Australian Government
Department of Health

phn
An Australian Government Initiative

Primary Health Networks Core Funding

Primary Health Networks After Hours Funding

Activity Work Plan 2016-2018

- Annual Plan 2016-2018
- Annual Operational and Flexible Funding Streams Budget 2016-2017
- After Hours Budget 2016-2017

Western NSW PHN 107

Introduction

Overview

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

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

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

Together with the PHN Needs Assessment and the PHN Performance Framework, PHNs will outline activities and describe measurable performance indicators to provide the Australian Government and the Australian public with visibility as to the activities of each PHN.

This document, the Activity Work Plan, captures those activities.

This Activity Work Plan covers the period from 1 July 2016 to 30 June 2018. To assist with PHN planning, each activity nominated in this work plan can be proposed for a period of 12 months or 24 months. Regardless of the proposed duration for each activity, the Department of Health will still require the submission of a new or updated Activity Work Plan for 2017-18.

The Activity Work Plan template has the following parts:

1. The Core Funding Annual Plan 2016-2018 which will provide:
    a) The strategic vision of each PHN.
    b) A description of planned activities funded by the flexible funding stream under the Schedule – Primary Health Networks Core Funding.
    c) A description of planned general practice support activities funded by the operational funding stream under the Schedule – Primary Health Networks Core Funding.
2. The indicative Core Operational and Flexible Funding Streams Budget for 2016-2017.
3. The After Hours Primary Care Funding Annual Plan 2016-2017 which will provide:
    a) The strategic vision of each PHN for achieving the After Hours key objectives.
    b) A description of planned activities funded under the Schedule – Primary Health Networks After Hours Primary Care Funding.
4. The indicative Budget for After Hours Primary Care funding stream for 2016-2017.

Annual Plan 2016-2018

Annual plans for 2016-2018 must:

- provide a coherent guide for PHNs to demonstrate to their communities, general practices, health service organisations, state and territory health services and the Commonwealth Government, what the PHN is going to achieve (through performance indicator targets) and how the PHN plans to achieve these targets;
- be developed in consultation with local communities, Clinical Councils, Community Advisory Committees, state/territory governments and Local Hospital Networks as appropriate; and
- articulate a set of activities that each PHN will undertake, using the PHN Needs Assessment as evidence, as well as identifying clear and measurable performance indicators and targets to demonstrate improvements.

Activity Planning

The PHN Needs Assessment will identify local priorities which in turn will inform and guide the activities nominated for action in the 2016-2018 Annual Plan. PHNs need to ensure the activities identified in the annual plan also correspond with the PHN Objectives; the actions identified in Section 1.2 of the PHN Programme Guidelines (p.7); the PHN key priorities; and/or the national headline performance indicators.

PHNs are encouraged to consider opportunities for new models of care within the primary care system, such as the patient-centred care models and acute care collaborations. Consideration should be given to how the PHN plans to work together and potentially combine resources, with other private and public organisations to implement innovative service delivery and models of care. Development of care pathways will be paramount to streamlining patient care and improving the quality of care and health outcomes.

Primary Health Networks After Hours Funding

From 2016-17, PHNs will have greater flexibility to commission programme specific services, having completed needs assessments for their regions and associated population health planning. PHNs are funded to address gaps in after hours service provision and improve service integration within their PHN region. Item B.3 of the After Hours Funding Schedule may assist in the preparation of the After Hours components of your Activity Work Plan (pages 12-15 of this document).

Measuring Improvements to the Health System

National headline performance indicators, as outlined in the PHN Performance Framework, represent the Australian Government's national health priorities.

PHNs will identify local performance indicators to demonstrate improvements resulting from the activities they undertake. These will be reported through the six and twelve month reports and published as outlined in the PHN Performance Framework.

Activity Work Plan Reporting Period and Public Accessibility

The Activity Work Plan will cover the period 1 July 2016 to 30 June 2018. A review of the Activity Work Plan will be undertaken in 2017 and resubmitted as required under Item F.22 of the PHN Core Funding Agreement between the Commonwealth and all Primary Health Networks.

Once approved, the Annual Plan component must be made available by the PHN on their website as soon as practicable. The Annual Plan component will also be made available on the Department of Health's website (under the PHN webpage). Sensitive content identified by the PHN will be excluded, subject to the agreement of the Department.

It is important to note that while planning may continue following submission of the Activity Work Plan, PHNs can plan but must not execute contracts for any part of the funding related to this Activity Work Plan until it is approved by the Department.

Further information

The following may assist in the preparation of your Activity Work Plan:

- Clause 3, Financial Provisions of the Standard Funding Agreement;
- Item B.3 of Schedule: Primary Health Networks After Hours Funding;
- Item B.4 of Schedule: Primary Health Networks Core Funding;
- PHN Needs Assessment Guide;
- PHN Performance Framework; and
- Primary Health Networks Grant Programme Guidelines.

1. (a) Strategic Vision

Our Strategic Plan

Vision

Supporting, strengthening and shaping a world class, person-centred primary health.

Purpose

Social justice, access and equity in quality primary health.

Our Region's Health Priorities	Aboriginal Health	Chronic and Complex Care	Older Persons Care	Maternal and Child Health	Mental Health & Substance Abuse	Risk Factors/ Prevention	Workforce	Access to Services	Coordination Integration Collaboration

1. (b) Planned activities funded by the flexible funding stream under the Schedule – Primary Health Networks Core Funding

Proposed Activities	
Priority Area	2.2 Child and Maternal Health 4.2 Health promotion 4.3 Preventative health and early intervention 6.1 Chronic disease support for patients 6.2 Chronic disease management 6.3 Older Persons Health
Activity Title / Reference	**NP 1.1 Regionally Integrated Allied Health Services, Early Intervention and Health Promotion**
Description of Activity	**Allied Health** - WNSW PHN contract the following Allied Health services across the region: Dietetics, Primary Health Care Nursing, Diabetes Education, Podiatry, Allied Health Assistant, Community Nursing (In home nursing coordination and case management), and Exercise Physiology. These services are provided within the school and preschool sector, community and home sector, General Practice and Primary health care setting and ACCHOS. **Health promotion** - Service providers across the region coordinate and participate in a number of health promotion activities targeting the whole population with a focus on Chronic Disease prevention. Other activities include Health Career days, falls prevention program, Tai Chi and Aqua program attending various health promotion community events, cancer screening services, Men's Sheds, Exercise Classes for people 50+, Smoking Cessation, Asthma Education. A number of health

	promotion activities are coordinated across the region, focussing on health screening assessment and pathway to care for children. Integration projects with AMSs to reduce the impact of Diabetes. **Early Intervention** - Paediatric Speech, Paediatric Occupational Therapy, School based Therapy sessions in small rural schools. Screening and early learning programs, Immunisation. **Transport** - Provide Transport from Enngonia to Bourke for Aboriginal people to attend General practice, specialist and allied health appointments. **Aboriginal health & Chronic disease** - Diabetes Service & Rehabilitation and lifestyle programs, Health promotion & nutritious eating and healthy lifestyle programs, Weight loss programs, Health home visiting in pregnancy & early childhood, preventative health with school aged people and young people, physical activity groups with Children, Child Health checks. Through key partnerships with service providers, WNSW LHD, General practice and ACCHOS, an integrated approach to Aboriginal Health is highlighted through programs such as Connecting Care and Closing the Gap. **Aged Care** - Physiotherapy and Social work, Podiatry, Palliative Care, Improve the quality and range of services for older people. Other services that support Aged care are though our After Hours program. **Outback Eye Service** - Provide a manager, ophthalmic nurse, orthoptist to Bourke, Cobar, Walgett, Brewarrina, Lightning Ridge and Dubbo. This service provides optometry treatment for diabetic retinopathy, monitoring glaucoma, eye ultrasound, treatment for macular degeneration, and cataract surgery in Bourke.
Collaboration	Prior regional collaboration & joint needs planning with the Local Health Districts (LHDs) has contributed to the original service design of most of these services. The ongoing development or redesign of these services into a whole of region service environment will also require further activity via the joint Health Intelligence Unit (HIU). All PHN funded services are required to work with the PHN to further define appropriate models of care that, where appropriate, engage and link well with General Practice, AMS/ACCHOs, and LHD services. The recent HNA engagement process identified the

	need for improved communication and collaboration across PHN boundaries to ensure patient access to services close to home. A strong focus of WNSW PHN over the next twelve months will be that of better connections between all service providers, and improved integration of care.
Indigenous Specific	WNSW PHN has emphasised with all providers the need for improved coordination of care for disadvantaged patient groups and at-risk populations. Given that 11% of the PHN are Aboriginal, to achieve this many 'mainstream' services are in effect being reoriented to better meet the needs of Aboriginal patients. Also some regional providers such as Maari Ma and Marathon Health have developed various indigenous specific activities such as transport & social support services targeting the remote or disadvantaged Aboriginal populations within WNSW. Aboriginal health and chronic disease focussed services include Diabetes Service & Rehabilitation and lifestyle programs, Health promotion & nutritious eating and healthy lifestyle programs, Weight loss programs, Health home visiting in pregnancy & early childhood, preventative health with school aged people and young people, physical activity groups with Children, Child Health checks. Through key partnerships with service providers, LHDs, General practice and ACCHOS, an integrated approach to Aboriginal Health is highlighted through programs such as Connecting Care and Closing the Gap.
Duration	Existing services that are funded will be extended for up to 12 months.
Coverage	Whole of Western NSW PHN Region
Commissioning approach	2015/16 services being delivered by current providers will be extended for up to 12 months. WNSW PHN will commence a service specification and contracting processes late 2016/ early 2017 to confirm new arrangements from 1 July 2017. A WNSW PHN evaluation framework will be utilised to assess the effectiveness of the funding, and alignment with the needs assessment.
Proposed Activities	
Priority Area	1.1 Workforce Planning 1.3 Enhancing practice & improving quality of care 3.1 Aboriginal Health planning 4.1 Integration and Collaboration 5.1 Regional planning 6.2 Chronic Disease management

	7.1 Access
Activity Title / Reference	**NP 1.2 Western NSW Health Planning, Integration and Coordination**
Description of Activity	**Western NSW LHD Integrated Care Strategy** The Western NSW ICS is one of the three NSW state demonstrator sites to trial large scale integrated care initiatives enabling new ways of working for general practice and other community providers. The program seeks to deliver to deliver holistic (mental, social and physical), patient-centred care across primary and secondary services, and across multidisciplinary provider teams. The WNSW PHN has been a core partner assisting the region, and general practices and Aboriginal and Community Controlled Health Services more specifically, to start to deal with the 33% projected growth in medical-surgical hospitalisations to 2030 (if there were no change in Average Length of Stay or avoidable admissions to hospital) through risk stratification. Key areas of focus include: - Improved health outcomes of patients who live regionally and remotely - Reduced waiting time for patients - Reduced avoidable hospitalisations - Improved experience for patients and families - Better use of health resources. Four State enablers have been prioritised for investment that also inform regional activities; 1. **HealtheNet:** allows for the mapping of different patient identifiers to create a single picture of patient information across LHDs, and is integrated with the national Patient Controlled Electronic Health Record (PCEHR) 2. **Risk Stratification:** developing tools to identify people at risk of chronic illness or chronic disease that can be followed up early and have targeted intervention 3. **Patient Reported Outcomes Measures:** investing in better measurement, tracking and feedback of patient outcomes across the system, with a view to achieving better patient follow-up and patient-centred care. 4. **Real time patient feedback:** investing in tools to measure the experience of the patient immediately after or during treatment. In 16/17 WNSW PHN staff will continue to strengthen the ICP connection between GPs, community health, non-government health organisations and hospitals via its practice support and eHealth

	support. This support is generic to all local demonstrator sites as part of normal PHN 'business as usual' within Western NSW. Some aspects of this support however is more complex challenging depending on the site trialling different prototypes of the integrated care model or the interplay between the site-based Local Leadership Groups, the regional Clinical Advisory Council, the regional Health Intelligence Unit, and the various state enablers or agency interest including those of eHealth NSW, NSW ACI, and the Ministry of Health. The five local demonstrator sites in Cobar, Dubbo, Wellington, Molong and Cowra have now commenced expansion and will also include Blayney, Coonamble, Mudgee and Walgett. While the ICS funding is limited to 30 June 2017 there is likely to be PHN support activity allocated beyond that time such as the possible transition of some ICS demonstrator activity or learnings to the new "Healthcare home" opportunity if or where relevant. **Far West LHD Integrated Care Program** The WNSW PHN works with the Far West LHD's "Staying Healthy Program" and local health providers, services and consumers to improve the community's health literacy and capacity to make informed choices leading to improved health outcomes for 20-55 year olds at risk of developing a life-style related chronic disease. The three-year project will address the high proportion of people who are disengaged in their health and the healthcare system within the community in order to reduce the demand on acute care services and increase patient, community and provider capacity to keep them well. WNSW PHN provides practical support to Far West practices and Aboriginal and Community Controlled Health Services including data collection and data analysis along with the development of a routine data collection protocol. The PHN will continue to broker and directly offer assistance with ongoing change management related to challenges such practices undertaking data cleansing (including the funding of GP and nurse time and joint technological resources to undertake the process), sorting through logistical or technical difficulties that hinder the project (for example where the PatCat data extraction tool doesn't interface with practice management software or non-Microsoft servers). The PHN also will work closely with the LHD on data extraction and specifically the refinement of shared clinical performance indicators and predictive risk modelling. **Health Intelligence Unit** While the Health Intelligence Unit was established as a WNSW ICS 'district wide enabler', it also continues to be a joint priority for the Chief Executives of both Western and Far West LHDs, the Chief

	Executive of Maari Ma, and the Chair of Bila Muuji alongside the Chief Executive and Board of Western NSW PHN beyond the life of the ICS. The key objective of the Unit, and the PHN staff working virtually within it, is to provide a single, shared platform that is able to support the data and information needs of all health care organisations in the region and which can facilitate collaborative planning and integrated service delivery. The HIU has moved from a scoping and analysis phase of development to a design and construction phase through facilitating collaboration between the participating organisations around the agreed use of business intelligence systems of mutual value: • A critical mass in the areas of data analysis, information and knowledge management • Support for decision makers around the complex and broad knowledge required to make effective decisions about health care delivery • Improvement in the capability of existing systems and service providers in interpretation and use of data and information • Greater capacity for innovations and quality improvement The HIU is currently leading a proof of concept for an online Business Intelligence portal which services Business Intelligence reporting for subscribing members. The service will demonstrate the flexibility, scalability, productivity and security within the data modelling technique. The following areas are in scope for testing and deployment over the next financial year: • Data Analytics – ready access to expert support and analysis of data • Research and Evaluation - evidence based best practice • Evidence Summaries • Reports – routine, special, ad-hoc – Reports developed within the region that meet local needs and reflect a strong understanding of the local environment as well as strong familiarity with the data • Website / Portal – one stop SharePoint environment

	• Advice and Support – enhance day to day operations through support on interpretation and use of data & information • Capacity Building – locally based experts across the region
Collaboration	Prior regional collaboration and joint needs planning with the Local Health Districts (LHDs) has contributed to the original service design of the majority of this joint activity. The ongoing service redesign both requires and informs a shift towards 'whole of sector' oriented systems as it involves integration at the macro, meso and micro levels so as to streamline more efficient activities within demonstrator site clinical teams and inform rapidly developing PHN change management and redesign support activities through such tools as the PC-PIT or shared regional clinical pathway developments.
Indigenous Specific	Through various key Aboriginal health oriented partnerships involving service providers, LHDs, General practice and ACCHOS, an integrated approach to patient-centred leadership is emerging within primary care in the region that will result in more culturally appropriate health service delivery and where relevant shared or targeted clinical data within the primary health care sector so as to inform closing the gap sometimes further exacerbated for rural and remote services.
Duration	12 months
Coverage	Whole of Western NSW PHN Region
Commissioning approach	Single provider based

1. (c) Planned core activities funded by the operational funding stream under the Schedule – Primary Health Networks Core Funding

Proposed general practice support activities	
Activity Title / Reference (eg. OP 1)	Workforce Support to Enhance Practice and Improve the Quality of Care (OP 1)
Description of Activity	**AIM** The HNA data highlighted that regional service providers face an ageing medical, nursing and health professional workforce which requires joint succession planning, new models of care, and ways to develop an adequately skilled, supervised and sustainable workforce so as to better meet both current and future service demands. **HOW THE ACTIVITY WILL SUPPORT THE PRIMARY HEALTH CARE SECTOR** The PHN will assist GPs and general practice staff with professional and multi-disciplinary team oriented care, quality systems training, workforce recruitment and retention support, and technology based learning opportunities. The PHN's robust Continual Professional Development program will meet the identified needs of GP's and local primary health care providers and include inter/multi-disciplinary needs through broader networking and interagency collaborations that are made available as close as possible to their work and social environments. This activity assists local healthcare providers (GPs, Pharmacists, Allied Health providers, LHD providers and Medical Specialists) to implement eHealth and Telehealth technologies, to enable improved patient access, patient-experience, and the co-design of better clinical outcomes including

	solutions for residential Aged Care Facilities and co-ordinated care programs around chronic diseases. General Practice and other providers will be enabled to improve their use of their clinical information and quality improvement systems so as to jointly manage chronic disease and acute care (including hospital presentations) through shared clinical data and integrated health records. **HOW THIS IS ALIGNED TO THE PHN OBJECTIVES** The active support of a more skilled and engaged general practice and primary health care workforce is key to practice-based service redesign as it enables new forms of specialist primary care and the building of new community-based alternatives to hospital care. Much of this activity is also core to the PHN's ongoing credibility within the region as without access to a skilled workforce the PHN offer minimal value to the community. Joint workforce planning also assists chronic disease outcomes through greater practice nurse leadership and the regional expansion of the person centred healthcare home approach including such elements as an Allied Health Assistant workforce, training pathways for Aboriginal staff, and more GP Proceduralists as part of our broader Primary care workforce redesign.
Collaboration	These activities are delivered in close collaboration with General Practice and Allied Health Providers to ensure that the support delivered addresses the current needs. The PHN engages the majority of its practices to work with General Practice Accreditation providers. It also works with the Department of Health to support the Practice Incentive Program and digital health agenda, as well as with quality prescribing and CTG compliance activity. WNSW PHN works closely with other NGOs, Government agencies and education institutions to develop quality professional development opportunities and leverage existing programs. Key partners include the Western and Far West Local Health Districts, the School of Rural Health Sydney University, Royal Australian College of General Practice and others. WNSW PHN collaborates broadly with national health associations to promote other professional development opportunities that are relevant for regional practitioners. Within the NSW State Integrated Care Strategy demonstrator program the PHN is critical to assist design integrated care data design, reporting and analytics that assists clinical governance and local clinical decision making for both LHDs. The PHN within the WNSW LHD program is also assisting with the development of clinical care pathways from a whole-of-locality service redesign perspective.

	As a cohort of our population fell under the Nepean Opt Out trial, there is also a need for close collaboration with the Department of Health eHealth team in the implementation and best practice use of Digital Health for greater self-care and improved health literacy within that project.
Duration	24 months
Coverage	Whole of Western NSW PHN Region
Expected Outcomes	The following outcomes relate to the PHN's objectives: • Provider plans developed address quality of care, practice enhancement, and clinical pathways. • GP professional development requirements are met, improving the medical services for patients • Existing or newly recruited GP workforce better retained in rural communities, providing access to services • High level of participants are satisfied with the CPD program • Recipients of workforce support are satisfied with the support provided • Improved sustainability of workforce with existing or newly recruited GP workforce better retained in rural communities • Increased usage of tele-health and Digital Health systems • Improved identification of patients at risk of or diagnosed with a chronic disease • Improved data capture and clinical information systems in General Practice • Practices submitting de-identified data to the secure primary care data portal • Improved accuracy of profile mapping of disease prevalence across the region, allowing for better utilisation of resources to areas in need and direct provision of services • Current local health information availability for PHN & LHD service delivery planning • Current local health information availability to participating GP's and local healthcare provider organisations for benchmarking and quality improvement activities • Reduction in acute care services consumed by patients enrolled in local chronic disease co-ordinated care programs • Increased community understanding of local health issues based on health data • Improved patient management and health outcomes

2. (a) Strategic Vision for After Hours Funding

The Western NSW PHN proposes the following three high level strategic goals (these may be further refined following more timely clinician and community consultation and joint service/utilisation mapping):

A) The PHN will seek to sustain after-hours services in regions where there is limited access to after-hours services informed by community need, continuity of care, and workforce impacts.
B) The PHN will support medical service providers to target and provide increased access to after-hours services in areas which currently have limited/no access. Wherever possible this support will include GP alternatives such as eHealth, home monitoring or different models of care as well as better targeted services or support for aged care to alleviate the impact on both the patient and the Emergency Departments.
C) The PHN will seek to address both awareness and health literacy issues in the community impacting access to after-hours services.

The following strategic activities are planned to further inform the PHN's vision above and result in more effective commissioning of after-hours services:

1. Detailed service/workforce mapping versus Utilisation of services during after-hours periods (i.e. supply versus demand) in each locality.
2. Clinician consultations (including GP teams, ED staff, Pharmacy, & RACF staff) in each locality regarding their awareness of GP availability and after-hours clinic contact details etc.
3. Community consultations covering all sectors of the community (and including consultations with patients who tend to make use of ED and other services during the after-hours periods).
4. During this consultation period the PHN will also seek to identify new shared workforce development opportunities such as joint Healthcare home development with partner LHDs, Aboriginal Health Councils, ACCHOs, NGOs, universities, and the RFDS so as to reduce gaps in local workforce availability and support greater continuity of care.
5. Prioritisation of localities at greatest need of after-hours solutions.
6. Feasibility studies for different models of after-hours care at these localities including the possible establishment of GP after-hours clinics at Hospitals wherever the demand has increased since previous ML planning, and Medical Deputising Services that might be available to complement and support General Practice in the provision of continuity of care to patients, both within and outside normal opening hour such as the provision of home visits, clinics and/or telephone triage / medical advice services.
7. Commissioning and/or support for existing organisations to allow implementation of these models of after-hours care.
8. The PHN will also review and implement community-based mental health service redesign recommendations from the Mental Health HNA where these have impacts on after-hours service redesign, and any GP VMO support associated with their provision of after-hours services.

2. (b) Planned activities funded by the Primary Health Network Schedule for After Hours Funding

Proposed Activities	
After Hours Priority Area (from Needs Assessment)	1.1 Workforce Planning – Reduce gaps in local workforce availability that support continuity care 5.3 Access – More flexible pathways or accessing primary care consultation 7.2 Access – Locally relevant service information available for use by service providers
After Hours Activity Title / Reference	AH 1.1 - After Hours GP Clinics in Bathurst and Dubbo and the After Hours Phone Service
Description of After Hours Activity	The After Hours GP Clinics are an initiative which implements services with the purpose of improving primary care access in the after-hours period. We currently operate two clinics; one in Dubbo and one in Bathurst. The clinics provide consultations by local GPs to patients who have an urgent medical condition and are unable to wait to see their regular GP during normal surgery hours. The clinics are staffed by a GP, a Registered Nurse and a receptionist. This model supports local GPs to provide after- hours services where there is minimal coverage and details regarding the Clinics are promoted within the community. The After Hours GP Clinics are located at Bathurst and Dubbo. Both clinics are located on the Local Health District hospital campus' in close proximity of the Emergency Departments. Both clinics operate on Saturdays and Sundays and public holidays (excluding Christmas Day and Good Friday), with clinics opened for 4 hours. The clinic operational times are 3pm to 7pm in Bathurst and 2pm to 6pm in Dubbo.

	The Clinics offer bulk billing and are a walk-in model so no appointments are necessary. All patients are triaged by a Registered Nurse prior to seeing the GP. Patient consultation notes are sent to their usual GP/practice to keep the patients doctor informed and in case there is any follow up required during the week. The main aims of the After Hours GP Clinics are to: • Provide after hour medical services for Bathurst and Dubbo, and the surrounding communities and visitors to these regions that meet the needs of those who require after hours health care. • Provide a quality focused service. • Support local General Practice in the ongoing care of patients. • Reduce unnecessary ED presentations for urgent but non-emergency care The After Hours phone service is provided by local GPs for Bathurst, Dubbo and surrounding regions. The phone service is provided using an on call phone system with the doctor deciding at the time if the person needs to be referred to the Emergency Department or if medical advice over the phone is sufficient. The service supports people in the primary care setting and residential aged care facilities, who have an urgent non-emergency medical condition requiring attention, or who are seeking reassurance or medical advice over the phone. The service also offers after hour's service visits to Residential Aged Care Facilities (RACFs) when the after-hours on call doctor is called. The phone service is available: • Mondays to Fridays from 6pm to 8am the following day • Saturdays from 12pm to 8am the following day in Bathurst; and 8am to 8am the following day in Dubbo • Sundays and Public Holidays (including Christmas Day and Good Friday), the service operates 24 hours. The main aims of the After Hours phone services is to: • Provide clinical advice/treatment to the participating practice population outside of regular practice hours • Provide clinical services which facilitates continuity of care with the person's regular GP • Facilitate access to a quality after hours medical service • Provide service visits to RACF's who contact the after-hours phone service

	Reduce unnecessary ED presentations for urgent but non-emergency care
Collaboration	Service Provider – Marathon Health partnership with WNSW LHD – located at Dubbo & Bathurst Hospitals.
Duration	After Hours Clinics - Current contract until June 2017 After Hours Phone Service – propose to extend contracted until June 2017.
Coverage	Dubbo LGA & Bathurst LGA
Commissioning approach	Direct engagement of the current service provider.
Proposed Activities	
After Hours Priority Area (from Needs Assessment)	1.1 Workforce Planning – Reduce gaps in local workforce availability that support continuity care 5.3 Access – More flexible pathways or accessing primary care consultation 7.2 Access – Locally relevant service information available for use by service providers
After Hours Activity Title / Reference	AH 1.2 – After Hours Innovation Program
Description of After Hours Activity	In November 2015 and March 2016 WNSW PHN undertook an After Hours Primary Care Innovation Program in two rounds. In the first round two streams were funded - Service Delivery and Service Development. The second round funded service delivery projects. The aim of the Innovation Program was to ensure efficient and sustainable delivery of after-hours care across the region. Services or projects funded under the program are considered 'pilot' projects with a view to further developing or expanding successful projects in 2016-17. The objectives of the innovation program are to reduce gaps and improve access in after-hour services. **Round 1 –** There were eight successful submissions in Service Delivery in the following disciplines, Palliative Care, Nurse-led Telehealth, Transport, Pharmacy, Diagnostic Services These grants involved going to market to attract service providers to work with priority groups to improve access, and efficiency to vulnerable and high risk patients specifically targeting Aged Care and Palliative Care patients.

	Round 2 – Tenders with the successful applicants will be confirmed shortly. WNSW PHN will review and evaluate services considering the following criteria: services that improve access to AH for vulnerable populations, innovation using eHealth/telehealth & home monitoring, improve access through transport options and provide local solutions that promote working in collaboration with other stakeholders. Funding will be provided to continue projects that rate highly in the evaluation aligned to these criteria.
Collaboration	Working with local service providers across the region to enhance After Hours services
Duration	12 months
Coverage	Bathurst, Dareton, Collarenebri, Broken Hill & Orange (subject to evaluation)
Commissioning approach	Direct engagement of service providers providers.
Proposed Activities	
After Hours Priority Area (from Needs Assessment)	1.1 Workforce Planning – Reduce gaps in local workforce availability that support continuity care 5.3 Access – More flexible pathways or accessing primary care consultation 7.2 Access – Locally relevant service information available for use by service providers
After Hours Activity Title / Reference	AH 1.3 – Aged Care
Description of After Hours Activity	**ISBAR Aged Care Training** The Aged Care Emergency Guidelines and Communication Training for Residential Aged Care facilities (RACFs) project provides education to RACFs in the ISBAR tool and Emergency Decision Guidelines. The Aged Care Emergency Guidelines and Communication project was developed from an identified need to improve communication skills between staff in RACFs and health professionals including GPs. The model adopted for use in RACFs uses the ISBAR (Introduction, Situation, Background, Assessment and Recommendation) model as a tool for structuring communication in an ordered and logical format, and incorporates Emergency Guidelines to guide staff as to when a situation needs to be escalated and acted upon immediately, or when it is appropriate to observe and monitor.

	The training involves a combination of online training and face to face training The training package takes approximately 2 hours to complete and is delivered by the service provider project officer. Training to RACFs is free and all equipment and resources are supplied. The Aged Care Emergency Guidelines and Communication Training for RACFs Project Officer is located at either the Bathurst or Dubbo offices with outreach to rural and remote communities.
Collaboration	Direct engagement with Service Provider & General Practitioners & Regional ACFs
Duration	Extend current contract until June 2017
Coverage	Dubbo LGA & Bathurst LGA
Commissioning approach	Extend Contract and evaluate.
Proposed Activities	
After Hours Priority Area (from Needs Assessment)	6.3 Older persons health
After Hours Activity Title	AH 1.4 Palliative Care
Description of After Hours Activity	Consideration will be given to the outcomes of the Service Development Stream round 1 of the Innovation Program in Palliative Care. A feasibility study is being conducted to establish an After Hours Palliative Care Service in the Central West.
Collaboration	General Practitioners, Western NSW LHD, Far West LHD, Ambulance, ACFs
Duration	12 months
Coverage	Regional
Commissioning approach	Direct engagement of service providers.

Proposed Activities	
After Hours Priority Area (from Needs Assessment)	4.1 Integration and Collaboration
After Hours Activity Title	**AH 1.5 General Practice Liaison Officer**
Description of After Hours Activity	Establish a liaison position which will be responsible for improving the interface between the hospital (particularly outpatient department) and primary health care by providing input into the planning and development of service at the local and regional level, ensuring care is integrated across the entire patient journey, and support the alignment with the After Hours program objectives.
Collaboration	General Practitioners, Western NSW LHD
Duration	To June 2017
Coverage	Regional – the role will be based at Dubbo Base Hospital
Commissioning approach	Role to be employed by WNSW PHN
Proposed Activities	
After Hours Priority Area (from Needs Assessment)	5.3 Access
After Hours Activity Title	**AH 1.6 Primary Health Care (PHC) Rural and Remote Telehealth**
Description of After Hours Activity	Project aim: To develop and implement a PHC rural and remote telehealth strategy, in conjunction with partner organisations, with a particular focus on our WPHN geography. The strategy would address the following needs: • better access to primary health care services for remote communities and isolated patients • the capacity to provide workforce (relief) solutions with a key focus on after hours in rural NSW small communities • the capacity to reduce T3,4,5 Emergency Department presentations, particularly in after-hours periods. • the capacity to provide workforce solutions for communities with intermittent or no resident providers

	• the development of robust and well-structured nurse led medically supported model(s) of care with particular reference to telehealth • increasing access to and affordability of specialist outreach services (medical, nursing and allied health) both public and private sector role and the relationship with HealthDirect • timely access to relevant, accurate clinical information and better integration of clinical records arising from remote/telehealth interventions • interoperability of telehealth infrastructure • development of an efficient back end support system for access to, and delivery of, remote clinical services This project would align with Digital Health initiatives being undertaken by the Western NSW LHD and Far West LHD.
Collaboration	WNSW PHN Clinical Council, Community Council and Aboriginal Health Councils
Duration	To 30 June 2017
Coverage	Rural and remote areas within the WNSW PHN region
Commissioning approach	Single Provider or Most Capable Provider (MCP) Approach