Australian Government
Department of Health

phn
An Australian Government Initiative

Updated Activity Work Plan 2016-2018:

Core Funding

AND

After Hours

The Activity Work Plan template has the following parts:

1. The updated Core Funding Annual Plan 2016-2018 which will provide:
    a) The updated strategic vision of each PHN.
    b) An updated description of planned activities funded by the flexible funding stream under the Schedule – Primary Health Networks Core Funding.
    c) An updated description of planned activities funded by the operational funding stream under the Schedule – Primary Health Networks Core Funding.
    d) A description of planned activities which are no longer planned for implementation under the Schedule – Primary Health Networks Core Funding.

2. The indicative Core Operational and Flexible Funding Streams Budget for 2016-2018 (attach an excel spreadsheet using template provided).

Hunter New England Central Coast

When submitting this Updated Activity Work Plan 2016-2018 to the Department of Health, the PHN must ensure that all internal clearances have been obtained and that it has been endorsed by the CEO.

The Activity Work Plan must be lodged to Kate McGregor via email Kate.McGregor@health.gov.au

Updated July 2017

Overview

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

1. (a) Strategic Vision

During the next 24 month period covering this Activity Work Plan the Hunter New England Central Coast Primary Health Network will continue to achieve the PHN key objectives in alignment with the PHN Programme Guidelines and Schedules of Funding.

Our plan, consisting of 20 main flexibly funded activities which address priority areas as identified through our Baseline Needs Assessment processes, and 3 key operationally funded activities, will involve a number of approaches, including commissioning, to best deliver and support Primary Care services across our vast geography. In addition to the PHN Programme objectives, and HNECC PHN's overall strategic direction (see below), our plan has been developed through a Quadruple Aim lens. This lens is applied to each of the activities presented, not only in this Activity Work Plan, but across all program plans and areas of the HNECC PHN. Our progress within the commissioning of health services has been substantial and we are now at a stage where we will be able to award contracts to service providers in a timely manner upon approval of plans. Submission of this plan, and others does, not mean that our understanding of health and health needs across this sector is complete. Our ongoing planning and assessment efforts aim to always ensure we are responsive to individual, community, provider and industry needs.

Our continued commitment to working with our 3 GP-Led Clinical Councils and Community Advisory Committees and additional consultative structures will further facilitate future planning and innovations to support our objectives. Our Strategic Plan is presented in full on our website: http://www.hneccphn.com.au

"Our Vision Healthy People and Healthy Communities"

Our Purpose to deliver innovative, locally relevant solutions that measurably improve the health outcomes of our communities.

Our Values Respect – Innovation – Accountability – Integrity – Cooperation – Recognition

Our Principles - We will deliver better health outcomes that are efficient, effective, equitable and sustainable by:

- having a whole of system focus that puts people and communities first
- being responsive to the diversity of, and differences in, our communities and address health inequalities

- helping people understand and care for their own health, and supporting them as partners in a better health system
- supporting and being guided by GPs and other clinicians as leaders in a better health system
- aiming for the best use of health resources, with locally relevant services that are high quality and cost-effective collaborating with other to enable and coordinate timely and appropriate health care, so that people can stay well in their communities

Our Business Fitness - We will:

- focus organisational performance on Flagship Innovation, Local Relevance, Leading Delivery, and Strong Evaluation
- underpin performance with agile, innovative, efficient, cost effective and robust internal administrative and governance functions
- ensure that operations are underpinned by organisational values, clear team-based objectives, staff training and development, effective communication and leadership, and a positive team culture
- utilise Community Advisory Committees and GP-led Clinical Councils that effectively enhance the performance and primary care engagement of the organisation.

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

HNECC PHN Activity Matrix

Activity	Priority Areas From Baseline Needs Assessment 2016	Activity status at July 2017
NPFlex 1.0 Health Literacy in Action	1. Health Literacy 14. Service Integration and Coordination	Ends June 30, 2018 Unchanged from February 2017 submission
NPFlex 2.0 Directories/ Information Sharing	1. Health Literacy 2. Health Needs and Access Issues of an Aged and Aging Population	Ends June 2018 Unchanged from February 2017 submission
NPFlex 3.0 - Undertake a codesign process and implement an initiative which reduces the need for patients from Residential Aged Care Facilities (RACFs) to be transported to hospital for x-rays.	2. Health Needs and Access Issues of an Aged and Aging Population 14. Service Integration and Coordination 16. Transport	Ends June 2018 Unchanged from February 2017 submission
NPFlex 4.0 Immunisation Service – Wyong	4. Child and Maternal Health	Unchanged from February 2017 submission
NPFlex 5.0 Health Pathways	14. Service Integration and Coordination 6. Mental Health 5. Youth Mental Health 18. Rural Health and Access to Services	Modified (July 2017) *Additional activities added
NPFlex 6.0 – Collaborative Approaches to Improve Service Integration and Coordination	2. Health Needs and Access Issues of an Aged and Aging Population 3. Aboriginal and Torres Strait Islander Health and Access to Services 10. Chronic Disease 12. Dementia 14. Service Integration and Coordination	Modified (July 2017) *Additional activities added
NPFlex 7.0 Priority Allied Health Services (PAHS)	14. Service Integration and Coordination 18. Rural Health and Access to Service	Ends June 2018 Unchanged from February 2017 submission
NPFlex 8.0 Provision of Accredited Professional Development and Education Programs	15. Health Workforce	Ends June 2018

		Unchanged from February 2017 submission
NPFlex 9.0 Workforce: Analysis and Support	15. Health Workforce	Ends June 2018 Unchanged from February 2017 submission
NPFlex 10.0 Primary Health Care Nurse Program	18. Rural Health and Access to Services 8. Health Risk Behaviours	Ends June 2018 Unchanged from February 2017 submission
NPFlex 11.0 General Practice Quality Improvement	15. Health Workforce 4. Child and Maternal Health 10. Chronic Disease	Ends June 2018 Unchanged from February 2017 submission
NPFlex 12.0 Cancer Screening Clinic – Wyong	11. Cancer Screening and Incidence	Ends June 2018 Unchanged from February 2017 submission
NPFlex 13.0 Aged Care Emergency – Extension	2. Health Needs and Access Issues of an Aged and Aging Population 13. After Hours	Ends June 2018 Unchanged from February 2017 submission
NPFlex 14.0 Health Development Initiatives	9. Overweight and Obesity 19. Innovation 14. Service Integration and Coordination	Ends June 2018 Unchanged from February 2017 submission
NPFlex 15.0 Community Cancer Screening Participation Strategy	11. Cancer Screening and Incidence	Ends June 2018 Unchanged from February 2017 submission
NPFlex 16.0 NSW Ambulance Alternate Pathways Initiative – Continue and Extend	14. Service Integration and Coordination	Ends June 2018 Unchanged from February 2017 submission
NPFlex 17.0 Healthy Weight Initiative	14. Service Integration and Coordination 10. Chronic Disease 2. Health Needs and Access Issues of an Aged and Aging Population	Modified (July 2017) *Additional projects added
NPFlex 18.0 Aged Care Information Sharing	2. Health Needs and Access Issues of an Aged and Aging Population	Ends June 2018 Unchanged from February 2017 submission
~~**NPFlex 19.0 Healthy Babies – Improving Birthweights**~~	~~4. Child and Maternal Health~~	**DELETED**

		*This was a limited life project. The activity has been completed and as such has been deleted from this AWP Update
NPFlex 20.0 Electronic Referral Extension	14. Service Integration and Coordination	Ends June 2018 Unchanged from February 2017 submission
NP Flex 21 Care packages and consumer support	14. Service Integration and Coordination 17. Cost of Health Services 18. Rural Health and Access to Services	New (July 2017) *Limited life project – 12 months only ends June 30,2018
NPFlex 22 Commissioning, capability, Design, Outcomes and Evaluation	14. Service Integration and Coordination 17. Cost of Health Services 18. Rural Health and Access to Services	New (July 2017) *Limited life project – 12 months only ends June 30, 2018
NPFlex 23 Workforce: Priorities	15. Health Workforce 18. Rural Health and Access to Services	New (July 2017) *Limited life project – 12 months only ends June 30, 2018

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 1.0 Health Literacy in Action**
Existing, Modified, or New Activity	Existing
Program Key Priority Area	Population Health
Needs Assessment Priority Area (eg. 1, 2, 3)	2. Health Literacy
Description of Activity	**Activity**: This activity aims to improve health consumers' ability to manage their own health by ensuring that health consumers are aware of available services and how to access them, and that health information is accurate, widely accessible and easy to understand. This will be achieved by continuing to update the National Health Service Directory and maintaining local health directories as appropriate. The Patient Info website, running parallel with HealthPathways, will be further enhanced to improve user friendliness, and to reduce the complexity of language used in consumer information. Relevant consumer resources will continue to be added and the design of the website will be simplified to make it easier to navigate. This will further assist consumers to find and use relevant health information. A health literacy guide will be produced and provided to service providers to support the adoption of health literacy principles in all consumer information. Service providers will be encouraged to use the guide in the development of all consumer information and materials to ensure that content and design does not exclude consumers with low literacy. Tools to assess the reading level of written material will be promoted to service providers to use in the development of consumer information. Equally, if this needs to be applied to a particular program area, then this should be considered. For example: If the direction of the Healthy Weight strategies or others is to increase Health Literacy in relation to nutrition and exercise, then this is a good outcome. **Aim**: This activity will build on the work done to date on HealthPathways, the Patient Info website and the literacy guide to better support consumer empowerment and self-management. HNECC will continue to improve access to, and the navigability of, health services as well as the user friendliness of patient and consumer information.
Target population cohort	This activity targets all population groups
Consultation	The HNECC PHN will work with a range of service providers to test and refine the draft health literacy guide to ensure its relevance and applicability to service providers.

Collaboration	For the Patient Info Website, the Hunter HealthPathways project will be jointly implemented by HNECC PHN and HNE LHD. The Central Coast HealthPathways project will be jointly implemented by HNECC PHN and CCLHD. If necessary, a health literacy workshop could be conducted with service providers to increase awareness of literacy barriers and the principles of health literacy.
Indigenous Specific	No
Duration	1/07/2016 – 30/06/2018
Coverage	This activity covers the entire HNECC PHN catchment area comprising of 15 SA3s
Commissioning method (if relevant)	This activity will not be contracted or commissioned, the Patient Info website portion of the activity it will be managed/delivered by HNECC PHN in collaboration with the LHDs. The rest of this activity will be managed and conducted by HNECC PHN.
Approach to market	N/A
Decommissioning	N/A
Funding from other sources	No funding will be sourced from other organisations to contribute to this activity.

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 2.0 Directories/ Information Sharing**
Existing, Modified, or New Activity	Existing
Program Key Priority Area	Other - system integration
Needs Assessment Priority Area (eg. 1, 2, 3)	1. Health Literacy 2. Health Needs and Access Issues of an Aged and Ageing Population
Description of Activity	**Aim:** Enhanced access to reliable and consistent health service information for health professionals and consumers. Improved consumer and health professional knowledge and awareness of primary health care. Supports HealthPathways and eReferral programs.

	Activity: Provide updates to the National Health Services Directory and promote the directory to stakeholders. Maintain Local Health Services Directories. Host the Home Care Package Provider Portal servicing the Central Coast and evaluate the ongoing relevance of the portal in the context of the MyAgedCare portal.
Target population cohort	This activity will target the whole of population.
Consultation	Health care providers including Hunter New England and Central Coast Local Health District's General Practices, Allied Health providers, specialists, Residential Aged Care Facilities regarding their information National Health Service directory regarding system capability and updates.
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 as a partner in both eReferral and HealthPathways programs. Central Coast Local Health District regarding HealthPathways program.
Indigenous Specific	No
Duration	1/7/2017 to 30/6/2018 Quarterly updates to National Health Service Directory (NHSD) Feasibility analysis regarding integration of NHSD / HealthPathways / eReferral solution.
Coverage	This activity covers the entire PHN catchment area comprising 15 SA3s.
Commissioning method (if relevant)	This is not a commissioned activity.
Approach to market	Not applicable
Decommissioning	This is not a commissioned activity.

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 3.0 - Undertake a codesign process and implement an initiative which reduces the need for patients from Residential Aged Care Facilities (RACFs) to be transported to hospital for x-rays.**
Existing, Modified, or New Activity	Modified (Formerly labelled NPFlex 3.0 Mobile X-Ray – Central Coast)
Program Key Priority Area	
Needs Assessment Priority Area (eg. 1, 2, 3)	2. Health Needs and Access Issues of an Aged and Ageing Population 14. Service Integration and Coordination 16. Transport
Description of Activity	**Activity:** Conduct a hospital avoidance trial which connects RACF residents to local existing diagnostic and transport resources. **Aim:** Reduce the need for patients living in RACFs to be transported to hospital in the event of unexpected deterioration.
Target population cohort	Residents of RACFs in the Gosford and Wyong LGAs
Consultation	2016 August Survey of RACFs Primary Care Support for RACFs Working Group (Membership includes HNECC PHN, NSW Ambulance, Local Health District and RACFs representatives)
Collaboration	This activity will not be jointly implemented with other stakeholders
Indigenous Specific	No
Duration	12 months
Coverage	Gosford and Wyong LGAs
Commissioning method (if relevant)	N/A

Approach to market	Multi-stage procurement process
Decommissioning	N/A

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 4.0 Immunisation Service - Wyong**
Existing, Modified, or New Activity	Existing
Program Key Priority Area	Other – Child and Maternal Health
Needs Assessment Priority Area (eg. 1, 2, 3)	4. Child and Maternal Health
Description of Activity	**Activity:** Commission the provision of administrative support to the Childhood Immunisation Service conducted by the Wyong Shire Council as a community support initiative in the Wyong region. **Aim:** To increase childhood immunisation rates in the Wyong SA3 by conducting free vaccination programs and communicating information about immunization to the public and health professionals.
Target population cohort	0 – 5 years
Consultation	Annual consultation is undertaken with the local provider and two (2) HNECC advisory bodies, i.e. Clinical Councils and Community Advisory Groups.
Collaboration	Service is delivered in partnership with Central Coast Local Council and the Central Coast Local Health District
Indigenous Specific	No

Duration	12 months
Coverage	Wyong LGA
Commissioning method (if relevant)	Renewal of contract is dependent on satisfactory performance. Selective tender will be undertaken only if required.
Approach to market	Multi-stage procurement process
Decommissioning	N/A

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. NP 1)	**NPFlex 5.0 HealthPathways**
Existing, Modified, or New Activity	Modified (July 2017)
Program Key Priority Area	Collaborating with stakeholders, developing and publishing local HealthPathways in as determined by the HealthPathways Operation Management group including these priorities: • Youth Health • Mental Health • Service Integration and Coordination • Rural Health and Access to Services • Cancer Screening
Needs Assessment Priority Area (eg. 1, 2, 3)	4. Youth Health 5. Mental Health 14. Service Integration and Coordination 18. Rural Health and Access to Services 11. Cancer Screening

Description of Activity	HealthPathways provide assessment, management and referral advice to support GPs' clinical decision-making at the point of care. Collaboration in pathway development between GPs and specialist services promotes integration between primary care and specialist service providers. In line with the PHN's vision and purpose, we develop locally relevant HealthPathways, which improve health outcomes for the community by enabling right treatment, right time and right referral **Youth Health** Aim is to provide clear, locally relevant roadmaps of youth mental health services according to presenting condition and geographically. Investment in HealthPathways PatientInfo to improve homepage, structure and the utility and appearance of key information such as end of life care, youth mental health and cancer screening. **Mental Health** and Youth Health – the following pathways will be developed by 30th June 17 • Eating Disorders in Children and Adolescents • Psychosis • Suicidal Ideation and Intent • ADHD in Children and Young People • Perinatal Mental Health • Depression in Adolescents and Young Adults • Anxiety in Adolescents and Young Adults • Deliberate Self Harm • Acute Severe Behavioural Disturbance **Service Integration and coordination** Well established with HNELHD by the HNE HealthPathways Operational Team Meeting with is co-chaired by the CQI Manager HNECCPHN and the Manager of Partnerships Innovation and Research from the LHD. Integration with CCLHD currently being progressed with the agreement to establish a strategic planning committee.

	Collaborating with the LHD in enabling the implement of pathway-based smart eReferral from practice software. **Rural Health and Access to Services** Stretch target for June 30th 2017 is 100% of HNE pathways localised to whole of PHN. Increased involvement of New England/North West and Manning in pathway planning and development. **New England Pathways Expansion** Utlising local clinical editors and champions, all pathways are being adapted to ensure that they contain relevant referral and treatment for the New England part of the HNECC region. Increasing local content and local education sessions should increase usage of the platform within the region. During this period, 10 education sessions and 15 practice visits will be undertaken to increase usage. HNECC is participating in the national evaluation of Health Pathways in 2017-18, which will enable measurement of take-up in the region. **Cancer Screening** Collaborating with PHN cancer screening initiatives to develop pages which provide GPs with current screening/referral information through HealthPathways. Patients with positive screens have rapid access to appropriate specialist services.
Target population cohort	Whole of HNECCPHN footprint
Consultation	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.
Collaboration	Collaboration with LHD through HNE HealthPathways is formalised through The HNE HealthPathways Operational Team Meeting with is co-chaired by the CQI manager from HENCCPHN and the Manager of Partnerships Innovation and Research from the LHD. Integration with CCLHD currently being progressed with the agreement between PHN and LHD executive to establish a strategic planning committee.
Indigenous Specific	This activity is not targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people but the HealthPathways teams will continue to demonstrate commitment to closing the gap

	by ensuring that by 30th June 25% of pathways include appropriate Aboriginal health and referral information.
Duration	Full year and ongoing activity. Target is for 25 new local clinical pathways each for HNE and CC HealthPathway teams
Coverage	Whole PHN region between two HealthPathways teams
Commissioning method (if relevant)	NA
Approach to market	NA
Decommissioning	NA

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 6.0 – Collaborative Approaches to Improve Service Integration and Coordination**
Existing, Modified, or New Activity	Modified (July 2017)
Program Key Priority Area	Other - Service Integration and partnerships
Needs Assessment Priority Area (eg. 1, 2, 3)	2. Health Needs and Access Issues of an Aged and Ageing Population 3. Aboriginal and Torres Strait Islander Health and Access to Services 10. Chronic Disease 12. Dementia 14. Service Integration and Coordination
Description of Activity	**Activity:** Partner in collaborative approaches to improve service integration and coordination, including for example: • The Hunter Alliance - Care in the Last Year of Life, Diabetes work stream, including the expansion of the Diabetes Model of Care into the New England region, and COPD work streams. HNECC co commissions the implementation of the Diabetes Model of Care, which enhances Diabetes care in Primary Care with HNE Local Health District.

	• 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 • Central Coast Integrated Care Program – which includes a Care Coordination pilot in the Peninsula and North Wyong areas; development of a Diabetes Model of Care and regional plan; an Antenatal Share Care redesign project; a multi-agency Out of Home Care project; and the Family Referral Service in School project • Chronic kidney disease programs; and Diabetes projects in collaboration with the Hunter Alliance. • Hunter Dementia Alliance and the re-engagement of a Central Coast Dementia Alliance • Dementia Partnership Project – development of shared diagnostic tools and resources • Central Coast Aged Care Task Force – a multi-agency representation including NSW Ambulance, CCLHD and Age Care Sectors representatives to consider a whole of system approach to integrating Aged Care (both residential care and community care) • GP Collaboration Unit – with joint funding from HNECC PHN and CCLHD, this includes representatives from the CCLHD, HNECC PHN and a cross section of General Practitioners, this Unit facilitates system improvements between primary and tertiary care • 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 HNELHD. • Diabetes Model of Care (Central Coast) – Co commissioning of new model of Diabetes Care for the Central Coast, enhancing care in Primary Health setting and reducing demand on tertiary services. **Aim:** Greater integration and coordination of health services through clinically-led service development and improvement. Health care services are connected in a way that builds on available health care resources and introduces pockets of innovation that are assessed for scalability and cost effectiveness. Health care is person-centred, seamless and delivered close to home. Improvement is seen in patient experience of care, provider experience of care, clinical outcomes, and health outcomes

Target population cohort	This activity targets all population groups.
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: Calvary; Hunter Primary Care; HNE LHD; CC LHD; HealthWISE New England North West; ACCHO's; 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
Indigenous Specific	YES, a number of the partnerships are focused on improving the health of Aboriginal and Torres Strait Islander peoples.
Duration	1/07/2016 – 30/06/2018.
Coverage	Each partnership encompassed by this activity focus on a sub-region within the HNECC PHN catchment, however the entire HNECC PHN catchment area comprising of 15 SA3s is covered by this activity.

Commissioning method (if relevant)	This is not a commissioned or contracted activity, it is carried out through HNECC PHN involvement in a number of partnerships
Approach to market	N/A
Decommissioning	N/A

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 7.0 Priority Allied Health Services**
Existing, Modified, or New Activity	Existing
Program Key Priority Area	Other – Rural Health and Access to Services
Needs Assessment Priority Area (eg. 1, 2, 3)	4. Health Needs and Access Issues of an Aged and Ageing Population 6. Mental Health 8. Health Risk Behaviours 9. Overweight and Obesity 10. Chronic Disease 12. Dementia 14. Service Integration and Coordination 18. Rural Health and Access to Services

Description of Activity	**Activity:** Commission a range of Allied Health Services throughout the Hunter and New England region through the Priority Allied Health Services Program. **Aim:** To improve the health and wellbeing of people across the HNECC PHN 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.
Target population cohort	The activity is primarily focused on residents living in small and more rural locations with identified health needs.
Consultation	Annual consultation is undertaken with local providers and two (2) HNECC advisory bodies, i.e. Clinical Councils and Community Advisory Groups.
Collaboration	This activity will not be jointly implemented with other stakeholders.
Indigenous Specific	No
Duration	12 months
Coverage	**Hunter Local Government Areas:** Cessnock, Dungog, Gloucester, Great Lakes, Greater Taree, Lake Macquarie, Muswellbrook, Newcastle, Port Stephens, Singleton and Upper Hunter Shire. **New England Local Government Areas:** Armidale Dumaresq, Glen Innes, Gunnedah, Guyra, Gwydir, Inverell, Liverpool Plains, Moree Plains, Narrabri, Tamworth Regional, Tenterfield, Uralla and Walcha.
Commissioning method (if relevant)	Renewal of contract is dependent on satisfactory performance. Selective tender will be undertaken only if required.
Approach to market	Multi stage procurement process

Decommissioning	N/A

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 8.0 Provision of Accredited Professional Development and Education Programs**
Existing, Modified, or New Activity	Existing
Program Key Priority Area	Health Workforce
Needs Assessment Priority Area (eg. 1, 2, 3)	12. Dementia 15. Health Workforce
Description of Activity	**Aim:** work with all internal and external stakeholders to minimise town/suburb vulnerability across the HNECCPHN region **Activity:** This activity will comprise the following key elements: • Collection of General Practice workforce data for the HNECCPHN area • Development a workforce vulnerability matrix to enable the allocation of a vulnerability index to each suburb/town. Key vulnerability indicators will include: town/suburb population against existing workforce FTEs, town/suburb median age, age of existing workforce, registration/provider number access limitations, specialist skills knowledge needed v what is available, known workforce intentions (move/retire etc.), distance from next closest service • Allocate vulnerability index to each town / suburb • Use vulnerability indices to identify and manage areas of immediate vulnerability while also developing a short- and longer-term workforce plan
Target population cohort	This activity will target the whole community.
Consultation	Data collection and consultation with individual General Practices Regular meetings including the stakeholders outlined in the Collaboration section below and internal stakeholders.
Collaboration	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).
Indigenous Specific	No
Duration	Activity start date 1/7/2017 – 30/6/2018 Key Milestones: • Bi monthly stakeholder succession planning meetings for Hunter • Bi monthly stakeholder succession planning meetings for New England • LGA level data validation of primary care workforce, numbers and distribution (initially General Practitioner and Practice staff expanding to Allied Health) • Development of workforce infographic at LGA level for publishing on web page
Coverage	This activity covers the entire PHN catchment area comprising 15 SA3s.
Commissioning method (if relevant)	This is not a commissioned or contracted activity, it will be managed / delivered by the PHN.
Approach to market	This activity does not require procurement.
Decommissioning	Not relevant to this activity as it is not a commissioned or contracted activity.

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 9.0 Workforce: Analysis and Support**
Existing, Modified, or New Activity	Existing
Program Key Priority Area	Health Workforce Other - Professional Development

	For all practice staff including General Practitioners, Practice Nurses, Allied Health, Practice Managers and administration.
Needs Assessment Priority Area (eg. 1, 2, 3)	15. Health Workforce
Description of Activity	**Aim:** Work with all internal and external stakeholders to provide continuing professional development opportunities to the region wide primary health workforce **Activity:** This activity will comprise the following key elements: • 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 • Monthly webinars, recorded and retained on PHN YouTube channel • Provision and promotion of relevant education events run by internal staff, our collaborators or external providers
Target population cohort	This activity will target the clinical community and their support staff.
Consultation	Central Coast Clinical Council, Central Coast GP Collaboration Unit, Hunter Postgraduate Medical Institute (HPMI), New England: Southern Continuing Professional Development (CPD) Advisory Group, New England CPD, Western CPD Practice Support and Development team via Practice Support Plans and regular practice contact. Internal PHN staff who engage with external stakeholders. Internal staff engaged with PHN priority activities.
Collaboration	Hunter Postgraduate Medical Institute and New England Division of General Practice – consult with members regarding education requirements and deliver education events and/or engage 3rd parties to do so. Hunter New England Local Health District, Central Coast Local Health District deliver education events to support internal programs and departments. HNECC consults with practitioners and their staff regarding education requirements, develops and delivers education, engages 3rd parties to deliver education, accredits education events. HNECC also promotes education being delivered by the above organisations.
Indigenous Specific	No

Duration	1/7/2017 – 30/6/2018 Quarterly meetings with collaborators Quarterly education calendars published Education events run throughout the year
Coverage	This activity covers the entire PHN catchment area comprising 15 SA3s.
Commissioning method (if relevant)	This is not a commissioned or contracted activity, it will be managed / delivered by the PHN.
Approach to market	This activity does not require procurement.
Decommissioning	Not relevant to this activity as it is not a commissioned or contracted activity.

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 10.0 Primary Health Care Nurse Program**
Existing, Modified, or New Activity	Existing
Program Key Priority Area	Rural Health and Access to Services Other – Health Education in small communities
Needs Assessment Priority Area (eg. 1, 2, 3)	8. Health Risk Behaviours 18. Rural Health and Access to Services
Description of Activity	**Activity:** This activity supports health screening, health education, preventative health and health promotion services, delivered in partnership with the community and other local stakeholders.

	Aim: Improved health and wellbeing of people living within small rural and remote communities (with a population of less than 2,000), achieved by identifying and addressing local preventative health needs.
Target population cohort	Residents living within small rural and remote communities (population < 2000)
Consultation	Annual consultation is undertaken with local providers and two (2) HNECC advisory bodies, i.e. Clinical Councils and Community Advisory Groups.
Collaboration	This activity will not be jointly implemented with any other stakeholders.
Indigenous Specific	No
Duration	12 months
Coverage	**New England Local Government Areas:** Armidale Dumaresq, Glen Innes, Gunnedah, Guyra, Gwydir, Inverell, Liverpool Plains, Moree Plains, Narrabri, Tamworth Regional, Tenterfield, Uralla and Walcha. **Hunter Local Government Areas:** Port Stephens.
Commissioning method (if relevant)	This activity is included in the commissioning process, the key stages of which are as follows: open Expression of Interest for providers to deliver services in 2016-17 (with a possible 12-month extension); select request for tender issued; evaluation of submissions; and contract negotiation and execution with successful tenderers. Future refinements to this activity are informed by regular performance monitoring and evaluation, and annual strategic planning.
Approach to market	Multi stage procurement process.
Decommissioning	N/A

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 11.0 General Practice Quality Improvement**
Existing, Modified, or New Activity	Existing
Program Key Priority Area	Health Workforce Other – Quality Improvement
Needs Assessment Priority Area (eg. 1, 2, 3)	15. Health Workforce 4. Child and Maternal Health 10. Chronic Disease.
Description of Activity	**Aim:** Improved patient outcomes, including improvement in national health priorities such as increased childhood immunisation rates across the HNECC PHN region. **Activity:** Make use of aggregated data collected 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 will involve extraction of de-identified health data from practices and provision of benchmarking data to practices. These activities will feed into the development and implementation of Practice Support Plans and support of other initiatives including Health Care Homes and Healthy Weight. 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 *Note: Refer to OP1.5 for more information regarding Practice Support Plans.*
Target population cohort	This activity will target the whole community.
Consultation	Clinical Councils, General Practices and other primary healthcare providers, communities, LHD's
Collaboration	These are PHN driven activities.

Indigenous Specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? NO
Duration	1/7/2017 to 30/6/2018 Data extraction occurs monthly, with reports back to practices quarterly
Coverage	Outline coverage of the activity. Where area covered is not the whole PHN region, provide the statistical area as defined in the Australian Bureau of Statistics (ABS), or LGA.
Commissioning method (if relevant)	This is not a commissioned or contracted activity.
Approach to market	This is not a commissioned or contracted activity.
Decommissioning	This is not a commissioned or contracted activity.

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 12.0 Cancer Screening - Wyong**
Existing, Modified, or New Activity	Existing
Program Key Priority Area	Cancer Screening
Needs Assessment Priority Area (eg. 1, 2, 3)	11. Cancer Screening and Incidence
Description of Activity	**Activity:** Commission the provision of administrative support to 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. **Aim:** 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.
Target population cohort	Women aged 20 -69 years of age
Consultation	Annual consultation is undertaken with the local provider and two (2) HNECC advisory bodies, i.e. Clinical Councils and Community Advisory Groups.
Collaboration	This activity will not be jointly implemented with any other stakeholders.
Indigenous Specific	No
Duration	12 months
Coverage	Wyong LGA
Commissioning method (if relevant)	This activity is included in the commissioning process, the key stages of which are as follows: open Expression of Interest for providers to deliver services in 2016-17 (with a possible 12-month extension); select request for tender issued; evaluation of submissions; and contract negotiation and execution with successful tenderers. Future refinements to this activity are informed by regular performance monitoring and evaluation, and annual strategic planning.
Approach to market	Multi stage procurement process.
Decommissioning	N/A

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 13.0 Aged Care Emergency**

Existing, Modified, or New Activity	Existing
Program Key Priority Area	After Hours Health Service Access
Needs Assessment Priority Area (eg. 1, 2, 3)	2. Health Needs and Access Issues of an Aged and Ageing Population 13. After Hours Health Service Access
Description of Activity	**Activity:** Extend the Aged Care Emergency (ACE) Program to the New England region. The ACE program is a nurse led model of care that provides support to Residential Aged Care Facilities (RACFs) staff to facilitate residents' non-life threatening acute care needs being met within the facility and thus avoiding an Emergency Department (ED) presentation. Where an ED presentation is required, the ACE program will enhance the flow and coordination of the care of the patient during their ED visit. **Aim:** Reduction in the need for residents of RACFs to present to an ED for non-life-threatening acute care, and where ED presentation are required, to proactively manage the presentation.
Target population cohort	Residents of Aged Care Facilities
Collaboration	This activity is a collaboration between HNECC PHN and HNELHD.
Indigenous Specific	No
Duration	2016 -2017
Coverage	Whole of HNECC PHN region
Commissioning method (if relevant)	N/A
Approach to market	N/A

Decommissioning	N/A

Proposed Activities	
Activity Title / Reference (eg. OP 1)	**NPFlex 14.0 Health Development Initiatives**
Existing, Modified, or New Activity	Existing
Description of Activity	A number of health development initiatives will be pursued, with the aim of improving health outcomes for priority populations in the region through collective or collaborative innovative endeavours between private, NGO and public organisations. **INNOV8 Health Development Initiative** INNOV8 is HNECC PHN's initiative to promote and facilitate innovation in health development for the PHN region. It includes the INNOV8 online portal which has now gone live. The INNOV8 online portal provides information, case studies and engaging and interactive content relevant to innovation throughout the PHN region. It is an online space for healthcare stakeholders to engage and collaborate. It serves as a clearing house for local innovative endeavours and provide a platform to host our initiatives, such as the Collaborative Health Innovation Project, INNOV8 Pitch Night and Local Health Innovation Awards - an awards scheme to build awareness, highlight achievements, facilitate further collaboration and provide a foundation to engage and attract future co-funding opportunities. **Collaborative Health Innovation ProjectIN1.1** The Collaborative Health Innovation Project forms part of HNECC's INNOV8 health development initiative. HNECC PHN invited grant applications for one-off seed funding. Proposals were sought that took a new approach to solving problems, especially those that can be evaluated and have

	potential for expansion and further development. Encouragement was provided for collaborations and partnerships that facilitate combining knowledge and resources to achieve a shared goal. This included facilitating multiple 'speed dating' events that enabled applicants to network with each other. Eighty applications were received, shortlisted to 25 submissions that moved to the final assessment. Representatives were selected from each PHN Clinical Council (Central Coast, Hunter New England Rural and Hunter New England Metro) to assess shortlisted applicants and provide recommendations for funding allocation across their sub-region. Seven projects were recommended for funding across Mental Health, Technology, Chronic Disease, Indigenous Health, Drug and Alcohol, Aged Care, and Health for vulnerable/homeless. HNECC will work with successful organisations to monitor and measure progress, and report on the outcomes. **INNOV8 Pitch Night1.1** HNECC PHN is planning a pitch night event for start-ups and primary health-related organisations to pitch their innovative ideas to gain exposure and funding. A hybrid of live crowd-funding and 'shark tank'. Prior to the event all of the participants will have their pitching skills honed in pitch training sessions. Each pitching organisation will get six minutes to deliver their pitch. After those six minutes there are four minutes allocated for questions, then the audience will determine the amount of funding they will receive. A pitch night provides an opportunity for not only organisations to showcase their innovative ideas, it also provides an avenue for sector influencers, local business and the health community to network and have direct input into the development of health innovation in the region. It also is a vehicle to raise the profile of the PHN and educate the community further on our role developmental role in primary health. **Aboriginal Health Innovation in Practice IN1.2**

	HNECC is proposing to scope a targeted, Indigenous-health focused programme that will develop outcomes-based projects in collaboration with Aboriginal Community Controlled Health Organisations (ACCHOs). The first stage of this is to identify best-practice or high impact Indigenous Health initiatives in the region. Following this, HNECC PHN will provide funding and in-kind support to identify and develop analysis of health outcomes, working in collaboration with successful organisations and with input from organisations with expertise in health outcomes analysis. We have identified need of capacity gaps in current Aboriginal Health practice, and believe this will enhance current practice that will develop local, innovative approaches that are measurable and scalable across Aboriginal health in key priority areas. HNECC will then seek opportunities to attract further funding or co-investment (through corporate or philanthropic support), with a priority on capability and capacity building in (or in partnership with) the ACCHO sector.
Supporting the primary health care sector	These initiatives support the development of the primary health care sector through the promotion of new approaches in the delivery of primary health car in the region. It recognises and aims to capture evolving models within the primary health care sector and facilitate collaboration between primary health care professionals and organisations within the community. Our scope to create innovative co-designed outcome-based models of care, has a focus on better supporting people with chronic disease risk factors. Its purpose is to identify, encourage and fund health initiatives that: • Address priorities or needs identified in the HNECC PHN Health Planning Compass and Needs Assessments • Delivers new or improved models of care • Demonstrates the development of better health outcomes, strong patient and clinician experience, and/or strong efficiency • Demonstrates clinical leadership or support • Demonstrates partnerships and drive new technology-enabled care models • Demonstrates reach to vulnerable groups or communities

	• Shows potential for sustainability and further scalability.
Collaboration	This activity will be led by HNECC PHN with the opportunity for a wide array of stakeholders to contribute and collaborate as appropriate.
Duration	01/07/2016 – 30/06/2018
Coverage	These activities cover the entire PHN region.
Expected Outcome	The expected outcome of these activities is to assist in the development of innovative approaches and solutions that includes: • An idea • Service • Approach • Model • Process, or • Product That is new, or applied in a way that is new, which improves the efficiency, effectiveness or co-ordination of locally based primary health care services. We believe that this will allow for further public or private investment in new, innovative models of primary health care that, if successful, could be scaled up further.

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 15.0 Cancer Screening - Wyong**
Existing, Modified, or New Activity	Existing
Program Key Priority Area	Cancer Screening
Needs Assessment Priority Area (eg. 1, 2, 3)	11. Cancer Screening and Incidence
Description of Activity	**Activity:** 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. It is expected over the 2017/18 period that the strategies employed over the 2016/17 period will be maintained and enhanced. These strategies have specifically focused on; • developing partnerships with primary care providers, clinicians and community to support targeted priority populations (CALD and Indigenous, particularly women under screened or never screened for breast and cervical cancer); • supporting and enhancing primary care system capacity and capability, through quality improvement activities relating to recall and reminder systems for breast. Bowel and cervical screening; • enhancing Clinician skills and knowledge, particularly in the area of renewed cervical screening guidelines, and to increase provider numbers of cervical screening clinicians where low participation rates are seen to link with service availability. HNECCPHN, through its affiliation with Cancer Institute NSW and National Cancer Screening programs, will be required to play a supportive role to embed system changes created by the

	establishment of; Cervical screening renewal program, National Screening registers (cervical and bowel) and new electronic results and referral systems for breast screen into general practice. This will be a focus of activity over 2017/18 and will assist to ensure patients screening records are current and improve screening rates through reminder systems. In the 2017/18 period there will be an increased emphasis on community engagement through. **Achievements:** Over 2016/17 reporting period the following has been achieved: • Partnership agreement with Family Planning NSW has enabled a scholarship program Practice Nurses to participate in Well Women's screening course from targeted Rural and Remote areas where screening rates are low, thus improving access to services. • Establishment of a Cancer Screening Network has supported an integrated approach to Cancer Screening with a special focus on Breast Screening for Aboriginal women. • Facilitating Education events across the HNECCPHN area for Clinicians (GP's and Nurses) in promoting the importance of Cancer Screening Primary Care. **Aim:** Increased Cervical, Breast and Bowel Screening participation rates within targeted populations and/or communities in the HNECC PHN region. Greater collaboration between HNECC PHN, Local Heath Districts and other agencies that have responsibilities in this area.
Target population cohort	This activity will target specific populations in line with the recognised Cancer Screening guidelines. • Women who are aged between 18 – 69#yrs who have ever been sexually active (cervical screening) • Women aged between 50 – 74yrs (breast cancer screening) • All Australians over 50yrs (Bowel cancer screening)

	# NB: Age limits will change pending adoption of new guideline 1 May 2017.
Consultation	Stakeholder engagement and consultation activities have included: • General practice workforce audit; • Consultation with the HNECC Practice support team and practice staff; • Multi-cultural services CCLHD and HNELHD; • GP and Clinician consultation • Aboriginal Health workers, clinicians and Aboriginal community members. A Cancer Screening Network has been established with representative membership from NGO's and Government organisations, with consultation a key role. Consultation and regular meetings has been undertaken with BreastScreen Hunter New England and North Sydney Central Coast. Two GP Clinical Advisors have been recruited to the project in a consultative capacity to ensure project activity is proactive as well as responsive to general Practice needs.
Collaboration	List stakeholders that will be involved in implementing the activity, including Local Hospital Network or state/territory government. Describe the role of each party. • Family Planning NSW; Partnership to deliver Well women's screening course to Practice Nurses in Rural and Remote areas and key partner in delivering education on cervical screening renewal program • Cancer Institute NSW -Primary Care Manager and PHN Cancer Screening network; connection to resources and information on National Cancer Screening programs • BreastScreen SAS's Hunter and Central Coast: general practice resources and education • Cancer Council NSW- resources and education activities • HNE LHD – Aboriginal Health Unit, Multicultural Health Unit, Community Health Committees

	• CC LHD- Women's Health Nurses, Multicultural Health Unit, Cancer Innovation and Planning, Aboriginal Health Unit- Advisory, education and consultation • Aboriginal Medical Services - Armajun and Yerin and others as National resources become available. Northern Settlement Services- CALD NGO service – consultation and community engagement
Indigenous Specific	No this activity is not Indigenous specific, but program activities will involve Aboriginal communities
Duration	1/06/2016 – 30/06/2017
Coverage	This activity will target specific SA3s within the HNECC PHN region based on identified need.
Commissioning method (if relevant)	This activity will not be commissioned or contracted, it will be managed/delivered by the PHN.
Approach to market	N/A
Decommissioning	N/A
Funding from other sources	N/A

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 16.0 NSW Ambulance Alternate Pathways Development – Continue and Extend**
Existing, Modified, or New Activity	Modified activity (2016-18 Activity Work Plan).
Program Key Priority Area	Other – Service Integration

Needs Assessment Priority Area (eg. 1, 2, 3)	14. Service Integration and Coordination
Description of Activity	**Activity:** HNECC is working collaboratively with NSW Ambulance (NSWA) to evaluate and implement the NSWA Alternate Pathways Initiative, which was initially piloted on the Central Coast. Paramedic assessment skills were enhanced through additional training as part of the pilot which has now been incorporated into routine business and provides patients that present with a low acuity need a more suitable alternative for treatment via their own GP or alternative After Hours Service. 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 have also been able to develop resources and information that educate users in the appropriate use of triple zero calls. The creation of a dedicated NSW Ambulance Referral pathway for GPs and RACFs on the *HealthPathways* website in the HNECC region has been develop and is pending release. This is expected to be shared across NSW *HealthPathways* sites by NSWA. A Mental Health Pilot within Hunter is expected to increase assessment skill of paramedics to assist manage mental health patient in crisis, deescalate the situation and assist in the reduction of unnecessary hospital admission rates for patient with mental health care plans. Other targeted projects will focus on increasing Authorised Care Plans for clients under Aged Care support, NDIS and those in the last year of life. **Aim:** The aim of this activity is to improve health and clinical outcomes for patients, whilst increasing satisfaction for consumers, GPs and NSW Ambulance staff. This initiative will also lead to a reduction in preventable Category 4 and 5 Emergency Department presentations. While

	improving patient centred cared through improved patient assessments and ensuring the right care, at the right time at the right place.
Target population cohort	This activity targets all population groups.
Consultation	Stakeholder consultation with the following key groups occurs on a regular basis: • HNECC NSWA Sector Directors and Health Relationship Managers; • NSWA state clinical innovation team; • NSWA low acuity care and Primary Community Care Team; • NSWA Mental Health Director Consultation Meetings; • Age Care Emergency Service; • Hunter Primary Care; • Key HNELHD staff; • Key CCLHD staff, including the Integrated Care Team; • Central Coast Aged Care Task Force representatives; • North Coast PHN Ambulance Liaison Officer; • Western Sydney University- Professor in Paramedicine; • La Trobe University – Professor in Paramedicine; Advisor for Beyond Blue Ambulance referral pathways.
Collaboration	The role of HNECC PHN Ambulance Liaison Officer is to continue to work collaboratively with NSW Ambulance to develop a communication strategy and resources that will inform practices and consumers of the expansion in the paramedics' role and the alternative transport options. Throughout the initiatives being undertaken, NSW Ambulance 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.

	The role of CCLHD was to fund the initial cost of training for existing P1 paramedics in clinical assessment protocols, and contribute ED data to the evaluation process, while providing input into the local roll-out that was planned as part of the pilot phase. The role of HNELHD is was to provide ongoing support to the development and implementation of Hunter and New England based initiative, and provide relevant ED data to complete relevant final evaluations of activities.
Indigenous Specific	NO
Duration	1/07/2016 – 30/6/2017
Coverage	These activities cover the entire PHN catchment area comprising of 15 SA3s
Commissioning method (if relevant)	This activity will not be commissioned or contracted, it will be managed/delivered by HNECC PHN in partnership with NSW Ambulance and Local Heath Districts
Approach to market	N/A
Decommissioning	N/A

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 17. Healthy Weight Initiative**
Existing, Modified, or New Activity	Modified
Program Key Priority Area	Other – Preventative Health
Needs Assessment Priority Area (eg. 1, 2, 3)	10. Chronic Disease 14. Service Integration and Coordination 2. Health Needs and Access Issues of an Aged and Aging Population

Description of Activity	**Aim:** to make systemic improvements to primary care support, food and active living environments and activate 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. **Activity:** • Provide education and support for General Practice to improve patient and clinician engagement with a focus on early identification of disease and reduction in risk factors for patients at risk of chronic disease. • Target at risk patients and utilise a nurse led clinic approach to assisting patents to manage their weight • Improve access to appropriate allied health support • Information and data – support and encourage the recording of weight and girth measurement for "Every patient- Every Time", ensure that clinically validated resources are available for both patents and clinicians. **Community engagement activities-** o Schools - support and encourage healthy eating initiative led by the LHD's o Workplaces – engage with key employers to adopt a healthy work place strategy aligned with the NSW WorkCover approach Healthy at work o Urban planning – Work with local council to encourage active recreation and active travel options of walking, cycling and public transport. o Food environment – Engage a provider to run number of cooking skills programs for socially disadvantaged communities. The provision of nutrition information in supermarkets and shopping centres will be facilitated. o Social media - undertake a locally developed social marketing campaign, targeting families to engage parents in healthy lifestyle behaviours including health food choices **Community Social Movement**- undertake a locally developed social movement campaign, harnessing existing local community groups and activities to activate individual and groups to participate in a healthy weight activity.

	Regional Strategy- work in collaboration with the LHD's, HMRI, University, Minerals Council and local government to ensure a consistent and collaborative approach that aligns messages and avoids duplication. **Primary Care Intervention** – undertake a series of interventions at a primary care level that leverages the individual practitioner contributions and the health care neighbourhood to ensure that individual who do not have a currently diagnosed chronic disease are identified and offered strategies to mitigate the progression of their overweight / obesity status to full blown chronic disease.
Target population cohort	This activity will target consumers with at risk of developing chronic disease in the targeted communities.
Consultation	Clinical Councils, Healthy Weight Task Force, Hunter New England and Central Coast Local Health Districts, clinicians in the targeted communities.
Collaboration	General Practices, Allied Health providers and interested community organisations in the targeted communities Hunter New England and Central Coast Local Health Districts
Indigenous Specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? NO
Duration	1/7/2017 to 30/6/2018 Clinical consultation Community consultation Develop (and/or select existing) initiatives and provide ongoing support for same Support community based initiatives
Coverage	Initial communities are: Wyong, Cessnock, Taree, Narrabri and Gunnedah
Commissioning method (if relevant)	This is not a commissioned activity
Approach to market	N/A

Decommissioning	N/A

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 18.0 Aged Care Information Sharing**
Existing, Modified, or New Activity	Existing
Program Key Priority Area	Digital Health Service Integration
Needs Assessment Priority Area (eg. 1, 2, 3)	2. Health Needs and Access Issues of an Aging Population 3. 14. Service Integration and Coordination
Description of Activity	**Activity:** Lead an Aged Care Information Sharing Project in partnership with National eHealth transition Authority (NEHTA), LHDs and local practitioners and providers. **Aim:** Improved communication between aged care facilities and healthcare providers. Improved upload rate of shared health summaries and greater identification of gaps in health information and/or access to such information.
Target population cohort	This activity will target residents of aged care facilities.
Consultation	Residential Aged Care Facilities, General Practitioners Digital Health Agency, iCare
Collaboration	Residential Aged Care Facilities, General Practitioners
Indigenous Specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? NO
Duration	1/6/2016 – 30/6/2017

Coverage	Central Coast only
Commissioning method (if relevant)	This is not a commissioned or contracted activity.
Approach to market	This is not a commissioned or contracted activity.
Decommissioning	This project is not funded post June 30, 2017.

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 20.0 Electronic Referral (eReferral) Extension**
Existing, Modified, or New Activity	Existing
Program Key Priority Area	Digital Health
Needs Assessment Priority Area (eg. 1, 2, 3)	14. Service Integration and Coordination
Description of Activity	Aim: to improve the quality of referrals to support improvements in efficiency, safety, quality and security of referrals to both public and private healthcare providers. Activity: This activity will comprise the following key elements: • 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
Target population cohort	This activity will target the whole community
Consultation	The content of the eReferrals leverages the consultation processes in place for the development of HealthPathways.

	General Practices and referral receivers via regular User Forums including public and private, specialists and allied health providers.
Collaboration	Hunter New England Local Health District (HNELHD) are a partner in the development and implementation of the eReferral solution, HealthPathways and the directory required to support both solutions. The referral requirements are taken from the referral processes agreed as part of the HealthPathways program. HNELHD are responsible for the IT development required to ingest the referrals into their existing systems and processes. HNECC are responsible for onboarding referrers, mainly General Practices, and private referral receivers.
Indigenous Specific	Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people? NO
Duration	1/7/2017 – 30/6/2018 Development of referrals for 12 clinical areas Installation into additional 100 practices Implementation into additional 100 private health care providers
Coverage	This activity covers the entire PHN catchment area comprising 15 SA3
Commissioning method (if relevant)	Contracted to June 30, 2018
Approach to market	Ongoing contract for services in place with Best Practice Advocacy Centre for the provision of the technical software elements of the eReferral solution.
Decommissioning	Contracted to June 30, 2018

Proposed Activities - copy and complete the table as many times as necessary to report on each Priority Area	
Activity(ies) / Reference (e.g. Activity 1.1, 1.2, etc)	**NP Flex 21 Care packages and consumer support**
Existing, Modified, or New Activity	New

	**limited project lifespan– 12 months*
Program Key Priority Area	Integrated Care
Needs Assessment Priority Area (eg. 1, 2, 3)	4. Aboriginal and Torres Strait Islander Health and Access to Services 6. Mental Health 7. Alcohol and Other Drugs 10. Chronic Disease 14. Service Integration and Coordination 15. Health Workforce 17. Cost of Health Services 18. Rural Health and Access to Services
Description of Activity	**Activity:** Develop a localised collaborative model of care between primary and tertiary providers and commission a packaged care program for consumers with complex care needs which could be managed through the primary health care system. **Aims:** 1. Reduction of avoidable presentation to emergency departments by complex needs consumers experiencing exacerbation of mild-moderate health issues due to situational crisis. 2. Reduction of avoidable admissions to acute services (including inpatient units). 3. Reduced average length of stay for consumers in inpatient units. 4. Increase the capacity of Primary Health Services to respond and manage complex consumers within the sector **Key Deliverables / Outcome Measures** • Number of consumers within the program readmitted to tertiary inpatient care within 28 Days • Completion of collaborative patient centered primary care plans and identification of primary health care coordinator**.**

	• Consumer engaged with all identified primary providers within 30 days post discharge from inpatient unit.
Target population cohort	Health service users with complex needs may include: • Substance misuse • Chronic disease • Personality Disorder • Family/relationship instability • Poverty • Self-harming behaviors • Forensic issues
Consultation	• HNECC PHN Clinical Councils • HNECC PHN Community Advisory Groups • Hunter New England Local Health District • Central Coast Local Health District • Primary Care Providers across the HNECC PHN footprint • Local implementation committee
Collaboration	This activity will be undertaken in collaboration with Hunter New England and Central Coast Local Health Districts.
Duration	July 1, 2017 – June 30, 2018
Coverage	Identified pilot, priority location sites based on need and negotiations with Local Health Districts.
Commissioning method (if relevant)	Based on negotiations with the LHD this activity will either be commissioned through selective tender or will be included in HNECC PHN's commissioning process, dependent on need. Should it be included in the HNECC PHNs Commissioning Process the key stages of the process will be: open Expression of Interest for providers to deliver services in 2017-18; select request for tender issued; evaluation of submissions; and contract negotiation and execution with successful tenderers.

	Future refinements to this activity are informed by regular performance monitoring and evaluation, and annual strategic planning.
Approach to market	Either through selective tender, or Multi-staged procurement process based on the commissioning method agreed upon by the LHDs and PHN in each identified priority location.
Decommissioning	N/A
Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 22 Continued development of commissioning capability**
Existing, Modified, or New Activity	New *Limited life project – 12 months only
Program Key Priority Area	Other – Service delivery and commissioning services
Needs Assessment Priority Area (eg. 1, 2, 3)	14. Service Integration and Coordination 17. Cost of Health Services 18. Rural Health and Access to Services
Description of Activity	**Aim:** HNECC is committed to undertaking value based commissioning activities which allow us to begin Commissioning for Outcomes. **Activity:** A range of capability development activities will be undertaken with the aim of improving the capability of HNECC, its providers and stakeholders with the skills and confidence to participate in Commissioning for Outcomes. **Activities include:** • Training in outcomes based commissioning, and change management • Implementation of outcome measures building on from work undertaken in 2016-17 • Service design of programs which will require external facilitation • Research Scholarships for providers
Target population cohort	This activity will target HNECC, its service providers, partners and stakeholders.

Consultation	National Commissioning Workgroup, LHD partners, service providers
Collaboration	Partners, consultants and users of the services
Indigenous Specific	No
Duration	July 1, 2017 – June 30, 2018
Coverage	Whole of HNECC PHN region
Commissioning method (if relevant)	Mix of EOI, Collaborative Procurement and Competitive tender
Approach to market	See above
Decommissioning	No – time limited initiatives
Funding from other sources	Potential cost recovery from service providers attending education activities.

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**NPFlex 23 Workforce: Priorities**
Existing, Modified, or New Activity	New
Program Key Priority Area	Health Workforce
Needs Assessment Priority Area (eg. 1, 2, 3)	3. Aboriginal and Torres Strait Islander Health and Access to Services 11. Cancer screening and incidence 15. Health Workforce
Description of Activity	**Aim:** Implement and trial innovative projects which will help to build capacity in the Primary Care Workforce across areas where there is an identified need. **Activity:** This activity will comprise the following key priority areas: **23.1 Aboriginal Health Workers**

	Consultations with GPs have highlighted the lack of understanding regarding cultural norms and safety for Aboriginal patients as well as the absence of pathways to refer these patients to Aboriginal health workers, which would provide a cultural safety net. This project would provide funding to support a clinical placement for Ten Aboriginal Health Workers (the response from community is that we have 10 scholarships with 25 enrolments into the course), who would liaise with mainstream GPs providing cultural education to the practice staff and a safe passage through the primary health care system for the Aboriginal patients. It is anticipated that this focus on cultural safety will result in increased patient visits, greater compliance with recall and follow-up visits as well as increased health management plans. This pilot project will develop, implement and trial the model with a view to refining the model to roll out in other areas. Historically, Aboriginal patients have avoided mainstream practices due to the absence of cultural safety when engaging with practitioners and practice staff. Those that do attend, often fail to return to the practice for follow-ups, recalls and health management plans. A referral pathway is required to ensure that Aboriginal patients can access a culturally appropriate health practitioner, who will understand the needs of Aboriginal people and facilitate their participation in services offered by mainstream practices. This service would be available to Aboriginal patients who are not comfortable accessing services through an Aboriginal Medical Service (AMS) as well as those who have traditionally used the AMS. It is specifically directed at areas of need. **Expected Benefits:** **For Aboriginal Patients** ○ Cultural safety in identifying and accessing mainstream health care ○ An alternative for patients that refuse to use Aboriginal Medical Services ○ Increased access to and benefits from primary health services **For General Practice** ○ Improved access to Aboriginal patients ○ Education in culturally safe methods or working with Aboriginal patients ○ Better relationships with Aboriginal communities

	○ Increased quantifiable measures such as number of referrals to the service and subsequent presentations for follow-ups, recalls and health management plans. **23.2 Cancer Screening and Practice Nurses** To deliver a cervical screening education program to 10 Practice Nurses in rural and remote LGAs, targeted at increasing their capacity to conduct cervical screening and thus improve participation rates for women known to be at risk of low screening rates by; • Undertaking a workforce analysis to determine access to female clinicians in areas of low screening (priority populations) participation for cervical screening • Collaborating with Family Planning NSW to deliver education in rural areas • Facilitating a scholarship program to support access to clinical competency component of training with impact evaluation measures associated with QI activities in Primary care settings. **23.3 Rural Workforce Alliance** Collaborate with NSW Rural Doctors Network to deliver added value through the development and implementation of an integrated partnership approach that strategically utilises HNECC PHN and RDN resources to improve access to quality primary healthcare for people in the HNECC PHN region by • Developing initial HNECC/RDN Workforce Needs assessment • Agree on prioritization mechanism • Develop initial Workforce Activity Plan • Enhance GP Succession Planning Process in Hunter Rural and NE Small Towns **23.4 Central Coast GP workforce strategy** Establish a Woking group of appropriate stakeholders to address the perceived shortage of GP on the Woy Woy Peninsula activities to include; • Develop resources and strategies to recruit and retain the health workforce on Woy Woy Peninsula • Develop business support to assist local practices and clinicians recruit and retain GP's • Fund and developing several GP Scholarships in collaboration with the CC LHD. • Develop and support innovative professional development and education programs for the local health workforce and general practices

	• In collaboration with GP Synergy assist practices to recruit registrars
Target population cohort	23.1 Whole of PHN region 23.2 Targeted LGAs (Locations TBC) 23.3 Whole of PHN region 23.4 Peninsula, Central Coast
Consultation	23.1 General Practice, Aboriginal Health Service, Education Providers, LHDs, HNECC PHN Clinical Councils and Community Advisory Groups 23.2 General Practice, General Practice Nurses, Education Providers, Cancer Screening Providers 23.3 General Practice, NSW RDN, LHDs, HNECC PHN Clinical Councils 23.4 Central Coast Clinical Council, General Practice, NSW RDN, LHDs,
Collaboration	• LHD's • NSW RDN • GP Synergy
Indigenous Specific	23.1 Yes 23.2 No 23.3 No 23.4 No
Duration	1/7/2017 – 30/6/2018* **limited project lifespan– 12 months*
Coverage	This activity covers the entire PHN catchment area comprising 15 SA3s.
Commissioning method (if relevant)	This is not a commissioned or contracted activity, it will be managed / delivered by the PHN.
Approach to market	This activity does not require procurement.
Decommissioning	Not relevant to this activity as it is not a commissioned or contracted activity.

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

Operational Activities	Activity Status at July 2017
OP 1.1 Stakeholder Management, Engagement and Relationships	Unchanged from February 2017 submission
OP 1.2 PHN Population Health Planning	**Modified** (July 2017) to include additional details *NOT reflective of slippage request, just to ensure clarity around direction of program.
OP 1.3 Supporting General Practice	Unchanged from February 2017 submission
OP 1.4 OP 1.4 Enterprise systems	New *Limited life project – 12 months only to be funded by slippage from 2016/2017

Proposed Stakeholder Management, Engagement and Relationships Activities	
Activity Title / Reference (eg. OP 1)	**OP 1.1 Stakeholder Management, Engagement and Relationships**
Existing, Modified, or New Activity	Existing
Description of Activity	HNECC PHN stakeholder management, engagement and relationship development is a key tenet of our activities. It reflects many of our strategic aims, including to: • 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, and • Create opportunities for stakeholders to contribute to the development of PHN initiatives. **Stakeholder Engagement Framework**

	The HNECC PHN Stakeholder Engagement Framework has been implemented. Parallel to the framework, mapping of external stakeholder touchpoints across the organisation has occurred, which sets baseline information to clarify relationships, identify gaps and set key contact points. The purpose of having a stakeholder engagement framework is to ensure that HNECC PHN is effectively building relationships and engaging with consumers, clinicians, community and other stakeholders and meeting their needs. 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. The stakeholder engagement framework is based on the International Association for Public Participation (IAP2) spectrum of public participation and included input from Health Consumers NSW and HNECC PHN Clinical Councils. The framework processes and methodology have also been embedded into HNECC PHN's project planning and management processes. 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** 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. **Roadshow/Listening Tour**

	Recognising that research consistently demonstrates that face-to-face communication builds stronger, more meaningful business relationships, we are strengthening our engagement with stakeholders with a series of consultations across key locations in the region. A key goal of our roadshow and listening tour will be to improve trust so we can strengthen opportunities for better collaboration and mutual understanding in these communities. **Clinical Council and Community Advisory Committees** The Clinical Councils across all three sub regions have continued to provide the PHN and Board with locally relevant perspectives on community health issues. They have provided direct input and advice into sub-regional selections for our Collaborative Health Innovation Project grant recipients, guided Continuing Professional Development (CPD) activities that were relevant to local clinical communities and have delivered advice in regards to commissioning processes and assessment methodology as it relates to local services. The Community Advisory Committees consist of community members who have a keen interest in improving the health of their communities, and an understanding of primary care and the issues which affect health outcomes. They have been keen advocates for articulating the aims of HNECC PHN through their own networks and are committed to improving access and navigation of the health system for the members of the community in which they live. The Community Advisory Committees have played a key role in providing guidance to best engage community stakeholders and were responsible for advising over our peoplebank development, which included undertaking user acceptance testing for feedback prior to launch. All Clinical Councils and Community Advisory Committees have played a role guiding the development of our Healthy Weight Initiative and the chairs of each actively participated in the HNECC PHN Board strategic planning process.
Supporting the primary health care sector	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.

Collaboration	This activity will be led by HNECC PHN with the opportunity for a wide array of stakeholders to contribute and collaborate as appropriate.
Duration	01/07/2016 – 30/06/2018
Coverage	These activities cover the entire PHN region.
Expected Outcome	It is expected that through the activities described above HNECC PHN will realise a growth in engagement that is reflective of the PHN region make-up, an increase of community commitment to activities and the capture of qualitative and quantitative information that will provide an evidence-based approach to engagement activities. Outcomes include: • A deeper understanding of the needs and expectations of primary health clinicians and consumers • Celebrated achievements offer the opportunity to change local primary health • Opportunity to facilitate further growth of recognised initiatives • All aspects of PHN activities take into account the need for stakeholder engagement • A comprehensive story of community and consumer input • Demonstration of locally relevant programs Demonstrated community awareness of PHN activities.

Proposed general practice support activities	
Activity Title / Reference (eg. OP 1)	**OP 1.2 PHN Population Health Planning**
Existing, Modified, or New Activity	Modified (July 2017)
Description of Activity	• Program Specific Needs Assessments - Finalise the Aboriginal Health Needs Assessment; Undertake a comprehensive Mental Health and Suicide Prevention Needs Assessment; Update the Drug and Alcohol Needs Assessment

	• HNECC PHN regional Needs Assessment - update with new information, data, and learnings gained from engagement activities, and through monitoring and evaluation of commissioned services • Health planning resources - Produce and/or update: HNECC Region Profile; HNECC Health Planning Compass; HNECC Aboriginal Health Profile; Local Government Area Profiles; Older Persons Health Profile; HNECC Population Health webpages • National Headline Performance Indicators - Research Potentially Preventable Hospitalisations in the region and provide recommendations as to how HNECC can address needs and issues • HNECC PHN Health and Wellbeing Outcomes Framework - Finalise and implement • Outcomes data from commissioned services (including PROMs and PREMs) - Establish processes to capture, collate and report • Health Planning and Commissioning Database - Expand and assess tools for sharing and visualising relevant data across the organisation • Analytical capability - PenCAT data; evaluation data – Expand HNECC's capacity • Support program staff across HNECC by- providing relevant data; assisting with literature reviews to inform service plans and programs; geospatially mapping service and population data; and supporting the evaluation of service plans and programs • External data requests – respond in a timely manner • Local, national and state working groups - Participate in and contribute National Qlik Sense implementation group - Central Coast Aboriginal Health Plan Data Working Group • Strategic partnerships in 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.
Supporting the primary health care sector	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.

	Continued support will also be provided to external key stakeholders and within the organisation through: responding to data requests; reviewing health service capacity; literature reviews; and market analysis. The work of the Health Planning Team supports 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. Through the Centre for Innovation in Regional Health, HNECC will enable primary care researchers to undertake pilot studies with experienced researchers, enhancing primary care delivery and furthering the reputation of the region for innovation.
Collaboration	Ongoing relationship with Central Coast Local Health District, Hunter New England Local Health District, 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 Centre for Health Economics Research and Evaluation, UTS – Monitoring & Evaluation 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. Focus in first year 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.
Duration	July 2017 – June 2018
Coverage	Entire Hunter New England Central Coast Primary Health Network
Expected Outcome	Ongoing population health planning activities will: • ensure key health and services needs and issues are continuously reviewed and updated, and new emerging needs are identified and prioritised

	• ensure a greater and more detailed understanding of particular health issues in our region, providing clear recommendations for action • assist in making evidence and resource based decisions to ensure the needs of local communities are met and access to health services is improved, particularly for populations at risk of poorer health outcomes • inform ongoing commissioning work and operational approach of the PHN, so that HNECC continues to deliver innovative, locally relevant solutions that measurably improve the health outcomes of our communities • Improve HNECCs capacity to capture, measure and report performance data from commissioned services NHMRC NSW Centre for Innovation in Regional Health • Foundation partner – Chief Executive is part of governing Board • Workshops to enhance capacity in Primary Care Researchers will be conducted • HNECC will be able to draw on research capacity from partners to support commissioning and evaluation activities.

Proposed general practice support activities	
Activity Title / Reference (eg. OP 1)	**OP1.3 Supporting General Practice**
Existing, Modified, or New Activity	Existing
Description of Activity	**Aim:** Through this activity, the HNECC PHN Practice Support and Development team supports general practices to maximise their business efficiency and sustainability, and provide high quality, evidence-informed care for their patient community. **Activity:** Practice Support and Development Officers (PSDO) offer guidance and assistance in a range of areas including: • Quality Improvement activities • Practice data extraction and analysis

	• Practice Management • Education / Professional Development • Digital Health • Accreditation • Chronic Disease Management • Preventative Health / models of care • Workforce Support • Immunisation Practice Support Plans - 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 - Target: 90% of the 428 practices across the region 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 Practice Nurse: - improve utilisation of Practice Nurses particularly in areas of workforce shortage Digital Health: - support uptake of MyHealthRecord and Secure Messaging by GPs, Allied Health and Specialists to improve information sharing across healthcare providers. - promote eReferrals and HealthPathways to all clinicians 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.

Supporting the primary health care sector	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.
Duration	1/7/2017 to 30/6/2018 Practice Support Plans are reviewed at least annually with General Practices. Data extraction occurs monthly, with reports back to practices quarterly Website information reviewed biannually
Coverage	Whole of HNECC PHN catchment
Expected Outcome	Through this activity, the HNECC PHN expects to be able to report improvement in the ways general practices across the 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.

Enterprise systems	
Activity Title / Reference (eg. OP 1)	**OP 1.4 Enterprise systems**
Existing, Modified, or New Activity	New
Description of Activity	Implementation of new and expansion of existing key Information Management systems to support the core functions and operations of HNECC and achieve operational efficiencies through the use of improved workflows and data capture and reporting. Key systems identified include Team Collaboration spaces, data warehouse, internal and external performance monitoring and reporting systems including online reporting functionality from our service providers.
Supporting the primary health care sector	The identified systems will support the primary health care sector by: • Enabling greater collaboration with key partners on strategic activities aimed at improving integration of services and improved health outcomes • Consolidating data enabling the provision of timely reports and information for decision making • Achieving efficiencies and cost savings from the reduction of manual processing and reporting of data including for our primary health care service providers
Collaboration	This activity will be led by HNECC PHN with the opportunity for a wide array of stakeholders to contribute and collaborate as appropriate.
Duration	01/07/2017 – 30/06/2018 *This would be a limited life project funded from 2016/2017 slippage*

Coverage	These activities cover the entire PHN region.
Expected Outcome	Efficiency gains from workflow improvements and improved reporting capability.

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

HNECC PHN will continue to deliver all activities previously outlined in its May 2016 Activity Work Plan.

Any modifications to activities listed in the May 2016 approved Activity Work Plan which differ from the originally approved activity, where necessary and appropriate, have been identified as “modifications” in the tables included in the previous Sections 1 b and c.

There are some programs being delivered that are only funded until June 30, 2017.

These programs are listed in the table below:

Planned activities which will no longer be delivered	
Activity Title / Reference (eg. NP 1/OP 1)	NPFlex 18.0 Aged Care Information Sharing Project
Description of Activity	**Activity:** Lead an Aged Care Information Sharing Project in partnership with National eHealth transition Authority (NEHTA), LHDs and local practitioners and providers. **Aim:** Improved communication between aged care facilities and healthcare providers. Improved upload rate of shared health summaries and greater identification of gaps in health information and/or access to such information.
Reason for removing activity	This activity in its current form will cease on June 30, 2017. Its future will be determined in line with the decision made surrounding the future of the After Hours Program.
Funding impact	No direct impact in funding as it has always been known these were short-term funded activities

Planned activities which will no longer be delivered	
Activity Title	NPFlex 19.0 Healthy Babies – Improving Birthweights
Description of Activity	**Aim:** This activity aims to increase understanding of the risk factors for poor birth outcomes, and improve access to culturally safe and appropriate ante natal care. Programs and activities successfully piloted in Aboriginal populations in 2016/17 will continue and potentially be expanded to other small communities at risk of poor birth outcomes.
Reason for removing activity	This project is short-term funded as a grant only available in 2016-2017 as such the activity will not continue into 2017-2018
Funding impact	No direct impact in funding as it has always been known these were short-term funded activities

Other projects included in this plan with initially estimated limited lifespan to June 30, 2018 include:

NP Flex 21 Care packages and consumer support	14. Service Integration and Coordination 17. Cost of Health Services 18. Rural Health and Access to Services	New *Limited life project – 12 months only ends June 30, 2018
NPFlex 22 Commissioning, capability, Design, Outcomes and Evaluation	14. Service Integration and Coordination 17. Cost of Health Services 18. Rural Health and Access to Services	New *Limited life project – 12 months only ends June 30,2018
NPFlex 23 Workforce: Priorities	15. Health Workforce 18. Rural Health and Access to Services	New *Limited life project – 12 months only ends June 30, 2018

*Limited life projects are considered by HNECC PHN to be primary care capacity building, pilot or short term projects which are designed to target a particular need. These projects are usually implemented to determine whether future investment is needed by HNECC PHN or whether the life of these projects can be self-funded after assistance to "start-up". As such the ongoing need for these projects is evaluated prior to end of life. If the evaluation reveals a further need, appropriate to HNECC PHNs Funding Deed with the Department of Health it is then it will be included in future HNECC PHN Activity Work Plan.

3. After Hours Primary Health Care 2016-2018
(a) Strategic Vision for After Hours Funding

In order to increase efficiency and effectiveness of After Hours Primary Care across the Hunter, New England and Central Coast Primary Health Network region, HNECC PHN aims to improve access and implement innovative locally-tailored solutions using a rigorous commissioning approach.
Through comprehensive consultation with a range of stakeholders, including the Clinical Councils and Community Advisory Committees, HNECC PHN will utilize sourced data to inform commissioning of After Hours Services. The ongoing needs assessment will identify gaps in After Hours service provision across the region, and inform collaborative opportunities to potentially redesign existing services, value-add to existing services and/or implement innovative pilot models of care to address patient/ consumer needs.
To achieve this strategic direction, HNECC PHN will commission service providers to deliver After Hours Primary Care programs across the region to ensure local solutions are relevant to the population needs.

The objectives of the HNECC Afterhours Primary Health Care program may include, but are not limited to:

- Develop innovative solutions to address service gaps and improve access to After Hours Primary Health Care, ensuring ongoing consideration for vulnerable populations and those populations who have not been well served by previous After Hours arrangements such as rural and remote populations;
- Address the lack of, or inequity of access to, After Hours Primary Health Care through targeted (and collaborative) programmes;
- Improve patient outcomes through working collaboratively with health professionals and services to integrate and facilitate a seamless patient experience;
- Address fragmentation, increase efficiency and effectiveness and implement systems to support effective communication and continuity of care across After Hours service providers and a patient's regular GP;
- Work with key local After Hours stakeholders, including State and Territory governments, to plan, coordinate, and support population based After Hours Primary Health Care;
- Foster local level solutions and enable a greater focus of specific target groups, particularly where the Practice Incentives Programme (PIP) After Hours Incentive may not reach; and
- Increase consumer awareness of After Hours Primary Health Care available in their community and improve patient health literacy on the appropriate Health Services to access in the After Hours period

The After Hours Primary Care program will commission a range of locally-tailored services to meet the needs of the population. The modalities of care that will be offered at sites across the region may comprise of:

- A phone based patient streaming service (PSS) that assesses and triages calls and directs them to the appropriate level of care that matches their clinical need
- GP Led After Hours Clinics located at multiple sites in the region
- On call GPs who provide home visits, including to residential aged care facilities, group homes and other location that patients/consumers might live
- Patient transport to the nearest clinic, should this be clinically indicated
- Nurse led telephone support for Residential Aged Care Facility (RACFs) to support staff and facilitate residents with non-life threatening acute care needs being met within the facility to avoid emergency department presentations when clinical appropriate
- Nursing support to enhance the flow and coordination of care for the RACF resident during their ED visit when an emergency department presentation is clinically appropriate

3. (b) Planned PHN Activities – After Hours Primary Health Care 2016-18

HNECC PHN After Hours Activities 2016- 2017
AH 13.1 Small Town After Hours (STAH)
AH 13.2 Aged Care Emergency (ACE) Programs
AH 13.3 GP After Hours Program – Hunter
AH 13.4 GP After Hours Programs – Central Coast

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**AH13.1 Small Town After Hours (STAH) Program**
Existing, Modified, or New Activity	Existing Activity
Needs Assessment Priority Area (eg. 1, 2, 3)	13. After Hours
Description of Activity	Continuation of the Small Town After Hours (STAH) Program in the New England region, provides telephone medical support to local hospitals for patient presenting with Triage Categories 3 - 5 when the usual general practitioner VMO is absent/unavailable from the town. **Aim**: Improved access to After Hours primary medical care for residents of small towns, and improved retention and job satisfaction of GPs working in small towns.
Target population cohort	Small rural communities, including disadvantaged groups and infrequent users of health care services are provided with accessible and effective after hour's primary health care services throughout the whole after hour's period.
Consultation	The STAH program is well established in the New England North West Region. It supports small town hospitals that are placed on by-pass when the towns GP Visiting Medical Officer (VMO) is unavailable

	after hours. The STAH program continues to build on established relationships with GPs in the New England and North West Region. Patient satisfaction surveys and stakeholder feedback.
Collaboration	The Hunter New England Local Health District is an integral stakeholder in the implementation of this program.
Indigenous Specific	No
Duration	01/07/2016 to 30/06/2018
Coverage	This activity will cover the New England region of the HNECC PHN catchment, or the Inverell-Tenterfield, Moree-Narrabri, Tamworth-Gunnedah and Armidale SA3's. More specifically, this activity will be delivered in the following towns: Barraba, Bingara, Boggabri, Emmaville, Manilla, Quirindi, Walcha, Warialda, and Wee Waa.
Commissioning method (if relevant)	This activity is directly contracted. This activity will be monitored through a comprehensive annual planning and quarterly reporting cycle. The provider will also provide an evaluation report at the completion of the funding cycle, which will include qualitative and quantitative data, clinician and consumer feedback and indicators of the benefit of the Service including the impact on local Emergency Departments. This data will inform the PHN's ongoing Needs Assessment and Commissioning cycle.
Approach to market	The key stages were: open Expression of interest for providers to deliver services in 2016-17; select request for tender issued; evaluation of submissions and contract negotiation and execution with successful tenderers.
Decommissioning	Not applicable

Proposed Activities

Activity Title / Reference (eg. NP 1)	**AH 13.2 Aged Care Emergency (ACE) Program**
Existing, Modified, or New Activity	Existing Activity from the 2016-2018 AWP: Funding for 2016/2017 was provided to included further expansion of support for the ACE service into the Tamworth and Armidale areas of the New England Region.
Needs Assessment Priority Area (eg. 1, 2, 3)	13. After Hours
Description of Activity	**Activity**: Commission the After Hours – Aged Care Emergency (ACE) Program in the Hunter, Tamworth and Armidale region. This service is a collaboration between HNECC, Hunter New England LHD, NSW Ambulance, Hunter Primary Care and local RACFs. The ACE program is a nurse led model of care that provides support to Residential Aged Care Facilities (RACFs) staff to facilitate residents' non-life threatening acute care needs being met within the facility and thus avoiding an Emergency Department (ED) presentation. Where an ED presentation is required, the ACE program will enhance the flow and coordination of the care of the patient during their ED visit. **Aim:** Reduce the need for residents of RACFs to present to an ED for non-life-threatening acute care, and where ED presentation are required, proactively manage by
Target population cohort	The Aged Care Emergency (ACE) Program is designed to address an identified gap in supporting staff in Residential Aged Care Facilities (RACF) to facilitate residents' non-life threatening acute care needs being met with the facility and this avoiding an emergency department (ED) presentation. The model is aimed not just at reducing the need for residents of RACFs to present to an ED for acute care, but also, where an ED presentation is required, to proactively manage the visit.
Consultation	Monthly meetings with ACE team to ensure services are well planned, coordinated and appropriate to community needs. Collaborate with other key stakeholders (NSW Ambulance, Hunter New England LHD, Hunter Primary Care, RACFs). Quarterly interagency meetings are held across the Hunter, Manning and New England regions. Facilitated by the partners, these are opportunities for knowledge sharing, innovation sharing and further enhancements of the program

Collaboration	This activity is a collaboration between HNECC PHN, HNELHD, Hunter Primary Care, NSW Ambulance and local RACFs. The ACE Program is a collaboration between General Practice and the primary care sector, LHD, Community providers and RACFs
Indigenous Specific	No
Duration	1/07/2016 – 30/06/2018.
Coverage	This activity will cover specific areas of the HNECC PHN footprint including Lake Macquarie, Newcastle, Port Stephens, Maitland, Singleton, Great Lakes and Taree, Tamworth and Armidale LGAs.
Commissioning method (if relevant)	In 2017-18, funding for the program which has been historically applied by HNECC and HNELHD will be combined into a joint commissioning activity. The service already has joint planning, monitoring and evaluation, governance and has been designed with the engagement of all stakeholders. Combining the funding will enable this to be truly jointly commissioned and enable the service providers to report jointly to the funding partners rather than separately against slightly different KPIs.
Approach to market	Direct contract negotiation is being undertaken with existing providers of the support of the program.
Decommissioning	Not applicable

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**13.3 GP After Hours Program – Hunter**
Existing, Modified, or New Activity	Existing
Needs Assessment Priority Area (eg. 1, 2, 3)	13. After Hours
Description of Activity	**Phone based Assessment Service** The phone based service assesses and triages callers and directs them to the appropriate level of care that matches their clinical need. The call centre is staffed by a mix of Registered and Enrolled Nurses and call takers. Service Hours are:

	○ Monday to Friday 5.30pm (4pm for RACF calls only) to 8am the following day ○ Weekends: 12MD Saturdays till 8am Mondays ○ On Public Holidays, the service will be operational for 24 hours/day The call centre staff use evidence based algorithms to assess callers and to triage them to the most appropriate care. Referral options available to call centre staff would include: ○ Health Direct ○ The nearest ED, ○ A clinic with an appointment time, ○ An on call GP, ○ NSW Ambulance, via its 000 or booked patient transport services • **GP Led After Hours Clinics** located at up to five (5) sites in the Hunter region operating in the hours of: ○ Monday to Friday: 6pm to 11pm ○ Saturday 1pm – 10pm ○ Sunday 9.00am to 10.00pm • **On call GPs** who provide home visits, including to residential aged care facilities, group homes and other location where patients/consumers might live • **Patient transport** to the nearest clinic, should this be clinically indicated **Aim**: Improved access to After Hours primary medical care for residents across the Hunter region.
Target population cohort	The GP After Hours Program provides GP led clinics to the community in the Hunter Region. The clinics are located: • Belmont Hospital, John Hunter Hospital, Calvary Mater Hospital, Maitland Hospital and Toronto Community Centre. • The clinics aim to provide patients access to appropriate, quality after hours primary care reducing low acuity presentations to emergency departments.
Consultation	Regular meetings scheduled with Toronto Community Centre facility Managers and Operational Management teams Maitland, Mater, Belmont and John Hunter Hospital Emergency Departments.

	Ongoing meetings and communication with the Director Research, Innovation & Partnerships HNE LHD Patient satisfaction surveys and stakeholder feedback
Collaboration	This activity is a collaborative initiative between HNECC PHN and HNHELHD. HNEC PHN is responsible for commissioning the service. HNELHD is responsible for housing the clinics.
Indigenous Specific	No
Duration	01/07/2016 to 30/06/2018
Coverage	This activity will cover the Hunter region of the PHN catchment, or the SA3's of: Maitland, Newcastle, Lake Macquarie-East; and Lake Macquarie- West; Port Stephens; Lower Hunter; Great Lakes; Taree-Gloucester; and Upper Hunter.
Commissioning method (if relevant)	In 2017-18, funding for the program which has been historically applied by HNECC and HNELHD will be combined into a joint commissioning activity. The service already has joint planning, monitoring and evaluation, governance and has been designed with the engagement of all stakeholders. Combining the funding will enable this to be truly jointly commissioned and enable the service providers to report jointly to the funding partners rather than separately against slightly different KPIs.
Approach to market	The key stages were: open Expression of interest for providers to deliver services in 2016-18; select request for tender issued; evaluation of submissions and contract negotiation and execution with successful tenderers.
Decommissioning	N/A

Proposed Activities	
Activity Title / Reference (eg. NP 1)	**13.4 GP After Hours Program – Central Coast**
Existing, Modified, or New Activity	**Existing Activity**
Needs Assessment Priority Area (eg. 1, 2, 3)	13. After Hours

Description of Activity	**Activity:** The After Hours Primary Care Service on the Central Coast includes up to three (3) GPLed After Hours Clinics. GP After Hours Clinics are available as follows: The Erina and Wyong clinic hours are: Monday to Friday: 7.00pm to 10.30pm Saturday 3.00pm to 10.30pm Erina: Sunday & Public Holidays 10.00am to 7.00pm Wyong: Sunday & Public Holidays 1.00pm to 6.00pm The Woy Woy clinic hours are: Monday to Friday: 6.00pm to 11.00pm Saturday: 12.30pm to 11.00pm Sunday & Public Holidays: 8.00am to 11.00pm **Aim**: Improved access to After Hours primary medical care for residents across the Central Coast region. **Note:** Due to the uncertainty of continued After Hours Primary Health Care funding for 2017-2018, HNECC PHN is working with current Service Providers and have requested 'transition plans' with their 2nd Quarterly reports.
Target population cohort	The GP After Hours Program provides GP led clinics to the community in the Central Coast Region at three locations. The clinics aim to provide patients access to appropriate, quality after hours primary care reducing low acuity presentations to emergency departments.
Consultation	During the previous period of service, a score of 87 was given for client's overall satisfaction with the After Hours Care they had received. (Max score 100). A feature of the 2017/18 HNECC After Hours commissioning cycle is a period of consultation involving review and focussed engagement, where current providers and community and clinical stakeholders, will have an opportunity to contribute towards existing (and future) After Hours activity on the Central Coast.
Collaboration	The commissioning of GP After Hours clinics on the Central Coast is a partnership with CCLHD. The CCLHD provides accommodation for the each of After Hours clinics at the following locations: • Erina (Erina Community Health Centre)

	• Kanwal (Wyong Hospital campus) • Woy Woy (Woy Woy Hospital campus)
Indigenous Specific	No
Duration	01/07/2016 to 30/06/2018
Coverage	This activity will cover the Central Coast region of the PHN catchment, or the SA3's of Wyong and Gosford.
Commissioning method (if relevant)	This activity will be monitored through a comprehensive annual planning and quarterly reporting cycle. The provider will also provide an evaluation report at the completion of the funding cycle, which will include qualitative and quantitative data, clinician and consumer feedback and indicators of the benefit of the Service including the impact on local Emergency Departments. This data will inform the PHN's ongoing Needs Assessment and Commissioning cycle.
Approach to market	The key stages were: open Expression of interest for providers to deliver services in 2016-18; select request for tender issued; evaluation of submissions and contract negotiation and execution with successful tenderers.
Decommissioning	No

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. NP 1)	**NPFlex 13.5 After Hours Integration Activities**
Existing, Modified, or New Activity	**New** (Existing)
Needs Assessment Priority Area (eg. 1, 2, 3)	13. After Hours
Description of Activity	**Activity:** 13.5.1 Newcastle After Hours Service **Aim:** 13.5.1 Continuation of support grant, ceasing Sep 30, 2017

Target population cohort	13.5.1 Patients of practices who use Newcastle After Hours as their medical deputising service
Consultation	HNECC Limited invited prospective Service Providers to submit Tenders to deliver innovative solutions in After Hours Primary Care. The contract period will conclude June 30, 2017, so the funds are best targeted at developing or testing innovative models. • Selective Request for Tender (RFT) was opened and closed in December 2016 Selection of providers and implementation of trials in conjunction with local stakeholders and LHD partners
Collaboration	This activity would not initially be jointly implemented in conjunction with any other stakeholders.
Indigenous Specific	No
Duration	25/06/2016 to 30/06/2018
Coverage	Newcastle and Central Coast
Commissioning method (if relevant)	Due to the short time frame of the funding cycle, this activity will be monitored with 'key performance indicators' and/or through the provider who will provide an evaluation report at the completion of the funding cycle, which will include qualitative and quantitative data, clinician and consumer feedback and indicators of the benefit of the Service including the impact on local Emergency Departments. This data will inform the PHN's ongoing Needs Assessment and Commissioning cycle.
Approach to market	The key stages were: select request for tender issued; evaluation of submissions and contract negotiation and execution with successful tenderers.
Decommissioning	No

3. (c) Activities submitted in the 2016-18 AWP which will no longer be delivered for After Hours Funding

Great Lakes After Hours MDS
Newcastle After Hours Medical Service – after 30/9/2017
After Hours GAP service - decommissioned in 2017