Australian Government
Department of Health

phn NORTHERN SYDNEY
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**

Northern Sydney PHN

The Activity Work Plan will be lodged to Alexandra.Loudon@health.gov.au on or before 6 May 2016.

Northern Sydney PHN ANNUAL PLAN 2016-18

Strategic Vision

The Northern Sydney PHN, operated by the Sydney North Health Network (SNHN), officially launched in July 2015, as a primary healthcare organisation to:

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

Better health outcomes for our community is achieved by working together with a network of health professionals including General Practitioners, Practice Nurses, Allied Health Providers, the Northern Sydney Local Health District (NSLHD) and other health services. This partnership approach and community focus is reflected in our vision: **Achieving together – *better health, better care***.

The Northern Sydney PHN Strategic Plan 2015-18, developed through Board and stakeholder discussions, identified four strategic priority areas for the next three years to realise this vision:

- Building primary healthcare capacity
- Service transformation by integrating systems for the user, the provider and the system
- Commissioning
- Organisational excellence

Download summary of Strategic Plan by CLICKING HERE

The PHN will drive improved health outcomes in our community by the commissioning of appropriate services that respond to regional need. This will be achieved by leading the planning, coordinating and integration of services, bringing all parts of the health system together so that the community is best served. As part of this journey, Northern Sydney PHN is proactively understanding the health care needs of communities and working directly with general practitioners, other primary health care providers, secondary care providers and hospitals to ensure improved health outcomes.

The first Northern Sydney PHN Baseline Needs Assessment reveals a changing demographic which faces a number of challenges across age groups with pockets of disadvantage. The region comprises eleven Local Government Areas (LGA) with a total estimated resident population of 892,566 (2014) [1]and projected population increase of 20% between 2016 and 2031 (43% for over 65 year olds)[2]. While the region has better reported health and health outcomes than many other Australian regions, there is great scope to improve health outcomes and the services offered, particularly for vulnerable communities within the region.

The PHN is already engaged with partner organisations including the NSLHD to support individuals with complex and chronic disease, and to reduce the need for acute services for such patients. The Baseline Needs Assessment process has enabled the PHN to investigate further and identify specific domains where there is a significant need for services and support in order to achieve improved health outcomes for vulnerable community groups, namely residents with mental health or drug and alcohol problems, disadvantaged youth and the frail elderly.

[1] Australia Bureau of Statistics (ABS) 2015. *Population by Age and Sex, Regions of Australia, 2014*. cat no 3235.0, ABS, Canberra

[2] NSW: Department of Panning & Environment 2016. New South Wales State and Local Government Area Population, Household and Dwelling: 2014 Final. NSW Planning Department of Panning & Environment, Sydney, viewed June 2016, http://www.planning.nsw.gov.au/Research-and-Demography/Demography/Population-Projections

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The opportunities and priority areas identified in the Baseline Needs Assessment triangulated with the strategic priorities identified through consultations in the development of the PHN Strategic Plan, has formed the basis for activities and programs for implementation over the next two years. A summary of these activities are in the following table, with further details provided in the activity schedules.

A Summary of Core/Flexible Activities 2016-18

PHN Strategy	Activity 2016-18	Summary of Tasks/Programs
Service Transformation	Access and Navigation of primary healthcare	•Developing targeted health pathways around key priority areas including aged care, chronic disease, end of life, urgent care, mental health, musculoskeletal and shared antenatal care. •Utilising the health pathways collaborative development process as an opportunity for system change and co-commissioning that leads to service transformation. •Working collaboratively on potentially preventable hospitalisation initiatives, including with hospital in the home, GP Liaisons and joint chronic condition initiatives with partners (LHD, private health insurers, and private hospitals).
	Patient Activation: supporting people to manage their health	•Development of Health literacy tools and initiatives, including health fact sheets and mapping. These initiatives and tools improve the navigation of services available and that support shared decision making. •Targeted prevention activities and promotion of screening and immunisation. •Explore patient activation tools/initiatives and potential role in PHC to support people in proactive management of their health – could include community pharmacies and community NGO initiatives commissioned and support for use of digital health technologies.
Commissioning	Health Intelligence	• Develop capacity and work with market to co-design, co-deliver and actively manage commissioned initiatives. • Building capacity and connectivity across PHC to promote sharing of information for improved health outcomes. • Build health informatics and joint health intelligence infrastructure to inform strategic commissioning and develop joint risk stratification approaches to supporting people to remain in the community.
	Community Health – vulnerable groups	• Targeted community initiatives for improved health outcomes. This would include CALD, Aboriginal health, homeless, health of the elderly, youth, co-morbidities, immunisation, mental health and alcohol and other drugs.

Building Primary Healthcare Capacity	**Building primary healthcare capacity**	• **Person Centred Medical Home (PCMH): co-design a program utilising the PCMH building blocks for interested practices.** • **Quality improvement initiatives to support PHC providers in achievement of the 'quadruple aim' and enhancing their capacity and capability to deliver high quality care.**

1. Flexible Funding Activities

Proposed Activities	
Activity Title / Reference	**Access & Navigation**
Priority Areas (from Needs Assessment)	Access and navigation; multiple co-morbidities; end of life; urgent care; discharge planning, mental health.
Description of Activity	1. Developing targeted **health pathways** around key priority areas including aged care, chronic disease, end of life, urgent care, mental health, musculoskeletal and shared antenatal care. Work in collaboration with the Northern Sydney Local Health District and Private Hospitals to implement the HealthPathways web-based portal to support local clinicians to plan patient care through primary, community and secondary health care systems within Northern Sydney. The process of prioritising local pathways will assist SNHN with developing an in-depth understanding of key clinical and systems based issues and will be utilised to highlight commissioning opportunities and inform key commissioning decisions. HealthPathways will be the key activity undertaken locally to address access and navigation issues for local health providers, to ensure people get the right care in the right place at the right time. 2. Utilising the health pathways collaborative development process as an opportunity for system change and **co-commissioning** that leads to **service transformation**. Work collaboratively in identifying gaps in pathways during development, and co-commission solutions. 3. Working collaboratively on potentially preventable hospitalisation initiatives, including hospital in the home, GP Liaisons and joint chronic condition initiatives with partners (LHD, private health insurers, and private hospitals). Commission and co-commission initiatives include: • Working with LHD and the Ministry of Health on joint chronic disease management redesign project and integrated care project and support PHC engagement with potentially preventable hospitalisations. • Working with Private Health Insurers, General Practices and Private Hospitals on joint chronic disease initiatives. • Working with Registered Aged Care Facilities (RACFs) on developing joint potentially preventable hospitalisation (PPH) initiatives.

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Proposed Activities	
Activity Title / Reference	**Access & Navigation**
Collaboration	The PHN will work closely with the PHN Clinical Council and Community Council in the design of PPH initiatives and development of health pathways across the primary and secondary sectors. Existing collaborative expert groups, such as Antenatal Shared Care Steering Group, Primary Care Diabetes Steering Group, Mental Health and Alcohol and Drug Steering Committee and the Dementia Pathways project group will be utilised where available to lead the health pathways development process and the PHN will work closely across the health community including: • NSLHD • General Practices • Private Hospitals • Private Health insurers • Community Allied Health • NGOs • RACFs • Community Groups
Indigenous Specific	No
Duration	1 July 2016 – 30 June 2018
Coverage	Entire PHN region
Commissioning approach	PHN will follow its integrated commissioning framework with key components being plan, deliver, monitor and review. The approach will be consistent with the nationally agreed commissioning principles incorporating stakeholder and market engagement throughout the process.
Performance Indicator	1. Number of pathways localised & number of practitioners using pathways 2. Appropriate indicators are identified in collaboration with stakeholders during 2016-2017 with the view to impacting on the national indicator for potentially preventable hospitalisations by 2017/18.
Local Performance Indicator targets	First year (16/17) will be establishing joint activity plan for delivering PPHs and target measures for 2018.
Data source	PHN for pathways indicators. Further sources to be defined.

Proposed Activities	
Activity Title	**Patient Activation: supporting people to manage their health**
Priority Areas (from Needs Assessment)	Consumer engagement and health literacy; health promotion activities relating to population health risk factors
Description of Activity	To explore mechanisms that enable the acquisition of knowledge, skills and confidence for people to manage their own health and health care such as:

Proposed Activities	
Activity Title	**Patient Activation: supporting people to manage their health**
	• Development of health literacy tools including health fact sheets and health mapping. • Development of tools that support navigation of services available (e.g. HealthPathways patient portal) and that support shared decision making. • Targeted prevention activities and promotion of screening and immunisation. • Explore the use of patient activation tools, such as PAMs, PROMs and PREMs (Patient activation measures, outcome measures and experience measures) in primary care to support people with proactive management of their health – could include initiatives commissioned through community pharmacies and NGO's. • Target clinical and educational information and devise tailored channels to specifically support health professionals to effectively respond to patient needs. • Explore and encourage the use of digital health technologies e.g. patient wearable devices, active engagement with MyHealth Record. • Outreach and partnerships with vulnerable groups.
Collaboration	The Northern Sydney PHN will lead the development of patient activation and health literacy tools and the implementation of targeted prevention and screening initiatives This will be done collaboratively with our general practice and allied health partners and with the community, utilising the PHN Community Council and community forums.
Indigenous Specific	Dependent on tools developed.
Duration	This major area of activity and infrastructure will develop and last for the duration of the PHN year two cycles in 2016-18.
Coverage	Entire PHN region.
Commissioning approach	Where commissioning is required, the PHN will follow its integrated commissioning framework with key components being plan, deliver, monitor and review. The approach will be consistent with the nationally agreed commissioning principles incorporating stakeholder and market engagement throughout the process.
Performance Indicator	This activity area will enable the identification and development of patient activation tools and prevention campaigns and specific indicators will be developed in collaboration with relevant stakeholders, with the longer term view to impact on cancer screening rates, immunisation rates and PPH's. For 2016/17 process indicators could include: 1. 100% of localised pathways have corresponding/relevant patient fact sheets 2. Patient portal into HealthPathways is developed 3. Number of practices implementing PAMs, PROMs & PREMs 4. Number of patients registered for My Health Record 5. Number of initiatives undertaken in prevention, health literacy, community engagement

Proposed Activities	
Activity Title	**Patient Activation: supporting people to manage their health**
Local Performance Indicator target	To be defined in collaboration with relevant stakeholders.
Data source	PHN, Department of Health (for My Health Record registrations)

Proposed Activities	
Activity Title	**Health Intelligence**
Priority Areas (from Needs Assessment)	Urgent Care, Health of the Elderly, Population Health, Mental Health, Drug and Alcohol, CALD
Description of Activity	The Northern Sydney PHN will build and develop capacity and connectivity across the health system to promote the sharing of valuable data which will drive efficiencies, improve outcomes and underpin informed commissioning activities for further quality improvement. Activities will include the following: • Design and build health informatics data 'warehouse'. • Design and implement joint health intelligence infrastructure with Local Health District. • Develop and support intelligent use of General Practice data, collected via data extraction tools (e.g. Pen Clinical Audit Tool), to inform commissioning direction and to provide proactive feedback to practices relating to Quality Improvement for their practice populations. • Collate appropriate data linkage and develop risk stratification approaches for commissioned activity and to build further capacity in primary healthcare. • Develop and further undertake strategic commissioning intelligence - qualitative and quantitative analysis, including stakeholder engagement, service capacity analysis and strengthening our needs assessment profile. • Purchase / build internal system to manage commissioning tender processes (e.g. Tenderlink). • Build internal organisational commissioning capabilities – training and development of key staff and partners. • Develop and build capacity to utilise Shared Care Planning/Facilitation of Team based Care technologies in primary healthcare. • Develop and build capacity to utilise digital health technologies, such as eReferrals, secure messaging, ePrescribing, utilisation of MyHealth record etc. in primary healthcare including aged care facilities, to support safe clinical handover.
Collaboration	The Northern Sydney PHN will lead the development and implementation of the Health Intelligence activity for 2016-2017 and will involve and collaborate with key partners and stakeholders throughout to deliver on KPI's. This will include:

Proposed Activities	
Activity Title	**Health Intelligence**
	• Working closely with the Local Health District to develop methods of sharing data, including establishing access to timely and useful data sets. • Working in collaboration with General Practice and the wider Primary Care sector to design and roll out health intelligence related outputs. Aged Care Facilities, Providers, Consumers and both the Clinical and Community Council's will be integral to provide support and facilitate the delivery of these activities.
Indigenous Specific	No
Duration	This major area of activity and infrastructure will be developed throughout the duration of the PHN two year cycle 2016 - 2018.
Coverage	The Northern Sydney PHN Health Intelligence activities will occur across the entire PHN region, to include primary care and the Local Health District.
Commissioning approach	This activity will underpin and inform the Northern Sydney PHN's entire commissioning approach and objectives. The PHN will follow its integrated commissioning framework with key components being plan, deliver, monitor and review. The approach will be consistent with the nationally agreed commissioning principles incorporating stakeholder and market engagement throughout the process.
Performance Indicator	This activity area will enable the identification and development of accurately informed performance indicators for strategic commissioning activities, and will engage and build relationships and partnerships with general practice, the wider primary care workforce and the Local Health District to further enhance efficiencies and coordination, as per the PHN's major objectives. For 2016/17 process indicators could include: 1. Number of General Practices submitting de-identified data to Northern Sydney PHN. 2. Number of primary health care clinicians (GPs, allied health, aged care, pharmacy, specialists) using eReferrals, ePrescribing, secure messaging and/or uploading Shared Health Summaries to the My Health Record.
Local Performance Indicator target	This key area of work will enable the establishment of measurable outcome indicators for PHN activity in the second year of commissioning activity.
Data source	PHN, LHD, Department of Health (for My HR registrations), further data sources to be defined.

Proposed Activities	
Activity Title	**Community Health and Vulnerable Groups**
Priority Areas (from Needs Assessment)	Urgent Care, Health of the Elderly, Population Health, Youth, Mental Health, Drug and Alcohol, CALD, Homeless.
Description of Activity	The Northern Sydney PHN will focus on improving outcomes for the local communities with a targeted approach to vulnerable groups. A commissioning budget is available for identified and agreed areas, for each target group, for the next two years. **Aboriginal and Torres Strait Islander Health** • Hold a Northern Sydney PHN Aboriginal Health Steering Forum to contribute to the co-design of commissioned services and activity. • Work with consumers and other stakeholders to increase understanding of issues with current system including barriers (actual or potential) to accessing services. • Work with local community, partners, LHD and primary care to promote better access and uptake of regional Aboriginal Health GP outreach unit. • Work with general practice and partners to increase percentage of Aboriginal and Torres Strait Islander peoples who receive MBS715 health assessment. **Culturally and Linguistically Diverse Populations (CALD) -including humanitarian entrants, Tibetan community, Northern Sydney Chinese population and vulnerable groups** • Work with stakeholders including consumers and cultural groups to understand issues with current system and services available. • Work with stakeholders to co-design and commission solutions. **Aged Care/ Health of the elderly** • Establish integrated processes and referral pathways at levels of general practice and community allied health services to identify older people at risk of falls and engage a whole of primary health care approach to falls prevention. • Adopt and support a multidisciplinary team approach to supporting the health of the elderly (e.g. falls prevention, transition of care, clinical handover activity, addressing polypharmacy). **Co-morbidities** • Review service provision for people with co-morbidities. • Develop in partnership, community-based models of care to support people with co-morbidities in the community (also links to 'Patient Activation') e.g. outreach services • Work with stakeholders to design and deliver integrated services • Increase health literacy **Youth** • Refer further to the Northern Sydney Mental Health Annual Plan for youth mental health activity.

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Proposed Activities	
Activity Title	**Community Health and Vulnerable Groups**
	• Work with partners to improve access to services for young people at risk of mental health illness, including, but not limited to self –harm, homelessness, bullying, causes for Emergency Department presentations, drug and alcohol and risk taking behaviour. • Better integration of services to ensure young people attending ED following self-harm are followed up by support service (postvention) • Undertake review of current Northern Sydney PHN youth intervention programs, 'GPs in Schools' and 'UConnectHealth' service to determine fitness for purpose and develop regionalised requirements. Depending on recommendations from review either re-commission, expand, redesign or decommission service, with review to focus on a regional solution and approach to meet need. **Homeless** • Co-design and commission identified initiatives. • Work with stakeholders including general practice, NGOs, FACS and the community to understand issues, current services and opportunities for collaboration. **Immunisation** • Supporting practices in LGAs with low coverage recorded to data cleanse • Work with LHD Public Health Unit, general practice and local communities to increase immunisation rates **Mental Health** • Refer further to the Northern Sydney Mental Health Annual Plan for related community health and vulnerable group mental health activity. **Drug and Alcohol** • Refer further to the Northern Sydney Drug and Alcohol Annual Plan for related community health and vulnerable group drug and alcohol activity.
Collaboration	Northern Sydney PHN will work with stakeholders across the health and social care economy to set the strategic direction, to drive service improvements and achieve system change beyond their direct circle of control. Relationships will build and will support co-design and co-delivery of services.
Indigenous Specific	Some of the activities are directly targeted to Aboriginal and Torres Strait Islander peoples.
Duration	This major area of activity will commence in 2016/17 and will continue through to 2018.
Coverage	The Northern Sydney PHN activities will occur across the entire PHN region, to include primary care and the Local Health District.
Commissioning approach	Northern Sydney PHN will adopt a collaborative approach to commissioning.

Proposed Activities	
Activity Title	**Community Health and Vulnerable Groups**
	We will work with patients, providers and the wider community to define problems and identify appropriate solutions.
Performance Indicator	Working with patients, carers, service providers and wider stakeholders to co-design services, Northern Sydney PHN will develop an evaluation framework in partnership with other stakeholders to ensure a shared approach and responsibility to developing and achieving outcomes. During the activity year for 2016-2017 there will be a requirement to achieve certain elements of process indicators, which will be developed further into actual performance outcome indicators for 2017 onwards and such measures will be developed in collaboration with stakeholders in 2016-17. The development of appropriate performance measures which are both measurable and meaningful takes time and should not be done in isolation. The measures listed below are potential measures for activity in 2017-2018 for consultation and agreement with partners: **Aboriginal and Torres Strait Islander health** • Improve uptake to culturally appropriate primary healthcare services by Aboriginal and Torres Strait Islander community in Northern Sydney PHN region. • Number of Aboriginal and Torres Strait Islander people who receive MBS 715 health assessment • Improve uptake of Bungee Bidgel Aboriginal GP Outreach Unit and receiving 'wrap around' support on transition of care. **Aged Care** • Number of practices engaged in the iSOLVE (falls prevention) research trial • Number of Allied Health providers trained in falls prevention management in primary care • Number of Residential Aged Care Facilitates involved in PHN activities and initiatives (e.g. relating to transition of care/clinical handover activity) • Number of Allied Health providers and RACFs in region using secure messaging **Co-morbidities** • Eventual reduction in PPH rates by disease cohort **Youth** • ED attendance for self-harm • Number of schools/students receiving PHN related intervention. **Immunisation** • Immunisation rates by LGA and by target cohort demographic. **Build capacity and capability** • Work with stakeholders to increase understanding of commissioning to enhance shared understanding of approaches and support productive partnership working and co-design • Market development

Proposed Activities	
Activity Title	**Community Health and Vulnerable Groups**
	• Support for wider stakeholder group throughout the design and implementation of any new service change. This will include market stimulation and development which in turn will promote competition between providers and drive quality. SNHN will also promote collaboration between providers.
Local Performance Indicator target	This key area of work will enable the establishment of measurable performance indicators and measurable outcome performance indicators for PHN activity in the second year of commissioning activity.
Data source	MBS, LHD, PHN, University of Sydney (iSOLVE participation), ACIR, further sources to be defined.

4. Planned Core Activities

Proposed general practice support activities	
Activity Title	**OP 1: Building Primary Care Capacity**
Description of Activity	SNHN will continue to work with our local Primary Care Providers to enhance their capacity and capability to deliver high quality, safe, evidence-based care to their communities, through a combination of strategies designed to provide clinical decision support, workforce development and system integration and maximise engagement with and between local providers. SNHN has a core team of Primary Care Advancement Coordinators (PCAC's), each assigned a sub-region within the SNHN catchment and act as the first point of contact for local providers requesting support and as a key engagement and implementation vehicle for targeted initiatives. This includes: - continual profiling of local primary health care providers, including GPs, primary care nurses, pharmacists and allied health etc. to inform the development and implementation of workforce planning and needs assessments - support for practice accreditation - support for uptake and implementation of digital health initiatives - support for health information management and data quality with a focus on chronic disease management and immunisations - delivery of quality improvement initiatives (QI Coach program) - support for the co-development and implementation of a local Health Care Home /PCMH program - networking and professional development opportunities that align with national and local priority areas

Proposed general practice support activities	
Activity Title	**OP 1: Building Primary Care Capacity**
	- support for uptake of the local HealthPathways program once launched - support for implementation of other key PHN initiatives as they arise In addition we will: - develop and implement allied health engagement strategy - develop a workforce plan, including a nurse transition program to attract and retain a viable local workforce - implement at least one "talk to us" forum or event to encourage input from a broad range of local stakeholders. These will form a portfolio of core support activities that will support the primary care sector to work towards achievement of the "quadruple aim", that is, improving patient experience, population health outcomes, value for money and improve the experience of providing care for the local workforce.
Collaboration	A key element of building capacity in primary health care (PHC) is engagement and working with providers in PHC. The PHN will work closely with the Clinical Council in the establishment of engagement approaches and tools to support PHC. The PHN will be the major contributor to delivery of support activities, however key components will be delivered collaboratively including: - The local Public Health Unit for immunisation support. The PHU can assist SNHN with in-depth data analysis to determine which specific areas to target and which interventions may have the biggest impact. SNHN can support the PHU's Immunisation Nurse to engage with practices in targeted areas. - The Improvement Foundation will assist PCAC staff to implement the QI Coach program - Macquarie University Institute for Healthcare Improvement to assist with evaluation of quality improvement initiatives and development and implementation of Health Care Homes/PCMH program - Working in partnership with general practice will remain a key focus, seeking regular input into support required, education focus and approaches to targeting quality improvement.
Duration	1 July 2016 – 30 June 2018
Coverage	Entire PHN region.
Expected Outcome	These PHN core support activities will form a key component of our market development strategy to build capacity within primary healthcare, in preparation for future commissioning decisions and to maximise the success of activities planned across other schedules (flexible, mental health, AOD etc.). It will support practices to enhance their ability to provide comprehensive, coordinated, integrated, quality care.

Proposed general practice support activities	
Activity Title	OP 1: Building Primary Care Capacity
	It will also support the primary care sector with achieving the "quadruple aim", that is, improving patient experience, population health outcomes, value for money and improve the experience of providing care for the local workforce.

5. After Hours

5a Strategic Vision for After Hours Funding

The PHN intent is to align after hours with the strategic vision of the organisation as a whole, which is to achieve better health and better care for the community, in collaboration with local stakeholders, including and most importantly the end user.

Furthermore, we believe the strategic focus of addressing after hours needs to be considered within the context of a broader system view of urgent care.

Our PHN seeks to:

- Maximise the contribution of community-based providers and health professionals as both providers of care and influences of patient-decision making;
- Reiterate the need to continue to develop comprehensive shared care plans and clinical pathways; and
- Leverage data and technology to enhance and facilitate the entire after hours system and improve the co-ordination of services, the integration of care, and both consumers' and providers' experience of the system.

There is continued interest and an expressed commitment from stakeholders in the region to continue the Northern Sydney After Hours Network established during 2015/16. This presents a considerable leadership opportunity for the PHN and provides a basis on which to drive system accountability and performance from the multiple organisations and providers. Integral to the Network is the continuance of a system-wide performance framework supported by shared data and aggregated performance reporting.

Over the next two years, we want to:

- Continue to build and maintain consumer awareness of alternatives to emergency departments after hours, especially for target cohorts such as CALD, frequent ED attenders, those with complex health and social needs.
- Build the capability of general practice in the after hours timeframe as patient-centred care providers.
- Improve the consumer journey through the after hours system.
- Identify commissioning opportunities through development of local health pathways.
- Lead the formalisation of an after-hours network for the Northern Sydney region.
- Support the design and implementation of digital health and enabling technologies across the urgent care system.

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5b Planned Activities Funded by the PHN
Schedule for After Hours Funding

Proposed Activities	
After Hours Activity Title	**AH 1.1– Better access to community based services**
After Hours Priority Area	Urgent Care / ED Admissions / End of Life Planning
Description of After Hours Activity	**HealthPathways** • Continue to work jointly with the LHD to prioritise and develop clinical pathways relevant to urgent care e.g. hospital in the home, palliative care, musculoskeletal, falls and any others identified through the after hours network, clinical and community councils. • Work collaboratively in identifying gaps in urgent care during pathway development and commissioning solutions. **Palliative Care** • Continue to work with the LHD and other stakeholders to co-design and implement an appropriate local model for community based palliative care, particularly in aged care facilities and for those with chronic (non-cancer) disease. **Alternative treatment options for minor injuries/ acute musculoskeletal injuries** • Work with the LHD, NSW Ambulance and general practice to develop capacity within the community to treat minor injuries and/or acute musculoskeletal injuries, to alleviate pressure on after hours ED presentations and provide alternative transport options for ambulances. This could include commissioning improved access to diagnostics and upskilling of primary care providers. **Extend After Hours Coverage** • Work with stakeholders to extend geographic coverage of after hours services in pockets where there are none (Cowan, Brooklyn) **Monitor outcome from 15/16 commissioned services** • Monitor outcomes of the dementia discharge follow up service & social work service commenced in 2016, to determine impact on re-admissions and whether to expand
Collaboration	NSLHD Medical Deputising Services – approached with EOI to extend coverage Aged Care Facilities NSW Ambulance Community providers (successful applicants for discharge follow-up and social work services)
Duration	July 2016 - June 2017

Proposed Activities	
After Hours Activity Title	**AH 1.1– Better access to community based services**
Coverage	Entire PHN region
Commissioning approach	Where commissioning is required, the PHN will follow its integrated commissioning framework with key components being plan, deliver, monitor and review. The approach will be consistent with the nationally agreed commissioning principles incorporating stakeholder and market engagement throughout the process.
Performance Indicator	**Pathways** • Pathways relating to urgent care are prioritised and localised **Palliative Care & Minor/Musculoskeletal Injuries** • Local community based models are agreed upon • Service specifications developed • RFP/RFT released **After Hours Coverage** • Coverage extended to Cowan & Brooklyn **15/16 services** • Relevant indicators to be developed with service providers
Local Performance Indicator target	To be developed in consultation with After Hours Network.
Data source	PHN, LHD, NSW Ambulance, Medical Deputising Services, HealthDirect, further sources to be defined.

Proposed Activities	
After Hours Activity Title	**AH 1.2 – Improved shared care planning**
After Hours Priority Area	Aged Care/ multiple co-morbidities / ED admissions / End of Life planning
Description of After Hours Activity	This activity will continue the work started in 15/16 which is to: • Work with healthcare providers to enhance the quality of care plans (including advance care plans) for targeted cohorts of patients where poor care planning results in urgent after hours presentations (e.g. palliative care, older persons, children with asthma, patients with multi-morbidity) • Work with the after hours network to enable connectivity between providers through electronic shared care and progress to a trial
Collaboration	Advance Care Plans & Authorised Care Plans – Decision Assist & NSW Ambulance Asthma Action Plans – Asthma Australia & National Asthma Council Shared Care Tools – LHD, successful vendor

Proposed Activities	
After Hours Activity Title	**AH 1.2 – Improved shared care planning**
	Aged Care Facilities – implementation of enabling technologies
Duration	July 2016 - June 2017
Coverage	Entire Region
Commissioning approach	Where commissioning is required, the PHN will follow its integrated commissioning framework with key components being plan, deliver, monitor and review. The approach will be consistent with the nationally agreed commissioning principles incorporating stakeholder and market engagement throughout the process.
Performance Indicator	To be developed in consultation with After Hours Network
Local Performance Indicator target	To be developed in consultation with After Hours Network
Data source	To be determined

Proposed Activities	
After Hours Activity Title / Reference	**AH 1.3 – Consumer Engagement & Health Literacy**
After Hours Priority Area (e.g. 1, 2, 3)	Consumer Engagement & Health Literacy
Description of After Hours Activity	Continue the implementation of a targeted communication strategy to improve consumer awareness about after hours healthcare options: • GP speakers for Adult Migrant English program through Northern Sydney Institute of TAFE • Targeted advertisements around major public holiday periods • Distribution of redesigned collateral
Collaboration	The Northern Sydney PHN will lead the implementation of these initiatives in collaboration with the After Hours Network, Community Council and NSLHD.
Duration	July 2016 - June 2017
Coverage	Entire Region
Commissioning approach	Where commissioning is required, the PHN will follow its integrated commissioning framework with key components being plan, deliver, monitor and review. The approach will be consistent with the nationally agreed commissioning principles incorporating stakeholder and market engagement throughout the process.
Performance Indicator	1. Number of AMEP programs delivered by GPs 2. Number of community members attending AMEPs 3. Further indicators to be developed in consultation with after hours network

Local Performance Indicator target	To be developed in consultation with After Hours Network
Data source	NSI TAFE & PHN records