strategies for integrated chronic care management** – In conjunction with Area Health Services, explore options for joint planning and service development across regions to support integrated responses to chronic disease. • **Strategies to develop integrated care pathways in partnership with WA Department of Health, Area Health Services, GPs and other clinicians** – Regionally and locally tailored *HealthPathways*. • **Strategic partnerships and service agreements to achieve targeted co-commissioning and integrated delivery plans** – Integration of planning and commissioning with East Metropolitan Health Service (EMHS), South Metropolitan Health Service (SMHS), WA Mental Health Commission and other government agencies and private health insurers. – Working collaboratively with other WA PHNs to maximise opportunities for integrated service development. **3. Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage** • **Strategies that are tailored to particular groups within a place-based context (p53)** – After-hours care for people with mental health and drug and alcohol problems via phone support lines/pharmacies. **4. System navigation and integration to help people get the right care at the right time in the right place** • **Strategies which incorporate service integration, consortia approaches, person-centred support and system navigation (p53)** – Increased inter-agency navigation to 'signpost' consumers and carers to right care, right time, right place. – Triage of clients to appropriate supports. – Effective referral pathways to care e.g. *HealthPathways.*

	– Improved system literacy to seek appropriate care in the right place. – Increase links between PHNs, health care providers and community services for continuity of care. • **Evidence-informed strategies for system integration (p50)** – Using small grants to test concepts. develop evidence for future service types or delivery. demonstrate program effectiveness. **5. Capable workforce tailored to these priorities** • **Develop strategies to increase the capacity of the multi-disciplinary team to understand and implement the concept of person-centred wrap-around care coordination (p51)** – CPC
Description of Activity	The PHN will work with the Pharmaceutical Society of Australia to scope, plan and implement a project to enhance the delivery of best practice pharmacotherapy in General Practice. This project aims to enhance capacity in General Practice to optimise pharmacotherapies for consumers with a range of conditions which may include chronic conditions and people requiring Opioid Substitution Therapy (OST). The first phase of activity will involve a rapid review of literature, and consultation and engagement with General Practice, pharmacists and consumers to identify and recommend best practice models. The second phase of activity will test best practice models in general practice in priority geographical areas as identified in the needs assessment. Options may include: • Services, general practitioners, pharmacists, other AOD services) to form partnerships to facilitate • Establishment of a professional support network for GPs providing expert advice and professional development opportunities • Providing GPs with access to specialised positions, such as pharmacists • Provision of ongoing support and wrap around support and mentoring to providers • Identifying expert GPs who can act as mentors to other GPs in the region • Develop localised integrated assessment and treatment referral pathways
Target population cohort	• Patients with chronic conditions who are taking a number of medications • Consumers who are using OST

	• GPs who work with these cohorts of consumers.
Consultation	As part of this project, consultation and engagement will be undertaken with GPs, consumers and pharmacists to identify examples of good practice and opportunities for improvement.
Collaboration	• Pharmaceutical Society of Australia – jointly develop the scope and undertake initial consultation. • GPs – input to opportunities for improvement and identifying examples of good practice.
Indigenous Specific	No
Duration	• Planning and consultation: March – June 2017. • Identifying options for implementation: July 2017. • Testing options: August 2017– June 2018.
Coverage	To be identified during scoping phase.
Commissioning method (if relevant)	The commissioning method will be identified during the scoping and planning phase.
Approach to market	The procurement approach will be determined during the planning phase. Options include EOI and direct engagement.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$125,000
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Not applicable.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. NP 1)	**NP 12 – Enablers for patient, service and system level integration**
Existing, Modified, or New Activity	New
Program Key Priority Area	Other: System Integration
Needs Assessment Priority Area (e.g. 1, 2, 3)	**1. Keeping people well in the community (p44/ p44).** • Strategies to keep people connected to primary health care – Telehealth, telemedicine and other resources to complement face to face health programs and to support education and self-management. • Strategies to enhance continuity of care – Additional *HealthPathways*. – Embedding data management systems to identify service gaps and GP business development opportunities. – Maximising GP use of care planning and other MBS items and incentive payments. – Supporting GPs to maximise existing incentives to provide care for vulnerable populations. • Strategies to improve self-management – Self-management as a cornerstone of commissioning in chronic disease and mental health/AOD. – Accessible self-management services for major chronic disease and mental health conditions. – Supporting GPs to explore options to enhance self-management strategies. • Focus on place-based strategies – Multiple data sources are used to identify places of high need. – Communities and service providers are partners in developing services which address identified unmet needs in specific communities. **2. People with multiple morbidities especially chronic co-occurring physical conditions and mental health conditions and drug and alcohol treatment needs. (p46/p46).** • Strategies for integrated chronic care management

	– In conjunction with Area Health Services, explore options for joint planning and service development across regions to support integrated responses to chronic disease. • Strategies to develop integrated care pathways in partnership with WA Department of Health, Area Health Services, GPs and other clinicians – Regionally and locally tailored *HealthPathways*. – Tailored practice support to enhance My Health Record take up, adoption of digital tracking programs and electronic discharge summaries. • Strategies to ensure chronic condition self-management principles are included in commissioning activities • Strategic partnerships and service agreements to achieve targeted co-commissioning and integrated delivery plans – Working collaboratively with other WA PHNs to maximise opportunities for integrated service development. **3. Services designed to meet the health needs of vulnerable and disadvantaged people, including those of Aboriginal heritage (p48/p48).** • Place-based planning and commissioning – Application of consistent methodology to determine the attributes of place that require change for better health outcomes. – Focusing on localities and populations within localities for targeted programs. – Investing in a range of programs in particular localities to achieve concerted change. • Mainstream transformation and cultural proficiency development – core and flexible funding. • Specialist In reach programs to practices with high- prevalence conditions referrals using e.g. cardiovascular, endocrinology and respiratory. • Strategies to improve access to primary health care **4. System navigation and integration to help people get the right services at the right time and in the right place (p48/p48).** • Strategies which incorporate service integration, consortia approaches, person-centred support and system navigation

	– Practice-based Mental Health Nurse, care management models that assist people with complex conditions to navigate the system. • Partnerships with GPs, WA Department of Health and Area Health Services to increase GPs' use of agreed referral pathways and processes, navigate the system and provide effective and timely management and referral – Promoting My Health Record. – Working with Area Health Services, Local Government Authorities and other local stakeholders to address coordination, integration and navigation in local communities. – Integrated Team Care specifically oriented to assisting Aboriginal people to navigate their way into and around the health system. • Digital solutions to improve system navigation and service integration - core and project funding – Promote My Health Record to provide service continuity. **5. Capable workforce tailored to these priorities (p49/p49).** • Strategies to increase the capacity of GPs to implement care management plans • Develop strategies to increase the capacity of the Multi-disciplinary team to understand and implement the concept of person-centred wrap-around care coordination – Primary Health Liaison practice support program. – Chronic disease management programs (including risk reduction).
Description of Activity	This activity provides enablers for service and patient level integration. These enablers facilitate integrated, holistic services to reduce the impact of chronic disease. The current health system provides healthcare in fragments which are often hard to access and coordinate. Primary health care is currently seen as part of the problem but is also part of the solution. ***HealthPathways* License** *HealthPathways* is an online system, designed to be used at the point of care. It provides GPs and primary health clinicians with additional clinical information to support their assessment, treatment and management of individual patient's medical conditions, including referral processes to local specialists and services. *HealthPathways* is central to the support that the PHN can provide to GPs and primary health clinicians. WAPHA administers *HealthPathways* in Western Australia (see activity OP 4). The PHNs'

	Primary Health Liaison Officers provide training and promote the use of *HealthPathways* (see activity OP 1). **Patient Opinion License** The PHN will be supporting use of Patient Opinion[1] to promote the vital role of consumer feedback in service improvement. Through a license agreement with Patient Opinion the PHN aims to encourage service and patient use of the site to inform continuous quality improvement of WAPHA funded services. The PHN is prioritising use of the site in areas where the local area health service has already adopted and is using the site. This approach seeks to assist in joining up the different areas of the health system, supporting a consistent approach to patient feedback across the whole patient journey. **My Community Directory License** My Community Directory is a directory of community services, accessibly online and available to download as a printable portable document format (pdf) which meets the identified needs of: • Community members: empowering people to stay well in their community and access local services where possible. • Service providers: the directory supports place-based collaboration and tools in the platform support the co-ordination and navigation of place-based care for consumersand the; • PHN: place-based health and service needs analysis (see activity OP 10) will be supported through the service mapping and search data generated from the directory. **Primary Health Exchange License** Primary Health Exchange is a website to support engagement with community and wider stakeholders in PHN activities (see activity OP 9 & 11). The PHN uses the site to: • Maintain open and transparent communication with communities around commissioning activities, including consultation to inform needs assessment and to outline anticipated timeframes; • As a central hub for information and as a key communication tool between PHN committees and service providers, with communities of practice continuing to be established to encourage learning and communication across providers and;

[1] Further information on Patient Opinion can be accessed at www.patientopinion.org.au

	• To monitor and evaluate levels, and the nature, of engagement from stakeholders and contribute to the evaluation of associated face to face engagement activities such as workshops and focus groups. **CAT Plus Suite Licences** The CAT Plus suite provides decision support to improve patient health outcomes at three levels of primary care: • the Patient (Topbar): for GPs and clinicians to support decision making at the point of engagement.; • the Practice (CAT4): for practice principles and managers for practice analysis. and; • the Population (PAT): for the PHN to aggregate general practice data for service planning, reporting and population health needs. This activity directly funds the licences for practices who have agreed to share data for population level analysis. The PHN supports practices to utilise the tools available under the licences (see OP 1 and OP 4. **Curtin University Contract** Curtin University collects, manages and analyses health data to support evidence-based decision making and the effective evaluation of performance. The PHN utilises the support of Curtin University.
Target population cohort	Primary Health Care patients who are at risk of poor health outcomes.
Consultation	The PHN has consulted widely with the sector to establish the most useful enablers for system, service and patient level integration e.g. WA Health, service providers, other PHNs, primary health care providers, GPs and Clinicians.
Collaboration	The PHN is collaborating with all the service providers above to provide the support to enable maximum utilisation of these patient, service and system integration tools. The PHN is also engaging with users to ensure that the tool and support provided is fit for purpose e.g. through CEC and CCC, engagement with General Practices, Area Health Services, Service Providers, Local Government Authorities and Health Consumer Council.

Indigenous Specific	No
Duration	Until June 2018.
Coverage	Perth South PHN.
Commissioning method (if relevant)	The enablers have been commissioned after consideration of the needs assessments, market research and consultation with key stakeholders.
Approach to market	Direct approach.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$536,087
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Not applicable.

2 (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 (e.g. OP 1)	**OP 1 – General practice support**
Existing, Modified, or New Activity	Modified activity (see p28)
Description of Activity	The PHN supports general practice by**:** • Designating a place based team which includes a Primary Health Liaison to support and work with general practice through an organised customer relations management process. This includes scheduled practice visits, provision of information and resources, telephone contacts and other support as requested by the practice; • Supporting general practices to adopt patient centred models of care with a focus on Comprehensive Primary Care, Mental Health Medical Home and the stepped care approach; • Assisting general practice with quality improvement, accreditation, My Health Record uptake and the adoption of clinical audit tools; • Targeting general practice support to those areas identified through the needs assessment process; • Providing access to *HealthPathways* and inviting participation in the localisation process and facilitating CPD events on the rollout of new protocols or changes documented within *HealthPathways*; • Linking Primary and Tertiary care through support of the network of Hospital Liaison General Practitioners (HLGPs); • Communicating through a range of channels about primary health care trends and initiatives, development opportunities, resources and data at the local, state and national level; • Co-ordinating networks and collaboration with practice staff. In addition, the PHN will continue to build on, and further enhance, the support it provides to general practice. As part of this process, we will be exploring the development, and introduction, of a support approach which may include a telephone service/helpdesk function. This approach will enable the PHN to better cater to the varying level of needs, and engagement, of general practice.

Supporting the primary health care sector	This activity will support the primary health care sector by building capability and capacity with a GP support model designed to enhance patient centred models of care. The PHN facilitates optimal access to integrated and comprehensive primary health care for people with chronic and complex conditions through the development of strong connections across community, health and social service settings at the local level.
Collaboration	The PHN team works in partnership with a range of stakeholder's dependent upon local needs: • Local Area Health Services. • WA Health. • WAGPET. • Aboriginal Medical Services. • general practitioners. • government agencies. • universities. • peak bodies. • community. • health and social care sector organisations.
Duration	Activity start date: July 2016. Key milestones: • Implementation of a tiered model of support. • CPD events. Completion date: June 2018.
Coverage	Throughout Perth South PHN region.
Expected Outcome	The expected outcome of this activity is to improve the quality of patient care in partnership with clinical and non-clinical colleagues and with input from patients, including the capacity to manage and coordinate the care of the patient cohort. Indicators include: • Increased number of patient follow ups. • Number of practices engaged with CPC or HCH. • Attendance at CPD events.

Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$5,363
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$5,460
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Not applicable.

Proposed general practice support activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. OP 1)	**OP 3 – General practice support - continuous quality improvement**
Existing, Modified, or New Activity	Modified activity (see p31)
Description of Activity	The PHN provides support to general practice in continuous quality improvement by: • Providing information resources covering the use and management of data to enable practice improvement. • Supporting practices who have received licences for the Cat Plus suite of tools (funded through activity NP 12) to enable data extraction, interrogation and analysis including providing practices with individualised reports on their practice, identifying areas for improvement. • Promoting and providing support to general practice to participate in accreditation and clinical audits. • Developing and implementing activities that target priority areas as identified in the Health Needs Assessment.
Supporting the primary health care sector	This activity will support the primary health care sector by building capability and capacity within general practice and by providing tools and training to optimise GP practice workflows.
Collaboration	The PHN team works in partnership with a range of stakeholders. • NPS Medicinewise- WAPHA provides support to enable access to GP practices to roll out this program. • Pen CS – in the provision of additional training and support to the PHN Practice Support team and General Practices to maximise the utilisation of the WAPHA provided licences for the Cat Plus suite of tools (funded through activity NP 12). • Curtin University - partnership to manage and govern datasets extracted through Cat Plus suite of tools (funded through activity NP 12).
Duration	Activity start date: July 2016. Key milestones: • July 2017 -Practices who have signed MOUs to install Pen CS will be operational. • Minimum of 12 practices per year recruited for Medicinewise program. Completion date: June 2018.
Coverage	Throughout Perth South PHN region.

Expected Outcome	The expected outcome of this activity is improvement in the efficiency and capacity within the general practice: • Number of practices participating in Quality Improvement activities. • Number of practices submitting de-identified clinical data. • Number of practices utilising their data to inform their practice.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$39,416
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Included in Operational Salaries.

Proposed general practice support activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. OP 1)	**OP 4 – General practice support – *HealthPathways***
Existing, Modified, or New Activity	Modified activity (see p32)
Description of Activity	The *HealthPathways* team works across the 3 WA Primary Health Networks to: • Identify priorities for pathway development using the needs assessment, GP feedback and health services recommendations. • Identify subject matter experts and working group members. • Facilitate working groups to identify current practice, gaps, issues and opportunities. • Localise pathways and/or develop new pathways. • Facilitate continuous professional development sessions focussing on pathway content as they are published. • Identify opportunities for system improvements and/or redesign.
Supporting the primary health care sector	This activity will support the primary health care sector by providing an online health information portal for general practitioners and primary health care clinicians, to assist with management and appropriate referral of patients when specialist input is required.
Collaboration	The PHN team works in partnership with a range of stakeholders: • WA Department of Health -partnership agreement to enable endorsement of process. • Hospital specialists- Expert opinion. • General practitioners- Expert opinion. • Nurses- Subject matter expertise. • Allied health clinicians – Subject matter expertise. • Other health professionals or peak bodies - Subject matter experts and review of pathway content.
Duration	Activity start date: July 2016. Key milestones: • October 2015 – WA *HealthPathways* launched. • July 2017 - 300 localised pathways. • July 2017 – 4 working groups held. • December 2017 – 8 CPD events held. Completion date: June 2018.

Coverage	Throughout Perth South PHN region.
Expected Outcome	GPs and primary health professionals use the system and are supported in their assessment, treatment and management of individual patient's medical conditions, including referral process to local specialist and services. Indicators include: • Annual increase in the number of page views. • Consistency of uptake through continual appearance of new users (sustainable product promotion). • Annual increase in the number of returning users – usefulness of actual service. • More positive experiences then negative. • Increased digital literacy of health practitioners.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$130,122
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Included in Operational Salaries.

Proposed general practice support activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. OP 1)	**OP 5 – General practice support - improve cancer screening rates**
Existing, Modified, or New Activity	Modified activity (see p33)
Description of Activity	• Identifying practices which could improve their rates of cancer screening and providing advice and tools to increase screening rates. • Building capacity of general practice to use data extraction tools to identify and support at risk groups. • Including cancer screening pathways within *HealthPathways* WA. • Promoting national awareness campaigns to General Practice through the various communication channels utilised by WAPHA.
Supporting the primary health care sector	This activity will support the primary health care sector by supporting general practice to build their capacity to identify patients who should be screened for cervical, breast and bowel cancer.
Collaboration	The PHN team works in partnership with a range of stakeholders. • Cancer Council WA – Promotion of awareness campaigns. • Breast Screen WA – Promotion of campaigns. • National Bowel Cancer Screening Program – promotion of initiatives. • Royal Australian College of General Practitioners (RACGP)- promotion of initiatives. • WA Health- promotion of initiatives and campaigns. • Local area health services- Collaborate to provide GP education sessions.
Duration	Activity start date: July 2016. Key milestones: • July 2016 – June 2018 – Engagement with peak bodies. • Publish *HealthPathways* on cancer screening. • Jan 2017 – June 2018 – Targeted contact with practices identified as having low screening rates. Completion date: June 2018.
Coverage	Throughout Perth South PHN region.
Expected Outcome	The expected outcome of this activity is to increase screening rates for breast, cervical and bowel cancer and subsequently improve population health.

	• Increasing cancer screening rates in practices which are below the benchmark. • Number of practices utilising data extraction tools to identify and recall at risk groups.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Included in Operational Salaries.

Proposed general practice support activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. OP 1)	**OP 6 – General practice support - improve immunisation rates**
Existing, Modified, or New Activity	Modified activity (see p34)
Description of Activity	The aim of the activity is to improve immunisation coverage and rates for children and adolescents, adults, including pregnant women and Aboriginal people. The PHN supports general practice to build their capacity to identify patients who should be immunised by: • Assisting general practice to use data extraction tools to identify at risk groups. • Focussed communication and regular follow up with practices with overdue children and immunisation rates below target. • Providing advice and training to Practice Nurses around the Australian Immunisation Register. • Promoting awareness of the immunisation recommendations available via the *HealthPathways* website. • Identifying areas falling below rates required for herd immunity and providing support and education to increase rates in these areas. • Communicating immunisation updates and strategies to general practice via the various communication channels in WAPHA.
Supporting the primary health care sector	This activity will support the primary health care sector to build their capacity to identify patients who should be immunised.
Collaboration	The PHN team works in partnership with a range of stakeholders • Communicable Disease Control Directorate (CDCD) to implement the WA Immunisation Strategy 2016 – 2020. CDCD's role is to lead the strategy and the PHN team will support the implementation of the strategy to general practice. • Local Area Health Services to provide support around local initiatives.
Duration	Activity start date: July 2016. Key milestones: • July 2016 - June 2018 Engagement with WA Health and local Area Health Services. • September - October 2016 – Practice Manager Networking Sessions on immunisation

	• November – December 2016 – training Primary Health Liaison staff on Adult Immunisation Register. • November 2016 – June 2018 – targeted contact with practices below immunisation targets. Completion date: June 2018.
Coverage	Throughout Perth South PHN region.
Expected Outcome	The expected outcomes of this activity are to increase immunisation completion rates and subsequently improve population health: • Improvement towards the national standard for childhood and adolescent immunisation rates. • Improved timeliness of immunisation for Aboriginal children. • Decreased hospitalisations for influenza like illness and other vaccine preventable hospitalisations.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Included in Operational Salaries.

Proposed general practice support activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. OP 1)	**OP 7 – General practice support - digital health**
Existing, Modified, or New Activity	Modified activity (see p35)
Description of Activity	The PHN will support general practice by: • Supporting general practices to utilise the tools provided by WAPHA (see activity NP 12). • Assisting general practices to register and actively participate in My Health Record. This will be supported by working with pharmacy and allied health professionals to also access and share data through the My Health Record system. • Providing support and training to GPs to use secure messaging systems.
Supporting the primary health care sector	This activity will support the primary health care sector to improve care coordination and integration, secure messaging and data management to enable general practice to increase efficiency and effectiveness.
Collaboration	The PHN team works in partnership with a range of stakeholders: • Commonwealth Department of Health- policy advice and information provision. • WA Health – Collaboration and coordination of My Health Record Primary Care initiatives to support WA Health activities and the geographical roll out of MYHR within hospitals. • WAGPET – collaboration and strategy planning. • RACGP - collaboration. • Australian Digital Health Agency – Strategy direction and collaboration. Provision of information. • Pharmacies- collaboration to enact strategy for My Health Record uptake. • Allied health professional peak bodies- collaboration to enact strategy for My Health Record uptake. • GPs – provide support and assistance around My Health Record and other relevant digital health initiatives.
July 2016 – June 2017.	Activity start date: July 2016. Key milestones: • April 2016 to October 2016 – My Health Record opt in trial site. • July 2017 – Practices signed up for PenCAT will be actively sharing data. • March 2017 – Activity commences with pharmacies and allied health professionals to support usage and upload to My Health Record.

	• December 2017 – Pharmacies are engaged and actively uploading to My Health Record. Completion date: June 2018.
Coverage	Throughout Perth South PHN region.
Expected Outcome	Building capacity in the practice and increasing care coordination with a seamless flow of clinical information between health care providers. The expected outcome of this activity will be an increase the: • Number of practices with Pen licenses that are utilising the software to analyse their practice data. • Number of practices registering for, and using, My Health Record. • Number of practices assisting patients to register to use My Health Record. • Increasing the number of types of health professions utilising and promoting My Health Record.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Included in Operational Salaries.

Proposed general practice support activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. OP 1)	**OP 8 – Strategic Direction**
Existing, Modified, or New Activity	Existing activity (see p36)
Description of Activity	WAPHA works with the PHN to create and develop the strategic framework which will facilitate the achievement of improved health care outcomes for the Western Australian community by: • Supporting the PHN to develop, align and operationalise WA population primary health priorities with Commonwealth primary health care policy direction utilising a systems approach and outcome based commissioning. • Advocating on behalf of primary care through submissions to government reviews and inquiries and driving WAPHA's policy stance through the corporate communications strategy and engaging with key stakeholder groups. • Working closely with PHN staff and external partners to develop a common vision for primary health care across the sector. • Providing guidance and advice to WAPHA, the Board and PHN in respect to relevant primary health care reform, reviews, inquiries and discussion papers. • Leading in the development of innovative, best practice models of primary health care service delivery and funding models.
Supporting the primary health care sector	This activity supports the primary health care sector by ensuring a consistent approach across the WA PHNs, while establishing frameworks within which a locally tailored place-based approach can be implemented in partnership with others. These partnerships are developed within a collective impact context and are guided by WAPHA's Stakeholder Engagement Framework and Toolkit.
Collaboration	Within this activity, WAPHA and the PHN work collaboratively with Commonwealth and State Government agencies, key primary health stakeholders, peak bodies and NGOs. These include, but are not limited to: • Commonwealth Department of Health and associated branches. • WA Area Health Services. • Mental Health Commission. • RACGP. • WA Association for Mental Health (WAAMH). • Australian Medical Association (AMA). • WA Network of Alcohol and Other Drug Agencies (WANADA).

	• Aboriginal Health Council of WA (AHCWA). • WAGPET • Health Consumers Council
Duration	July 2016 – June 2018.
Coverage	Perth South PHN.
Expected Outcome	The expected outcome of this activity is that a strategic framework is developed which facilitates the achievement of improved health care outcomes for the Western Australian community, to ensure efficient and effective medical services for patients, particularly those at risk of poor health outcomes and improving the coordination of care to ensure patients receive the right care, in the right place at the right time.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Included in Operational Salaries.

Proposed general practice support activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. OP 1)	**OP 9 – Commissioning**
Existing, Modified, or New Activity	Existing activity (see p37)
Description of Activity	The PHN continues to work with key stakeholders from the primary health and social care sectors to develop responses to the Needs Assessment. This activity is being localised wherever possible to ensure that commissioned services meet the local identified population health needs and encourage the coordination and capacity building of local services to meet the needs of their community. Where appropriate, whole of PHN or multi PHN solutions are being commissioned to meet identified broader needs. The PHN's commissioning activity has three main aims: • Integration - Simplify access and navigation - Coordinate across the continuum of care - Bring together health and social care stakeholder • Reducing the burden - Increase the use of early and low intensity interventions - Stepped care approaches • Bridge the gaps - Increase access for vulnerable, underserviced and hard to reach groups As commissioners, the PHN aims to use our role to encourage local stakeholders to design and deliver services with the needs of their local population in mind. The PHN will provide the framework that encourages this approach through our planning, procurement and evaluation cycles.
Supporting the primary health care sector	This activity will open up the commissioning process to local influence and decision making to ensure that responsive solutions are achieved in line with identified needs.
Collaboration	Within this activity, WAPHA and the PHN work collaboratively with key stakeholders including but not limited to service providers, Commonwealth Department of Health, WA Health, Aboriginal health organisations, WA MHC, WANADA, GP Professional bodies and colleges, patients, consumers, their families and carers.

Duration	July 2016 – June 2018.
Coverage	Throughout the whole Perth South PHN region.
Expected Outcome	The expected outcome of this activity is that the PHN will commission high quality, cost effective services that are sustainable, meet the identified population health needs, meet PHN objectives and lead to the best possible health care outcomes for Western Australians.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Included in Operational Salaries.

Proposed general practice support activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. OP 1)	**OP 10 – Population health planning**
Existing, Modified, or New Activity	Modified activity (see p38)
Description of Activity	The PHN undertakes population health planning on an ongoing basis to ensure that the current and future health and service needs of the PHN region are addressed and gaps are identified. Inequitable access to appropriate health care by disadvantaged and vulnerable groups is a key focus. WAPHA's internal analysts, in conjunction with our academic partner, Curtin University (supported by activity NP 12), undertakes analysis to identify health needs and service gaps by assessing and analysing a broad range of qualitative and quantitative data that we have either collected ourselves, have had provided to us by external partners, or which is publicly available. This analysis is used to identify the health and service priorities of the local population. Our analytical team (internal analysts with research partners at Curtin University) will continue to build and review our evidence base on an ongoing basis to: • Continue population health planning based on an in-depth understanding of local health needs. • Identify gaps and barriers in primary health care service delivery, particularly to those most vulnerable groups. • Undertake/develop issue-specific population health planning e.g. mental health, drug and alcohol treatment etc.. • Elucidate population health trends when recent historical data is available. • Identify market factors and drivers around the provision of health and service needs where possible. • Identify and prioritise needs. • Undertake evaluations of the outcomes of commissioned services and use these evaluations to feed back into the commissioning cycle, on an ongoing basis. • Identify evidence-based opportunities for activity. • Educate and support providers to collect and analyse their own data. • Complete future Needs Assessments.

Supporting the primary health care sector	This activity will support the primary health care sector by enabling the targeted allocation of limited resources to those most in need, or where the most difference can be made.
Collaboration	This activity is a collaborative partnership between WAPHA and Curtin University's Health Systems and Health Economics Group, School of Public Health with the PHN's CCCs and CECs playing a pivotal role in ongoing planning. The PHN also works in collaboration with the Area Health Services and the Aboriginal Health Improvement Unit and undertakes broader consultation with service providers, communities, consumers, health professionals, funders etc. WAPHA has a data sharing relationship with the WA Department of Health where we help fund the acquisition of data and they provide us with local hospital data and analytical expertise with the shared aim of meeting health needs within the primary sector, resulting in fewer preventable hospitalisations.
Duration	July 2016 – June 2018.
Coverage	Throughout Perth South PHN region.
Expected Outcome	The expected outcome of this activity is that the PHN undertakes population health planning on an ongoing basis to ensure that health and service needs of the PHN region are addressed. The population health planning is used to inform the Needs Assessment and that the identified priorities and proposed options align to the PHN objectives.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$119,878
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0

Funding from other sources	Included in Operational Salaries.

Proposed general practice support activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. OP 1)	**OP 11 – Stakeholder engagement**
Existing, Modified, or New Activity	Existing activity (see p42)
Description of Activity	WAPHA, as the backbone organisation, supports the PHN by taking a shared approach to stakeholder mapping and engagement. WAPHA-led activities include the: • Establishment of WAPHA's Stakeholder Engagement Working Group which provides a coordinated and consistent approach to engagement across all three PHNs. • Implementation of a centralised customer relationship management system. • Implementation of, and training in, International Association of Public Participation (IAP2) programs. The engagement principles of IAP2 underpin all stakeholder engagement activity. • Implementation of Bang the Table - an online tool which is one method of engagement with stakeholders. The PHN's stakeholder engagement and management involves: • Identifying and engaging key stakeholders identified in the Needs Assessment and population health planning. • Building strong and effective alliances with WA Health and other key stakeholders to understand health issues specific to certain groups, improve primary care at the local level, improve care pathways and embed a patient centred and systems approach into primary care services, and develop acute care collaborations. • Establishing and managing PHN Council, Clinical Commissioning Committees and Community Engagement Committees. • Working with service providers to ensure contract deliverables are met and to build the capacity of the sector in outcomes based commissioning. • Supporting peak health bodies and academic institutions to conduct research and development. • Building capability for integrated care in local communities by facilitating stakeholder forums to identify priorities and develop foundations for long term sustainable change. • Engaging meaningfully with disadvantaged and vulnerable groups to improve equitable service delivery in local communities and build cultural proficiency in services.
Supporting the primary health care sector	This activity supports the primary health care sector by:

	• Establishing and supporting accessible mechanisms to enable interaction and engagement across the sector amongst stakeholders. This includes the facility to support communities of practice, responsive consultations and providing feedback on activities to stakeholders. • Providing qualitative input to the PHN's Needs Assessment for consideration alongside quantitative data.
Collaboration	The PHN works meaningfully with all stakeholders.
Duration	Ongoing – July 2016 – June 2018.
Coverage	Throughout Perth South PHN region.
Expected Outcome	The expected outcome of this activity is that the PHN will establish trusted and purposeful relationships and will work in collaboration with stakeholders, clinicians and community representatives to co-design and deliver the best possible health care outcomes for Western Australians, in line with the PHN objectives.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Included in Operational Salaries.

Proposed general practice support activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. OP 1)	**OP 12 – Communication and Marketing**
Existing, Modified, or New Activity	Existing activity (see p30)
Description of Activity	WAPHA supports the PHN to effectively communicate and market its activities through the delivery of a communications strategy. Our communication activity is aimed at stakeholder engagement including, but not limited to, all levels of government, GPs and allied health professionals, peak bodies and community. Key Activities include: **Strategic communications** The Communications unit develops communication plans for specific commissioning activities to ensure community and stakeholders are aware of new initiatives and opportunities. It also supports the PHN with keeping the Commonwealth Department of Health informed of PHN achievements and activities. **Website** The WAPHA website is the place where all information, update and news relating to the PHN is displayed. The communication unit is responsible for ensuring the website is updated regularly with latest news and events to keep community and stakeholders informed. **Newsletters** • WAPHA Connect, a monthly e-newsletter which promotes the activities of WAPHA and the PHN. • GP Connect, a monthly newsletter (hard copy and e-newsletter) which provides information, updates and events to GPs and their practice staff. • Practice Connect, a fortnightly e-newsletter which provides information, updates and events for practice managers. **Social Media** The communications unit is responsible for the management of promoting the PHN's activity through its social media channels – Facebook, Twitter and LinkedIn. Social media is used to engage our stakeholders and community through news stories and videos.

	Media Relations The communications unit provides media relations support through writing and publishing media releases and responding to media enquiries relating to PHN activity. It also develops specific communication and marketing plans to support commissioning activities and promote PHN initiatives. It also provides media advice and media monitoring for the PHN. **Promotion and marketing** The communications unit work with the PHN to promote its activity through newsletters and specific marketing campaigns including newspaper advertising, promotional flyers and brochures, annual report and sponsorship. The communications unit ensures that PHN branding is applied correctly both internally and externally. **Events** The Communications unit works with the PHN in the delivery of events to promote activity to stakeholders and raise awareness of its brand. **Internal communications** The communications unit is responsible for internal communications through a weekly newsletter and video, which keeps staff informed. It is also responsible for the staff intranet which is a platform where resources are housed and a place where staff can interact and communicate across the organisation.
Supporting the primary health care sector	This activity supports the primary health care sector by ensuring stakeholders in primary care, social care and the broader health sector are aware of key initiatives which WAPHA and the PHNs are leading and or contributing to.
Collaboration	WAPHA and the PHN work in collaboration with WA Health and associated Area Health Services, Curtin University, Mental Health Commission, key stakeholders and service providers.
Duration	Ongoing – July 2016 – June 2018.
Coverage	Throughout Perth South PHN region.
Expected Outcome	Our stakeholders know, trust and understand the worth of the PHN and their ability to increase the efficiency and effectiveness of primary health 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.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$118,556
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$120,690
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Not applicable.

3. (a) Strategic Vision for After Hours Funding

- Increasing the efficiency and effectiveness of After Hours Primary Health Care for patients, particularly those with limited access to Health Services.
- Improving access to After Hours Primary Health Care through effective planning, coordination and support for population based After Hours Primary Health Care.

In 2016-17 and onwards, your organisation is required to:

- Implement innovative and locally-tailored solutions for after-hours services, based on community need.
- Work to address gaps in after-hours service provision**.**

Please note, although PHNs can plan for activities in the 2017-18 financial year, at this stage, current funding for PHNs After Hours is confirmed until 30 June 2017 only. PHNs must not commit to spend any part of the funding beyond 30 June 2017.

Due to the revision of the PHN Performance Framework, performance information relating to the After Hours Schedule for this update to the 2016-18 Activity Work Plan deliverable is not required. Further information will be provided separately.

3. (b) Planned PHN Activities – After Hours Primary Health Care 2016-17

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. NP 1)	**AH 1 – After Hours - Metro South**
Existing, Modified, or New Activity	Modified activity (see p42)
Needs Assessment Priority Area (e.g. 1, 2, 3)	*Provide the number, title and page reference for the priority as identified in Section 4 of your Needs Assessment that this activity is addressing. If this activity is a 'possible option' in Section 4 of the Needs Assessment, provide details.* 1. **Keeping people well in the community** (p44) • Strategies to keep people connected to primary health care - Use of urgent after-hours access to primary health care and enhanced scope of existing after hours' services.
Description of Activity	The after-hours activity will pilot and evaluate a range of enhancements to the way urgent after-hours healthcare is delivered and funded in the after-hours period with the purpose of increasing efficiency and effectiveness of medical services and improving coordination of care and improving system integration and navigation. The after-hours activity will focus on services that integrate with and enhance other key activities of system reform that the PHN commissions or co-commissions including but not limited to: • The Comprehensive Primary Care program. • Local Integrated Team Care. • Innovation and evidence. In addition to integrating after-hours activity with other PHN activities, the PHN will implement several targeted activities: • Improving access to after-hours care for vulnerable people

	- 50 Homes for 50 Lives – the PHN has funded increased after-hours access to this project which collaboratively addresses the ongoing challenges of housing and supporting homeless people with complex needs who are sleeping rough in the inner-city Perth area. • Increasing consumer awareness of after-hours options and their use - This Activity aims to raise consumer awareness of the services available after hours so they can make informed decisions and navigate the system better to access and receive the right care at the right place and time. - WAPHA is working with WA Health to develop an intensive awareness campaign to better educate consumers on which after-hours services are available and when and how to access them. The awareness campaign will be integrated with the promotion of existing services such as National Health Services Directory (NHSD) and Health Direct, to facilitate consumer and provider education, awareness of services and appropriate use and access. The campaign may include adverts on GP TVs and brochures in waiting rooms as well as other channels.
Target population cohort	People at risk of poor health outcomes who need after-hours medical services.
Consultation	The PHN consulted with the CCC and CEC. Discussions are also on-going with local Health Services.
Collaboration	Consumer awareness campaign – the PHN and WA Health are jointly developing and funding this activity After-hour services for vulnerable people – the PHN is working with service providers to deliver this activity.
Indigenous Specific	No
Duration	After-hour services for vulnerable people: July 2016 – June 2017. Consumer awareness campaign: April – June 2017.
Coverage	Consumer awareness campaign – whole PHN region. After-hour services for vulnerable people: Perth LGA.
Commissioning method (if relevant)	Consumer awareness campaign – service will be commissioned in collaboration with WA Health. After-hour services for vulnerable people: Perth LGA.

Approach to market	Direct engagement.
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$1,488,848
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Not applicable.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (e.g. NP 1)	**AH 2 After Hours centre continuity of care**
Existing, Modified, or New Activity	Existing activity (p47)
Needs Assessment Priority Area (e.g. 1, 2, 3)	**1. Keeping people well in the community (p44)** • Strategies to keep people connected to primary health care - Use of urgent after-hours access to primary health care and enhanced scope of existing after-hours services to include Nurse Practitioners, Mental Health Nurses or Aboriginal Health Workers.
Description of Activity	**Aim of activity** Provide continuity of after-hours services to people at risk of poor outcomes. **How the activity will address the priority** In line with the service continuity measures in 2015-2016, the PHN has provided funding to several after-hours clinics that were previously funded under the Medicare Local arrangements. The PHN evaluated clinics to identify clinics that were ineligible or where there was obvious duplication of service provision. This activity has been extended beyond the current term to allow for additional evaluation and transition of plans to assure best outcomes for the community and procedural transparency. It should be noted that AH funding will NOT be used to cover any GP services for which they are eligible to receive an after-hours practice incentive payment (regardless of whether the practice is claiming the payment or not). Both after-hours clinics accept walk-ins (no appointments required), however the clinics offer patients the opportunity to access the online health directory and appointment booking service Health Engine with patients seen in order of arrival. Urgent cases take priority. PHN funding for these services will end in June 2017.
Target population cohort	Persons whose health condition are urgent and/or semi-urgent and cannot wait for treatment until regular GP medical services are next available.

Consultation	The PHN is in consultation with the provider of these services to support them to identify sustainable alternative options.
Collaboration	The after-hours clinics work closely with other GPs in the region, and the local tertiary hospital.
Indigenous Specific	No.
Duration	1 July 2016 to 30 June 2017.
Coverage	Perth South East (Belmont and Armadale LGAs).
Commissioning method (if relevant)	These services were continued as part of a service continuity approach.
Approach to market	Direct engagement
Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding	$70,000
Planned Expenditure **2016-17** (GST Exc) – Funding from other sources	$0
Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding	$0
Planned Expenditure **2017-18** (GST Exc) – Funding from other sources	$0
Funding from other sources	Not applicable.