Activity Work Plan 2018-2019:

Core Funding

General Practice Support Funding

After Hours Funding

PERTH NORTH PHN

The Activity Work Plan has the following parts:

1. **Core Operational and Flexible Funding**
2. **General Practice Support Funding**[1]
3. **After Hours Primary Health Care Funding**

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

Overview

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

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

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

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

1.   (a) Strategic Vision for PHN

WA Primary Health Alliance (WAPHA) operates the three PHNs in Western Australia: Country WA PHN, Perth North PHN and Perth South PHN. WAPHA's strategic vision can be viewed at http://www.wapha.org.au/wp-content/uploads/2018/04/39027-WAPHA-Strategy-Booklet_WEB.pdf.

2. (b) Planned PHN activities

– Core Flexible Funding Stream 2018-19

Proposed Activities	
Activity Title / Reference	**CF 1: Managing Chronic Conditions**
Existing, Modified, or New Activity	Modified - incorporates activities NP2 (Chronic Disease Management), NP3 (Community-based Integrated Pain Management) and NP 9 (Local Integrated Team Care, LITC) from Updated Activity Work Plan (AWP) 2016-2018.
Program Key Priority Area	Population Health

Needs Assessment Priority Area	WAPHA's strategic priorities are:
	
	• **Health equity and access**: identifying barriers to access by applying an evidence-based monitoring and evaluation approach to prioritise the commissioning of services in the areas of greatest need.
	• **Person centred models of care**: addressing the priority health gaps and inequities identified by developing contextualised, person centred models of care.
	• **Integrated and outcomes focused commissioning**: commissioning services with a focus on quality and value based outcomes within the following domains:
	   o Person: improving patient's experience of their care.
	   o Clinical: reducing burden of disease for individual patients and the prevalence of disease across our community.
	   o System: getting better at working together.
	   o Provider: improving the experience of organisations and staff providing healthcare services.
	• **Strong partnerships**: building sustainable relationships with clinicians, communities, providers and other stakeholders to improve coordination across the patient journey.

	• **Primary care capability**: uplifting the capacity and capability in the primary care environment to support the development of a skilled and sustainable workforce. The following priorities from the Needs Assessment Report 2017[2] apply: Priority 1 (P1): Orient Primary Health care towards people experiencing high socio-economic disadvantage especially in regions where there are lower levels of primary care providers p36 P2: Orient primary health care towards vulnerable people supporting primary health care providers to adopt appropriate approaches for targeted groups p37 P3: Primary care providers work with Aboriginal people and groups to plan and design strategies that address localised priorities p37 P4: Improve transitions between services by supporting effective care pathways, care coordination and service linkages p38 P5: Orient primary health care to ensure that risk factors for poor health outcomes are addressed or modified as early as possible p47 P6: Support local communities to be connected to primary care in and out of hours p39 P7: Build the capacity for patient self-management particularly for patients with co-occurring and multiple morbidities through the support of appropriate primary care providers p40 P8: Build community awareness of when and where to seek non-urgent health care p41 P9: Reduce rates of potentially preventable hospitalisations (PPHs) by working with primary care providers to target specific areas where there are higher than average rates p42 P10: Promote the effectiveness of digital health technologies to optimise patient care p42 P11: Invest in services that have demonstrated health outcomes by commissioning to a validated Outcomes Framework in order to demonstrate services are efficient and effective p43

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[2] The Perth North PHN 2017 Needs Assessment Report can be viewed at http://www.wapha.org.au/wp-content/uploads/2018/02/180228_PHN_NeedsAssessment_Core_PerthNorth_v2_ForPublication.pdf

Aim of Activity	The aim of this activity is to fund services for people with chronic conditions including respiratory and circulatory conditions, diabetes and chronic pain where need has been demonstrated and with the support of core operational health systems improvement funding (activity HSI1: System Integration), to determine the degree to which these services and are making an impact on the health needs of the populations they service and to ensure they are meeting their contractual obligations.
	
	In 2017-2018, with the support of core operational funding, Perth North PHN was engaged in:
	
	• Designing and contracting metro wide and regional place-based services to address the needs of people with chronic conditions including those with circulatory, diabetes and respiratory conditions as outlined in the Needs Assessment Report 2016.
	• Shaping the structure of supply to:
	    o increase access for people with chronic conditions
	    o support self-management
	    o sustain engagement with General Practitioners (GPs) and other primary health care professionals
	    o develop the capacity of the workforce.

Description of Activity	**In 2018-19 funding for the following services will be continued from 2017-2018**: • PHN wide: Respiratory Care Coordination. The service provides community based coordination for patients with advanced respiratory disease - specifically those who require domiciliary oxygen. • PHN wide: Improving Access to Primary Health (IAPH) to vulnerable people. A service that takes healthcare into the homes of some of Perth's more vulnerable people, whether that be a house, hostel or community residential facility. Nurse practitioners work collaboratively with community service providers to identify and build trusted relationships with clients with chronic conditions to develop a holistic plan for ongoing management. • PHN wide: Workforce Capacity Building to build the capacity and capability of primary health care providers to respond to the health care needs of people with comorbid chronic health conditions and problematic drug and alcohol usage". • In each of the North East and North West Regions: a Persistent Pain Program and one off funding for related Data Collection and licenses: The service aims to assist pain sufferers improve their

	self-management of their condition and to enable primary carers to provide improved chronic pain management.
	
	In 2018-2019 the following service will be funded:
	
	• North West Region: Integrated Chronic Disease Care Service providing better service coordination and self-management for people with chronic conditions through care coordinators and multidisciplinary teams**.**
	
	In 2018-2019 funding for the following services will be commenced:
	
	• Integrated Chronic Disease Care (ICDC) Services to better integrate primary health services for people who are most in need of those services including developing linkages with mental health and AOD services. Integrated Chronic Disease Care Services are regionally tailored and can consist of:
	    o multidisciplinary teams providing clinical and self-management support for vulnerable and disadvantaged persons with chronic diseases with priority given to people with cardiology, diabetes and respiratory conditions.
	    o Care coordinators/Primary Health Nurse Practitioners to ensure that patients are followed-up, receive the best wrap around care and are linked successfully with general practice or appropriate health professionals.
	    o The provision of culturally appropriate support and information to enable patients to work towards self-management of their condition.
	    o The use of evidence based self-management apps and other digital health technology in a patient's care plan to monitor their health and wellbeing. The Model will also include group based self-management interventions.

Target population cohort	Financially disadvantaged and vulnerable people, including those in more geographically isolated, peri-urban areas and those unable or unwilling to access mainstream primary health services who live in the Perth North PHN.
Consultation - HSI Component	In monitoring and evaluating the effectiveness of services WAPHA will consult with a range of state-wide and regional peak bodies and advisory groups, as well as service providers and community members.

Collaboration - HSI Component	Perth North PHN will works closely with WA Health, including the Health Service Providers (HSP) as co-commissioning body in managing performance where appropriate. WAPHA is currently working with commissioned providers, General Practice and consumer and carer groups to develop and strengthen strategic partnerships, co-commission where appropriate with the state health services and better utilise existing funding where possible. The aim is to secure effective and sustainable local and virtual primary health service provision, supporting GPs and the consumer with care closer to home.
HSI Component – Other	The activities outlined in **Core Operational HSI 1** support this activity by: • continuing to monitor emerging trends in health needs and service needs and develop a quality assurance (QA) process which will be applied to contracted services. • applying an increased focus on managing performance of contracted providers.
Indigenous Specific	No.
Duration	• July 2018: Annual Report for 2017/2018. • July 2018: Development of a relevant data set. • October 2018: Implementation of Model Outcome Maps which include a suite of required and optional indicators across the four outcome domains. • January 2019: Six Month Review – analysis of Outcome Maps and implementation of data set. • July 2019: Annual Report 2018/2019 – analysis of data set and Outcome Maps.
Coverage	Perth North PHN
Commissioning method (if known)	As the PHNs are largely operating within the monitoring and evaluation component of the commissioning framework with a low level of uncommitted funds, there will be limited opportunity for the commissioning of new services. As funds are identified, and should the service evaluations highlight a need for recommissioning or should one of the providers be unable to continue to deliver the commissioned services, consideration will be given to the appropriate procurement method.
Decommissioning	As the PHNs are operating within the monitoring and evaluation component of the commissioning framework within this activity, it is not planned to decommission services.

Planned Total Expenditure 2018-19 (GST Excl.) – Commonwealth funding	$2,566,767
Planned Flexible Expenditure 2018-19 (GST Excl.) - Commonwealth funding.	$2,566,767
Planned Health System Improvement Expenditure 2018-19 (GST Excl.) – Commonwealth funding	$0
Planned Expenditure 2018-19 GST Excl.) – Funding from other sources	$0
Funding from other sources	N/A

Proposed Activities	
Activity Title / Reference	**CF 2: Developing System Capacity and Integration**
Existing, Modified, or New Activity	Modified - incorporates a component of activity NP 12 (Enablers for patient, service and system level integration) in the Updated AWP 2016-2018.
Program Key Priority Area	Other (please provide details) System capacity/integration
Needs Assessment Priority Area	WAPHA's strategic priorities are: • **Health equity and access**: identifying barriers to access by applying an evidence-based monitoring and evaluation approach to prioritise the commissioning of services in the areas of greatest need. • **Person centred models of care**: addressing the priority health gaps and inequities identified by developing contextualised, person centred models of care. • **Integrated and outcomes focused commissioning**: commissioning services with a focus on quality and value based outcomes within the following domains: o Person: improving patient's experience of their care.

	- Clinical: reducing burden of disease for individual patients and the prevalence of disease across our community. - System: getting better at working together. - Provider: improving the experience of organisations and staff providing healthcare services. **Strong partnerships**: building sustainable relationships with clinicians, communities, providers and other stakeholders to improve coordination across the patient journey. **Primary care capability**: uplifting the capacity and capability in the primary care environment to support the development of a skilled and sustainable workforce. The following priorities from the Needs Assessment Report 2017 apply: P 4: Improve transitions between services by supporting effective care pathways, care coordination and service linkages p38 P 7: Build the capacity for patient self-management, particularly for patients with co-occurring and multiple morbidities, through the support of appropriate primary care providers p40 P 10: Promote the effectiveness of digital health technologies to optimise patient care p42
Aim of Activity	To support the primary health care sector by providing an online health information portal (HealthPathways) for general practitioners and primary health care clinicians, to assist with management and appropriate referral of patients when specialist input is required. To facilitate integrated holistic services to reduce the impact of chronic disease by providing enablers.
Description of Activity	**HealthPathways License and Support** An online system for GPs and primary health clinicians providing additional clinical information to support their assessment, treatment and management of individual patient's medical conditions, including referral processes to local specialists and services.
Target population cohort	HealthPathways: Primary Health Care patients who are at risk of poor health outcomes, and the health/social care workforce who work with this population.

Consultation - HSI Component	HealthPathways: Consultation with general practice has indicated a willingness to utilise tools to enhance their practices however licence costs prohibit strong update.
Collaboration - HSI Component	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. A relationship established between HSP, PHN Regional Managers and the HealthPathways staff facilitates the inclusion of local AHS Pathways.
HSI Component – Other	The activities outlined in **Core Operational HSI 1** support this activity
Indigenous Specific	No.
Duration	• July 2018: Annual Report 2017-2018 • January 2019: Six Month Review 2018-2019 • July 2019: Annual Report 2018-2019
Coverage	The activity will be implemented throughout Perth North PHN region, targeting priority Local Government Authorities (LGAs) as identified in the 2017 Needs Assessment Report.
Commissioning method (if known)	N/A
Decommissioning	N/A
Planned Total Expenditure 2018-19 (GST Excl.) – Commonwealth funding	$125,000
Planned Flexible Expenditure 2018-19 (GST Excl.) - Commonwealth funding.	$125,000

Planned Health System Improvement Expenditure 2018-19 (GST Excl.) – Commonwealth funding	$0
Planned Expenditure 2018-19 GST Excl.) – Funding from other sources	$0
Funding from other sources	N/A

3.   (c) Planned PHN activities

a. Core Operational Funding Stream: Health Systems Improvement 2018-19
b. General Practice Support Funding 2018-19

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

Proposed Activities	
Activity Title / Reference	**GPS 1: Supporting General Practice**
HSI/GPS Priority Area	General Practice Support
Existing, Modified, or New Activity	Existing – incorporates activities OP 1 (General Practice support), OP 3 (General Practice support – continuous quality improvement), OP 5 (General Practice support – improve cancer screening rates) & OP 6 (General Practice support – improve immunisation rates) from Updated AWP 2016-2018.
Aim of Activity	This activity aims to support general practice staff and clinicians to provide high quality care for patients, particularly those at risk of poor health outcomes. Support is provided through a variety of channels including a practice assist helpdesk, practice visits from Primary Health Liaison staff and access to subject matter experts on a range of topics.

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[3] HSI funding is to be used to deliver core functions within the PHN program such as population health planning, system integration and stakeholder engagement, as well as support to general practice which is not funded under the General Practice Support Funding Schedule. PHNs are able to use flexible funding to commission referral or health pathways activities (including non-staff costs such as 'Streamliners') but all associated PHN staff costs must be funded from HSI funding. HealthPathways activity to be undertaken by commissioned services should be separately identified as a Core Flexible Activity in *1. (b) Planned PHN activities – Core Flexible Funding Stream 2018-19*.

PHNs cannot commission frontline services using HSI funding. PHNs may use HSI funding to subcontract specific activities under this stream, for example a health data analyst or consultant may be contracted to identify priorities for improved care coordination. Contracted or consultant arrangements are particularly appropriate for time-limited and specialist projects.

Practice support is to be provided through HSI funding and must be primarily delivered through PHN employees. Practice support cannot be commissioned out to a third party. Practice Support includes general practice support not funded under the General Practice Support Funding Schedule and support provided by your PHN to other practices, eg. allied health practices

Description of Activity	Specific activities include:

	• Working collaboratively with the Communicable Disease Control Directorate (CDCD) and AHS to develop and promote appropriate interventions to improve childhood, Aboriginal, Adolescent and Adult immunisation coverage.
	
	• Educating practices about the use of recalls and reminder systems for children with overdue Immunisations and targeted adult populations.
	
	• Working with practices to improve the transfer of immunisations data to the Australian Immunisation Register (AIR) in a timely and accurate manner.
	
	• Educating practices about the recall and reminder systems for bowel, breast and cervical cancer screening and providing PDSA templates.
	
	• Working in partnership to better understand workforce capacity, creating opportunities to address gaps and avoid duplication in:
	   o workforce recruitment and retention
	   o capacity building of the workforce in place
	   o building the infrastructure and support mechanisms.
	
	• Support general practices to prepare for accreditation.
	
	• Support general practice workforce to improve cultural appropriateness and address clinical skills gaps.
	
	• Assisting with analysis of practice data to improve the quality of care for the practice population and implement QI activities including PDSA cycles.
	
	In addition, the PHN will support general practice by:
	• Providing Pen CS licences and supporting general practices to utilise the tools available.
	
	• Assisting general practices to register and actively participate in My Health Record (MYHR). This will be supported by working with pharmacy and allied health professionals to also access and share data through the MYHR system.
	
	• Providing support and training to GPs to use secure messaging systems.
	
	• Developing and maintaining a comprehensive library of resources to support general practices. These will be accessible to all WA general practices via www.practiceassist.com.au.

	• Contributing to service directories which will be made available via a variety of channels, containing information that practices require making referrals to specialist and community based services.
Supporting the primary health care sector	This activity will support the primary health care sector by building capability and capacity within general practice.

Collaboration	The PHN team works with a range of stakeholders, dependent upon place-based needs and including but not limited to:
	• Partner in education activities:
	    o WA Health
	    o HSP
	    o WAGPET
	    o peak bodies.
	• Partner for education and quality improvement activities:
	    o Australian Government Department of Health
	    o RACGP
	    o Non-Government Organisations including Cancer Council, Diabetes WA, Asthma WA, The Lung Foundation
	    o Pharmaceutical companies e.g. Novartis and Seqirus
	    o CDCD
	    o Universities.
	• Active participants in activities:
	    o Aboriginal Community Controlled Health Services (ACCHS)
	    o general practices
	• Inform quality improvement activities
	    o Community, carers and consumers
	    o health and social care sector organisations.
	• Partnership to address workforce shortages
	    o WACHS
	    o Rural Health West
	    o WAGPET
	    o RACGP
	    o Local Governments

	o Aboriginal Communities.
Duration	July 2018 – June 2021.
Coverage	Perth North PHN.
Expected Outcome	• Improving the quality of care for patients with a focus on keeping patients well in the community. • Improving the coordination of care for patients, particularly those at risk of poor health outcomes. • Building strong and collaborative relationships with general practice to achieve the PHN strategic vision. • Improving data quality; increased uptake of quality improvement activities.
Planned Core Operational Funding Stream b) Health Systems Improvement Expenditure 2018-19 (GST Excl.) – Commonwealth funding	$15,881
Planned General Practice Support Funding Expenditure 2018-19 (GST Excl.) – Commonwealth funding	$256,018
Planned Expenditure 2018-19 (GST Excl.) – Funding from other sources	$0
Funding from other sources	N/A

Proposed Activities	
Activity Title / Reference	**GPS 2: Integrating Services & Systems**
HSI/GPS Priority Area	System Integration
Existing, Modified, or New Activity	Modified - incorporates activities OP 4 (General Practice Support – HealthPathways) & OP 7 (General Practice Support – Digital Health) from Updated AWP 2016-2018.

Aim of Activity	The current health system is fragmented and pressured by a growing population of people with complex chronic health needs. This activity provides enablers for service, system and patient level integration. These enablers facilitate integrated, holistic care to reduce the impact of chronic disease.

Description of Activity	• The HealthPathways Team works across the three WA PHNs to develop and localise WA health pathways to ensure best practice clinical pathways are available, ensuring that patient care is well coordinated, efficient and effective. WA health pathways provides an opportunity for collaboration and integration between primary, secondary and tertiary care including general practice, pharmacy and allied health. This collaboration also contributes towards population health planning through the identification of service gaps. WA HealthPathways supports the roll out of the My Health Record initiative by acting as one of the communication channels to General Practice.
	 • CAT Plus Digital Health Licenses:
	     o CAT Plus is a combination of market-leading technologies that directly targets three primary care layers to improve patient health outcomes; the Patient (Topbar), the Practice (CAT4) and the Population (PAT).
	     o The CAT Plus solution provides decision support to health providers at the point of engagement, extracts general practice data for practice analysis and aggregates general practice data for service planning, reporting and population health needs, including the Needs Assessment.
	 • Building capacity and capability of our providers to work in an integrated manner and supporting general practice to respond to Commonwealth policy direction.
	 • Preparing general practices to be change enablers and effectively manage change.

Supporting the primary health care sector	This activity will support the primary health care sector through the integration of systems and services.
Collaboration	The PHN team works with a range of stakeholders, dependent upon place-based needs and including but not limited to: Providers: • Streamliners • PenCS Delivery partners:

	- WA Health - AHS - HealthPathways Communities - Australian Digital Health Agency Facilitate communications: - RACGP - AMA WA Contribute and review content: - Cancer Council - CDCD - Australian Government Department of Health - peak bodies - health, allied health and social care sector organisation - general practitioners - medical specialists.
Duration	July 2018 – June 2021.
Coverage	All practices in Perth North PHN.
Expected Outcome	General practice is supported to continually improve the quality of care for patients with a focus on supporting and developing integrated services and systems to keep patients well in the community and will improve the coordination of care to ensure patients receive the right care, in the right place, at the right time.
Planned Core Operational Funding Stream b) Health Systems Improvement Expenditure 2018-19 (GST Excl.) – Commonwealth funding	$9,768
Planned General Practice Support Funding Expenditure 2018-19 (GST Excl.) – Commonwealth funding	$157,475

Planned Expenditure 2018-19 (GST Excl.) – Funding from other sources	$0
Funding from other sources	N/A

Proposed Activities	
Activity Title / Reference	**HSI 1: System Integration**
HSI/GPS Priority Area	System Integration
Existing, Modified, or New Activity	Existing – incorporates activities OP 8 (Strategic Direction), OP 9 (Commissioning), OP 10 (Population Health Planning) from Updated AWP 2016-2018.
Aim of Activity	**Strategic Direction** The fragmentation of health and social care commissioning is unsustainable. Health and social care services need to be better co-ordinated around the individual to ensure that the right care is available at the right time and the right place. The purpose of this activity is to develop the landscape for joint planning, co-commissioning, pooled funding and shared accountability; positioning WAPHA as a leader in primary care to steward system integration across WA; and cultivating regionally appropriate governance structures both state-wide at the system manager level with WA Health and the MHC and the local level with HSPs and public/private hospitals. **Population Health Planning** • Identify the health priorities of the local populations in WA with a key focus on those who are disadvantaged and vulnerable. • Understand supply and demand and identify service shortages based on 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.

	• Identify barriers and enablers for access to primary health care for people with a key focus on those who are disadvantaged and vulnerable. • Work towards effective partnerships with other organisations around shared data capture and linkage to inform planning. **Commissioning** • Identify opportunities for state-wide and place-based joint planning and co-commissioning. • Utilise frameworks, e.g. Outcomes, Commissioning and Prioritisation, to apply a consistent, state-wide and yet locally tailored, place-based approach to the design, commissioning, monitoring and evaluation of outcome based-interventions to address prioritised health and service needs. • Ensure that commissioned services in WA are evidence based, meet local identified population health needs effectively and efficiently and are nested in pathways to ensure integration and access. • Encourage the coordination and capacity building of local services to meet the needs of their community. • Join up the system and improve access. • Where appropriate, to commission whole of PHN or multi PHN solutions to meet identified broader needs. • Continue to monitor emerging trends in health needs and service needs and develop a quality assurance (QA) process which will be applied to contracted services. One component of this QA will be the embedding of requirements for robust clinical governance frameworks in service provider contracts. • Applying an increased focus on managing performance of contracted providers and evaluating the impact of commissioned programs.
Description of Activity	**WAPHA**: • Supports the three WA PHNs to develop, align and operationalise WA population primary health priorities within the context of Commonwealth primary health care policy utilising a systems approach and outcome based commissioning. • Provides guidance and advice to the WA PHNs in respect to relevant primary health care policy and strategy and its impact on commissioning priorities, design and implementation.

- Leads in the development of innovative, best practice models of primary health care service delivery and funding models.
- Informing Federal and State Government policy and strategic direction based on identified priority health and service needs.

Population Health Planning:
- WAPHA, in conjunction with our academic partner, Curtin University, undertakes analysis to identify service and supply shortages based on 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 inform primary care workforce planning and identify the health and service need priorities of the local population.

Commissioning – the WAPHA Commissioning cycle for both state-wide and place-based services involves:
- Planning - identifying local needs and service gaps based on data and service analysis and consultation with key stakeholders.
- Designing - using best practice models and working with local and state-wide service providers and stakeholder to develop appropriate service responses.
- Procurement - using a range of approaches based on an analysis of the marker place including EOIs, Request for Proposals and Request for Tenders.
- Monitoring and review - including development of outcome based contracts and reporting are developed and implemented across WAPHA.
  - The Needs Assessment Report 2017 identified long term expected outcomes and possible performance measures. This has informed the Outcome Maps which include a suite of required and optional indicators across the four outcome domains.
- Evaluating - the performance of services and determine whether and to what extent a reshaping of the structure of supply is required using the Outcome Maps, provider and client reported outcomes and other relevant data.

- The PHN will apply an increased focus on managing performance of contracted providers including reviewing/monitoring and evaluating services to determine:

	• How well targeted and efficient services are - using a diverse range of data collection methods (i.e. provider reports, referral agency feedback, patient opinion) for each of the commissioned services will provide the PHN with the information to:
	    o Assess improvements to health outcomes.
	    o Help shape future service provision and/or seek alternative commissioning activity.
	    o Determine the degree to which those in receipt of services reflect the populations most in need, as outlined in the Needs Assessment Report 2017 and the *Lessons of Location: Potentially Preventable Hospitalisation Hotspots in Western Australia 2017*[4].
	• How effective services and systems are in relation to:
	    o Patient experience
	    o Patient health outcomes with focus on the efficacy of treatment to deliver a positive client outcome
	    o Service/system integration
	    o Service sustainability including provider experience/governance.
	    o Findings of formal evaluation e.g. the Integrated Chronic Disease Care program evaluation, undertaken by WA Centre for Rural Research in 2017/2018, will also inform performance management.
	• Findings of formal evaluation e.g. Integrated Team Care Evaluation undertaken by Curtin University, will also inform performance management.

Supporting the primary health care sector	This activity will help Perth North PHN support the primary health care sector through:
	
	• Commissioning of services
	    o in the areas of greatest need.
	    o with a focus on quality and value.
	• Development of evidence informed, person-centred models of care which address priority health gaps and inequities
	• Building collaborative, strong and sustainable partnerships to improve coordination throughout the patient journey

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[4] Vaike Vohma, Alex Xiao, Changying Shao, Peter Somerford (2017). Lessons of Location: Potentially Preventable Hospitalisation Hotspots in Western Australia. Department of Health Western Australia and WA Primary Health Alliance. Perth, Western Australia.

	• Strengthening capacity and capability in primary care to ensure the development of a sustainable workforce.
Collaboration	WAPHA will work with WA Health and the MHC as system coordinators and co-commissioning bodies in informing primary care workforce planning, identifying the health and service need priorities of the local population and shaping the structure of supply.
	Perth North PHN will work with HSPs, Local Government, commissioned providers, General Practice, peak bodies and membership organisations, Aboriginal Community Controlled Health Organisations, individual consumers, carers and representative groups, non-government organisations, health and social services organisations and professionals to develop and strengthen strategic partnerships, identify local needs and service gaps, co-design and better utilise existing funding where possible.
Duration	2018 – 2021.
Coverage	Perth North PHN.
Expected Outcome	• Improved health care outcomes for the Western Australian (WA) community. • Efficient and effective medical services for patients, particularly those at risk of poor health outcomes. • Improved coordination of care to ensure patients receive the right care, in the right place at the right time.
Planned Core Operational Funding Stream b) Health Systems Improvement Expenditure 2018-19 (GST Excl.) – Commonwealth funding	$2,918,728
Planned General Practice Support Funding Expenditure 2018-19 (GST Excl.) – Commonwealth funding	$0
Planned Expenditure 2018-19 (GST Excl.) – Funding from other sources	$0
Funding from other sources	N/A

Proposed Activities	
Activity Title / Reference	**HSI 2: Stakeholder Engagement and Communication**
HSI/GPS Priority Area	System Integration
Existing, Modified, or New Activity	Existing – incorporates activities OP 11 (Stakeholder Engagement) and OP 12 (Communication and Marketing) from Updated AWP 2016-2018.
Aim of Activity	Stakeholder engagement has enormous value in the identification and management of risks, building support, facilitating change management within the context of transitioning priorities for PHN programs. WAPHA's stakeholder and communications strategy aims to: • enable strong partnerships so our stakeholders support and work with us to achieve our vision of health equity. • generate awareness and build our reputation by demonstrating the positive impacts of our work throughout the broader health care environment.
Description of Activity	WAPHA will continue to mature relationships with key strategic stakeholders including the Australian Government Department of Health, WA Health, peak bodies, health providers, social service providers, consumer groups, Aboriginal groups and communities and the wider community to address priorities identified in the Needs Assessment Report 2017. WAPHA will facilitate multi-disciplinary partnerships to support the development of integrated models of care. WAPHA will achieve this by: • Developing a targeted approach for key stakeholder groups (GPs and other general practice staff and allied health professionals, all levels of government, peak bodies and membership organisations, health service providers, and community and consumers). • Updating and developing place-based stakeholder engagement plans with a significant focus on the implementation of sustained and meaningful collaboration within local communities to inform all stages of the commissioning cycle and system integration. • Funding Digital Health Licenses including:

	o Patient Opinion to promote the vital role of consumer feedback in service improvement[5]. o Primary Health Exchange - an online community engagement site where stakeholders can engage with the planning and design of primary health care in WA6. o My Community Directory - to help Australians find health and community service information and in doing so provide usage data which can contribute to population health planning to assist in the identification of health needs and service gaps. • Leading integration and championing primary care future focussed proactive planning • Establishing trusted and purposeful strategic relationships with stakeholders, clinicians and community representatives underpinned by the international Association for Public Participation (IAP2) Stakeholder Engagement Framework7. • Strengthening the following enablers: o Brand positioning, key messages, stakeholder relationship management, digital channels (website, e-newsletters, social media and Primary Health Exchange (community engagement / consultation tool)). o Campaigns to raise community awareness on topics such as depression and obesity. • Optimising the use of customer relationship management systems.
Supporting the primary health care sector	• Perth North PHN has a relatively small proportion of the health system funding, which restricts our scope to achieve system-wide reform. The PHN provides critical leadership to the primary health care sector by bringing other stakeholders to the table to leverage resources, form partnerships, steer the market and strategically invest in key areas. • Perth North PHN also champions change within the primary health care sector by embedding a commissioning approach and new ways of working across the system. Commissioning will result in a change to the roles and requirements of some individuals and organisations. The PHN's leadership and stakeholder engagement are key factors in enabling this culture change.
Collaboration	WAPHA will work closely with the following stakeholders to ensure appropriate and targeted stakeholder engagement and communication across the sector: • Australian Government Department of Health.

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[5] See https://www.patientopinion.org.au/
[6] See https://phexchange.wapha.org.au/
[7] International Association for Public Participation (IAP2). 2007. IAP2 public participation spectrum

	• System Manager level:
	    ○ WA Health
	    ○ WA MHC.
	• State-Wide / PHN level:
	    ○ HSP
	    ○ peak bodies and membership organisations
	    ○ local government
	    ○ Aboriginal Community Controlled Health Organisations
	    ○ individual consumers, carers and representative groups
	    ○ non-government organisations
	• health and social services organisations and professionals.

Duration	July 2018- June 2021.
Coverage	Perth North PHN.
Expected Outcome	The expected outcome of this activity will be to strengthen partnerships with Perth North PHN's key stakeholder groups, increase awareness of the positive impacts of the PHN; therefore building the reputation of the PHN program within Western Australia.
Planned Core Operational Funding Stream b) Health Systems Improvement Expenditure 2018-19 (GST Excl.) – Commonwealth funding	$218,078
Planned General Practice Support Funding Expenditure 2018-19 (GST Excl.) – Commonwealth funding	$0
Planned Expenditure 2018-19 (GST Excl.) – Funding from other sources	$0
Funding from other sources	N/A

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4. (a) Strategic Vision for After Hours Funding

The Perth North PHN will achieve the After Hours key objectives of:

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

In 2018-19 and onwards, Perth North PHN will:

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

Vision

- Efficient and effective after hours primary health care - well-coordinated, easily accessible, patient centred and able to be seamlessly navigated by all patients in the community with General Practitioners at the heart of the Primary Care relationship.
- All people receiving primary health care are empowered to make informed decisions on getting the right treatment in the right place and at the right time.

Aim

- To improve the efficiency and effectiveness of after hours primary health care, particularly for populations with limited access to Health Services.
- To improve access to after hours primary health care through effective planning, coordination and support for population based after hours primary health care.

Strategic priorities

- **Health equity and access**: identifying barriers to access by applying an evidence-based monitoring and evaluation approach to prioritise the commissioning of services in the areas of greatest need.
- **Person centred models of care**: addressing the priority health gaps and inequities identified by developing contextualised, person centred models of care.
- **Integrated and outcomes focused commissioning**: commissioning services with a focus on quality and value based outcomes.
- **Strong partnerships**: building sustainable relationships with clinicians, communities, providers and other stakeholders to improve coordination across the patient journey.
- **Primary care capability**: uplifting the capacity and capability in the primary care environment to support the development of a skilled and sustainable workforce.

Commissioning principles

- Perth North PHN has concentrated on areas of need identified through sound need and evidence analysis and our consultations with key stakeholders which include local communities, health professionals and all levels of government,
- Commissioning of services gave priority to patients from disadvantaged/vulnerable groups. These groups include: residents of aged care facilities, people with palliative primary health care needs; homeless; disadvantaged Aboriginal people and people made vulnerable through violence and abuse.

- Taking a longer-term approach to planning for after-hours services, Perth North PHN seeks to build the capacity of the primary health care sector to provide after-hours services. Many primary carer service providers across chronic conditions, mental health, drug and alcohol treatment services have only recently commenced programs and may in time be able to provide the foundations for after- hours services where they are required.

Outcomes

- In keeping with WAPHA's Outcome Framework, Perth South WA PHN will monitor outcomes for commissioning of primary health care service provider using suite of mandatory and optional outcome indicators across four outcome domains:
    - Person: improving patient's experience of their care.
    - Clinical: reducing burden of disease for individual patients and the prevalence of disease across our community.
    - System: getting better at working together.
    - Provider: improving the experience of organisations and staff providing healthcare services.

- Of relevance to WAPHA will be indicators that relate both to access to after-hours services and the outcomes for patients using these services.

4. (b) Planned PHN Activities

– After Hours Primary Health Care Funding 2018-19

Proposed Activities	
Activity Title / Reference	**AH 2: Support to disadvantaged and vulnerable populations**
Existing, Modified, or New Activity	Existing - previously activity AH 3 (After Hours – Support to disadvantaged and vulnerable populations) from Updated AWP 2016-2018.

Needs Assessment Priority Area	WAPHA's strategic priorities are:
	
	• **Health equity and access**: identifying barriers to access by applying an evidence-based monitoring and evaluation approach to prioritise the commissioning of services in the areas of greatest need.
	• **Person centred models of care**: addressing the priority health gaps and inequities identified by developing contextualised, person centred models of care.
	• **Integrated and outcomes focused commissioning**: commissioning services with a focus on quality and value based outcomes within the following domains:
	   o Person: improving patient's experience of their care.
	   o Clinical: reducing burden of disease for individual patients and the prevalence of disease across our community.
	   o System: getting better at working together.
	   o Provider: improving the experience of organisations and staff providing healthcare services.
	• **Strong partnerships**: building sustainable relationships with clinicians, communities, providers and other stakeholders to improve coordination across the patient journey.
	• **Primary care capability**: uplifting the capacity and capability in the primary care environment to support the development of a skilled and sustainable workforce.
	
	The following priorities from the Needs Assessment Report 2017 apply:
	
	P1: Orient Primary Health care towards people experiencing high socio-economic disadvantage especially in regions where there are lower levels of primary care providers p36

	P2: Orient primary health care towards vulnerable people supporting primary health care providers to adopt appropriate approaches for targeted groups p37
	P3: Primary care providers work with Aboriginal people and groups to plan and design strategies that address localised priorities p37
	P4: Improve transitions between services by supporting effective care pathways, care coordination and service linkages p38
	P5: Orient primary health care to ensure that risk factors for poor health outcomes are addressed or modified as early as possible p47
	P6: Support local communities to be connected to primary care in and out of hours p39
	P7: Build the capacity for patient self-management particularly for patients with co-occurring and multiple morbidities through the support of appropriate primary care providers p40
	P8: Build community awareness of when and where to seek non-urgent health care p41
	P9: Reduce rates of PPHs by working with primary care providers to target specific areas where there are higher than average rates p42
	P10: Promote the effectiveness of digital health technologies to optimise patient care p42
	P11: Invest in services that have demonstrated health outcomes by commissioning to a validated Outcomes Framework in order to demonstrate services are efficient and effective p43
Aim of Activity	The aim of this activity is to fund after hours services in areas where need has been demonstrated and with the support of core operational health systems improvement funding (activity HSI1: System Integration), to determine the degree to which these services are making an impact on the health needs of the vulnerable populations they serve and to ensure that services are meeting their contractual obligations. In 2017-2018 Perth North PHN, with the support of core operational funding was engaged in: • Designing and contracting placed based services to address the primary health care needs of people who are homeless or at risk of homelessness. • Shaping the structure of supply to: o increase access

	o support self-management o sustain engagement with GPs and other primary health care professionals o develop the capacity of the workforce.

Description of Activity	**In 2018-2019 the following PHN Wide services will continue to be funded from 2017-2018**:
	
	• Street Doctor After Hours Service: A mobile GP clinic which operates in an around central Perth and the North-East Region of Perth North PHN offering a bulk billed service to people who are disadvantaged.
	• After Hours Support Service (AHSS) component of the 50 Lives 50 Homes program. After hours workers link in the with business hours case workers to follow up clients. Shared care plans are being managed around the clock as a cooperation of 46 services from 30 organisations.
	
	In 2018-2021, Perth North PHN will continue to monitor emerging trends and develop a quality assurance (QA) process which will be applied to contracted services. One component of this QA will be the embedding of requirements for robust clinical governance frameworks in service provider contracts.
	
	Perth North PHN will apply an increased focus on managing performance of contracted providers including reviewing/monitoring and evaluating services to determine:
	
	• How well targeted and efficient services are - using a diverse range of data collection methods (i.e. provider reports, referral agency feedback, patient opinion) for each of the commissioned services will provide the PHN with a variety of information to assess improvements to health outcomes, help shape future service provision and/or seek alternative commissioning activity. The PHN will use the data to determine the degree to which those in receipt of services reflect the populations most in need, as outlined in the Needs Assessment 2017 and the *Lessons of Location: Potentially Preventable Hospitalisation Hotspots in Western Australia 2017.*
	
	• How effective services and systems are in relation to:
	
	    o Patient experience
	    o Patient health outcomes with particular focus on the efficacy of treatment to deliver a positive client outcome
	    o Service/system integration
	    o Service sustainability including provider experience/governance.

	The Needs Assessment Report 2017 identified long term expected outcomes and possible performance measures. This has informed the Outcome Maps which include a suite of required and optional indicators across the four outcome domains.
	Using the Outcome Maps and provider and client reported outcomes and relevant data the PHN will evaluate the performance of services and determine whether and to what extent a reshaping of the structure of supply is required.
	In 2018-2021, Perth North PHN will focus on limited further shaping of supply where required.
Target population cohort	People who are homeless or at risk of homelessness.
Consultation	In monitoring and evaluating the effectiveness of services WAPHA will consult with a range of state-wide and regional peak bodies and representational groups, as well as service providers and community.
Collaboration	Perth North PHN will work with WA Health and the MHC as system coordinators and co-commissioning bodies in shaping the structure of supply.
	WAPHA is working with commissioned providers, General Practice and consumer and carer groups to develop and strengthen strategic partnerships, co-commission where appropriate with the state health services and better utilise existing funding where possible. The aim is to secure effective and sustainable local and virtual primary health service provision, supporting GPs and the consumer with care closer to home.
	50 Lives 50 Homes is a joint initiative of 46 business hour services from 30 organisations, among them: • Ruah Community Services – Psychosocial support • Homeless Health Care – Nursing support • Community service providers • Housing providers • Department of Housing • Department of Communities
Indigenous Specific	No.
Duration	• July 2018: Development of a relevant data set.

	• July 2018: Implementation of Model Outcome Maps which include a suite of required and optional indicators across the four outcome domains. • July 2018: Annual Report for 2017/2018. • January 2019: Six Month Review – analysis of data set and Outcome Maps. • July 2019: Annual Report 2018/2019 – analysis of data set and Outcome Maps.
Coverage	Perth North PHN.
Commissioning method	As the PHNs are largely operating within the monitoring and evaluation component of the commissioning framework with a low level of uncommitted funds, there will be limited opportunity for the commissioning of new services. As funds are identified, and should the service evaluations highlight a need for recommissioning or should one of the providers be unable to continue to deliver the commissioned services, consideration will be given to the appropriate procurement method.
Decommissioning	If the PHN is no longer able to access after hours funding, contracts for the after hours services will end at June 2019. The PHN will work with those service providers to ensure that activities are completed and that stakeholders are aware of alternative options.
Planned Expenditure 2018-19 (GST Excl.) – Commonwealth funding	$987,509
Planned Expenditure 2018-19 (GST Excl.) – Funding from other sources	$0
Funding from other sources	N/A

Proposed Activities	
Activity Title / Reference	**AH 3: – After Hours Mental Health, Suicide Prevention, and Drug and Alcohol Treatment. Services**
Existing, Modified, or New Activity	Existing - previously activity AH 6 (After Hours Integrated Mental Health, Suicide Prevention and Drug and Alcohol Treatment Services) from previous Updated AWP 2016-2018.
Needs Assessment Priority Area	WAPHA's strategic priorities are:

	• **Health equity and access**: identifying barriers to access by applying an evidence-based monitoring and evaluation approach to prioritise the commissioning of services in the areas of greatest need.
	• **Person centred models of care**: addressing the priority health gaps and inequities identified by developing contextualised, person centred models of care.
	• **Integrated and outcomes focused commissioning**: commissioning services with a focus on quality and value based outcomes within the following domains:
	   ○ Person: improving patient's experience of their care.
	   ○ Clinical: reducing burden of disease for individual patients and the prevalence of disease across our community.
	   ○ System: getting better at working together.
	   ○ Provider: improving the experience of organisations and staff providing healthcare services.
	• **Strong partnerships**: building sustainable relationships with clinicians, communities, providers and other stakeholders to improve coordination across the patient journey.
	• **Primary care capability**: uplifting the capacity and capability in the primary care environment to support the development of a skilled and sustainable workforce.
	
	The following priorities from the Needs Assessment Report 2017 (pages 36 – 43) apply:
	
	P1: Orient Primary Health care towards people experiencing high socio-economic disadvantage especially in regions where there are lower levels of primary care providers p36
	
	P2: Orient primary health care towards vulnerable people supporting primary health care providers to adopt appropriate approaches for targeted groups p37
	
	P3: Primary care providers work with Aboriginal people and groups to plan and design strategies that address localised priorities p37
	
	P4: Improve transitions between services by supporting effective care pathways, care coordination and service linkages p38
	
	P5: Orient primary health care to ensure that risk factors for poor health outcomes are addressed or modified as early as possible p47
	
	P6: Support local communities to be connected to primary care in and out of hours p39

	P7: Build the capacity for patient self-management particularly for patients with co-occurring and multiple morbidities through the support of appropriate primary care providers p40
	P8: Build community awareness of when and where to seek non-urgent health care p41
	P9: Reduce rates of PPHs by working with primary care providers to target specific areas where there are higher than average rates p42
	P10: Promote the effectiveness of digital health technologies to optimise patient care p42
	P11: Invest in services that have demonstrated health outcomes by commissioning to a validated Outcomes Framework in order to demonstrate services are efficient and effective p43

Aim of Activity	The aim of this activity is to to provide afterhour services in areas where need has been demonstrated and with the support of core operational health systems improvement funding (activity HSI1: System Integration), to determine the degree to which Perth North PHN After Hours services are making an impact on the mental health needs of the people they serve and meeting their contractual obligations.
	
	In 2017-2018 Perth North PHN with the support of core operational funding, was engaged in:
	
	• Designing and contracting services to:
	    o provide access for people including young people who need a mental health/AOD response after hours including those at risk of suicide.
	    o redirect patients from emergency departments to appropriate primary mental health/AOD services and increase capacity and communication between GPs and Primary Mental Health Care Teams.
	• Shaping the structure of supply to:
	    o increase access
	    o support self-management
	    o sustain engagement with GPs and other primary health care professionals
	    o develop the capacity of the workforce.

Description of Activity	**In 2018-2019 the following services will continue to be funded from 2017-2018:** • **North-East and North-West:** headspace centre after hours services in Midland, Joondalup, Osborne Park.

- **PHN wide**: After Hours AOD counselling. To extend services provided by Cyrenian House for clients and their families affected by drug and alcohol issues.

In 2018-2019 the following services will be funded:

- **North-East**: After Hours AOD counselling. To extend service provision by Holyoake into the afterhours for clients and their families affected by drug and alcohol issues in the Midland area.

In 2018-2021, Perth North PHN will continue to monitor emerging trends and develop a quality assurance (QA) process which will be applied to contracted services. One component of this QA will be the embedding of requirements for robust clinical governance frameworks in service provider contracts.

The PHN will apply an increased focus on managing performance of contracted providers including reviewing/monitoring and evaluating services to determine:

- How well targeted and efficient services are - using a diverse range of data collection methods (i.e. provider reports, referral agency feedback, patient opinion) for each of the commissioned services will provide the PHN with a variety of information to assess improvements to health outcomes, help shape future service provision and/or seek alternative commissioning activity. The PHN will use the data to determine the degree to which those in receipt of services reflect the populations most in need, as outlined in the Needs Assessment 2017-2018 and the *Lessons of Location: Potentially Preventable Hospitalisation Hotspots in Western Australia 2017.*

- How effective services and systems are in relation to:
  - Patient experience
  - Patient health outcomes with particular focus on the efficacy of treatment to deliver a positive client outcome
  - Service/system integration
  - Service sustainability including provider experience and governance.

The Needs Assessment Report 2017 identified long term expected outcomes and possible performance measures. This has informed the Outcome Maps which include a suite of required and optional indicators across the four outcome domains.

	Using the Outcome Maps and provider and client reported outcomes and relevant data the PHN will evaluate the performance of services and determine whether and to what extent a reshaping of the structure of supply is required.
Target population cohort	People who need a mental health, drug and alcohol treatment response or primary health care response after hours.
Consultation	In monitoring and evaluating the effectiveness of services WAPHA will consult with a range of state-wide and regional peak bodies and representational groups, as well as service providers and community members.
Collaboration	Perth North PHN will work with WA Health and the WA MHC as system managers and co-commissioning bodies in managing performance where appropriate. WAPHA is currently working with commissioned providers, community mental health teams, General Practice and consumer and carer groups to develop and strengthen strategic partnerships, co-commission where appropriate with the state health services and better utilise existing funding where possible. The aim is to secure effective and sustainable local and virtual primary mental health service provision, supporting GPs and the consumer with care closer to home.
Indigenous Specific	No however in some services Aboriginal people may represent a significant proportion of clients.
Duration	• July 2018: Annual Report for 2017/2018. • July 2018: Development of a relevant data set. • October 2018: Implementation of Model Outcome Maps which include a suite of required and optional indicators across the four outcome domains. • January 2019: Six Month Review – analysis of Outcome Maps and implementation of data set. • July 2019: Annual Report 2018/2019 – analysis of data set and Outcome Maps.
Coverage	Perth North PHN.
Commissioning method	As the PHNs are largely operating within the monitoring and evaluation component of the commissioning framework with a low level of uncommitted funds, there will be limited opportunity for the commissioning of new services. As funds are identified, and should the service evaluations highlight a need for recommissioning or should one of the providers be unable to continue to deliver the commissioned services, consideration will be given to the appropriate procurement method.

Decommissioning	If the PHN is no longer able to access after hours funding, contracts for the after hours services will end at June 2019. The PHN will work with those service providers to ensure that activities are completed and that stakeholders are aware of alternative options.
Planned Expenditure 2018-19 (GST Excl.) – Commonwealth funding	$566,849
Planned Expenditure 2018-19 (GST Excl.) – Funding from other sources	$0
Funding from other sources	N/A