Australian Government
Department of Health

phn
An Australian Government Initiative

Activity Work Plan 2019-2022:

Core Funding

GP Support Funding

This Core Activity Work Plan template has the following parts:

1. The Core Activity Work Plan for the financial years 2019-20, 2020-2021 and 2021-2022. Please complete the table of planned activities funded under the following:
    a) Primary Health Networks Core Funding, Item B.3 – Primary Health Networks – Operational and Flexible
    b) Primary Health Networks General Practice Support, Item B.3 – General Practice Support.
2. The Indicative Budget for the financial years 2019-20, 2020-21 and 2021-22. Please attach an excel spreadsheet using the template provided to submit indicative budgets for:
    c) Primary Health Networks Core Funding, Item B.3 – Primary Health Networks – Operational and Flexible
    d) Primary Health Networks General Practice Support, Item B.3 – General Practice Support.

Hunter New England and Central Coast PHN

Version 2
Updated June 2019
Approved August 2019

Overview

This Core Activity Work Plan covers the period from 1 July 2019 to 30 June 2022. To assist with PHN planning, each activity nominated in this work plan can be proposed for a period of up to 36 months. Regardless of the proposed duration for each activity, the Department of Health will require PHNs to submit updates to the Activity Work Plan on an annual basis.

1. (a) Planned PHN activities for 2019--20, 2020-21 and 2021-22 – Core Flexible Funding Stream

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	*CF1 Services Commissioned in response to community need*
Existing, Modified, or New Activity	Modified Activity *Sub-activity CF1.3 will not continue into 2019/2022, it has been embedded into other work under this activity.* *Similarly Activity CF1.2 Immunisation Service-Wyong from 2018/2019 will not continue into 2019/2022, please see the notes in the Decommissioning row of this activity.*
Program Key Priority Area	Population Health
Needs Assessment Priority	NxPH1 Low levels of Health Literacy – p.43 NxPH3 Lower than average life expectancy – p.43 NxPH5 Health needs of an aging population – p.43,44, 48, 49,50 NxPH9 Poor health and developmental outcomes for infants and young children – p.43 NxPH 11 Rural Health disparities –p. 43 NxPH18 Higher Cancer incidence and mortality – p. 44 NxPH28 Barriers to screening in primary care – p.44 NxPH32 High proportions of semi-urgent and non-urgent emergency departments presentations – p.43 NxPH33 Reduced access to services for older people – p.43 NxPH34 Reduced access to services in rural and remote areas – p.43,44, 48, 49, 50 NxPH35 Transport limitations NxPH36 Cost barriers to healthcare
Aim of Activity	Commission and monitor the delivery of a number of specialised primary care services designed to specifically address locally identified health service gaps across the HNECC PHN region.
Description of Activity	**CF1.01 Cancer Screening Clinic – Wyong** Commission the Wyong Shire Council to administer the bulk-billing Cancer Screening Clinic in the Wyong LGA, which conducts PAP tests and breast checks in partnership with Central Coast Local Health District. Using the principles and recommendations of NSW Cervical Screening Program and Breast Screen NSW (Cancer Institute), actively targeting and recruiting women aged 20 - 69 years for biennial screening, to facilitate increased access to screening for socially disadvantaged women, and greater early detection of cancer and other abnormalities. **CF1.04 Mobile X-ray – Central Coast** Reduce the need for patients living in RACFs to be transported to hospital in the event of unexpected deterioration by undertaking co-designed hospital avoidance trial which connects RACF residents to local existing diagnostic and transport resources. A 5 day per week Mobile X-Ray Service which provides non-urgent on-site radiography to all residential aged care facility patients living in the Central Coast region. The van is operated by staff from the Central Coast Local Health District (CCLHD) during business hours.

	CF1.05 Primary Care Nursing Clinics and Community Participation programs – New England North West NSW Improved health and wellbeing of people living within small rural and remote communities (with a population of less than 2000), achieved by identifying and addressing local preventative health needs through the supports health screening, health education, preventative health and health promotion services, delivered in partnership with the community and other local stakeholders. The Primary Health Care nursing program targets 50 small communities within the New England Region (population less than 2000 people). The program incorporates a number of strategies to improve the health of these small communities, e.g. health screening, health education, preventative health activities. The program is delivered in partnership with other organisations to build effective partnerships, e.g. Local Health District, Cancer Council, NSW Police, community groups. **CF1.06 Priority Allied Health Services – New England North West NSW** To improve the health and wellbeing of people across the region by increasing access to a range of primary and allied health services and activities provided in targeted communities and improving the local linkages between allied health and general practice through the commissioning of a range of Allied Health Services throughout the Hunter and New England region.
Target population cohort	Residents living in small and more rural locations with identified health needs Residents living within small rural and remote communities (population < 2000) Women aged 20 – 69 years Patients living in residential aged care facilities
Indigenous specific	No
Coverage	Wyong LGA Wider Central Coast region Communities of the New England and North West NSW
Consultation	Regular consultation is undertaken with providers and HNECC PHN Advisory groups including Clinical and Community Advisory Groups, this consultation is ongoing.
Collaboration	Activities will be designed with either existing service providers, or in the case of the Mobile X-ray service within the partnership with Central Coast Local Health District, which is known as the Central Coast Health Alliance. Planning for the service allocations will occur in conjunction with service providers and based on input from local councils, clinicians and other stakeholders.
Activity milestone details/ Duration	Services will be commissioned and managed by the Primary Care Commissioning team. This will include contract admin, stakeholder engagement, and management of the relationship with service providers and evaluation of the contracted service.
Commissioning method and approach to market	☒ Continuing service provider / contract extension 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process?

	No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	Yes PHN commissioning activity for the immunisation clinics consisted of funding for the administrative support function of the service in one specific sub-area of the PHN region, i.e. Wyong LGA. Child immunisation services are available across the sub-area and adjacent areas of the PHN through general practice and the Central Coast Local Health District.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	*CF2 Collaborative models of care*
Existing, Modified, or New Activity	Modified Activity *CF2 has been split out into two separate activities due to growth. In 2018/2019 this activity was called Chronic Disease an Obesity, it will now be reported as CF2 Chronic Disease and CF4 Healthy Weight and Obesity Strategy. The name of the activity has also changed to more accurately reflect the intention of this group of activities.*
Program Key Priority Area	Population Health
Needs Assessment Priority	NxPH5 Health needs of an aging population – p.48, 49 NxPH13 Increasing prevalence of dementia – p.49 NxPH17 High rates of chronic disease – p. 45, 46 NxPH20 A lack of health service integration, coordination and information sharing – p. 44, 45, 46, 47, 48 NxPH25 Limited capacity of services to address dementia – p.44, 48 NxPH27 High rates of chronic disease hospitalisations – p.45, 46
Aim of Activity	To make systemic improvements to primary care through partnerships, innovation projects and collaborations designed to support the development, trial, implementation and uptake of new models of care designed to reduce the burden of chronic diseases and demands on health services.
Description of Activity	**CF2.01 Central Coast Alliance** The Central Coast Alliance is a joint collaboration between HNECCPHN and the Central Coast Local Health District. The alliance seeks to facilitate and support improved systems integration, collaboration and partnership between primary care, tertiary and community settings and sectors through the co-design, hot-housing and piloting of projects in six key focus areas to respond to community need on the Central Coast. The six key focus areas are: • Aged Care Taskforce • Urgent Care Working Group • Palliative Care Taskforce

	• Mental Health • Drug & Alcohol • Diabetes All taskforces and working groups have broader multiagency representation including but not limited to including HNECCPHN, CCLHD, GP representation, Ambulance NSW, RACF, Community representation. **CF2.02 Central Coast Diabetes Case Conferencing in General Practice** Design and deliver a diabetes case conferencing model in general practice involving specialist endocrinology input and engagement. The model aims to provide increased support and training to GP's to better manage their diabetes patients by co delivering diabetes consultations in general practice with an endocrinologist. This model aims to improve patient outcomes whilst reducing demand on tertiary services. **CF2.03 Hunter New England Alliance** The Alliance works together to co-design, hot house and pilot projects that respond to across 12 identified shared priority areas in partnership with Hunter New England Local Health District (HNE LHD), including existing work with Chronic kidney disease programs; and Diabetes projects in collaboration with the HNE LHD across the New England region. **CF2.04 COPD Model of Care** (Hunter) - A pilot is planned of a new model of care which places pulmonary rehab and specialist appointments in Primary Care settings, increasing the proportion of patients who commence and complete Pulmonary Rehab and reducing patient admissions. Co-commissioning project with HNE LHD. **CF2.05 Hunter New England Diabetes Model of Care** to further expand the Diabetes Model of Care. HNECC PHN co-commissions the implementation of the Diabetes Model of Care, which enhances Diabetes care in Primary Care with HNE LHD. This model reduces the demand on tertiary services. The Hunter New England Integrated Care Alliance **CF2.06 Dementia** Hunter Dementia Alliance and Central Coast Dementia Alliance including support, education and training initiatives for consumers, families/carers and health professionals **CF2.07 E-referral** commissioned component includes licencing and purchasing of portal and third party IT Support required to successfully deliver activities detailed in HSI1. (HSI1 is where further details about internal HNECC PHN support for this program are provided from). **CF2.08 HealthPathways Hunter** commissioned components– This activity includes funding of costs associated with HealthPathways Streamliners contracts and the associated development and delivery of the online platform. **CF2.09 HealthPathways Central Coast** commissioned components – This activity includes funding of costs associated with HealthPathways Streamliners contracts and the associated development and delivery of the online platform.

Target population cohort	This activity targets all population groups
Indigenous specific	No
Coverage	This activity covers the entire HNECC PHN region
Consultation	Extensive consultation has and continues to occur across the programs and projects that foster collaboration and partnership. Collaboration is project specific and includes, but is not limited to: • HNECC PHN Board • HNECC PHN Clinical Councils and Community Advisory Committees • LHD Consumer Advisory Committees • Primary care practitioners through established forums and meetings (i.e. GP Collaboration Panel and engaged Clinical Advisor roles) • Project/ Program Steering Group meetings that include key stakeholder representation • Stakeholder and Community forums • Stakeholder surveys Established formal and informal feedback mechanisms.
Collaboration	Each of the initiatives which form a component of this activity are conducted in collaboration with various stakeholders, including: Calvary; Hunter Primary Care; HNE LHD; CC LHD; HealthWISE New England North West; ACCHOs; NSW Ambulance; Family and Community Services representatives; NSW Department of Education representatives; General Practitioner representatives; Residential Aged Care representatives; and Community Aged Care Provider representatives. The role of each of these organisations varies for each partnership, however HNECC PHN is the lead organisation in a number of these initiatives.
Activity milestone details/ Duration	Activity start date: 01/07/2019 Activity end date: 30/06/2022
Commissioning method and approach to market	☒ Other approach (please provide details) This activity is linked to HNECC PHNs alliances with the region's two Local Health Districts. Many of the activities undertaken are co-designed and developed and where appropriate the outcomes of those processers are or may be jointly commissioned. These activities and alliances are ongoing and have continued to develop and grown since HNECC PHN's inception. 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? Yes 3b. Has this activity previously been co-commissioned or joint-commissioned? Yes

Decommissioning	No

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	*CF3 Health Partnerships and Priorities*
Existing, Modified, or New Activity	Modified Activity *To simplify HNECC reporting some of these activities have been refined from 2018/2019, some sub-activities which were short-term have also been removed.*
Program Key Priority Area	Population Health
Needs Assessment Priority	NXPH1 Low levels of Health Literacy – p.44 NxPH2 Poor self-assessed health status – p. 44, 45, 46 NxPH8 High rates of smoking during pregnancy – p. 44 NxPH9 Poor health and developmental outcomes for infants and young children – p. 48 NxPH21 Areas of primary care workforce vulnerability –p. 47, 48
Aim of Activity	Collaborate and partner with key stakeholders, organisations and lead agencies to improve integration and coordination of primary care services, building on available resources, introducing innovation, encouraging cost effectiveness and improving the use of available data with the intention of improving patient and provider experiences of care and, clinical and health outcomes.
Description of Activity	**CF3.01 Health Sector Partnerships** HNECC PHN partners with a number of other primary care agencies. These partnerships include: - GP Collaboration Unit – with joint funding from HNECC PHN and CC LHD, this includes representatives from the CCL HD, HNECC PHN and a cross section of General Practitioners, this Unit facilitates system improvements between primary and tertiary care. This partnership activity is a key component of the Central Coast Alliance, and will transition to become a mechanism to seek GP advice and input into Alliance activities. - The Hunter Aboriginal Health and Wellbeing Alliance – maintain and foster ongoing engagement with key stakeholders - Central Coast Aboriginal Partnership Agreement – maintain and foster ongoing engagement with key stakeholders - As a result of these partnerships HNECC PHN contributes to the co-commissioning and delivery of a number of services including: provision of an endocrinologist and diabetes educators. **CF3.02 Workforce Priorities** Co-commissioning, in partnership with RDN and Hunter New England Local Health District (HNE LHD), scholarships and education programs in response to specifically identified client needs. For example upskilling of practice nurses. **CF3.04 Research collaborations**

	- Foundation partner in NHMRC NSW Centre for Innovation in Regional Health, building capacity in Primary Care research through scholarship and supported research activities. **CF3.05 Rural Communities Project** The Rural Communities Project identifies health needs, inequitable access and utilisation from the community's perspective and uses this information to co-design a local solution in the form of pilot programs designed to respond to specifically identified community needs, increase local rural health access and ensure better health outcomes in partnership with local communities.
Target population cohort	People living and working the specific areas as identified in the specific coverage areas identified by activity below.
Indigenous specific	No
Coverage	3.01 Whole of HNECC PHN region 3.02 Hunter New England region 3.03 Whole of HNECC PHN region 3.04 Whole of HNECC PHN region 3.05 New England North West region of NSW
Consultation	Extensive consultation has and continues to occur across the programs and projects that foster collaboration and partnership. Collaboration is project specific and includes, but is not limited to: • HNECC Board • HNECC Clinical Councils and Community Advisory Committees • LHD Consumer Advisory Committees • Primary care practitioners through established forums and meetings (i.e. GP Collaboration Panel and engaged Clinical Advisor roles) • Project/ Program Steering Group meetings that include key stakeholder representation • Stakeholder and Community forums • Stakeholder surveys • Established formal and informal feedback mechanisms
Collaboration	Each of the initiatives which form a component of this activity are conducted in collaboration with various stakeholders including: HNE LHD; CC LHD; ACCHOS; Rural Doctor's Network; NSW Ambulance; Family and Community Services representatives; Department of Education representatives; General Practitioner representatives; Police; Department of Premier & Cabinet; Department of Education; Local Government; Residential Aged Care representatives; and Community Aged Care Provider representatives. The role of each of these organisations varies for each activity, however HNECC PHN is the lead organisation in a number of these initiatives.
Activity milestone details/ Duration	Activity start date: 1/07/2019 Activity end date: 30/06/2022
Commissioning method and approach to market	This is not a specifically commissioned or contracted activity, it is carried out through HNECC PHN involvement in a number of partnerships Activities grouped under CF 3, are co-contributed to by the PHN however the commissioning process and subsequent contracting work are managed by the partners and not necessarily the PHN.

	The only exception is 03.05 Rural Communities Strategy. Rural Communities Strategy is still developing and is likely to be co-contributed to but depending on the market and nature of the priority activity to be commissioned may be either commissioned wholly by the PHN or commissioned and managed by the partner organisations.
Decommissioning	No

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	*CF4 Healthy Weight and Obesity Strategy*
Existing, Modified, or New Activity	Modified Activity *This activity was previously groups with Chronic Disease as part of CF2 in2018/2019 due to the sizes of the activities they have now been split apart.*
Program Key Priority Area	Population Health
Needs Assessment Priority	NxPH14 High rates of overweight and obesity – p.45, 49 NxPH15 High rates of physical inactivity and poor nutrition – p.45, 49
Aim of Activity	The Healthy weight and obesity strategy is designed to encourage food and active living environments through a social movement in order to support residents of the HNECC PHN region to engage in healthier behaviours.
Description of Activity	**CF4.01 Healthy Weight Initiative** is designed to encourage food and active living environments through a social movement in order to support residents of the HNECC PHN region to engage in healthier behaviours. In turn, the evidence suggests that these will have positive effects on waistlines, productivity, and in the long-term reduce the burden of chronic disease and demand on health services. The initiative consists of a structured, evidence-based weight management program over 12 weeks and Commences with baseline assessment, goal setting for weight loss; calorie intake and physical activity levels,; weekly weight checks and/or education sessions on nutrition and physical activity and utilising additional services and health providers for provision of support to participants progress is tracked and support through a Virtual Fitness Platform (VFP). **CF4.02 Healthy Weight- Lifestyle Community Grants** is designed to expand on the evidence that supports models of primary prevention strategies that increase the likelihood of shifting physical activity, healthy eating and lifestyle choices towards an energy balanced approach being delivered at a community or locality level.
Target population cohort	Whole of HNECC PHN region
Indigenous specific	No
Coverage	Whole of HNECC PHN region
Consultation	• HNECC PHN Board • HNECC PHN Clinical Councils and Community Advisory Committees

	• The wider HNECC PHN community including local councils, sporting groups, schools etc • Primary care practitioners through established forums and meetings (i.e. GP Collaboration Panel and engaged Clinical Advisor roles) • Project/ Program Steering Group meetings that include key stakeholder representation • Stakeholder and Community forums • Stakeholder surveys • Established formal and informal feedback mechanisms.
Collaboration	HNECC PHN collaborates with a number of other organisations to deliver on the outcomes of the initiative these include existing service providers, other members of the region's primary care community, ACCHOs; Family and Community Services representatives; NSW Department of Education representatives; General Practitioner representatives; local and regional councils, sporting groups. HNECC PHN is the lead organisation in this initiative however, the role of each of the listed organisations varies depending on what is deemed most appropriate to achieve an outcome or ensure its execution at the time.
Activity milestone details/ Duration	Activity start date: 1/07/2019 Activity end date: 30/06/2022
Commissioning method and approach to market	☒ Continuing service provider / contract extension – 4.01 ☒ Expression of Interest (EOI) – 4.02 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	No

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	*CF5 Care Navigation*
Existing, Modified, or New Activity	New Activity
Program Key Priority Area	Population Health

Needs Assessment Priority	As identified in the Priorities, Options and Opportunities Section of the Needs Assessment, provide the number, title and page reference for the priority that this activity is addressing. If this activity is a "possible option" in the Needs Assessment, provide details. NxPH26 Lack of prevention and early intervention services – p.45, 46 NxPH32 High proportions of semi-urgent and non-urgent emergency department presentations – p.44, 45 NxPH36 Cost barriers to healthcare – p. 44, 45, 46
Aim of Activity	To improve vulnerable / disadvantaged individuals' health literacy and ability to navigate and overcome barriers to accessing to services (health, social and community).
Description of Activity	**CF5.01 Care navigation development of health literacy** and empowerment to enable individuals to engage decisions their healthcare and improve self-management. – Understand and disseminate health promotion information (but not clinical advice) – To understand and inform clients of the rights and responsibilities of patients **CF5.02 Navigators** signposting and/or connecting individuals to primary health care services (including preventative screening) and complimentary community-based services as a means of social prescribing (including local programs, groups, networks and services). – Providing information / education regarding services – Making referrals, assist with appointment scheduling and reminders – Working with the client to identify, troubleshoot and overcome personal barriers to accessing these services in a timely manner. Examples of this may include: Signposting towards local public transport services, community transport services or if required developing an alternative transport solution. – Contributing to the ongoing development of local service directories (Health Pathways/Patient Info) by the use and contribution to local service information. **CF5.03 Care Navigation Training Package -** development of a Care Navigation training package that is applicable and scalable to a range of populations, is evidence based, demonstrates cultural competency and is interactive.
Target population cohort	HNECC PHN Core Needs Assessment (2019-21) identified priority groups for care navigation services who are currently experiencing service gaps including (but not limited to): • Socially isolated people aged over 65 years • Culturally and linguistically diverse populations • People in regional and rural areas • People in socioeconomically disadvantaged areas • Youth transitioning to adults in the health system • People experiencing or at risk of homelessness • People requiring access to drug and alcohol services • Aboriginal and Torres Strait Islander people • People experiencing a mental health condition Currently there are existing gaps within the provision of care navigation services within Cessnock, Taree and Tamworth.

Indigenous specific	No However, Aboriginal and Torres Strait Islander people are included and to avoid unintended negative impacts on Aboriginal and Torres Strait Islander Communities, this project was designed to include strategies that: - Require Providers to demonstrate cultural competency and safety for those individuals engaging with the services. – Additional support (including de-briefing) provided for the employed Care Navigator by the Provider.
Coverage	Cessnock, Tamworth, Taree Local Government areas for the initial three pilot sites.
Consultation	Consultation for this project has included a range of stakeholders: - Service Design and Population Health Committee - Clinical / Community Advisory Committees - External subject matter experts (please see list referred to in collaboration)
Collaboration	HNECC PHN is the lead organisation in this initiative however, the role of each of the organisations listed below varies between consult and collaborate depending on what is deemed most appropriate to achieve the aims and objectives of this activity. HNECC PHN collaborates with a number of other organisations to deliver on the outcomes of the initiative and to date has consulted with external organisations including general discussions with existing service providers, other members of the region's primary care community, ACCHOs; Family and Community Services representatives; NSW Department of Education representatives and General Practitioner representatives.
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 Other key dates: 1. February 2020 have achieved the anticipated number of clients using local navigator services in each pilot. 2. End June 2020 have completion of 12 months of Care Navigation services in each pilot. 3. Care Navigation training package deliverable due end July 2020. Service delivery start date: July 2019 Service delivery end date: June 2022
Commissioning method and approach to market	1. ☒ Expression of Interest (EOI) Expressions of interest in the form of Request for Proposals commenced March 2019. 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? No

	3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	No

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	*CF6 Early Start to Life*
Existing, Modified, or New Activity	New Activity
Program Key Priority Area	Population Health
Needs Assessment Priority	NxPH9 Poor health and developmental outcomes for infants and young children – p.43 NxPH10 Youth health needs – p.43, 44 NxPH11 Rural health disparities – p.47 NxPH30 Reduced access to services for children and youth – p. 44, 46, 49
Aim of Activity	Develop and implement a pilot program designed reduce health and development disparities for children 0-11 years, identified in communities with high alcohol consumption, through the implementation of childhood intervention and prevention programs.
Description of Activity	Recognising an emerging need resulting from the 2019/2022 Needs Assessment, HNECC PHN has identified existing issues of child health and development disparities and high adult alcohol consumption in both the Moree Plains, Cessnock and Tamworth Local Government Areas have been identified as the most appropriate pilot sites for this activity. **CF6.01 Community Partner Grants** - to deliver innovative, evidence-based initiatives and activities according to the *Early Start Community Partner Grants Framework.* Examples of potential Community Partner organisations include early learning centres, neighbourhood centres, Playgroup NSW's, PCYC. The program's initial focus areas will be: - Maternal Child Health (0-3 years) Pre and post-natal support and education to reduce risk behaviours and build parenting skills - School Readiness (3-6 years) Programs engaging and improving access to high quality early learning opportunities that target key development domains - Building Resilience (7-11 years)

	Programs to build resilience, emotional intelligence and support engagement in school and community The activity involves identifying a community-based 'Facilitating Partner' for each local government area who will be engaged to conduct the following activities: • Early Start Committees – to engage local stakeholders in the evaluation and endorsement of initiatives to be delivered by Community Partners. • Build capability of Community Partners -- by providing support opportunities for quality improvement and staff training to improve early identification of developmentally vulnerable children.
Target population cohort	At risk children and their families living in the identified communities of Walcha Shire LGA and Moree Plains Shire LGAs.
Indigenous specific	No However there are high Indigenous populations in both of the nominated pilot LGAs
Coverage	Walcha Shire LGA Moree Plains Shire LGA
Consultation	To date a number of consultations have already occurred and are ongoing with: - Identified pilot communities - Early Learning centres - Neighbourhood centres - Playgroup NSW's - PCYCs - ACCHOS - Department of Education - Family and Community Services - Relevant potential community partners for example: Smith Family, Primary Care organisations HNECC PHN Community Advisory Committees.
Collaboration	This will likely become more clear as the pilot developed however it is anticipated through this approach a number of collaborative partnerships will develop including with but not limited to: - Residents of the identified communities - Early Learning centres - Neighbourhood centres - Playgroup NSW's - PCYCs - ACCHOS - Department of Education - Family and Community Services - Relevant potential community partners for example: Smith Family, Primary Care organisations. - Local Health District - Local councils
Activity milestone details/ Duration	Activity start date: 1/07/2019 Activity end date: 30/06/2022 Service delivery start date: July 2019

	Service delivery end date: June 2022
Commissioning method and approach to market	☒ Not yet known This approach may vary depending on the differing needs of the two communities and may include a mix of direct engagement or Expression of Interest as appropriate and the pilot develops further. 2a. Is this activity being co-designed? No However it is being developed as a result of a considerable amount of collaboration and consultation. 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	No

1. (b) Planned PHN activities for 2019-20 to 2021-22 – Core Health Systems Improvement Funding Stream – General Practice Support funding

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	*HS1 Digital Health and information Sharing*
Existing, Modified, or New Activity	Existing Activity
Needs Assessment Priority	NxPH1 Low levels of health literacy NxPH20 A lack of health service integration, coordination and information sharing – p. 47 NxPH23 Targeted support for General Practice – p.47, 48, 49
Aim of Activity	To enhance, support and better connect health professionals and consumers to primary care by improving their understanding and uptake of digital health systems and to work with the primary care sector to improve the quality of referrals to support improvements in efficiency, safety, quality and security of referrals to both public and private healthcare providers.
Description of Activity	• Improved upload rate of shared health summaries and greater identification of gaps in health information and/or access to such information. • Updates to the National Health Services Directory and promote the directory to stakeholders. • Host the Home Care Package Provider Portal servicing the Central Coast and evaluate the ongoing relevance of the portal in the context of the My Aged Care portal. • Development of 'smart' eReferral forms, which facilitate first level triage by GPs and automatic inclusion of relevant clinical information • To maintain a database of both public and private health care providers (specialists and allied health) including the clinical areas and conditions or issues they receive referrals to • To implement the eReferral solution into both General Practices and private healthcare providers to support the receipt of referrals into the public health system.
Associated Flexible Activity/ies:	CF2.07 E-Referral
Target population cohort	These initiatives provide the mechanisms to support GPs, clinicians and consumers across the region with promotion, uptake and ongoing use of digital and eHealth resources and emerging technologies including eReferrals and health service directories, ensuring information is up-to-date- accurate and tailored to the appropriate audience. Information is provided to GPs, clinicians and consumers to facilitate provision of the right care at the right place, supporting the integration between primary and tertiary health sectors, and improving the health literacy of our community.
Indigenous specific	No
Coverage	Whole of PHN region

Consultation	National Health Services Directory, Best Practice Advocacy, Streamliners, GPs, clinicians and consumers.
Collaboration	National Health Service Directory regarding updates. Best Practice Advocacy Centre and Streamliners regarding the potential for system integration between National Health Service Directory, eReferrals and HealthPathways. Hunter New England Local Health District (HNE LHD) as a partner in both eReferral and HealthPathways programs. Central Coast Local Health District regarding HealthPathways program.
Activity milestone details/ Duration	Activity start date: 1/07/2019 Activity end date: 30/06/2022
Commissioning method and approach to market	This is not a commissioned activity.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	*HS2 Systems Integration and pathways*
Existing, Modified, or New Activity	Existing Activity
Needs Assessment Priority	NxPH2 Poor self-assessed health status – p.46 NxPH3 Lower than average life expectancy – p. 46 NxPH5 Health needs of an aging population – p.46 NxPH6 Poorer outcomes for culturally and linguistically diverse – p.44 NxPH18 High cancer incidence and mortality - p.45, 47, NxPH20 A lack of health service integration, coordination and information sharing – p.47 NxPH28 Barriers to screening in primary care – p. 46
Aim of Activity	To improve health and clinical outcomes for patients, whilst increasing satisfaction for consumers, GPs and sector staff through improved patient assessments and ensuring the right care, at the right time at the right place.
Description of Activity	**HS2.01 HealthPathways** The CC and HNE HealthPathways will continue to facilitate local involvement and consultation in pathway development and review. Included will be: GPs, Staff Specialists, Allied Health and nurses and midwives. HNECC PHN contributes a number of staff to the HealthPathways project and the collaboration with the LHD is formalised through The HNE HealthPathways Operational Team Meeting. Integration with CCLHD currently being progressed with the agreement between PHN and LHD executive to establish a strategic planning committee. This component of the HealthPathways activity involves use of local clinical editors and champions, pathways are developed and adapted to ensure that they contain relevant referral and treatment and include increasing amounts of local content, including education sessions to further bolster usage of the platform within the region. **HS2.02 Community Cancer Screening Participation** Development and implementation of a Community Cancer Screening Participation Strategy under the guidance of key stakeholders and community

	groups. This strategy will lead to the implementation programs aimed at increasing access to and participation in cancer (bowel, breast, cervical) screening programs, and the revision of existing information and referral pathways where required. Vulnerable communities within the region are a key focus of these activities, including Aboriginal and Torres Strait Islander people, rural and remote communities and culturally and linguistically diverse (CALD) populations. **HS2.03 Ambulance Alternative Pathways** HNECC is working collaboratively with NSW Ambulance (NSWA) to further imbed NSWA Protocol 5 (Non-transport recommended) and build awareness across primary and tertiary care. This stems from an initiative piloted on the Central Coast that has now been incorporated state-wide by NSWA. System improvements, development and expansion of the NSWA Protocol 1 (Authorised and Palliative Care Plans) are also underway to achieve a reduction in hospital admission rates, with a state wide implementation planned by NSWA as a result of this work. Ongoing collaboration with NSWA, GPs and RACFs will continue to develop resources and information that educate users in the appropriate use of triple zero calls and the completion of Authorised Care Plans when clinically indicated. Other targeted projects will focus on increasing Authorised Care Plans for patients recognised as requiring chronic disease management, for clients under Aged Care support, NDIS and those in the last year of life. **HS2.04 General Practice Quality Improvement** Commission third party provider to extract and collect aggregated data from general practices using the PAT CAT tool to benchmark and identify those practices which would benefit most from intensive quality improvement activities focused on key priority areas, such as childhood immunisation and other national and local health priorities. This commissioned activity supports the HNECC PHN Primary Care Improvement team to deliver activity GPS1 General Practice Support **HS2.05 General Practice in Residential Aged Care Telehealth Project** Development and implementation of a GP led integrated telehealth model of care for the provision of care services in residential aged care facilities in the New England, North West region. This work recognises and attempts to address the considerable issues faced when accessing general practice services for residential aged care facilities in rural and remote locations. The project will involve extensive collaboration and consultation with key stakeholders including general practice, RACFs, HNE LHD, RDN and service provider HealthWISE. Aged care population is the primary target of this intervention.
Associated Flexible Activity/ies:	HS2.04 General Practice Quality Improvement supports the successful execution of GPS1 General Practice Support and Development.
Target population cohort	2.02, 2.03, 2.04 are designed to target the whole HNECC PHN region. 2.05 is specifically designed to target the aged care population living in facilities across the New England North West.

Indigenous specific	No
Coverage	2.02, 2.02, 2.03, 2.04 are designed to target the whole HNECC PHN region. 2.05 is specifically designed to target the aged care population living in facilities across the New England North West region.
Consultation	Provide details of stakeholder engagement and consultation activities to support this activity.
Collaboration	The CC and HNE HealthPathways will continue to facilitate local involvement and consultation in pathway development and review. Included will be: GPs, Staff Specialists, Allied Health and nurses and midwives. As a result of the Community Cancer Screening Participation activities, HNECC PHN has established and developed mechanisms that enhance collaboration. The Central Coast Cancer Screening Network is a multi-agency network tasked with improving cancer screening participation on the Central Coast. Initially established with key partners including Yerin Aboriginal Medical Service, Central Coast Local Health District (CC LHD) (Aboriginal Health and Multicultural Health), NSW Cancer Council and Breastscreen NSW, it was identified that this platform was scalable across the region. Additional work also identified the need for ongoing peer support between primary care/ practice nurses and the tertiary sector. Women's Health Communities of Practice have been established across the PHN region to enhance ongoing education and learning opportunities. The role of HNECC PHN Integrated Care Officer - Ambulance Liaison Access and demand is to continue to work collaboratively with NSW Ambulance and other stakeholders to develop a communication strategy and resources that will inform practices, the tertiary health sectors and consumers of the expansion in the paramedics' role and the alternative transport options. Throughout the initiatives being undertaken, NSWA have provided data and resources to assist with implementation, evaluation and decision-making. NSWA role has also been to ensure scalability of successful initiatives elsewhere within their models of practices. Other collaborative partners include: ACCHOs, HNE LHD, CC LHD and key Residential Aged Care Facilities
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022
Commissioning method and approach to market	☒ Not yet known ☒ Continuing service provider / contract extension Activities 2.01, 2.02 and 0.03 are **not commissioned.** 2.04 PEN CAT Tool – **continuing service provider / contract extension.** 2.05 General Practice in Residential Aged Care Telehealth Project – it is **not yet known** how this activity will be commissioned, however a direct approach is likely as the project is being developed in a close working partnership with an

	existing HNECC PHN service provider who has been working in this space for some time.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	*HS3 Planning and Engagement*
Existing, Modified, or New Activity	Modified Activity *This activity was previously reported as HSI3 Planning, process and engagement. Which included Commissioning Capability. Work in this area has expanded in the last 12 months and will continue to grow across 2019/2022 as such HNECC PHN has determined it more appropriate to report Commissioning Capability as a standalone activity, now HSI5.*
Needs Assessment Priority	This activity generates the Needs Assessment collects and facilitates data collection and ensures stakeholders and consumers are provided a platform for HNECC PHN to understand community need. It is not intrinsically linked to a single Needs Assessment priority but facilitates HNECC PHNs ability to understand, capture and report the region's health needs, context and informs its decision making processes.
Aim of Activity	• Build and maintain relationships that effectively engage consumers, community and stakeholders • Improve understanding and awareness of HNECC PHN's role in the community and primary health care • Create opportunities for stakeholders to contribute to the development of PHN initiatives. • Undertake and facilitate population health planning activities to support the work of the PHN, including the commissioning of high quality, locally relevant and effective health services across the region in alignment with the Quadruple Aim approach and the needs of the community
Description of Activity	**HS3.01 Health Planning** • HNECC PHN regional Needs Assessment – ongoing monitoring of the health needs of the region and updating the needs assessment accordingly • Conduct further investigation into the needs of: – People from culturally and linguistically diverse backgrounds – People with a disability – People experiencing homelessness • Conduct further investigation into potential activities to improve the health outcomes of infants and young children with a view to commissioning solutions or working with key partners • Support the commissioning of Primary Mental Health Care & Suicide Prevention activity, including: – Conducting further investigation into early intervention services targeted at youth at risk of, or experiencing, mental illness with a view to commissioning appropriate services in response to local need – Investigating culturally appropriate low intensity social and emotional health and suicide prevention initiatives with the view to commissioning appropriate services in areas of need – Undertaking targeted consultation and further investigation to ascertain the mental health and suicide prevention needs of

	LGBTIQ community members, including the size of the population affected – Expanding on the use of the NMHSPF – Measuring the impact of stepped care implementation – PHMC MDS support to PHN Mental Health Program Managers and providers as required • Continue the implementation of the Needs Prioritisation Project, including evaluation and refinement of the methodology • Monitoring and evaluation of HNECC's commissioned services and other activities, with aim to of produce and implement a HNECC Evaluation Framework. This will include the development of program specific evaluation frameworks, data collection, analysis and reporting as required • Monitor the HNECC Population Health webpages and the suite of population health resources and update when needed • HNECC PHN Health and Wellbeing Outcomes Framework – provide ongoing support to the organisation to implement program logic according to the framework • HNECC Outcomes-Based Commissioning (OBC) 2020 plan – continue to establish processes to capture, collate and report PROMs & PREMs within HNECC programs and services in line with the 2018 HNECC Health and Wellbeing Outcomes Framework. • PHN Program Performance and Quality Framework – continue to support the implementation of this framework • Mental Health and Suicide Prevention Regional Plan – support the development of this plan including through the use of the NMHSPF-PST • Health Planning and Commissioning Database – Continue to expand collection and integrate key data sets, assess, develop and implement tools for sharing and visualising relevant data across the organisation. • HNECC PHN Health Planning database development - this database is a collection of key resources and datasets that assist both the Health Panning team with their data needs, as well as other staff and teams in the PHN in regard to project development, reporting, and program monitoring. Key information in the database presently includes: – Clinical (PATCAT) data – Critical health planning resources (eg ABS, PHIDU datasets) – PMHC MDS extracts – ATAPS data archive – Google analytics extracts (HealthPathways) data – eReferral (SeNT) data, and – Other project specific data as required • Critical Health Planning database activities include – Development of new databases, tables, views and procedures – Maintenance of existing database components – Data extraction, transformation and consolidation of datasets (see above) • Developing and implementing the HNECC Connect database which captures and links key elements guiding the work of the PHN. It enables tailored reporting of activities and indicators. The following elements are linked: – The HNECC PHN Strategic plan and constituent parts

	– Activity Work plans – Team level activities – identified health needs – PHN Program Performance and Quality Framework Indicators, responsibilities, data sources and indicator history – PHN Project Management Register – Future plans include linkage to Finance and Contract Management systems, Implementation of relevant data entry interfaces on HNECC PHN SharePoint site and development of workflows and triggers related to activity and project approvals and monitoring • Reporting, analytics and dashboards from a variety of data sources • Respond to internal and external requests for data within data governance framework requirements and processes, in a timely manner • Active participation in organisation, regional, state and national Working groups and other forums such as: – NSW PHN Data Information Network – Qld PHN Data Collaborative (by invitation) – AMS Chief Executive/HNECC PHN Data Sub Committee – PEN CS Users Group – National QlikSense Implementation Group – PHN Information Management Working Group • General data and database support including: – CRM support and report development – Support and expertise for PHN-wide IT and IM projects as required – PHMC MDS administrative support to PHN Mental Health Program Managers and providers as required – PHN website support and maintenance as required **HS3.02 Stakeholder Engagement and PeopleBank** Clinicians, consumers and other stakeholders are an important part of our efforts to improve local health outcomes, and we have made a commitment to consulting broadly about what works, and also what needs to change. For HNECC PHN, the benefits include an improved and consistent information flow (internally and externally) and the opportunity to align initiatives to local need, resulting in better planned, targeted and informed programs, services, policies and projects. For stakeholders, they benefit from greater understanding of HNECC's role in primary health care, have an opportunity to contribute their expertise to collaborate on program and service development, have their issues heard and participate in HNECC PHN's decision making process. Communication to all stakeholders includes a range of options appropriate to the type of engagement required (inform, consult, involve, collaborate or empower) and is outlined on a content and communication calendar. Communication channels include, but are not limited to: web site, fact sheets, EDM newsletter distribution, email alerts, surveys, media releases, focus groups, committee meetings, public and industry forums and social media. Peoplebank is HNECC PHN's online consultation tool that is used to include stakeholders in conversations about improving local health. It is a key initiative of our stakeholder engagement strategy and framework. Peoplebank allows HNECC PHN to broaden its reach of engagement activities through a digital consultation platform. This technology enables us to minimise the physical challenges of engaging with stakeholders across our geographically vast region. Peoplebank is not designed to replace traditional face-to-face

	engagement and consultation activities, but to complement them. Offering a number of benefits, it: • Is convenient for the audience • Allows us to reach the harder to reach audience in order to get a more representative view of issues – such as people who are time poor or geographically isolated • Makes engagement analysis easier through data mining tools • Allows conversations to evolve through time (where face-to-face requires participants to 'think and respond in the moment'), and therefore has the potential to be more of a dialogue – a conversation instead of broadcast • Demonstrates a commitment to the community through accessibility. It has the ability to be used across all HNECC PHN functions and can be segmented to target the appropriate audience (eg. consumers/clinicians) for engagement and consultation, which reduces unnecessary communication and digital noise which may become off-putting. It offers the ability for stakeholders to engage and be consulted via story sharing, discussion forums, managing formal submissions (if required), surveys and deliberative, quick polling. Digital consultation also enables us to spatially map consultation content so as to pinpoint sentiment or feedback trends by location. This will assist local decision-making and planning considerations. To monitor and quantify engagement, peoplebank supports analytics across the PHN region, a stakeholder database supports the engagement framework so as to map and report on the 'who, what, where, why and how' of our stakeholder engagement activities. The database is an online CRM platform that is able to be segmented across all PHN programs and initiatives, geographic location and representative group. This allows for the provision of an engagement health-check and to identify potential gaps in engagement activities. Online analytics for website visits, survey responses and email newsletter open rates is also be used to measure engagement and identify gaps. Discussions with the communications and engagement teams of Hunter New England and Central Cost Local Health District and all three parties are developing opportunities to expand the use of peoplebank for joint consultation initiatives. **HSI3.03 Operational Expenditure Activity** This activity is designed to support and enable to engagement, delivery and commissioning required to ensure the effective execution of activities included in Core Flexible Activities CF2 Collaborative Models of Care and CF3 Health Partnerships.
Associated Flexible Activity/ies:	These activities support all of the activities covered in all HNECC PHN Activity Work Plans. These initiatives provide the mechanisms to recognise and support GPs, clinicians and consumers to provide informed input to strengthen the local primary health sector and address issues of importance in each community. Our key stakeholders can offer important insights and it's important that we are relevant and consistent in our consultation, as well as ensuring that they are actively engaged as partners in improving local health outcomes. The Health Planning team is responsible for population health based needs assessment activities, to identify health needs and system shortcomings in our region, and determine priorities for action. The team works with stakeholders

	to identify evidence-based strategies, and develop innovative plans to better align HNECC activities to population health needs, and national and PHN priorities. This work supports and results the commissioning of high quality, locally relevant and effective health services across the region. Monitoring and evaluation of commissioned services and HNECC activities will assist to determine progress towards achieving expected cost-effective outcomes.
Target population cohort	Whole of HNECC PHN region
Indigenous specific	No
Coverage	Whole of HNECC PHN region
Consultation	- HNECC PHN Board and Staff - HNECC PHN Clinical Councils and Community Advisory Committees - Anyone living or working in the HNECC PHN region - Local Health Districts - Clinicians - Community Members - Primary Care providers both current and potential - Research organisations - Partners, both formalised and potential - Local government - Other health care providers as appropriate
Collaboration	This activity will be led by HNECC PHN with the opportunity for a wide array of stakeholders to contribute and collaborate as appropriate. • In terms of Health Planning, ongoing relationship with Central Coast Local Health District (CC LHD), Hunter New England Local Health District (HNE LHD), Population Health teams and Health Planning teams; Establish relationship with Rural Doctors Network • Data sharing for specific projects e.g. Diabetes project on the Central Coast • Joint planning for Program Specific and Regional Needs Assessments to align efforts and avoid duplication • Partnering with Hunter New England, Central Coast and Lower Mid North Coast Local Health Districts, The University of Newcastle, University of New England and Hunter Medical Research Institute in Research Centre. An ongoing focus will be on strategies to manage and prevent obesity across the region – with a focus on primary care and community development and Clinical Research Trials capacity building.
Activity milestone details/ Duration	Activity start date: 1/07/2019 Activity end date: 30/06/2022
Commissioning method and approach to market	This is not a commissioned activity.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	*HS4 Primary Care Quality Improvement*

Existing, Modified, or New Activity	Modified Activity *This activity has been refined slightly when compared with HNECC's 2018/2019 version*
Needs Assessment Priority	NxPH21 Areas of primary care workforce vulnerability – p. 47, 48 NxPH22 Locally relevant professional development and education for primary care clinicians – p. 47, 48, 49
Aim of Activity	To improve the ways general practices across the HNECC PHN region are supported to operate their businesses in a way which improves their efficiency and sustainability, and in turn, results in the provision of provide high quality, evidence-informed care for their patient community.
Description of Activity	HS4.01 comprises of: • Consultation with education recipients including regional consultation groups, practice support plans, event evaluation feedback, stakeholder feedback via all staff. • Education calendars released quarterly based on consultation and PHN priorities • Webinars, recorded and retained on PHN YouTube channel • Provision and promotion of relevant education events run by internal staff, our collaborators or external providers • Collection of General Practice workforce data for the HNECC PHN area
Associated Flexible Activity/ies:	This work supports and results the commissioning of high quality, locally relevant and effective health services across the region. Monitoring and evaluation of commissioned services and HNECC activities will assist to determine progress towards achieving expected cost-effective outcomes and is linked closely to : CFL03.02 Workforce priorities GPS01.01 General Practice Support and Development
Target population cohort	If relevant, describe the cohort that this activity will target.
Indigenous specific	No
Coverage	Whole PHN region
Consultation	HNECC PHN Clinical Councils Hunter New England Local Health District Central Coast Local Health District Rural Doctors Network HNECC PHN regional general Practices and their staff Other General Practice and Primary Care stakeholders as appropriate
Collaboration	This activity will not be jointly implemented with other stakeholders. Hunter New England Local Health District (Role = Local Health District), Central Coast Local Health District (Role = Local Health District) Rural Doctors Network (Role = Rural Workforce Agency (RWA) (for health) in New South Wales (NSW) GP Synergy (Role = provider of vocational general practice education and training, GP Registrar placement coordination) General Practice representatives (Role = Provide local clinical community knowledge)
Activity milestone details/ Duration	Activity start date: 1/07/2019 Activity end date: 30/06/2022

Commissioning method and approach to market	This is not a commissioned activity. These initiatives provide the mechanisms to recognise and support GPs, clinicians and consumers to provide informed input to strengthen the local primary health sector and address issues of importance in each community. Our key stakeholders can offer important insights and it's important that we are relevant and consistent in our consultation, as well as ensuring that they are actively engaged as partners in improving local health outcomes.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	*HS5 Commissioning Capability*
Existing, Modified, or New Activity	Modified Activity *This activity was originally part of HSI3 during 2018/2019 however due to continuing growth has been made an independent activity*
Needs Assessment Priority	NxPH5 Health needs of an aging population – p.43,44, 48, 49,50 NxPH10 Youth Health Needs – p.43, 44 nxPH11 Rural health disparities – p.47 NxPH14 High rates of overweight and obesity – p.45, 49 NxPH20 A lack of health service integration, coordination and information sharing – p. 43, 44, 45, 46 NxPH27 High rates of chronic disease hospitalisations – p.45, 46 NxPH31 Limited access to after-hours GPs – p. 47, 49, 50 NxPH33 Reduced access to services for older people – p.43, 49, 50 NxPH34 Reduced access to services in rural and remote areas – p. 43,44, 48, 49,50 NxMH1 High rates of mental illness, intentional self-harm and suicide – p.52 - 59 NxMH2 Mental health and suicide prevention needs of youth – p. 52, 53, 54 NxIH1 Poorer health outcomes for Aboriginal and Torres Strait Islander people – p.60, 61 NxAOD1 Higher rates of alcohol misuse – p.62 - 65
Aim of Activity	This activity seeks to provide a range of activities to build the capability of HNECC PHN, our system partners and service providers to enhance the current level of commissioning and move it towards internationally recognised commissioning excellence. HNECC PHN is striving to be a leading commissioning organisation that maximises the health outcomes for our population against the quadruple aims and maximises the health return on the commissioning investment. This is a multi-year journey noting that the commissioning capabilities of HNECC PHN, its system partners and service providers will need to continue to mature through practical application of commissioning techniques, ongoing learning with shared opportunities across the sector and jurisdiction, and re-assessment against the HNECC PHN commissioning competency framework to guide progress. It is expected that through the key domains of: Maintaining the commissioning cycle; Developing strategic partnerships; Procurement, monitoring and evaluation; and Showcases and Forums HNECC PHN, its system partners and service providers will have enhanced confidence and skills to participate in co-

	commissioning activities and commissioning for better health outcomes. To achieve this overall commissioning maturity, investment in capability building activities is essential.
Description of Activity	Commissioning capability will be undertaken and delivered through: **5.01 Maintaining the commissioning cycle** • Focused continuous learning opportunities in commissioning based on themes identified in the previous competency assessment, while developing internal capacity secondary to recruitment as required; • Areas of focused learning include but are not limited to: contract management and innovation; market shaping; provider performance management and outcomes-based commissioning; • Align all learning opportunities with 05.02, 05.03 and 05.04 to maximise an integrated commissioning approach to capability development. **5.02 Developing strategic partnerships** • Enhancing strategic Alliancing partnerships to ensure commissioned services align to Alliance priorities and contribute to the health outcomes being achieved across a 'whole of system' focus • Developing service providers as system partners to maximise health outcomes across the 'whole of system' **5.03 Procurement, monitoring and evaluation** • Implementation of outcome measures across relevant contracts building on from work undertaken in 2017-2018/ 2018 – 2019; • Implementation of co-design framework building on from work undertaken in 2018-2019; • Ongoing service redesign of programs, some of which may require external facilitation; • Re-assessment of the HNECC PHN Commissioning Competencies using the HNECC PHN Commissioning Competency Assessment Framework, which may require external facilitation; • Maximise co-commissioning opportunities through Alliancing arrangements, and between PHNs and other system partners; • Program evaluation using health economic input to measure efficiencies and effectiveness of commissioned services. **5.04 Showcases and Forums** • Opportunities to build strategic relationships with all service providers, while facilitating ongoing engagement through regular service provider forums that encourage shared learnings, networking and educational events relating to commissioning processes; • Program specific small group forums to develop specific opportunities that encourage consistency in the market, strong network collaboration and skills development; • Building collegial opportunities across the national PHN network through participation in the NSW/ACT Commissioning Network, the PHN National Commissioning Working Group and by co-hosting an annual PHN Commissioning Showcase. This work supports and results in the commissioning of high quality, locally relevant and effective health services across the region. Monitoring and evaluation of commissioned services and HNECC activities will assist to determine progress towards achieving expected cost-effective outcomes.

Associated Flexible Activity/ies:	CF1.01 Cancer Screening -Wyong CF1.04 Mobile X-Ray – Central Coast CF1.05 Primary Care Nursing Clinics and Community Participation programs – New England North West NSW CF1.06 Priority Allied Health Services – New England North West NSW This activity also aims to support the ongoing development of HNECC PHN commissioned activities as outlined in other Activity Work Plan including but limited to: Primary Mental Health, Alcohol and Other Drugs, Psychosocial Support, Integrated Team Care.
Target population cohort	This activity will target HNECC, its service providers, partners and stakeholders.
Indigenous specific	No
Coverage	Whole of HNECC PHN region
Consultation	• HNECC PHN Board, Clinical Councils and Community Advisory Committees • National Commissioning Workgroup • NSW/ACT Commissioning Network • LHD and other system partners • Service Provider partners
Collaboration	Initiatives that form components of this activity are conducted (where relevant) in collaboration with various stakeholders, including but not limited to; • Local Health District partners - HNE LHD and CC LHD; • Aboriginal Community Controlled Health Organisations; • Rural Doctors Network representatives; • NSW Ambulance representatives; • Family and Community Services representatives; • NSW Department of Education representatives; • General Practitioner representatives; • Residential Aged Care and Community Aged Care Provider representatives; • Service Provider partners; • Consumers and community members • Universities and Research hubs; and • Consultants. Roles of stakeholders will vary dependent on the activity undertaken, but may include: • Participant • Co-commissioner/ partner • Advisor Educator or teacher
Activity milestone details/ Duration	Activity start date: 1/07/2019 Activity end date: 30/06/2022 It should be noted that dependent on the activity being undertaken to build capacity, and the target audience of the activity will determine the activity start date and completion dates. Rolling learning opportunities will be informed by current trends, re-assessment of Commissioning Competency and other portfolio requirements. The exceptions are:

	• Re-assessment of HNECC PHN Commissioning Competency, and the engagement of a consultant to facilitate this activity, will occur in the 2019/20 FY; • An annual provider forum complimented by one each program specific/ small group forum or networking opportunity per annum. Each provider forum or small group forum will have relevant themes and learning objective as part of the event planning (2019/20; 2020/21; 2021/22) • An annual PHN Commissioning Showcase with agendas determined based on current themes taken from national or international learnings, and collaborative partnership within the PHN network (2019/20; 2020/21; 2021/22) • An annual program evaluation of one commissioned service by whole of program to determine the health economic benefits in line with the quadruple aim approach to guide the commissioning cycle (2019/20; 2020/21; 2021/22). It is not expected that service provision will occur as part of this activity.
Commissioning method and approach to market	☒ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☒ Expression of Interest (EOI) It is anticipated that some activities under *HIS5 Commissioning Capability* may require the engagement of external facilitators and/or consultants. Engagement (as required) would be completed using an approach to the market, either as an expression of interest should multiple providers be available. Direct engagement may occur from time-to-time when consultant or facilitator performance is well known, an existing relationship is strong or there is a historical relationship linked to the activity occurring. 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? No It is anticipated that some aspects of the activities under *HIS5 Commissioning Capability* may be co-design. HNECC PHN recognises the benefits of co-designed activities to ensure that activities remain fit-for-purpose and achieve the objectives. 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? Yes Some activities under *HIS5 Commissioning Capability* may be co-commissioned. 3b. Has this activity previously been co-commissioned or joint-commissioned? Yes

Proposed Activities - copy and complete the table as many times as necessary to report on each activity

ACTIVITY TITLE	*GP1 General Practice Support and Development*
Existing, Modified, or New Activity	Existing Activity
Needs Assessment Priority	NxPH20 Lack of health service integration, coordination and information sharing – p.43, 44, 45, 46, 50 NxPH21 Areas of primary care workforce vulnerability – p. 47, 48, 49 NxPH22 Locally relevant professional development and education for primary care clinicians – p. 47, 48, 49 NxPH23 Targeted support for general practice – p.47, 48, 49 NxPH36 Cost barriers to healthcare – p.45-49
Aim of Activity	Support General Practice to maximise their business efficiency and sustainability, and provide high quality, evidence-informed care in contemporary models of care for their patient community.
Description of Activity	Primary Care Improvement Officers (PCIO's) offer guidance and assistance in a range of areas. **GP1.01 Quality Improvement activities** • Practice data analysis • Practice Management • Education / Professional Development • Digital Health • Accreditation • Chronic Disease Management • Preventative Health / models of care • Workforce Support • Immunisation. **GP1.02 Quality Improvement Resources** • Developed in conjunction with key practice staff and form the basis for practice engagement for the following year • Identify priorities and key support areas • assists with enhanced health outcomes and quality of care for patient and communities, practice viability and efficiency, staff development • Influenced by: national and local health priorities and practices unique challenges and areas of interest • Support the adoption of new models of care **GP1.03 Data extraction** • De-identified health data • Help identify health priorities at a Local Government and Statistical Local Area level (see NPFlex 11.0) • Peer comparison will be provided to practices. **GP1.04 Practice Nurses** • Improve utilisation of Practice Nurses particularly in areas of workforce shortage. • Scholarships to support the professional development of Practice Nurses **GP1.05 Digital Health** • Support the uptake of MyHealth Record and Secure Messaging by GPs, Allied Health and Specialists to improve information sharing across healthcare providers.

	• Promote eReferrals and HealthPathways to all clinicians. **GP1.06 Information distribution** Mechanisms include PHN website and newsletters information covers a range of topics such as those indicated above and other PHN programs such as eReferrals and HealthPathways.
Associated Flexible Activity/ies:	CF2.07 E-referral CF3.02 Workforce priorities HS1.01 Digital Health and Information Sharing HS4.01 Primary Care Quality Improvement HS2.04 General Practice Quality Improvement
Target population cohort	People employed in general practice and other primary care services across the HNECC PHN region
Indigenous specific	No
Coverage	Whole of PHN region
Consultation	Consultation is undertaken with general practices and their staff on a one-to-one or small group speciality basis. Practice nurse meetings and Practice manager meetings are held quarterly. Consultation and feedback with clinicians undertaken regularly. The focus of all consultations is how to actively support the primary care sector through the identified areas of: This activity will support the primary health sector by: • Helping primary care providers keep abreast of the latest health information, best practice standards and initiatives; • Support continuing quality improvement; • Develop and maintain practice viability and sustainability; • Develop workforce capacity and capability; • Improved patient outcomes.
Collaboration	This is a HNECC PHN lead activity but at varying times may include collaborations with General Practices and their staff, the region's Local Health Districts, and other Primary Care Providers as deemed appropriate.
Activity milestone details/ Duration	Quality Improvement resources are reviewed at least annually. Data extraction occurs monthly with reports back to practices quarterly Website information is reviewed biannually Activity start date: 1/07/2019 Activity end date: 30/06/2022
Commissioning method and approach to market	This is not a commissioned activity.