Australian Government
Department of Health

phn
An Australian Government Initiative

Activity Work Plan 2019-2022:

Core Funding

GP Support Funding

This Core Activity Work Plan template has the following parts:

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

Northern Sydney PHN

When submitting this 2019-2022 Activity Work Plan to the Department of Health, the PHN must ensure that all internal clearances have been obtained and the Activity Work Plan has been endorsed by the CEO.

Overview

Strategic Vision

The Northern Sydney PHN (NSPHN), operated by the Sydney North Health Network, is heading into its 5th year of operations and remains firmly focussed on supporting the community who are at greatest risk of poor health outcomes, striving to achieve the quadruple aim – better population health, better experience of care, better value for the system and doing so with an exceptional workforce. The PHN has an important role to support and strengthen primary healthcare in the Northern Sydney region and we believe this is best achieved by working collaboratively with our network of local health providers including General Practice, Allied Health, the Northern Sydney Local Health District (NSLHD) and other public and private health and social care services. This is reflected in our approach to commissioning, which aims to drive improvements in quality, safety, integration and person-centredness.

A comprehensive Needs Assessment was conducted by NSPHN in early 2016, with deep dives and updates undertaken annually. The NSPHN region is experiencing a changing demographic which continues to face several challenges across various age groups, including pockets of socio-economic disadvantage scattered across the region. Geographic hot spots and specific health issues exist within certain populations, despite the public health profile of the region being one of the nation's best. Despite this relative advantage, the impact of the social determinants of health remain, such as access to and awareness of primary care and other services, anxiety and stress, addiction, a growing CaLD population with complex health issues and an ageing demographic. The top four major health priority areas identified are:

- **Health of the older person**
- **Youth health**
- **Mental health**
- **Vulnerable populations**

The common themes pertinent to the top four health priority areas are:

- **Awareness** (health literacy through to awareness of available and appropriate services)
- **Access** (ability to access the right services – at both a consumer and system level)
- **Navigation** of the health system (at both a consumer and system level).

The **NSPHN Strategic Plan 2018 – 2023**, has been developed through Board and stakeholder discussions. As a PHN, we are in the business of making sure the people of Northern Sydney are the healthiest people in Australia. We can do this when our primary healthcare system is trusted to do four things:

1. Services are delivered where and how people want them.
2. People can find and get what they need.
3. People understand and build fundamental habits for best health and wellbeing.
4. Communities are supportive of each other.

We work and advocate on behalf of all 907,008 people in our region, but particularly want to make sure:

- **Older people** remain independent, longer.
- **Young people** are resilient and connected.
- People with **mental health conditions** maximise economic and social participation.
- Those who are **vulnerable** know about, and get, care that is relevant to them.

- We do this by investing in five things:

A. **Community Activation:** support our community to self-determine and help itself**System Transformation**: catalyse change by enabling new approaches to health and healthcare.

B. **Commissioning**: attract and distribute resources to provide services that people need most.

C. **Member and Provider Support**: build capacity for all providers of primary healthcare to adopt new tools, deal with disruption and improve outcomes.

D. **An Exceptional Organisation**: develop excellence in our operations, our people and our visibility.

Download Strategic Plan by CLICKING HERE

The opportunities and priority areas identified in the Comprehensive 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 three years. A summary of these activities are in the following table, with further details provided in the activity schedules.

DoH Funding Stream	Activities 2019-22 aligned with Needs Assessment	PHN Strategy Alignment	Summary of Focus
Core Flexible	Community Health – Vulnerable Groups	A	• GPs in Schools • Healthy Living programs: GPs in Schools, SNAPO +, digital health tools • Health Literacy tools • Connected Communities
	Primary Care Access	D	• Health Pathways • End of Life Care in RACFs • Specialists in primary care
	Care Coordination	B	• Hospital avoidance activities • Navigation and coordination services
	Healthy Ageing and Frailty	A	• Joint projects around frailty, falls, dementia, end of life
Health Systems Improvement	Health Intelligence	C	• Build health informatics and joint health intelligence infrastructure • Planning, performance and quality framework, and needs assessment • Data linkage
	Systems Integration	B	• Joint work on service redesign, pathways, new models of care.
	Stakeholder engagement	D	• Relationship building, partnerships • Marketing and branding the impact of work achieved
	Primary Care Support	D	• Allied health and GP engagement • Digital health adoption and usage • Capacity building and spreading innovation

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

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2019-2022.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	**CF.1 – Community Health - Vulnerable Groups**
Existing, Modified, or New Activity	Existing Activity - CF.1 Community Health – Vulnerable Groups
Program Key Priority Area	Population Health Including: • CALD • Aged Care • Young people • Indigenous Health • Homeless • Mental Health and Drug and Alcohol
Needs Assessment Priority	**Priority Area:** Access - pages 77-78 Aboriginal and Torres Strait Islander People - pages 78, 85, 89 Health of older people-access to and navigation of aged care system – page 79
Aim of Activity	Targeted community capacity building to enhance access to primary care for vulnerable populations and to improve health outcomes.
Description of Activity	Community activities, including health talks, GPs in Schools, CALD health programs. NSPHN will: • Continue to deliver and expand the GPs In Schools program across the region, introducing new partners and sponsors. • Continue to deliver and expand the healthy living program (Smoking, Nutrition, Alcohol, Physical Activity and Obesity management) across the region, working in partnership with key stakeholders to target vulnerable groups. • Support communities to mutually support one another through a Connected Communities program focused on young people, older people, people with mental illness and those who are vulnerable. • Build upon NSPHN community engagement strategy to continually engage the local population, with People Bank portal – promoting sign-up and developing program of activities to support the community members engaged. • Facilitate use of evidence-based digital self-help tools to support self-management and consumer engagement in healthcare. A component of this activity may include commissioning of digital technology

	Aboriginal and Torres Strait Islander Health • Continue to work with consumers and other stakeholders to increase understanding of issues with current system, including barriers (actual or potential) to accessing services. • Continue to work with local community, partners, LHD and primary care to promote better access and uptake of regional Aboriginal Health services (including NSPHN Aboriginal Health commissioned services and activities) and the local Aboriginal Health GP outreach unit.
Target population cohort	Targeting vulnerable groups (particularly lower socio-economic, CALD, older people, Aboriginal and Torres Strait Islander people, young people), however supporting improved health literacy and access to primary care for the entire NSPHN population.
Indigenous specific	Yes - Part of this activity is dedicated to supporting Aboriginal and Torres Strait Islander people.
Coverage	This activity will cover the entire PHN region.
Consultation	Northern Sydney PHN (NSPHN) has undertaken extensive community and sector consultation in the design of the above activities, ongoing feedback will be sought from: • The NSPHN Board • NSPHN Community Council • NSPHN Clinical Council • NSPHN Mental Health and AOD Advisory Committee • Northern Sydney Local Health District • Primary care providers • Non-Government Organisations (local, state, national) • People with lived experience, consumers, and carers • Local schools, Local Government Councils and Family and Community Services (FACS) NSPHN will continue to utilise the NSPHN Commissioning Evaluation Framework, based on the quadruple aim, to continually monitor and evaluate activity – including patient/consumer and provider experience measure, which will inform any future service redesign or areas for service improvement.
Collaboration	NSPHN will work with stakeholders across the health and social care economy to set the strategic direction, support activity delivery and enhance access to services for vulnerable populations. NSPHN will continue to work in collaboration with key stakeholders, including: • Northern Sydney LHD – implementation of joint activities with NSPHN supporting key vulnerable population groups. • Local Councils – identification and provision of access to target population groups across the region. • General practice - delivery of GPs in Schools program and Healthy Living Workshops • Community groups - implementation of community-led activities in partnership with NSPHN. • Local Schools - implementation of GPs in Schools program and broader healthy living activities in partnership with NSPHN • NGOs – delivery of Connected Communities activities in partnership with NSPHN
Activity milestone details/ Duration	Commissioned service activity continues. The timelines relevant to this activity work plan are outlined below:

Activity milestone details/ Duration	Commissioned service activity continues. The timelines relevant to this activity work plan are outlined below: Activity start date: 1/07/2019 Activity end date: 30/06/2022
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☒ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	No

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	**CF 2 – Primary Care Access**
Existing, Modified, or New Activity	Existing Activity CF 2 – Building Primary Care Capacity
Program Key Priority Area	Workforce
Needs Assessment Priority	• Access to and navigation of services for people with dementia – pg 81 • End of life planning – pg 80 • Cancer screening & Childhood Immunisation – pg 76 (General population) pg 79 (CALD) • Develop activities relating to population health risk factors - pg78 • Emergency department admissions – pg 77
Aim of Activity	This activity aims to increase access to high quality, patient-centred, comprehensive, coordinated, integrated services, in line with identified local needs and national priorities. Specifically, this includes; - access to general practice and relevant allied health services for people at high risk of hospitalisation (Dementia, chronic disease) - access to general practice for screening and immunisation - end of life care and hospital avoidance services in Aged Care Facilities - improved access and navigation of public and private specialist outpatient services to reduce ED presentations - access to specialist outreach models in primary care for diabetes and musculoskeletal conditions
Description of Activity	We will do this by: 1. Commissioning General Practice, with a targeted focus on: • Care of patients with Dementia • Weight management program for people with Diabetes (replication of DiRECT study in General Practice) • Management of patients with multiple chronic diseases • Screening for breast, bowel and cervical cancer • Childhood immunisations • Addressing rates of preventable hospitalisations through adoption of Person-Centred Medical Home building blocks 2. Continued commissioning of HammondCare to provide end of life care services in local RACFs (including expansion to more facilities) 3. Pilot expansion of Nurse Practitioner in RACF model of care 4. Commission the HealthPathways platform to facilitate improved access to ambulatory care services for Royal North Shore Hospital and expand to local private hospitals, including the Sydney Adventist Hospital and the new Northern Beaches Hospital 5. Deliver diabetes and musculoskeletal specialist outreach clinics in general practice

Target population cohort	• General practices • Populations diagnosed with at least one of the targeted focus areas • Populations eligible for cancer screening and immunisations with a particular focus on CALD communities • Residents of Aged Care Facilities requiring end of life care and their families
Indigenous specific	No
Coverage	Whole PHN region. An estimated 400,000 patients will be directly impacted by these activities.
Consultation	Most of the consultation and co-design has already occurred for this activity however ongoing feedback will be sought from: • Participating general practices • Northern Sydney Dementia Collaborative • Diabetes NSW PHN Advisory Group • PCMH Clinical Lead • Clinical & Community Councils • RACFs • HammondCare • NSLHD • Sydney Adventist Hospital • Northern Beaches Hospital
Collaboration	• NSLHD Public Health Unit – provision of data to assist with identifying practices with overdue children • NSLHD – Provision of specialists for outreach services, joint governance and funding contributor for ACC HealthPathways • BMP Consulting – delivery of local PCMH program • Streamliners – provision of the HealthPathways platform • Diabetes NSW – provision of dieticians for DiRECT study implementation
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2020 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Any other relevant milestones? This activity is ongoing from 2018/19, hence service delivery is underway, but we expect expansion in numbers of practices and RACFs participating and hence patients impacted. Exception to this is the DiRECT project. Practice recruitment and service delivery expected to commence late 2019/early 2020, subject to agreement with collaborating PHNs. Key milestones for HealthPathways include launch of RNSH ambulatory care service info, followed by SAN and then NBH.

Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☒ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? Yes 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	**CF.3 – Care Coordination Services**
Existing, Modified, or New Activity	Existing Activity - CF.3 Care Coordination Support
Program Key Priority Area	Population Health Including: • CALD • Aged Care • Young people • Indigenous Health • Homeless • Mental Health and Drug and Alcohol
Needs Assessment Priority	**Priority Area:** Health of older people - pages 79-80 Potentially preventable hospitalisation - Urgent care services - Page 76 Aboriginal and Torres Strait Islander people - pages 78-79 People with severe mental illness and complex needs - page 83
Aim of Activity	Establishing a program of care coordination and navigation support across primary health care, mental health and the community to support both consumers improve health outcomes and providers, particularly general practitioners meet patients needs.
Description of Activity	NSPHN will continue to commission a range of services to support hospital avoidance, whilst establishing a further roll out of care coordination initiatives across the region, including: • Hospital discharge follow-up and care coordination service for people at risk of hospitalisation or re-admission. • Social work service to support GPs with patients with chronic and /or complex health care conditions, who are at risk of hospital admission or re-admission • Establish a further roll out of care coordination initiatives in the community, e.g. nurse led clinics; shared care models, service navigation initiatives e.g WellNet, concierge - based on identified needs and opportunities for service development. • Identify and design potential joint initiatives in areas of identified need (e.g. General Practice support; Care coordination – chronic disease; Aboriginal health; urgent care; aged care; palliative care; youth; mental health; AoD; vulnerable groups; and RACFs)
Target population cohort	Targeting vulnerable groups (particularly lower socio-economic, CALD, older people, Aboriginal and Torres Strait Islander people, young people), however supporting improved health literacy and access to primary care for the entire NSPHN population.
Indigenous specific	Yes - Part of this activity is dedicated to supporting Aboriginal and Torres Strait Islander people.
Coverage	This activity will cover the entire PHN region.

Consultation	Northern Sydney PHN (NSPHN) has undertaken extensive community and sector consultation in the design of the above activities, ongoing feedback will be sought from: • The NSPHN Board • NSPHN Community Council • NSPHN Clinical Council • NSPHN Mental Health and AOD Advisory Committee • Northern Sydney Local Health District • Primary care providers • Non-Government Organisations (local, state, national) • People with lived experience, consumers, and carers • Local schools, Local Government Councils and Family and Community Services (FACS) NSPHN will continue to utilise the NSPHN Commissioning Evaluation Framework, based on the quadruple aim, to continually monitor and evaluate activity – including patient/consumer and provider experience measure, which will inform any future service redesign or areas for service improvement.
Collaboration	NSPHN will work with stakeholders across the health and social care economy to set the strategic direction, drive service improvements and enhance access to services for vulnerable populations. NSPHN will continue to work in collaboration with key stakeholders, including: • General practice - implementation of care coordination, nurse led clinics, shared care models in partnership with NSPHN. • Northern Sydney LHD - implementation of joint activities with NSPHN supporting key vulnerable population groups. • Private Health Insurers – design of joint initiatives in areas of identified need. • Allied health - delivery of care coordination activity. • Service providers – delivery of hospital avoidance programs. • Community groups - implementation of community-led activities in partnership with NSPHN.
Activity milestone details/ Duration	Commissioned service activity continues. The timelines relevant to this activity work plan are outlined below: Activity start date: 1/07/2019 Activity end date: 30/06/2022
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? Yes

	3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? 2. No

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	**CF 4 – Healthy Ageing & Frailty**
Existing, Modified, or New Activity	New Activity
Program Key Priority Area	Choose from the following: Aged Care
Needs Assessment Priority	Health of Older People: • Access to and navigation of aged care system – pg 79 • Multiple Co-morbidities – pg 80 • Access to and navigation of services for people with dementia – pg 81
Aim of Activity	This activity aims to support the health and wellbeing of those aged 65+ by: • Developing Dementia Friendly Communities on the Northern Beaches and Hornsby • Identification of frail elderly people using the FRAIL scale and delivery of early intervention services based on the frailty management tool • Identification of older people at risk of falls and engaging a whole of primary care approach to fall prevention.
Description of Activity	• Implementation of the Dementia Alliance Action Plan, including community forums to raise awareness, targeted education for loca businesses, an intergenerational program and a music therapy program involving primary schools and aged care facilities. • Implementing screening for Frailty in Primary Care and delivery of appropriate allied health services to provide evidence-based interventions • Continued implementation of iSOLVE Fall prevention program and delivery of Stepping On fall prevention services targeting CALD patientsl
Target population cohort	• People aged 65yo+ with dementia, frailty and/or high risk of falls CALD people 65yo+ with high falls risk
Indigenous specific	• No
Coverage	Whole PHN region for Falls and Frailty. Dementia Friendly Communities (Northern Beaches and Hornsby LGA specific)

Consultation	<u>Dementia Friendly Communities Consultation</u>: • Northern Sydney Dementia Collaborative (includes carer) • Northern Beaches Dementia Alliance (includes people living with dementia and carers) • Hornsby Council • Northern Beaches Council • Clinical & Community Councils • University of Western Sydney • UNSW <u>FRAILTY:</u> • NSLHD • Clinical & Community Councils • General Practice • Allied Health providers • Community Aged care services <u>iSOLVE / Fall prevention</u> • NSLHD • Clinical and Community Councils • General Practice • Allied Health providers • University of Sydney
Collaboration	• Northern Beaches Dementia Alliance & Northern Sydney Dementia Collaborative - Delivery of forums, education sessions - Governance - Stakeholder engagement and communication • NSLHD - Joint governance - Co-funders - Service delivery (Stepping On, frailty interventions) • General Practice - Implementation of frailty and falls risk screening • Allied Health - Delivery of fall prevention and frailty interventions • U Syd - iSOLVE program developer & evaluation • UWS – DFC evaluation - UNSW – DFC program material developer

Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Any other relevant milestones? • Dementia Friendly Community forums have commenced, local business education expected to be delivered from July 2019, intergenerational and music therapy program between July – Dec 2019. Further expansion dependent on evaluation results. • FRAILTY – recruitment of general practices for screening activity by June 2019, allied health services expected to be operational early 2020 • iSOLVE fall prevention – screening is ongoing and a continuation from previous years. Stepping on fall prevention services estimated – early 2020
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☒ Open tender ☒ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? Yes 3b. Has this activity previously been co-commissioned or joint-commissioned? No
Decommissioning	1a. Does this activity include any decommissioning of services? No

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

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2019-2022.

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	**HSI 1- Health Intelligence**
Existing, Modified, or New Activity	Existing Activity- HSI 1- Health Intelligence
Needs Assessment Priority	Health intelligence to inform identification of Needs Assessment priority areas.
Aim of Activity	NSPHN will further develop the health intelligence infrastructure to successfully plan and deliver health services and support the integration of the wider primary health care sector. This activity will be informed and underpinned by analysing and linking a range of data sets. This activity will be core to supporting general practice to access timely information and will build capacity to understand local health priorities of their populations and develop appropriate strategies to address and drive improved health outcomes. In addition, the NSPHN annual planning and consultation with the primary care sector and wider community will provide a sophisticated level of understanding of emerging needs to inform subsequent health service planning and commissioning activity.
Description of Activity	• Undertake annual planning processes, including review of population health data to confirm priority areas and areas of need against existing NSPHN Needs Assessment. • Ongoing collection and analysis of commissioned service level data (including Primary Mental Healthcare Minimum Data set) to inform continuous quality improvement, in alignment with the NSPHN Commissioning Evaluation Framework and PHN Program Performance Quality Framework. • Establish a shared data linkage program with the Local Health District. • Implementation of the NSW Ministry of Health Primary Care Data Linkage Project. • Collaboration with the wider PHN collective to build national and local health intelligence platform (including the National Data Warehouse). • Establishment of new joint research initiatives with universities.
Associated Flexible Activity/ies:	This activity will support all Core Flexible activities.
Target population cohort	This activity will target the entire NSPHN population.

Indigenous specific	No
Coverage	This activity will cover the entire PHN region.
Consultation	Extensive consultation and engagement from a broad cross-section of the local community and service-sector to inform planning process, including: • The NSPHN Board • NSPHN Community Council • NSPHN Clinical Council • NSPHN Mental Health and AOD Advisory Committee • Northern Sydney Local Health District • Primary care providers • Non-Government Organisations (local, state, national) • People with lived experience, consumers, and carers • Local schools, Local Government Councils and Family and Community Services (FACS) • NSW Population Health Data and Information Network
Collaboration	NSPHN will work in partnership with: • Northern Sydney Local Health District - joint activities accessing relevant datasets and identifying population health needs. Overseen by the PHN/LHD Joint Executive Council. • Primary care providers - data driven service improvement activities. • Commissioned services - data driven service improvements aligned to the NSPHN Evaluation Framework and PHN Program Performance Quality Framework. • NSW Ministry of Health - implementation of data linkage project • NSW Population Health Data and Information Network – identification of joint activities across PHNs
Activity milestone details/ Duration	Timelines relevant to this activity include: Activity start date: 1/07/2019 Activity end date: 30/06/2022 Continued monitoring of health needs and service gaps within the region to inform updates to the Needs Assessment. Needs Assessment 2022-25 to be completed in Nov 2021.
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☒ Other approach (please provide details) Not Applicable – function delivered directly by PHN 2a. Is this activity being co-designed? Click to choose 2b. Is this activity this result of a previous co-design process? Click to choose

	3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? Click to choose 3b. Has this activity previously been co-commissioned or joint-commissioned? Click to choose

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	**HSI 2 – System Integration.**
Existing, Modified, or New Activity	Existing Activity HSI 2 – System Integration
Needs Assessment Priority	• System Integration – pg 78 • Emergency Department admissions – pg 77 • Multiple comorbidities – pg 80
Aim of Activity	To work collaboratively with partners to redesign selected services and/or develop new models of care so that they: - are more person centred - better integrated with Primary Care - provide better value for the health system - are easier to access and navigate with a focus on aged and chronic & complex care services.
Description of Activity	• Continue to jointly plan and develop new HealthPathways and strengthen service mapping with the private sector • Work collaboratively with NSLHD and other partners to redesign diabetes and musculoskeletal service delivery, to include specialist outreach and shared care • Work collaboratively with NSLHD to develop and deliver the selected Ministry of Health (MoH) integrated care models (To be confirmed, but likely to be targeted support for RACFs and specialist outreach in primary care) • Work with partners to develop and expand new models of care (such as Nurse Practitioners in RACFs)
Associated Flexible Activity/ies:	This activity will support all Core Flexible activities.
Target population cohort	People 65yo+ People with chronic co-morbidities People within Residential Aged Care Facilities
Indigenous specific	No
Coverage	Whole PHN region

Consultation	• Consultation on development of HealthPathways occurs through governance structures and clinical workgroups • Clinical & Community Councils • NSPHN/NSLHD System Integration Committee & Joint Executive • NSLHD Musculoskeletal & Diabetes services • Private hospital services • Private Health Insurers • RACFs • General Practice • Allied Health providers • Consumers & carers
Collaboration	• Consumers – co-design • NSLHD – co-fund HealthPathways, governance, joint-planning, data sharing, co-design • Clinicians from across primary and acute settings – participants in HealthPathways work groups • Private Hospitals – co-design, service mapping • Private Health Insurers – potential co-funders, co-design • Ministry of Health – potential co-funders
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. • Service delivery end date: Month. Year. Any other relevant milestones? As per CF 3 – Primary Care Access
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☒ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☐ Other approach (please provide details) 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? Yes 3b. Has this activity previously been co-commissioned or joint-commissioned? Yes

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	***HSI 3 – Stakeholder Engagement***
Existing, Modified, or New Activity	Existing Activity **HSI 3 – Stakeholder Engagement**
Needs Assessment Priority	N/A - Will inform identification of Needs Assessment priority areas.
Aim of Activity	Working collaboratively across sectors to: - engage consumers - continue to identify key stakeholder groups - enable extensive consultation So that: - local needs are continuously identified - local system barriers and enablers are identified and validated - solutions are co-designed to meet end-user needs - services are optimised - joint opportunities that will enhance and strengthen primary health care are fostered - the PHN brand is recognised and respected.
Description of Activity	• Strengthen primary health care engagement and value with the PHN • Continuously monitor engagement through identified and co-designed metrics • Continue to promote NSPHN brand and achievements through strategic marketing • Maintain strong website and social media functioning • Identify and build new relationships with critical partners to ensure future success and sustainability of programs and services
Associated Flexible Activity/iess:	This activity will support all PHN Core Flexible activities
Target population cohort	Key stakeholders
Indigenous specific	No
Coverage	Whole PHN region
Consultation	All identified stakeholders – existing and new
Collaboration	All identified stakeholders – existing and new

Activity milestone details/ Duration	Provide the anticipated activity start and completion dates (including the planning and procurement cycle): Activity start date: 1/07/2019 Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Any other relevant milestones?
Commissioning method and	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☒ Other approach (please provide details) Not Applicable – function delivered directly by PHN 2a. Is this activity being co-designed? No 2b. Is this activity this result of a previous co-design process? No 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint commissioned? No

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
ACTIVITY TITLE	**GPS 1 – General Practice Support**
Existing, Modified, or New Activity	Existing Activity GPS 1 – Core Practice Support
Needs Assessment Priority	N/A – core PHN function
Aim of Activity	To enhance the capacity of General Practice and other Primary Care Services to deliver high quality, safe, evidence-based, integrated care to their communities and respond to local population health needs.
Description of Activity	• Continuously assess and monitor needs and capacity of primary care services to inform program development, commissioning and integration of services • Support general practice accreditation • Targeted support to general practices with low immunisation rates • Support adoption and use of digital health technologies • Support general practices to prepare for and implement QI PIP – data extraction, data cleaning, data quality & development of QI activities • Provide networking and professional development opportunities that align with local need and national priorities • Continue to deliver and expand the Primary Care Nurse Transition Program, to support graduate nurses in their first year in primary care, and provide an alternative career pathway to the acute system • Support increased awareness of value of Patient Reported Measures • Support clinician wellbeing (Caring for the Carers) This will be delivered through a combination of on-site practice visits, development and distribution of resources, access to information online, workshops and education events.
Associated Flexible Activity/ies:	This activity supports engagement with Primary Care which underpins all other PHN activities (including across other PHN funding schedules).
Target population cohort	General Practice
Indigenous specific	No
Consultation	• Clinical & Community Councils • Consumers • General Practice • Allied Health Providers • Hospital based Services
Collaboration	• General Practice – identify needs & co-design support • Allied Health - identify needs in relation to integration with general practice & co-design support • Public & Private Hospital Services – identify key interface issues

	with Primary Care • Consumers – identify challenges and experiences and co-design solutions
Activity milestone details/ Duration	Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle): • Activity start date: 1/07/2019 • Activity end date: 30/06/2022 **If applicable**, provide anticipated service delivery start and completion dates **(excluding** the planning and procurement cycle): Service delivery start date: Month. Year. Service delivery end date: Month. Year. Any other relevant milestones?
Commissioning method and approach to market	1. Please identify your intended procurement approach for commissioning services under this activity: ☐ Not yet known ☐ Continuing service provider / contract extension ☐ Direct engagement. If selecting this option, provide justification for direct engagement, and if applicable, the length of time the commissioned provider has provided this service, and their performance to date. ☐ Open tender ☐ Expression of Interest (EOI) ☒ Other approach (please provide details): Not Applicable – support delivered directly by PHN 2a. Is this activity being co-designed? Yes 2b. Is this activity this result of a previous co-design process? Yes 3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements? No 3b. Has this activity previously been co-commissioned or joint-commissioned? No