

**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:
1. Primary Health Networks Core Funding, Item B.3 – Primary Health Networks – Operational and Flexible
2. Primary Health Networks General Practice Support, Item B.3 – General Practice Support.
3. The IndicativeBudget 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:
4. Primary Health Networks Core Funding, Item B.3 – Primary Health Networks – Operational and Flexible
5. Primary Health Networks General Practice Support, Item B.3 – General Practice Support.

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| ***South Western 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**

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

**Important documents to guide planning**

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

* Activity Work Plan guidance material;
* PHN Needs Assessment Guide;
* PHN Program Performance and Quality Framework;
* Primary Health Networks Grant Programme Guidelines;
* Clause 3, Financial Provisions of the Standard Funding Agreement.

**Formatting requirements**

* Submit plans in Microsoft Word format only.
* Submit budgets in Microsoft Excel format only.
* Do not change the orientation of any page in this document.
* Do not add any columns or rows to tables or insert tables/charts within tables – use attachments if necessary.
* Delete all instructions prior to submission.
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.

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| **Proposed Activities** - copy and complete the table as many times as necessary to report on each activity |
| ACTIVITY TITLE | CF1-Enablement |
| Existing, Modified, or New Activity | Modified ActivityCF1-Enablers CF2-Information |
| Program Key Priority Area | Choose from the following:Digital Health |
| Needs Assessment Priority | *Chronic Disease pg 102*Train practice nurses in health assessments, cycles of care and quality care planning.*Strengthening Prevention pg 105*Implement in-practice quality improvement activities in General Practice to improve the measure and documentation of chronic disease risk factors and provide education, training and resources to general practitioners and practice nurses.*Alliances & partnerships pg 105*Develop and strengthen alliances and partnerships with relevant agencies to improve the health of the population through primary care.*Digital Health pg 106*Continue support and education to primary health care providers to utilise the My Health Record system.Work in partnership with SWSLHD to develop and implement an Interoperability framework as a platform for real-time data sharing.*Workforce pg 107*Support general practice clinicians to use digital health systems.Support general practice as a business, including providing support to practices to achieve accreditation. |
| Aim of Activity | As a foundational step towards integrated care, SWSPHN will work with general practices and other primary health providers to improve the care and experience of patients with chronic conditions through increasing the capacity and effectiveness of patient care teams to provide care that is person-centred and coordinated. This will include advocating and assisting integrated use of electronic communication and information technology. |
| Description of Activity | Capacity building and Integrated care activities will be delivered, aimed to improve the health of patients with one or more chronic diseases who are at risk of hospitalisation and increasing their access of health services.CF1.1 – Enhance general practice capacity in South Western Sydney with the aim to improve patient safety, experience and outcomes, while also reducing cost and unnecessary duplication of services.CF1.2 – Enhance provider access to patient information and improve communication between health providers to improve care coordination and information sharing between general practice, LHDs and other health providers.CF1.3 – Enhance primary health care provider access to digital health information through interoperable ICT and embed change management to support provider usage. |
| Target population cohort | The activity will work with general practitioners, practice nurses, general practice staff, allied health professionals, specialists and SWS Local health District to improve the health of patients with one or more chronic diseases, who are at risk of accessing an increasing range of health services, including tertiary care. |
| Indigenous specific | Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?No |
| Coverage | Activities will initially occur in 1-3 LGAs, this activity may be extended to cover the other LGAs. |
| Consultation | A working group was convened comprising of SWSPHN staff, SWSLHD staff, general practitioners, general practice nurses, practice managers and a consumer representative. Three workshops were conducted, and high-level recommendations were presented to the SWS Integrated Care Collaborative where the proposed model was supported. |
| Collaboration | SWSPHN Staff – to further enable capacity building in general practice, embed change management processes and support general practices in implementation.SWSLHD staff – Implement care coordination between LHD and general practice and participate in communication and information sharing.General Practice staff- to implement and participate in capacity building activities, integrate processes for risk stratifying patients and participate in care coordination with the LHD and other providers.Allied health & specialists – participate in care coordination with general practice, the LHD and other providers. |
| Activity milestone details/ Duration | Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle):Activity start date: 1/07/2019Activity end date: 30/06/2021 |
| Commissioning method and approach to market | 1. Please identify your intended procurement approach for commissioning services under this activity:[ ]  Not yet known[x]  Continuing service provider / contract extension[x]  Direct engagement – SWSLHD- Direct engagement required to support sharing of savings and/or appropriate integration and clinical governance of care enabler workforce[ ]  Open tender[x]  Expression of Interest (EOI)[ ]  Other approach (please provide details)2a. Is this activity being co-designed?Yes2b. Is this activity this result of a previous co-design process?Yes3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?Yes3b. Has this activity previously been co-commissioned or joint-commissioned?No |
| Decommissioning | 1a. Does this activity include any decommissioning of services?No |
| Total Planned Expenditure | Enter the planned expenditure for this Activity in the following table. Include commissioned service expenditure only. |
| **Funding Source** | **2019-2020** | **2020-2021** | **2021-2022** | **Total** |
| Planned Commonwealth Expenditure - Core Flexible Funding |  |  |  |  |
| Funding from other sources |  |  |  |  |
| Funding from other sources | If applicable, name other organisations contributing funding to the activity (ie. state/territory government, Local Hospital Network, non-profit organisation).South Western Sydney Local Health District. |

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| **Proposed Activities** - copy and complete the table as many times as necessary to report on each activity |
| ACTIVITY TITLE | CF2-HealthPathways |
| Existing, Modified, or New Activity | Existing ActivityCF3-2018-2019 AWP |
| Program Key Priority Area | Choose from the following:Workforce |
| Needs Assessment Priority | *Multiple needs assessment priorities pg 78-106**Chronic disease – diabetes and CVD pg 102*Promote patient portal for HealthPathways, Health Resource Directory.org.au, along with Your Health Your Time Your Way to community as a trusted source for relevant and localised health information, in both English and translated versions, about chronic disease management. |
| Aim of Activity | HealthPathways: Develop and review local clinical pathways which support primary care providers in the delivery of seamless care. Provide a locally relevant, evidence based online resource for general practice teams which includes:* Clinical guidance on medical conditions
* Local health service information
* Education
* General practice resources
* Review and improvement of existing pathways

Health Resource Directory.org.au: Provision of a curated list of endorsed patient information on a range of health conditions. Development of patient factsheets based off HealthPathways clinical guidance provided in a range of languages to ensure the health information provided compliments the management provided by primary care. |
| Description of Activity  | CF 2.1 – Continue commitment to HealthPathways program and ensure pathways exist for local priority areas and are regularly reviewed.CF 2.2 – Continue commitment to provision of a patient portal to ensure patient access to a curated list of patient information. Development of patient factsheets consistent with clinical guidance on HealthPathways and identification of local health services in a range of languages and formats. |
| Target population cohort | General practice teams and other health professionals in south western Sydney.Health consumers in south western Sydney as well as general practice teams. |
| Indigenous specific | Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?No |
| Coverage | Whole SWSPHN region. |
| Consultation | Running of clinical workgroups with GPs, hospital specialists and other health professionalsGeneral practice reference groupReview of patient factsheets by SWSPHN Community Advisory Council |
| Collaboration | South Western Sydney Local Health District* Strategic direction
* Provision of medical specialists for pathway review and development

General practitioners* Strategic direction
* Clinical editors involved in development of pathways
* Review of pathway content

SWSPHN* Community Advisory Council reviews and endorses the factsheet content as part of the development process.
* Program oversight
* SWSPHN Stakeholder team supporting communications strategy
* Service support team supporting ongoing promotion and practice awareness
 |
| Activity milestone details/ Duration | Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle):Activity start date: 01/07/2019Activity end date: 30/06/2021 |
| 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)2a. Is this activity being co-designed?No2b. Is this activity this result of a previous co-design process?No3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?Yes3b. Has this activity previously been co-commissioned or joint-commissioned?Yes |
| Decommissioning | 1a. Does this activity include any decommissioning of services?No |
| Total Planned Expenditure | Enter the planned expenditure for this Activity in the following table. Include commissioned service expenditure only. |
| **Funding Source** | **2019-2020** | **2020-2021** | **2021-2022** | **Total** |
| Planned Commonwealth Expenditure - Core Flexible Funding |  |  |  |  |
| Funding from other sources |  |  |  |  |
| Funding from other sources | South Western Sydney Local Health District. |

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| **Proposed Activities** - copy and complete the table as many times as necessary to report on each activity |
| ACTIVITY TITLE | CF3-Prevention |
| Existing, Modified, or New Activity | CF 3.1 Existing (2018 – 19 AWP CF 4 Prevention)CF 3.2 Existing (2018 – 19 AWP CF 4 Prevention)CF 3.3 Existing (2018 – 19 AWP CF 4 Prevention) |
| Program Key Priority Area | Population Health |
| Needs Assessment Priority | *Cancer pg 83** Promotion of importance of cancer screening and the local cancer screening options to community – particularly communities with low screening rates.

*Pregnancy and the early years pg 104** Develop strategies to increase GP antenatal shared care program participation.
* Promotion of SWS immunisation campaign through Your Health Your Time Your Way, social media and other promotion platforms.

*Strengthening prevention pg 105** Implement in-practice quality improvement activities in General Practice to improve the measure and documentation of chronic disease risk factors and provide education, training and resources to general practitioners and practice nurses.

*Overweight and obesity pg 100** Promotion of the Get Healthy and Go4Fun services to GPs in SWS to increase referrals to the program.
* Promotion of addressing overweight and obesity to community through online and social media engagement.
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| Aim of Activity | Support primary healthcare providers to contribute to improved health outcomes and ensure our community is informed and empowered with access to relevant health strategies according to need with a focus on local vulnerable community groups.Strategies include improved awareness and access to health prevention services, with a focus on targeted specific cohorts where access, uptake and awareness is poor. |
| Description of Activity | CF 3.1– Enhance the heath literacy of the South Western Sydney Aboriginal and Torres Strait Islander community to help them make better informed health decisions by raising awareness of the importance of prevention and early detection by participating in Cancer Screening activities delivered by upskilled Aboriginal community members.CF 3.2 – Provide information and promote community awareness of targeted age specific scheduled immunisations in high risk and vulnerable populations. Implement quality improvement activities in General Practice to improve the measure and documentation of immunisations, identify skill gaps, and provide training and resources to general practitioners and practice nurses as a whole of practice approach.CF 3.3 – Explore opportunities to target health preventative initiatives, continue to work in partnership with key local stakeholders to implement localised action plan to reduce the rates of adult and childhood obesity. Implement quality improvement activities in General Practice to improve the measure and documentation of weight screening and BMI documentation, identify clinical skill gaps, and provide training and resources to general practitioners and practice nurses while promoting appropriate referral options including but not limited to HealthPathways. Continue partnership with Western Sydney University to deliver the Active Breed program and explore opportunities for expansion. |
| Target population cohort | CF 3.1 – South Western Sydney Aboriginal and Torres Strait Islander population:* Cervical: 25-70 years women
* Breast: 50-75 years women
* Bowel: 50-74 years women and men

CF 3.2 – High risk and vulnerable children cohort (12-27 months) and general practices within targeted LGA’s identified as having high rate of overdue children. This activity will work with general practitioners, practice nurses, general practice staff.CF 3.3 – Children aged 0-16 years who are overweight or obese, and overweight adults including those at risk of possible preventable chronic disease. This activity will work with general practitioners, practice nurses, general practice staff. |
| Indigenous specific | Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?YesCF 3.1 – Yes. Upskilling Aboriginal Health Workers within SWS to engage with the local Aboriginal communities to provide information regarding the benefits of Cancer Screening, hence improve health literacy and empower individuals and communities to make better informed choices regarding their health.CF 3.2 – NoCF 3.3 – No |
| Coverage | CF 3.1 – South Western Sydney Aboriginal and Torres Strait Islander population.CF 3.2 – LGA’s with low immunisation rates, and general practices with high rates of overdue children. Quality improvement activities will be delivered, aimed to improve the general practice data quality, who are at risk of poor data practices and improving their immunisation in-practice processes.CF 3.3 – Education and promotion all 7 LGAs. Commissioned service delivery, to prioritise high risk areas and those practices that are engaged. Active Breed – Bankstown LGA. |
| Consultation | CF 3.1 – Consultations with the following: PHN Aboriginal Health Committee reps (community members, NGO, Allied Health Professionals, GP’s AMS), SWSLHD Aboriginal Chronic Care Team, SWSLHD Deputy Director Aboriginal Health, cancer Screening Working Group (Breast Screen NSW, Bowel screen, FPNSW, Aboriginal Health Service.Identified that a local approach was required, local community members, local stories, sister to sister, brother to brother support networks- barriers were: lack of knowledge (no link between health education and the benefits of screening), not a regular conversation that is had in community, fear of the unknown, fear of diagnosis.CF 3.2 – Consultation included key stakeholders such as SWSPHN staff, SWSLHD Public Health Unit, GP’s, consumers, general practice nurses, and NCIRS to identify data need within general practice to support the targeted immunisation approach both for consumers and general practices.CF 3.3 – WSU,SWSPHN staff, SWS LHD community and population health staff, general practitioners, general practice nurses, allied health and expert healthy lifestyle organisations. |
| Collaboration | List and describe the role of each stakeholder that will be involved in designing and/or implementing the activity, including stakeholders such as Local Health Networks, state/territory governments, or other relevant support services.*CF 3.1** Working Group members -to reconvene for clinical guidance and health promotion initiatives/activities within the SWSPHN area.
* Local community members, Elders, Land Council, Gandangara Aboriginal Health service will provide access to community groups for forums and information sessions.
* Breast Screen NSW, Miller community Health, Gandangara Health Service for breast screen activities aligning with the mobile screening van dates.
* SWSLHD Aboriginal Chronic Care Program: engage an Aboriginal Health Worker to conduct community engagement activities.
* Gandangara LALC/Health Service; engage their general practice consumers in health promotion activities.
* SWSLHD health promotion team – support designing resources.
* SWSPHN- Contract Management and commissioning, evaluation and monitoring, provide capacity building opportunities.

*CF 3.2** SWSPHN staff – to further enable capacity building, quality improvement activities, embed improved immunisation in practice processes and support implementation.
* SWSLHD Public Health Unit and NCIRS participation in resource sharing, data sharing and analysis.
* GP’s and general practice nurses- to implement and participate in capacity building activities, integrate processes to enable quality improvement activities.

*CF 3.3** SWSPHN staff- to support ongoing community awareness, SWSPHN- Contract Management and commissioning, evaluation and monitoring, provide capacity building opportunities.
* SWS LHD community and population health staff- resources sharing, co- design community promotion activities.
* General practitioners, general practice nurses ­- to implement and participate in capacity building activities, integrate processes to enable quality improvement activities.
* Allied health and expert healthy lifestyle organisation- provide expert knowledge and deliver healthy lifestyle training.
* Western Sydney University – Provide oversight of Active Breed program.
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| Activity milestone details/ Duration | Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle):Activity start date: 1/07/2019Activity end date: 30/06/2020 |
| Commissioning method and approach to market | 1. Please identify your intended procurement approach for commissioning services under this activity:[ ]  Not yet known[x]  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[x]  Expression of Interest (EOI)[ ]  Other approach (please provide details)2a. Is this activity being co-designed?Yes2b. Is this activity this result of a previous co-design process?Yes3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?No3b. Has this activity previously been co-commissioned or joint-commissioned?No |
| Decommissioning | 1a. Does this activity include any decommissioning of services?No |
| Total Planned Expenditure | Enter the planned expenditure for this Activity in the following table. Include commissioned service expenditure only. |
| **Funding Source** | **2019-2020** | **2020-2021** | **2021-2022** | **Total** |
| Planned Commonwealth Expenditure - Core Flexible Funding |  |  |  |  |
| Funding from other sources |  |  |  |  |
| Funding from other sources | If applicable, name other organisations contributing funding to the activity (ie. state/territory government, Local Hospital Network, non-profit organisation). |

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| **Proposed Activities** - copy and complete the table as many times as necessary to report on each activity |
| ACTIVITY TITLE | CF4-Integration |
| Existing, Modified, or New Activity | Existing ActivityCF 5 2018-19 AWP Integration |
| Program Key Priority Area | Population Health |
| Needs Assessment Priority | CF 4.1 – pg 27 Chronic Disease – Diabetes/Opportunities priorities and options pg 80-82 Chronic Disease – Diabetes and CVDCF4.2 – Workforce pg 87-88CF 4.3 – CALD pg 91-92CF 4.4 – Pregnancy and the Early Years pg 83-84 |
| Aim of Activity | Continue the commitment to work with key partners to achieve an integrated health system that is fit for purpose. Integration initiatives will focus on local needs identified from the needs assessment and be achieved through strategic engagement, supported by the existing SWSLHD/SWSPHN Integrated Care Collaborative which provides high level governance for all integration activities. |
| Description of Activity | Describe the activity, including what work will be undertaken, and how the activity and/or services will be delivered.CF 4.1 – In collaboration with SWSLHD support capacity building in general practitioners through improved access to Diabetes specialist. Continue commitment to an integrated model of diabetes care linking primary and acute care providers, which support the improvement of Diabetes management in primary care through increasing skilled workforce within general practice.Partner with SWSLHD to develop an integrated regional Diabetes service plan.CF 4.2 – Continue commitment to Wollondilly and Fairfield Health Alliances providing strategic localised health initiatives that targets locally identified health and associated social issues.CF 4.3 – Partner with SWSLHD Population Health to implement Hepatitis B and C treatment strategies. Continue the commitment of a joint PHN / LHD project through the delivery of key activities aimed at supporting general practices to improve screening and treatment rates of Hep C.CF 4.4 – Continue to develop and promote strategies in partnership with SWSLHD to increase GP antenatal shared care participation. |
| Target population cohort | Describe the cohort that this activity will target.CF 4.1 – People with diabetes, general practice and other primary health care providers.CF4.2 – General practice staff, GP’s, general practice nurses, NGO’s, and local community members.CF 4.3 – People with Hep B and Hep C, General practice staff, GP’s, general practice nurses.CF 4.4 – Pregnant women, General practice staff, GP’s, general practice nurses. |
| Indigenous specific | Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?No |
| Coverage | Outline coverage of the activity. Where area covered is not the whole PHN region, provide the statistical area as defined in the Australian Bureau of Statistics (ABS), or LGA.CF 4.1 – whole SWSPHN regionCF 4.2 - Wollondilly and Fairfield LGA’sCF 4.3 – whole SWSPHN regionCF 4.4 – whole SWSPHN region |
| Consultation | Provide details of stakeholder engagement and consultation activities to support this activity.CF 4.1 – Consultation has occurred with SWSLHD, PHN staff, and within SWS Integrated Care Collaborative and as part SWSLHD Diabetes Review.CF 4.2 – Consultation has occurred within existing Health Alliances which includes local councils, NGO’s, LHD, CHETRE, and PHN. Further consultation will inform the implementation of future activities.CF 4.3 – Consultation has occurred with SWSLHD, PHN staff, and specialists. Ongoing consultations has informed a model of care that will provide capacity building activities and in practice clinical support aimed at improving clinical knowledge and confidence in treating patients with Hep B/ Hep C.CF 4.4 – Consultation has occurred with LHD, specialists, PHN, consumers and general practitioners. The SWSPHN ANSC committee provides an advisory role and assists with addressing clinical skills gaps, barriers to accessing ANSC providers, and provides clinical oversight. |
| Collaboration | List and describe the role of each stakeholder that will be involved in designing and/or implementing the activity, including stakeholders such as Local Health Networks, state/territory governments, or other relevant support services.*CF 4.1*Shared collaboration in the design, governance and implementation continues with SWSLHD, SWSPHN, general Practices, SWSICC and Wollondilly Health Alliance.* SWSPHN staff- to support ongoing community awareness, contract Management and commissioning, evaluation and monitoring, provide capacity building opportunities.
* SWS LHD community and population health staff- resources sharing, program input, specialist clinical oversight.
* General practitioners, general practice nurses to implement and participate in capacity building activities, integrate processes to enable quality improvement activities.

*CF 4.2*Each stakeholder contributes to the shared governance approach between PHN, LHD and local council, underpinned by an MoU and supported by the SWSPHN/SWSLHD integrated care collaborative. * Local council - identify local needs and contribute to co design of strategies and assist in the delivery of activities to the communities they support.
* NGOs - provide specific skill knowledge to local activities.

*CF 4.3** SWSLHD - provides clinical support and shared co design of the project.
* SWSPHN - to further enable capacity building in general practice, embed quality improvement activities that supports Hep B/C screening and treatment activities. Contract management, monitoring and evaluation activities.
* General practice - to implement and participate in capacity building activities, to integrate quality improvement activities that contribute to reduction in Hep C rates at a practice level that encourages a whole of population approach.

*CF 4.4** SWSLHD - participate in information sharing, planning and data analysis, promotion of activities, and clinical oversight.
* General practice - provide access to ANSC providers, participate in capacity building activities and provide primary care perspective to ANSC activities.
* SWSPHN - Contract Management and commissioning, evaluation and monitoring, provide capacity building opportunities.
* The SWSPHN ANSC committee provides an advisory role and assists with addressing clinical skills gaps, barriers to accessing ANSC providers, and provides clinical oversight.
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| Activity milestone details/ Duration | Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle):Activity start date: 1/07/2019Activity end date: 30/06/2020 |
| Commissioning method and approach to market | 1. Please identify your intended procurement approach for commissioning services under this activity:[ ]  Not yet known[x]  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?Yes2b. Is this activity this result of a previous co-design process?Yes3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?Yes3b. Has this activity previously been co-commissioned or joint-commissioned?Yes |
| Decommissioning | 1a. Does this activity include any decommissioning of services?No1b. If yes, provide a description of the proposed decommissioning process and any potential implications. |
| Total Planned Expenditure | Enter the planned expenditure for this Activity in the following table. Include commissioned service expenditure only. |
| **Funding Source** | **2019-2020** | **2020-2021** | **2021-2022** | **Total** |
| Planned Commonwealth Expenditure - Core Flexible Funding |  |  |  |  |
| Funding from other sources |  |  |  |  |
| Funding from other sources | If applicable, name other organisations contributing funding to the activity (ie. state/territory government, Local Hospital Network, non-profit organisation).Local Health District. |

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| **Proposed Activities** - copy and complete the table as many times as necessary to report on each activity |
| ACTIVITY TITLE | CF5-Aged and Palliative Care |
| Existing, Modified, or New Activity | Indicate if this is an existing activity, modified activity, or a new activity.CF 5.1 Existing (2018 – 19 AWP CF 6.1)CF 5.2 Existing (2018 – 19 AWP CF 6.2)CF 5.3 NewCF 5.4 New |
| Program Key Priority Area | Aged Care |
| Needs Assessment Priority | Aged and Palliative Care pg 108-110 |
| Aim of Activity | CF 5.1 and 5.2 – To increase the capacity of the SWS health and aged care systems to provide quality aged and palliative care through collaborative quality improvement, capacity building and integrative activities that cement a role for PHNs in aged and palliative care.CF 5.3 – Older people in the SWSPHN region are supported to receive quality primary health care services that encourage healthy aging and assist in the timely management of health needs.CF 5.4 – To increase the capacity of the SWS health and aged care systems to provide quality aged and palliative care through collaborative quality improvement, capacity building and integrative activities that cement a role for PHNs in aged and palliative care. |
| Description of Activity  | CF 5.1 – Implement service map and action plan for Aged Care in South Western Sydney.CF 5.2 – Support the development and implementation of models of care and supporting tools for the delivery of quality aged and complex care within the primary health setting.CF 5.3 – Develop a quality improvement activity to increase the rate, regularity and quality of 75+ Health Checks.CF 5.4 – Explore opportunities to support the provision of primary health services in residential aged care. |
| Target population cohort | People aged 65 years and over |
| Indigenous specific | No |
| Coverage | Whole of SWSPHN region. |
| Consultation | SWSPHN maintains engagement and consultation activities on an ongoing basis with community representatives, GPs, NSW Ambulance, community aged care services and residential aged care services. |
| Collaboration | CF 5.1 – This activity involves collaboration with Western Sydney University, General Practice, SWSLHD and NSW Ambulance.CF 5.2 – This project is being undertaken collaboratively with SWSLHD, General Practice, Community Pharmacies and NSW Ambulance.CF 5.3 – Consultation activities will be carried out with general practices and GPs.CF 5.4 – This project will involve collaboration between SWSPHN, residential aged care, General Practice, NSW Ambulance, relevant LHD services and other key stakeholders identified. |
| Activity milestone details/ Duration | *CF 5.3*Activity start date: July 2019Activity end date: June 2021*CF 5.4*Activity Start Date: 01/07/ 2019Activity end date 30 /06/ 2021 |
| Commissioning method and approach to market | 1. Please identify your intended procurement approach for commissioning services under this activity:[x]  5.1 and 5.2 - contract extension2a. Is this activity being co-designed?Yes2b. Is this activity this result of a previous co-design process?Yes3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?No3b. Has this activity previously been co-commissioned or joint-commissioned?No |
| Decommissioning | 1a. Does this activity include any decommissioning of services?No |
| Total Planned Expenditure | Enter the planned expenditure for this Activity in the following table. Include commissioned service expenditure only.  |
| **Funding Source** | **2019-2020** | **2020-2021** | **2021-2022** | **Total** |
| Planned Commonwealth Expenditure - Core Flexible Funding |  |  |  |  |
| Funding from other sources |  |  |  |  |

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| **Proposed Activities** - copy and complete the table as many times as necessary to report on each activity |
| ACTIVITY TITLE | CF7-Aboriginal and Torres Strait Islander HealthCF 7.1-Aboriginal Health Capacity building for General PracticeCF 7.2-Aboriginal Health and Wellbeing Adolescent Health Promotion Project |
| Existing, Modified, or New Activity | New Activity |
| Program Key Priority Area | Aboriginal and Torres Strait Islander Health |
| Needs Assessment Priority | *CF 7.1*Strengthening Prevention pg 84 (Implement Quality Improvement practices)Workforce pg 86-87 (support General practice as a business, including support for practices to achieve accreditation)Aboriginal Health – Cultural awareness pg 88Aboriginal Health – Care Coordination pg 88* Content of activity supports all of the above

*CF 7.2*Overweight and Obesity pg 100Tobacco Control pg 101Strengthening Prevention pg 105Alliances and partnerships pg 105Aboriginal Health pg 134Increase the uptake of the MBS 715Content of activity supports all of the above |
| Aim of Activity | *CF 7.1*The aim of the activity is to improve patient care, increase awareness about cultural sensitivity in general practice, increase the uptake of the MBS 228, 715, ensure PIPIHI Practices are aware of their responsibilities regarding identification, registration and re-registration requirements.This will aid in providing an environment for the Aboriginal and Torres Strait Islander population to feel safe and supported; improve health literacy to empower consumer to make better informed choices regarding their healthcare; focus on health prevention activities such as increasing uptake of MBS 228, 715 Health Assessments, referral processes for supports and programs that are available locally.The workshops can be used as either a preamble to a Cultural Awareness training session (RACGP approved) &/or as a follow up post cultural awareness training with a practical focus.*CF 7.2*The aim of the project is to introduce the target audience (young Aboriginal and Torres Strait Islander men aged between 12 and 18 years of age), their families and the greater school community to the suite of primary health care services available locally, including Aboriginal specific services.The information and activities will provide the foundational steps required to navigate through the Primary Health Care system and provide the building blocks to develop new health behaviours that will influence the choices made throughout Adolescence and track to adulthood. |
| Description of Activity | *CF 7.1*Small Group sessions/workshops to be delivered by an AHW/RN with AMS experience.* Implement a support network for Practice nurses and staff by means of a communication portal, a safe environment with a one stop shop to ask questions and receive feedback.
* Reflection activities – current processes within individual workplaces, identify barriers, workshop ideas to reduce barriers for patients.
* Fluency with the PIPIHI processes; identification, registration, criteria for re-registration of patients.
* Increase confidence of practice staff to better engage with the Identified patient cohort.
* Provide capacity building activities that focus on Aboriginal specific health prevention strategies. This will include but not limited to MBS items 228 and 715’s. Step through processes of completing a thorough and relevant 228, 715- identifying and addressing specific requirements for the life stages.

*CF 7.2*1. Health risk behaviours (smoking, alcohol, drug misuse, sexual health and risk taking)
2. Parent-adolescent communication
3. Depression and mental health
4. Violence
5. Physical activity, nutrition and obesity (Chronic conditions)
6. Health inequalities and social exclusion

These activities, presentations will be delivered at an individual level; peer education, mentoring programmes.School level; curriculum and Academy based via Clontarf Academy Director & teams.An in-house health promotion day with all key stakeholders will be held at the High School, each participant will be allocated a health passport which they must have completed during the course of the day.Activities to include: MBS 715 Aboriginal Health assessment with the Practice Nurse/Aboriginal Health Worker and General Practitioner (AMS), attend mini presentations (break-out sessions) addressing above topics. |
| Target population cohort | *CF 7.1 –* General practice staff, including a focus on Practice nurses, Practice Manager, and GP’s.*CF 7.2 –* Aboriginal and Torres Strait Islander Adolescents – male 12-18 years of age. (those registered with Clontarf Academy)Female students will also be included. |
| Indigenous specific | Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?YesIf yes, briefly describe how this activity will engage with the Indigenous sector.CF 7.1 –Provide the tools for Practice staff to engage confidently with their Indigenous patients, provide support and ideas for improving the cultural safety and understanding of local and historical Aboriginal health inequalities, thus reducing barriers to accessing primary health care and provide a mainstream primary care that is culturally appropriate.CF 7.2 –Aboriginal and Torres Strait Islander students enrolled at participating high schools, and parents of the students will be the target of the Aboriginal Health and Wellbeing Adolescent Health Promotion Project.This activity will engage the local Elders, the Aboriginal Medical Service and other Providers. The activity will provide cultural connections to community and to healthcare. |
| Coverage | *CF 7.1*Whole SWSPHN region.*CF 7.2*SWSPHN – Campbelltown and Camden LGA2016 Census* Campbelltown - 5971 (total population)
* Camden - 1933 (total population)

Male population (12-18 years of age)* Campbelltown LGA - 663
* Camden LGA - 263

Female population (12-18 years of age)* Campbelltown LGA - 671

Camden LGA - 200 |
| Consultation | *CF 7.1** Practice staff, Practice Managers, Practice Nurses
* SWSPHN colleagues
* Aboriginal PHN network
* ITC commissioned provider
* SWSLHD Aboriginal health unit
* Local elders and Indigenous consumers
* WoTWoD pilot trial outcomes to provide information for the co design of roll out in

*CF 7.2** Clontarf Academy Directors and staff of Airds High School & Elizabeth Macarthur High School
* Aboriginal Health Promotions Officers SWSLHD
* Tharawal AMS
* Gandangara Health Service/Marumali Brokerage
* Campbelltown Urban Aboriginal food Security Project Group workshop SWSPHN
 |
| Collaboration | *CF 7.1*Shared collaboration in the design and implementation will be undertaken with SWSLHD Aboriginal Health Unit, SWSPHN staff and NSW/ ACT PHN Aboriginal Health network, general Practices, local elders, and WSU.* SWSPHN staff - to support ongoing community awareness and co design, project input, provide capacity building opportunities.
* SWSLHD Aboriginal Health Unit - resources sharing, program input, co design.
* General practitioners, general practice nurses to implement and participate in cultural awareness activities.
* WSU - to identify evaluation and research opportunities.
* Local elders - provide cultural insight and cultural direction of resource development and awareness activities.

*CF 7.2*These include the following but not limited to:* Clontarf Foundation – Academy Directors will coordinate the school agenda to suit activities, consents for student participation, venues.
* Tharawal Aboriginal Medical Service – clinical support, cultural expertise.
* SWSLHD Aboriginal Child and Family Aboriginal Health Education Officer (Sexual Health, Mental health, Domestic Violence) – mini educational presentations, cultural support, resources.
* Integrated Team Care team SWSLHD – chronic care.
* Mainstream primary care service – Mental Health, AOD.
* SWSPHN – Financial (GP, PN) in kind support; coordinate meetings, resources and the promotion of the community awareness event.
* SWSLHD Health Promotion team- smoking cessation provide education.

Others – TBD. |
| Activity milestone details/ Duration | Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle):Activity start date: 1/07/2019Activity end date: 30/06/2021 |
| Commissioning method and approach to market | 1. Please identify your intended procurement approach for commissioning services under this activity:[x]  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?CF 7.1 NoCF 7.2 Yes2b. Is this activity this result of a previous co-design process?No3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?No3b. Has this activity previously been co-commissioned or joint-commissioned?No |
| Decommissioning | 1a. Does this activity include any decommissioning of services?No |
| Total Planned Expenditure | Enter the planned expenditure for this Activity in the following table. Include commissioned service expenditure only. |
| **Funding Source** | **2019-2020** | **2020-2021** | **2021-2022** | **Total** |
| Planned Commonwealth Expenditure - Core Flexible Funding |  |  |  |  |
| Funding from other sources |  |  |  |  |
| Funding from other sources | If applicable, name other organisations contributing funding to the activity (ie. state/territory government, Local Hospital Network, non-profit organisation). |

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.

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| **Proposed Activities** - copy and complete the table as many times as necessary to report on each activity |
| ACTIVITY TITLE | HSI 1-Transformative Capacity Building |
| Existing, Modified, or New Activity | Modified ActivityHSI1, HSI2, GPS1 |
| Needs Assessment Priority | *Overweight and Obesity pg 100*Support the SWSLHD Growing Healthy Kids – Paediatric Weight Management Model of Care by increasing screening of BMI in quality improvement program tier 2 practices and promoting appropriate referral options when children are identified in need of services.Increase education in GP practice through CPD events, HeLP GP study and promotion of HealthPathways and online training.*Chronic Disease pg 102*Train practice nurses in health assessments, cycles of care and quality care planning.Explore opportunities to work with peak bodies to expand quality improvement strategies in general practice.*Strengthening Prevention pg 105*Implement in-practice quality improvement activities in General Practice to improve the measure and documentation of chronic disease risk factors and provide education, training and resources to general practitioners and practice nurses.*Digital Health pg 106*Continue support and education to primary health care providers to utilise the My Health Record system.Work in partnership with SWSLHD to develop and implement an Interoperability framework as a platform for real-time data sharing.Continue to maintain the NHSD within South Western Sydney and support the addition of provider languages.*Workforce pg 107*In collaboration with the SWSLHD, UWS and other universities, RTOs and Tharawal AMS, identify and develop workforce strategies for South Western Sydney which includes cultural appropriateness and identifying and addressing clinical skill gaps.Support general practice clinicians to use digital health systems.Continue commitment to Practice Nurse professional development in SWS, including provision of appropriate training, professional development, recruitment and professional support, including the mentoring of new PN graduates by experienced PNs.*Aged Care & Palliative Care pg 108*Work with CPD providers, DBMAS, SWSLHD and UWS to compile a CPD program on Dementia for GPs and PNs.Work with CPD providers to compile a CPD program on Advance Care Planning for GPs and PNs. Explore opportunities for training of RACF staff and resident’s families.Explore quality Improvement activity to increase rate, regularity and quality of 75+ Health Checks.*Culturally and Linguistically Diverse Populations pg 111*Work with community and stakeholders to identify options to address Hepatitis C and B incidence/prevalence in CALD communities and newly arrived migrants and refugees. Facilitate GP CPD for improved knowledge of appropriate management of Hep C and B in CALD communities.*Primary Mental Health (including suicide prevention pg 125*Approaches to increase GP understanding including CPD opportunities and a GP working group formed to assess the needs of GPs to be best able to adopt and work effectively within a stepped model of care.Develop a psychosocial education program for GPs in the region to increase their understanding of psychosocial disability-related psychosocial needs and supports, as well as referral pathways.*Indigenous Health pg 136*Partner with local Aboriginal health services to deliver cultural awareness training for primary health care. |
| Aim of Activity | The aim is to facilitate improvements in general practice workflow/processes and patient health outcomes through digital health solutions, regular data collection, reporting, addressing clinical skill gaps and education. |
| Description of Activity  | HSI 1.1 – Quality Improvement in Primary Care -working with general practice staff to facilitate measurable quality improvement activities (quantitative & qualitative) in general practice through SWSPHN’s established RACGP/ACRRM accredited *Quality Improvement in Primary Care* program (QIPC). This will be achieved through working one on one with general practices to improve their quality of care by upskilling the general practice team, provision of quarterly reports through practice-based data extraction, and facilitation of QI activities to achieve practice goals.HSI 1.2 – Clinical Support- Supporting and strengthening general practitioner/practice nurse capacity building in SWSPHN. Health practitioners will be supported with in-house visits and education sessions, telephone and email support, promotion of continuing professional development, orientation and mentoring and resources.HSI 1.3 – Digital health- Advocate and assist use of electronic communication and information technology in SWSPHN. General practices will be supported to adopt change and utilise digital health technologies to assist in the provision of quality and timely care and sharing of information.HSI 1.4 – CPD- Ongoing Continuing Professional Development sessions for GPs, Practice Nurses and Practice Managers, staff and other health professionals with education topics informed by local clinicians and local and national priority areas. |
| Associated Flexible Activity/ies: | CF 1-6 |
| Target population cohort | General practitioners, practice nurses, general practice staff, specialists, allied health providers. |
| Indigenous specific | Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?No |
| Coverage | All seven (7) LGAs within SWSPHN region: Canterbury Bankstown, Fairfield, Liverpool, Campbelltown, Camden, Wollondilly and Wingecarribee. |
| Consultation | SWSPHN Clinical Council, SWSPHN Local Health Councils, SWSPHN Workforce Committee, SWSPHN Community Advisory Committee, general practices, specialists, allied health providers, local Health District, Public Health Unit, University of Wollongong, Western Sydney University. |
| Collaboration | SWSPHN will collaborate with practice teams including GPs, Practice Nurses and Practice Managers to implement change and contribute to improved practice capabilities.SWSPHN has existing collaborative relationships with a range of stakeholders to contribute to the guiding and development of improved practice capabilities and best practice. These stakeholders include: SWS Local Health District, Aboriginal Medical Services, Western Sydney University, University of Wollongong, GP Synergy, Cancer Institute of NSW, Pharmacists, Allied Health Providers, Specialists, RTOs, ADHA, RACGP, ACRRM and other PHNs. |
| Activity milestone details/ Duration | N/A |
| Commissioning method and approach to market | N/A |
| Total Planned Expenditure | Enter the planned expenditure for this Activity in the following table. |
| **Funding Source** | **2019-2020** | **2020-2021** | **2021-2022** | **Total** |
| Planned Commonwealth Expenditure - Core Health Systems Improvement Funding |  |  |  |  |
| Planned Commonwealth Expenditure – General Practice Support Funding |  |  |  |  |
| Total Planned Commonwealth Expenditure |  |  |  |  |
| Funding from other sources |  |  |  |  |
| Funding from other sources | If applicable, name other organisations contributing funding to the activity (ie. state/territory government, Local Hospital Network, non-profit organisation). |

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| **Proposed Activities** - copy and complete the table as many times as necessary to report on each activity |
| ACTIVITY TITLE | HSI 2-Ambitious Integration |
| Existing, Modified, or New Activity | New Activity |
| Needs Assessment Priority | Chronic Disease – Diabetes/Opportunities priorities and options pg 27Chronic Disease – Diabetes and CVD pg 80-82Workforce pg 87-88CALD pg 91-92Pregnancy and the Early Years pg 83-84 |
| Aim of Activity | Work with key partners to achieve an integrated health system that is fit for purpose. Integration initiatives will focus on local needs identified from the needs assessment and be achieved through strategic engagement, partnership development and commissioning. Integration initiatives are supported by the existing SWSLHD/SWSPHN Integrated Care Collaborative which provides high level governance for all integration activities. |
| Description of Activity | * Co-design innovative models of care which support an integrated patient journey across the system, consistent with needs assessment priorities.
* Provide subject matter expertise and oversight of commissioned services, ensuring providers secure improved patient outcomes and represent value for money. Undertake sector development activities to enhance connection and integration between providers.
* Continue and strengthen integration partnerships including South Western Sydney Integrated Care Collaborative, Health alliances and other strategic activities.
* Develop localised HealthPathways and associated patient resources, including translated health information, to enhance consumer literacy.
 |
| Associated Flexible Activity/ies: | CF 1-6 |
| Target population cohort | * General practice teams
* Health care consumers
* Health and social providers
 |
| Indigenous specific | Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?No |
| Coverage | Whole South Western Sydney PHN region. |
| Consultation | * SWS Integrated Care Collaborative – SWSLHD clinicians, SWSPHN and SWSLHD executive, GPs, consumers, universities, local government.
* Health Alliances – SWSLHD, SWSPHN, GPs, consumers, universities, local government, research agencies, non-government organisations.
* Standing committee structures including program committees and place based local health councils with cross sector representation.
* HealthPathways clinical work groups, general practice reference group, community advisory committee.
 |
| Collaboration | Each stakeholder contributes to design, and implementation of integration approaches between LHD, PHN, local governments, universities, general practice and consumers supported by the SWSPHN/SWSLHD integrated care collaborative.* Local council - identify local needs and contribute to co design of strategies and assist in the delivery of activities to the communities they support
* NGOs - provide specific skill knowledge to local activities
* LHD - shared governance
* GP - clinical governance
* All - advisory

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| Activity milestone details/ Duration | Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle):Activity start date: 1/07/2019Activity 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: July 2019Service delivery end date: July 2022 |
| Commissioning method and approach to market | 1. Please identify your intended procurement approach for commissioning services under this activity:[ ]  Not yet known[x]  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?Yes2b. Is this activity this result of a previous co-design process?Yes3a. Do you plan to implement this activity using co-commissioning or joint-commissioning arrangements?Yes3b. Has this activity previously been co-commissioned or joint-commissioned?Yes |
| Total Planned Expenditure | Enter the planned expenditure for this Activity in the following table. |
| **Funding Source** | **2019-2020** | **2020-2021** | **2021-2022** | **Total** |
| Planned Commonwealth Expenditure - Core Health Systems Improvement Funding |  |  |  |  |
| Planned Commonwealth Expenditure – General Practice Support Funding |  |  |  |  |
| Total Planned Commonwealth Expenditure |  |  |  |  |
| Funding from other sources |  |  |  |  |
| Funding from other sources | If applicable, name other organisations contributing funding to the activity (ie. state/territory government, Local Hospital Network, non-profit organisation). |

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| **Proposed Activities** - copy and complete the table as many times as necessary to report on each activity |
| ACTIVITY TITLE | HSI 3-Intelligent Commissioning |
| Existing, Modified, or New Activity | New Activity |
| Needs Assessment Priority | This activity is associated with all possible options related to commissioning as identified in Section 4 of the Needs Assessment. |
| Aim of Activity | To provide a transparent, reproducible and systematic commissioning process which delivers value for money and improved health outcomes of the community.SWSPHN will deliver robust health planning, procurement, contract management and monitoring and evaluation. |
| Description of Activity | SWSPHN will implement data analytics, population health planning, evaluation methodology, contract management and procurement processes which secure value for money and are in line with international best-practice.Outcomes-based commissioning will be a keen focus of the 19/20 FY. This includes development of a practical plan for implementation and change management for our commissioned service providers.SWSPHN will implement an electronic contract management system to improve existing contract management processes. |
| Associated Flexible Activity/ies: | CF 1-6 |
| Target population cohort | This activity will benefit all consumers of SWSPHN commissioned service providers. |
| Indigenous specific | Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?No |
| Coverage | Whole South Western Sydney PHN region. |
| Consultation | This activity will utilise consultation and stakeholder engagement identified in other activities detailed within this Activity Work Plan. |
| Collaboration | This activity will demonstrate continued collaboration with other PHNs, and South Western Sydney LHD. Shared learning and shared change management strategies will increase the market capacity and appetite for commissioning in south western Sydney. |
| Activity milestone details/ Duration | Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle):Activity start date: 01/07/2019Activity 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) |
| Total Planned Expenditure | Enter the planned expenditure for this Activity in the following table. |
| **Funding Source** | **2019-2020** | **2020-2021** | **2021-2022** | **Total** |
| Planned Commonwealth Expenditure - Core Health Systems Improvement Funding |  |  |  |  |
| Planned Commonwealth Expenditure – General Practice Support Funding |  |  |  |  |
| Total Planned Commonwealth Expenditure |  |  |  |  |
| Funding from other sources |  |  |  |  |
| Funding from other sources | If applicable, name other organisations contributing funding to the activity (ie. state/territory government, Local Hospital Network, non-profit organisation). |

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| **Proposed Activities** - copy and complete the table as many times as necessary to report on each activity |
| ACTIVITY TITLE | HSI 4-Stakeholder Engagement |
| Existing, Modified, or New Activity | Modified ActivityHSI 2 Stakeholder Engagement |
| Needs Assessment Priority | *Overweight and obesity* pg 100Promotion of the Get Healthy and Go4Fun services to GPs in SWS to increase referrals to the program.Promotion of addressing overweight and obesity to community through online and social media engagement.*Tobacco control* pg 101Support the promotion and dissemination of online resources of the “one small step, one big difference” initiative.Promote patient portal for HealthPathways, Health Resource Directory.org.au, to community as a trusted source for relevant and localised, and translated health information about tobacco use and its health impacts.*Chronic disease* – diabetes and CVD pg 102Promote patient portal for HealthPathways, Health Resource Directory.org.au, along with Your Health Your Time Your Way to community as a trusted source for relevant and localised, and translated health information about chronic disease management.*Cancer* pg 102Promotion of importance of cancer screening and the local cancer screening options to community – particularly communities with low screening rates with a targeted approach to Aboriginal and Torres Strait Islander people Increase promotion of importance cancer screening to community through online and social media engagement.*Pregnancy and the early years* pg 104Develop strategies to increase GP antenatal shared care program participation.Promotion of SWS immunisation campaign through Your Health Your Time Your Way, social media and other promotion platforms.*Workforce* pg 107Continue commitment to local health councils within each LGA to inform workforce and community needs.*Aged care and palliative care* pg 108Work with LHD and community-based organisations to deliver community education on Dementia.Work collaboratively with Advance Care Planning Australia to promote Advanced Care Planning (ACP) to the community of SWS.*Culturally and linguistically diverse populations pg 111*Continuing project with NSW Refugee Health Service (NSW RHS), Migrant Resource Centres and Settlement Services International (SSI) to link newly arrived refugees to culturally safe primary care providers.Work with community and stakeholders to identify options to address Hepatitis C and B incidence/prevalence in CALD communities and newly arrived migrants and refugees. Facilitate GP CPD for improved knowledge of appropriate management of Hep C and B in CALD communities.Work with community and relevant stakeholders to continue to relevant resources to enhance the health literacy of CALD communities. Potential focus areas include appropriate access to general practice, understanding of the role of a GP; appropriate use of hospital services, particularly ED; immunisation and cancer screening, tobacco control and overweight and obesity.*After hours medical care community awareness pg 112*Refine community awareness campaign to promote appropriate options other than ED for after-hours care. Including articles, online promotion of these options, local media, video and promotion during hospital discharge.*Primary mental healthcare pg 112*Promote mental health through:* Developing phone App which contains mental health information and directory of local programs and services for people in SWS.
* Developing an e-mental health tool kit to support GPs and Allied mental health professionals to refer e-mental health tools to complement face-to-face services Participation in relevant network and stakeholder meetings, advisory committees and clinical councils across the region SWSPHN Consumer Website – Your Health Your Time Your Way – SWSPHN Community Pulse Newsletter - Participation at Mental Health related Expos held in the region - CPD events -Mental health promotion videos.
* Develop a program/project that will promote and educate the region about psychosocial disability, psychosocial support needs, and the services and supports available to consumers in the region.

*Alcohol and other drugs treatment needs pg 131*Promote patient portal for HealthPathways, Health Resource Directory.org.au, to GP’s and community as a trusted source for relevant and localised, and translated health information about AOD management. |
| Aim of Activity | To ensure GPs, practice nurses, practice managers/staff, consumers, LHD, NGOs and other key stakeholders are identified through the SWSPHN Stakeholder Engagement Framework, engaged on an appropriate level and given a voice in the planning, development, implementation and evaluation of our commissioned services, programs and initiatives.To ensure stakeholders are provided with appropriate online and face-to-face platforms to provide feedback on key areas of SWSPHN business which results in improved integration, builds capacity of health professionals and consumers and ensures the health needs of our community are identified, assessed and understood.To proactively engage all SWSPHN stakeholders and provide them with timely, relevant and accessible communications mechanisms which help to enhance and connect primary health care so residents achieve better health outcomes.To contribute to the improved health literacy of our community by providing relevant, localised information, within appropriate and accessible information platforms, so the community is better informed, is empowered to access relevant self-management strategies and take charge of their health, and is able to make better informed health decisions, especially those in our community from Culturally and Linguistically Diverse and Aboriginal or Torres Strait Islander populations and those who have, or are at risk of developing, chronic conditions. |
| Description of Activity  | HSI 4.1 – Support and enable consultation and engagement with, and representation of, key stakeholder groups – including general practice, allied health and other primary health providers, LHD, NGOs, peak bodies, local councils, commissioned services, the community, and other relevant organisations and groups identified in the SWSPHN Stakeholder Engagement Framework – on SWSPHN committees, councils, working groups, focus groups, co-design sessions and evaluation panels, to build and strengthen networks and to understand the health needs of our community.HSI 4.2 – Continue to provide multiple platforms for feedback and engagement, to stakeholders and the broader community through online feedback mechanisms and face-to-face provisions, ensuring all voices are heard and that stakeholders understand who the PHN is, our role in capacity building and in the integration and commissioning of local health services.HSI 4.3 – Continue to provide communications mechanisms to general practice and the community to deliver timely and relevant updates and information through multiple communications channels including website, newsletters, social media, GP and general practice awareness campaigns, consumer awareness campaigns within our priority areas, and increase brand awareness of the PHN.HSI 4.4 – Contribute to the improved health literacy of our community by providing localised, timely and relevant health information and supports, delivered through easily accessible and trusted channels, and translated where appropriate, to support the community to be informed about their health, to understand primary health and the role of the GP and their own role in taking charge of their health, and to empower local residents to make better informed health decisions and to navigate the health system efficiently and appropriately. |
| Associated Flexible Activity/ies: | CF 1 - 6 |
| Target population cohort | General practice, consumers of SWSPHN commissioned services. Broader community and all other SWSPHN stakeholders. |
| Indigenous specific | Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?No |
| Coverage | Whole PHN region. |
| Consultation | SWSPHN staff; Board; Clinical Council; Community Advisory Committee; steering committees and Local Health Councils; working groups; Local Health District; GPs; Practice Nurses; Practice Managers; NGOs; peak bodies; universities; local government. |
| Collaboration | SWSPHN staff, Board, Clinical Council, Community Advisory Committee – to guide strategic direction and approval of Stakeholder Engagement Framework, community information campaigns, general information campaigns and initiatives, and relevant communications and engagement planning.GPs, practice nurses, practice managers, practice staff – engaged to provide feedback on communications mechanisms, consultation and input into activities and initiatives through representation on Board (strategic direction), Clinical Council, steering committees, working groups and focus groups and satisfaction with PHN and PHN activities.Local Health District – engaged on multiple layers and through multiple mechanisms to enhance integration and capacity building activities.NGOs, peak bodies, local government and universities – engaged through advisory committees, steering committees, health councils to provide feedback and insight around population health needs, initiatives and programs being run and developed by the PHN, ensuring multi-sectorial partnerships support and enable integration and capacity building. |
| Activity milestone details/ Duration | Provide the anticipated activity start and completion dates **(including** the planning and procurement cycle):Activity start date: 01/07/2019Activity end date: 030/06/2021 |
| 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) |
| Total Planned Expenditure | Enter the planned expenditure for this Activity in the following table. |
| **Funding Source** | **2019-2020** | **2020-2021** | **2021-2022** | **Total** |
| Planned Commonwealth Expenditure - Core Health Systems Improvement Funding |  |  |  |  |
| Planned Commonwealth Expenditure – General Practice Support Funding |  |  |  |  |
| Total Planned Commonwealth Expenditure |  |  |  |  |
| Funding from other sources |  |  |  |  |
| Funding from other sources | If applicable, name other organisations contributing funding to the activity (ie. state/territory government, Local Hospital Network, non-profit organisation). |

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| **Proposed Activities** - copy and complete the table as many times as necessary to report on each activity |
| ACTIVITY TITLE | HSI 5-General Practice Support |
| Existing, Modified, or New Activity | Modified ActivityGPS 1 |
| Needs Assessment Priority | *Workforce pg 107*Support general practice as a business, including providing support to practices to achieve accreditation. |
| Aim of Activity | Improve practice capabilities through the provision of timely and relevant service supports through the promotion of best practice, business support, training and distribution of information. |
| Description of Activity  | HSI 5.1 – Supporting General Practices across SWS to contribute to improved health outcomes to deliver safe, high quality, timely evidence-based health care.This will be achieved by working one on one with general practices through regular visits and email/telephone support by the practice support team through the promotion of best practice, training, business and accreditation support and distribution of information. |
| Associated Flexible Activity/ies: | CF 1-6 |
| Target population cohort | General practitioners, practice nurses, general practice staff  |
| Indigenous specific | Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?No |
| Coverage | All seven (7) LGAs within SWSPHN region: Canterbury Bankstown, Fairfield, Liverpool, Campbelltown, Camden, Wollondilly and Wingecarribee. |
| Consultation | SWSPHN Clinical Council, SWSPHN Local Health Councils, SWSPHN Workforce Committee, general practices, specialists, allied health providers, local Health District, Public Health Unit, University of Wollongong, Western Sydney University. |
| Collaboration | SWSPHN will collaborate with practice teams including GPs, Practice Nurses and Practice Managers to implement change and contribute to improved practice capabilities.SWSPHN has existing collaborative relationships with a range of stakeholders to contribute to the guiding and development of improved practice capabilities and best practice. These stakeholders include: SWS Local Health District, Aboriginal Medical Services, Western Sydney University, University of Wollongong, GP Synergy, Cancer Institute of NSW, Pharmacists, Allied Health Providers, Specialists, RTOs, ADHA, RACGP, ACRRM and other PHNs. |
| Activity milestone details/ Duration | N/A |
| Commissioning method and approach to market | N/A |
| Total Planned Expenditure | Enter the planned expenditure for this Activity in the following table. |
| **Funding Source** | **2019-2020** | **2020-2021** | **2021-2022** | **Total** |
| Planned Commonwealth Expenditure - Core Health Systems Improvement Funding |  |  |  |  |
| Planned Commonwealth Expenditure – General Practice Support Funding |  |  |  |  |
| Total Planned Commonwealth Expenditure |  |  |  |  |
| Funding from other sources |  |  |  |  |
| Funding from other sources | If applicable, name other organisations contributing funding to the activity (ie. state/territory government, Local Hospital Network, non-profit organisation). |

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| **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 | Modified ActivityGPS 1 |
| Needs Assessment Priority | *Workforce pg 107*Support general practice as a business, including providing support to practices to achieve accreditation. |
| Aim of Activity | Improve practice capabilities through the provision of timely and relevant service supports through the promotion of best practice, business support, training and distribution of information. |
| Description of Activity  | HSI 4.1- Supporting General Practices across SWS to contribute to improved health outcomes to deliver safe, high quality, timely evidence-based health care.This will be achieved by working one on one with general practices through regular visits and email/telephone support by the practice support team through the promotion of best practice, training, business and accreditation support and distribution of information. |
| Associated Flexible Activity/ies: | CF 1-6 |
| Target population cohort | General practitioners, practice nurses, general practice staff. |
| Indigenous specific | Is this activity targeted to, or predominantly supporting, Aboriginal and Torres Strait Islander people?No |
| Coverage | All seven (7) LGAs within SWSPHN region: Canterbury Bankstown, Fairfield, Liverpool, Campbelltown, Camden, Wollondilly and Wingecarribee. |
| Consultation | SWSPHN Clinical Council, SWSPHN Local Health Councils, SWSPHN Workforce Committee, general practices, specialists, allied health providers, local Health District, Public Health Unit, University of Wollongong, Western Sydney University. |
| Collaboration | SWSPHN will collaborate with practice teams including GPs, Practice Nurses and Practice Managers to implement change and contribute to improved practice capabilities.SWSPHN has existing collaborative relationships with a range of stakeholders to contribute to the guiding and development of improved practice capabilities and best practice. These stakeholders include: SWS Local Health District, Aboriginal Medical Services, Western Sydney University, University of Wollongong, GP Synergy, Cancer Institute of NSW, Pharmacists, Allied Health Providers, Specialists, RTOs, ADHA, RACGP, ACRRM and other PHNs. |
| Activity milestone details/ Duration | N/A |
| Commissioning method and approach to market | N/A |
| Total Planned Expenditure | Enter the planned expenditure for this Activity in the following table. |
| **Funding Source** | **2019-2020** | **2020-2021** | **2021-2022** | **Total** |
| Planned Commonwealth Expenditure - Core Health Systems Improvement Funding |  |  |  |  |
| Planned Commonwealth Expenditure – General Practice Support Funding |  |  |  |  |
| (Salaries) |  |  |  |  |
| Total Planned Commonwealth Expenditure |  |  |  |  |
| Funding from other sources |  |  |  |  |
| Funding from other sources | If applicable, name other organisations contributing funding to the activity (ie. state/territory government, Local Hospital Network, non-profit organisation). |