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An Australian Government Initiative

Updated Activity Work Plan 2016-2018: Core Funding

Western Sydney PHN

Overview

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

1. (a) Strategic Vision

The Strategic Vision of WentWest

Healthier communities, empowered individuals, sustainable primary health care workforce and system

WentWest, operating as the Western Sydney Primary Health Network (WSPHN) developed a comprehensive strategic plan for the period 2016-19, a one page overview of which is an attachment to this document. The strategic plan places the consumer and community at the centre of our work and is strongly aligned to and driven by the PHN primary requirements of:

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

The strategic plan was approved by the WentWest Board and formed the basis for the planning and delivery of all we undertake on behalf of the western Sydney community.

1 (b) Core Flexible funding

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Health Capability & Quality Improvement

Proposed Activities -	
Activity Title / Reference (eg. NP 1)	NP 1.1: Health Capability and Quality Improvement **Strengthen primary care by supporting general practice to improve capability, capacity and quality of care.** **Enhancing capability and capacity of the primary care workforce to provide improved care for chronic and complex patients.**
Existing, Modified, New	Modified
Program Key Priority Area	Other – Capability & Quality Improvement
Needs Assessment Priority Area (eg. 1, 2, 3)	Section 4: System Priorities (page reference 153)
Description of Activity	Continue to implement the WSPHN quality improvement framework to lift capability, capacity and quality of care. This will include the following: Clinical Support: • Chronic Disease Management • Cold Chain Management • Health Assessments • Infection Control, Sterilisation and Spills • Practice Nurse Resources, Education & Training • Recalls and Reminders • Women's Health • Clinical Pharmacists in General Practice Business Support: • Accreditation

	• Data Driven Improvement – WSPHN Data Dashboard, PCMH-A, PROMS/PREMS, RedBack Patient Feedback Systems, HappyOrNot, Consumer Engagement Forums, General Practice Staff Vision and Engagement Surveys • Human Resources Support • IMIT • MBS item numbers and billing • PIPs and SIPs • Practice Management • Privacy & Confidentiality • Staff Training • Workforce • Business & Clinical Leadership Program • Cert-IV – Medical Assisting Program Programs & Other Activities • E-Health • PCMH • Program Specific Resources Continue structured implementation of Patient Centred Medical Home (PCMH) activities in the current 8 practices including all of the above as well as: • Capture and understanding of the patient consumer current and desired healthcare experience • Alignment of activities to the Ten Building Blocks of High Performing Primary Care (Bodenheimer et. al, 2012) as a model for Primary Care transformation • Intense Business and Clinical Leadership Coaching • Consistency in data capture and reporting PCMH-A as a primary tracking tool • Planning and evaluation of progress against the Quadruple Aim (IHI Triple Aim Initiative – Berwick and Whittington, 2008 and From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider Bodenheimer and Sinsky, 2014) • Fostering required practice Capability and Capacity • This work will align with and complement the anticipated Health Care Home rollout details captured in section 5.
Target population cohort	WSPHN whole of region

Consultation	More effective integration with the western Sydney medical neighbourhood and support activities incorporating the NSW Health, WSLHD and WSPHN Integrated Care Demonstrator, HealthOne and Kids GPs initiatives and services
Collaboration	• WSLHD, WSDPMI, UNE, GP Leaders, PCMH Leaders Group, NSW Agency for Clinical Innovation (ACI), PushMyButton Co. NZ , RACGP, Cambridge Health Alliance (Cambridge, MA, USA), Inspire Health Solutions, San Francisco, CA, USA), Institute for Healthcare Improvement (IHI) (Cambridge, MA, USA) UK, NZ, USA (refer PA4 Chronic Disease)
Indigenous Specific	No
Duration	Ongoing for the plan period
Coverage	These proposed activities will be available to all practices in the western Sydney PHN jurisdiction
Commissioning method (if relevant)	Consulting and contracted services will be sought for ongoing Business and Clinical Leadership programs pending an assessment of resources provided as part of the Health Care Home roll-out. Pending the outcomes of a recent trial, Push My Word services will potential be re-contracted for provision of patient experience tracking and reporting capability. .
Approach to market	EoI.
Decommissioning	Not relevant

Digital Health

Proposed Activities	
Activity Title / Reference (eg. NP 1)	NP 2.1 **Ongoing deployment of the Pen Clinical Audit Tool and support for implementation, training and data-driven improvement through its effective utilisation.**
Existing, Modified, or New	Modified
Program Key Priority Area	Other -System Priorities: Data Driven Improvement
Needs Assessment Priority Area (eg. 1, 2, 3)	System Priorities (page reference number 153)
Description of Activity	Contract and deploy the Pen Clinical Audit Tool to raise awareness of practice population health needs, quality and proactivity of care provision and tracking of improvements by: 1. Continuing to partner with PEN to evolve functionality including capture of data on communicable disease 2. Expanding the current number of practices using the Pen CAT, Topbar and PAT tools 3. Support practices with training on effective use of Pen CAT and Topbar 4. Support data cleansing activities 5. Deployment of a common data dashboard to provide consistency of data captured and used to inform quality improvement and reporting activities with a particular focus on the Health Care Home sites 6. Improve PEN capability to support and enhance NSW data linkage project
Target population cohort	Entire WSPHN
Consultation	WSPHN consulted with the Clinical Advisory Council and the Consumer Advisory Council for advice and guidance on the planning of health care responses in the region and on patient experiences and expectations. This consultation informed operational priorities and commissioning decisions.
Collaboration	The Pen CAT tool will continue to be utilised to identify and support risk stratification of patients eligible for the Integrated Care Demonstrator by providing access to the WSLHD Care Facilitators and WSLHD staff working on the Diabetes Management and Prevention Initiative (WSDPMI) and identifying those requiring case conferencing.
Indigenous Specific	No
Duration	These activities are anticipated to run, with some refinement, for the duration of the Plan
Coverage	Coverage will be the whole of the western Sydney PHN region.

Commissioning method (if relevant)	Potential data extraction tool provider offerings will be reviewed in timeframe that aligns with the current Pen contract renewal date to ensure appropriate consideration is given to the most efficient and cost effective solution. Active discussions and review of provider offerings are underway on an ongoing basis in the NSW PHN Data Working Group.
Approach to market	See above. There may be a combined approach to market
Decommissioning	Not relevant

Proposed Activities	
Activity Title / Reference (eg. NP 1.1)	NP 2.2 **Commission shared care plan services and expand utilisation via linkedEHR to support Health Care Home and PCMH sites, Integrated Care, HealthOne and WSDPMI patient self- management initiatives.**
Existing, Modified, New	Modified
Program Key Priority Area	Digital Health
Needs Assessment Priority Area	Digital Health – Increase effectiveness of care (page reference number 153)
Activity Title / Reference (eg. NP 1.1)	**Commission shared care plan services and expand utilisation via LinkedEHR to support Health Care Home and PCMH sites, Integrated Care, HealthOne and WSDPMI patient self- management initiatives.**
Description of Activity	• Ongoing purchase of licenses, support and development work for LinkedEHR (LEHR), an electronic shared care plan, to support effective creation, sharing and review of electronic shared care plans to support and enable the right care in the right place by the right provider. • Continue work to expand the community of users including clinical staff in WSLHD and private allied health providers • Ongoing support and training by WSPHN for all users • Support activities to expand the number of patients with a shared care plan with a particular focus on acquisition through Western Sydney Integrated Care Program and Health Care Home sites • Evolve functionality of LEHR to integrate with and support the MyHealthRecord

Target population cohort	People with chronic and complex care needs in the WSPHN and participating providers in the health system.
Consultation	WSLHD, GPs, consumers with chronic and complex conditions, Clinical Advisory Council.
Collaboration	• Partnership with WSLHD on the Integrated Care Demonstrator and utilising LinkedEHR as a key enabler of the project. • As part of the WSDPMI, collaboration with WSLHD to source and deploy and App for patient self-management will rely on LinkedEHR to populate the self-management application via smart phone or computer with personalised management content and other supporting resources delivered to patients who register.
Indigenous Specific	No
Duration	Ongoing for Planned period.
Coverage	LinkedEHR will be offered to any and all practices, allied health providers, specialists and their patients within the western Sydney PHN region funded by WSPHN.
Commissioning method (if relevant)	LinkedEHR was originally commissioned from Ocean Informatics after an extensive provider review via a formal EoI process. LinkedEHR has had an evaluation by Clinical Governance Committee of NEHTA on two occasions, and is also undergoing evaluation as part of the Integrated Care Demonstrators and an evaluation of the three differing electronic care planning tools currently being utilised at the three pilot sites. Any App for self-management will be sourced via an approach to market for potential providers.
Approach to market	EOI
Decommissioning	Not relevant.

System Integration

Proposed Activities	
Activity Title / Reference	NP 2.3 **Data Integration Pilot with NSW Health and WSLHD**
Existing, Modified, or New	Modified
Program Key Priority Area	Other- System Integration: Improve coordination of care
Needs Assessment Priority	System Priorities (page reference 153)
Description of Activity	The project, now entering its second year, will continue to explore the utility of general practice data for linkage to multiple NSW Health related data sets and will provide information that will: • Increase General Practitioners understanding of care to their patient cohort in the acute care setting • Determine patterns of General Practice patients attendance to other health service settings (acute care) utilisation which will assist in the stratification of a patients' risk of health deterioration **Goals** • To trial a method to, create a dataset linking the GP EHR to NSW hospitals, ED's and mortality data for the first time. • To explore the utility of such a dataset for informing better health policy and practice **Aims** • To investigate the care delivered to GP patients outside of the GP setting and describe this health utilisation • To investigate predictors of health deterioration and poor health outcomes in order to develop a risk stratification model for these outcomes Eventual outcomes are anticipated are dataset in which GP EHR can be linked to administrative health data of NSW Ministry of Health, and death registrations and from Registry of Births, Deaths and Marriages to better inform quality and continuity of care.
Target population cohort	150,000 thousand patients from 25 general practices in western Sydney area.
Consultation	-Ongoing updates and consultation will be organised for the participating practices. Key GP's and LHD senior staff will continue to be consulted on the intent and implementation of this project.

	-WSPHN will also continue to consult with the Clinical Advisory Council and the Consumer Advisory Council for guidance on how this capability and emerging insights can be best harnessed to improved patient care.
Collaboration	This work is a collaboration between NSW Health, WSLHD, and WSPHN making an in-kind contribution in terms of supporting headcount for analysis and implementation from WSPHN.
Indigenous Specific	No
Duration	Tranche 1 completed by March 2017, Tranche 2 completed by December 2017
Coverage	25 practices across western Sydney and a target of 150,000 patient files
Commissioning method (if relevant)	Services of PEN Computing contracted by NSW Health for data extraction needs from practice CMS
Approach to market	EOI
Decommissioning	NSW Health will decommissioning aspects of this work undertaken by PEN Computing at the completion of the project

Health Care Home Development

Proposed Activities	
Activity Title / Reference (eg. NP 1)	NP 3.1 **Enable, support and implement new models of care to drive achievements of the Quadruple Aim. This will influence improvement in health outcomes, cost reduction in service delivery, reduced/avoidable hospitalisation, equity of access & improved health outcomes, improved teamwork, leadership and quality improvement culture.**
Existing, Modified, or New	**Modified**
Program Key Priority Area	Other: System Priorities: Increase efficiency and quality of care
Needs Assessment Priority Area (eg. 1, 2, 3)	System Priorities (page reference number 154)
Description of Activity	Support and enable those General Practices and Aboriginal Community Controlled Health Services (ACCHS) selected into the Health Care Home trials to improve their current practice to provide enhanced access to holistic coordinated care and

	wrap around support for multiple health needs. This activity will include support for practices to undertake a transformation based on the 10 Building Blocks of High Performing Care outlined by Bodenheimer et al. The PHN role in the HCH trials is still being developed. We anticipate the role of PHNs will include the following: 1. Successfully 'on board' practices selected as HCHs in western Sydney 2. Develop an implementation plan for successful evolution of participating practices. 3. Recruit and allocate staff with the required skill set to support the HCH requirements 4. Equip and train all participating practices to capitalise on key system enablers such as Linked EHR electronic shared care planning, Pen Clinical Audit Tools and HealthPathways. 5. In alignment with the training modules currently under development, provide a structured program of practice support visits and PDSA cycles to support the required practice evolution. 6. Develop and deploy a CPD program, aligned to the 11 HCH training modules to deliver workshops and training activities with a focus on tailored programs for HCH staff including practice managers and practice nurses as well as GPs. 7. Ensure appropriate data capture and timely completion of any reporting required by the DoH as part of the HCH trial. 8. Ensure enrolment of HCH practices into Integrated Care and the WSDPMI case conferencing activities to fully capitalise on current resources in western Sydney.
Target population cohort	GP's and enrolled patients of selected HCH sites
Consultation	Other participating PHN's, WSLHD, Clinical Advisory Council and relevant GP's.
Collaboration	This work will be undertaken in collaboration with AGPAL as the contracted developer on the training modules and planned Train the Trainer activities. Practices will be encouraged to enrol in the Integrated Care Program and will therefore be able to draw upon the benefits of WSPHN's collaboration with the Western Sydney Local Health District.

	WSPHN has also developed an extensive network of international collaborators and experts in the UK, USA and New Zealand to inform this work.
Indigenous Specific	No
Duration	Two year period (2016-2018)
Coverage	It is anticipated applicants that are successful for the Stage One rollout will be announced in March 2017. There will be a likely cohort of 20-25 Aboriginal Community Controlled Health Services (ACCHS) and General Practices in 2017-18 as well as support for practices currently progressing their transformation to Patient-Centred Medical Homes which may be captured in the HCH cohort.
Commissioning method (if relevant)	Grants will be made available to practices via a formal Expression of Interest to provide support for their work and for the model implementation. The nature of these will be determined once a full understanding of available resources and support is clarified.
Approach to market	EOI implemented by the DoH with appropriate WSPHN input for interested practices
Decommissioning	Not relevant

Workforce Capacity- Chronic and Complex Care Development

Proposed Activities	
Activity Title / Reference	NP 4.1 **Enhanced prevention and management of chronic disease in primary care**
Existing, Modified, or New Activity	A range of programs and initiatives are planned in relation to this activity these being:- • Prevention of Diabetes in Samoan Population – Existing Activity • Western Sydney Diabetes Prevention & Management Initiative (WSDPMI) – Existing Activity • Diabetes Detection and Management Strategy (DDMS) - *New Activity*

	• • Giving Asthma Support to Patients (GASP) - Existing Activity • Peer Facilitator Workforce Chronic Disease – Existing Activity • Primary Nurse Education Curriculum – Existing Activity • DaPPHne – *New* Activity • Non-dispensing Pharmacist in General Practice – Existing Activity
Program Key Priority Area	Other - Chronic Disease
Needs Assessment Priority	Chronic Disease (page reference 151)
Description of Activity	W **Prevention of Diabetes in Samoan Population** Samoan people experience higher rates of type 2 diabetes, obesity, hypertension and cardiovascular disease (CVD) and mainstream approaches to diabetes prevention are not impacting sufficiently on the Samoan community. Data analysed from a GP system in South Western Sydney identified that: • 95% were overweight or obese, • 15-20% already had diabetes and many had end stage complications requiring e.g. dialysis. To address this, WSPHN is partnering with Western Sydney University to conduct a study to collect and evaluate baseline GP data for Samoan people with diabetes or its risk factors in south west Sydney (SWS), western Sydney (WS) and Nepean Blue Mountains (NBM), with a view to extending the diabetes management support program to these areas in a future randomised clinical trial. **Western Sydney Diabetes Prevention & Management Initiative (WSDPMI)** Western Sydney is a diabetes hotspot with an average diabetes prevalence of 5.9% compared to the national average of 5.1%. The WSDPMI is a formal partnership between WSPHN and WSLHD with the aim of implementing region wide diabetes prevention and management initiative. This uniquely integrates primary and acute care to address the needs of western Sydney. This initiative encompasses a number of projects including:

	• *Diabetes Case Conferencing:* offers general practices access to an endocrinologist and diabetes educator who conduct case conferences with GPs and any other health professional involved in the care of patients (e.g. primary care nurse/ allied health professionals)to discuss the management of complex diabetes patients. This is to empower primary care practitioners to better manage diabetes patients in the practice. • *HbA1C testing in ED:* through this initiative, all patients who are admitted to ED get their HbA1C checked as part of the blood tests the hospital conducts. Due to the significant results of the initial pilot, this project will rolled out more broadly. • *Diabetes Detection and Management Strategy* (DDMS): An extension of the HbA1C testing in ED activity above. In partnership with WSLHD and WSDPMI has recruited a Support Nurse (commencing 30th Jan 2017) whose primary role is to directly contact patients identified at the Hospital with an elevated HbA1C and ensure follow up with their GP, as well as contacting General Practices to facilitate follow up of those patients. • *Save A Leg:* Continued promotion and implementation of the 60 Second Foot Check developed in 2015 as a resource supporting the Diabetes Cycle of Care (available on Western Sydney Health Pathways). • *Community Eye Care:* The Western Sydney Diabetes Eye Screening Project is developing a standardised referral and reporting system and processes to enhance communication between GPs and optometrists. • Work is also planned to identify and deploy a patient self-management and monitoring App. • All initiatives within the WSDPMI will be incorporated into HealthPathways to ensure accuracy and consistency of the pathways. . **Giving Asthma Support to Patients - GASP** Asthma is a growing issue across Australia, in particular in western Sydney due to the demographics of the region. The rate of asthma among Indigenous Australians is almost twice as high as that of non-Indigenous counterparts. Additionally,

	asthma is more common in people living in socioeconomically disadvantaged areas. In addition to the high hospitalization rates, western Sydney's death rate due to asthma is higher than the NSW average. GASP is a best practice asthma management program, using web based clinical assessment and decision support technology designed for the improved management of asthma. Complementing evidence-based accredited training, the GASP tool uses a sophisticated set of rules and logic, handling various combinations of lung function, asthma control and risk assessment to develop individualised patient asthma care plans. GASP was developed in the UK and has been implemented with significant results and improvements in asthma management across New Zealand. The WSPHN, in partnership with Asthma Foundation Queensland and NSW, have tailored the GASP program to Australian standards and have launched the program in the western Sydney region. The aim of this pilot is to evaluate the impact GASP will have on asthma management in the Australian setting. This includes a research and evaluation component with the University of NSW. In total 27 nurses have been trained as accredited GASP nurses. Their role will be to deliver GASP sessions to eligible patients with a target of 300 patients enrolled into the pilot. Work will continue in the Plan period to foster increased usage in currently established practices and to support identification and recruitment of additional practices. **Peer Facilitator Workforce Chronic Disease** Recent research has highlighted the potential value in utilising peer facilitators in the management of patients with chronic disease. WSPHN will continue to explore the use of peer facilitators to work in general practices with chronic disease patients. The role of the peer facilitators will not be clinical management of the patients but rather empowering patients to self-manage their conditions. The facilitators will undergo chronic disease self-management training to become accredited facilitators. WSPHN will work with Health Change Australia or other provider to tailor a training program suitable for peer workers in this setting, with the aim of creating of a volunteer Peer Facilitator Workforce in partnership with interested practices. **Nurse Education Curriculum** Western Sydney has a primary care nurse workforce which is relatively new to this area of nursing, with 46% of nurses working as primary care nurses for 2 years or less.

	WSPHN continue to develop and deliver a comprehensive primary care nurse education curriculum focused on the management of chronic disease in the primary care setting. The aim of these sessions will be to increase primary care nurse confidence and capability to become more involved in the management of chronic disease patients. This curriculum will be aligned and modified to support participating Health Care Home site Practice Nurses once training resources are available. A series of sessions will be run for each chronic disease covering topics such as: • Incidence of the disease in western Sydney, • Disease pathophysiology, • Medicare billing items, • Available medications, their use and potential side effects, • The role of the nurse in the management of the disease, • Early identification of complications and • Available services and support throughout western Sydney The chronic diseases which will be addressed through the education curriculum include diabetes, COPD and heart failure. Additionally, enablers such as HealthPathways will be discussed to ensure that nurses are familiar with and aware of the pathways available. A key component of the Health Care Home is team based care and utilising the expertise of all health professionals to enhance patient care. The aim of the nurse education curriculum is to enhance primary care nurse confidence and capability to be involved in the management of chronic disease patients. By doing so, WSPHN is assisting primary care nurses to be ready to take part of the Health Care Home model. **DaPPHne** The DaPPHne project (Diagnosing Potentially Preventable Hospitalisations) aims to determine what proportion of hospital admissions for COPD, CHF, diabetes and angina are *actually* preventable, and to better understand the needs of these patients and gaps in current services. As the factors contributing to these admissions are currently not well understood, our ability to develop and target appropriate interventions is limited. The DaPPHne study is being undertaken by the University Centre for Rural Health (University of Sydney) at Blacktown Hospital (in collaboration with and funded by WSLHD and the NSW Agency for Clinical Innovation).

	Assessments of patients will be conducted by an expert panel, appointed through the University of Sydney. Assessments will be completed by early 2018
Target population cohort	WSPHN whole of region
Consultation	Selected GP's, WSLHD, Western Sydney University, Agency for Clinical Innovation
Collaboration	WSLHD, WSDPMI, Western Sydney University, Asthma Foundation, NBMPHN, SWPHN, Health Change Australia, NSW Agency for Clinical Innovation
Indigenous Specific	No
Duration	Case Conferencing- ongoing GASP – ongoing
Coverage	WSPHN whole of region
Commissioning method (if relevant)	The key commissioned service will be provision of peer facilitator workforce training and this will go out via EoI.
Approach to market	EoI to suitable qualified providers
Decommissioning	Not relevant
Funding from other sources	

HealthPathways

Proposed Activities	
Activity Title / Reference	NP 5.1 **Care Pathways (HealthPathways) to improve care between primary, secondary & tertiary care.**
Existing, Modified, or New Activity	Existing
Program Key Priority Area	Other : Care Pathways
Needs Assessment Priority	**PA 9.4.1** (Page reference 156)
Description of Activity	HealthPathways is web based health informational portal for General Practitioners and other health care providers to utilise during a consultation to assist with assessment, management and appropriate referrals to local specialists and services. It also provides patient information, reference materials, and education resources to increase the capacity for patients to actively assist in the management of their own health The WSPHN have an established HealthPathways program, in partnership with Western Sydney Local Health District and the Sydney Children's Hospital Network. This activity will continue to develop and update new and existing localised care pathways, providing: • Evidence based, best practice management and treatment options for common medical conditions; agreed on by clinicians from primary, secondary and tertiary care. • Local Information on how to refer to appropriate local services and specialists • Educational resources and information to improve self-efficacy and health literacy WSPHN will continue to : • Promote integration and collaboration between WSPHN, WSLHD, SCHN, Specialty, General and Allied Health Practices in both the public health and private health domains to improve the quality and efficacy of the patient experience. • Advocate and ensure the effective embedding of WS HealthPathways with other relevant identified programmes to add value and synergy to health service improvements across the Western Sydney district. • Identify areas of service failure and need for redesign to address in partnership with WSLHD, SCHN, Primary care providers and other relevant organisations Development and subsequent usage of care pathways will aim to:

	• Avoid unnecessary hospital admissions and more effectively manage chronic and more complex care in a community setting • Increase access to current referral clinic information; • Increase referral acknowledgement; • Standardize referral processes
Target population cohort	Local healthcare providers, specifically those working in Primary Care and their patients
Consultation	• Western Sydney HealthPathways Steering Committee • Western Sydney HealthPathways Paediatric Advisory Group • Clinical Stream Planning Meeting members • WSPHN Clinical Council • Pathway Development Working Group Meeting members • HealthPathways Educational Events participants • Broad range of specialist and generalist health providers who request the development of specific Pathways.
Collaboration	• Western Sydney Local Health District for strategic Governance and Coordination of hospital clinicians and services participation • Sydney Children's Hospital Network for strategic governance and coordination of hospital clinicians and services participation • HealthPathways Community – Sharing of pathways • Local Primary Healthcare Providers – Participation in working groups and pathway reviews • Local community health groups – Consultation and participation in working groups • Streamliners New Zealand – Website administration and Technical Writing
Indigenous Specific	No
Duration	Two year period (2016-2018)
Coverage	Entire WSPHN region
Commissioning method (if relevant)	Not relevant
Approach to market	Direct Engagement - Streamliners New Zealand are the sole provider of the HealthPathways platform
Decommissioning	Not relevant

Healthy Western Sydney

Proposed Activities	
Activity Title / Reference	NP 6.1 **Improve consumer health literacy, and access to reputable, evidence-based, quality health information and resources.**
Existing, Modified, or New	**Modified**
Program Key Priority Area	Population Health/HealthPathways
Needs Assessment Priority Area	Care Pathways (page reference 156)
Description of Activity	Healthy Western Sydney is an open access, publically available website for consumers and the community, which enables access to a curated compilation of appropriate, reputable, evidence-based, quality health resources, phone support lines, service information, health professional directories, and links. Information is available on a wide variety of health conditions and preventative care topics, with further information on additional conditions and clinical topics continually being added. The primary aim of the Healthy Western Sydney website is to improve access to appropriate and reliable patient health information, resources, and local health services to the population of western Sydney. The health professionals who contribute to the HealthPathways Program, including GP Clinical Editors, specialists, GPs, nurses, allied health professionals, health service managers, and the HealthPathways Program Team, compile and curate the resources and links which are published on the Healthy Western Sydney website, ensuring that those selected are evidence-based, appropriate, quality resources, which are safe, tailored, and useful for consumers and the community. New Activity *Healthy Western Sydney TV* is a new initiative aimed at improving access to CALD appropriate health information through the Healthy Western Sydney portal. A tender provider will be sought, to compile, curate, and promote evidence based CALD specific online health resources that will be made accessible through the Healthy Western Sydney portal. The database will consist of multimedia content sourced from peak health organisations in a variety of languages aimed at improving the health literacy of Western Sydney's culturally diverse community.

Target population cohort	Population of Western Sydney
Consultation	• Health consumers from diverse backgrounds • HealthPathways Working Group members
Collaboration	• WSPHN • WSLHD • SCHN • Health Direct (National Health Services Directory) • General Practices • Health consumers from diverse backgrounds • Agencies with an advocacy or educational brief who are recognised as providing evidence-based, appropriate materials.
Indigenous Specific	No
Duration	2 year period (2016-2018)
Coverage	Entire Western Sydney PHN Region
Commissioning method (if relevant)	Open Tender
Approach to market	Not relevant
Decommissioning	Not relevant

Aged Care

Proposed Activities	
Activity Title / Reference	NP 7.1 **Older Person's Health**
Existing, Modified, or New	Modified
Program Key Priority Area	Aged Care

Needs Assessment Priority Area	PA 8 - Strategies to enhance healthy ageing (Page reference 153) Work in partnership with the LHD and relevant stakeholders to identify strategies to reduce unnecessary hospitalisation admission by identifying and implementing integrated models of care
Description of Activity	The WSPHN will continue to commission services to improve access to falls risk reduction programs and provide an integrated model of care for residents in Residential Aged Care Facilities which can better address non-life threatening conditions/events. The PHN will also participate in relevant working groups with WSLHD and other partners to identify gaps, map services and jointly introduce opportunities to improve models of care for older people in the areas of falls prevention, dementia, End of Life decision making and palliative care. –The PHN will co-convene a Residential Aged Care Network with the LHD, bringing together RACFs in the region and relevant stakeholders to build capacity and identify opportunities to improve care for residents in nursing homes who are significant users of ambulance and hospital services. –The PHN will also participate in the PHN Aged Care Network with other Sydney Metro PHNs to build capacity and advocate for the role of PHNs in Aged Care. Capacity building and support will be provided for health professionals and service providers in the implementation of aged care reforms, in particular with the transition to My Aged Care. Promote access to health services and preventative health programs, and provide information to consumers through our own channels and in partnership with other organisations. A focus on diverse groups, including the older CALD group will be maintained. Ensure access to information for health professionals and service providers to provide education and resources, build capacity and confidence of GPs and practice nurses to refer to palliative care services and promote Advanced Care Planning. Facilitate and identify new opportunities for integrated care of older people by adapting The models of care of the Western Sydney Integrated Care Program (WSICP) to ensure integrated and person centred care for older people with complex care needs including dementia

	Drive the establishment of a multi-sector governance mechanism to provide leadership and facilitate collaboration in the aged health sector WSPHN will work closely with the WSLHD and other stakeholders to maximise timely referrals to specialist palliative care services, existing and new programs, advance care planning and crisis planning with GPs. Dementia: The WSPHN will participate in interagency steering and implementation groups, assist with the development of the Western Sydney Dementia Action Plan, upskill health professionals on dementia diagnosis and management, and identify strategies to facilitate referrals to specialist aged care health services
Target population cohort	People aged 65 + and ATSI aged 45+
Consultation	WSLHD – Western Sydney Dementia Strategy Implementation group, Healthy Older People Partnership, Geriatric outreach services, community health centre Chronic and Aged Care aged team, Aged Care Assessment Team, Blacktown Council Residential Aged Care Facility (RACF) managers NSW Ambulance WSLHD - End of Life committee members
Collaboration	WSLHD -RACF Geriatric Outreach services – assistance with the development of tenders, selection panel members , co-chairing of RACF network with WSPHN Western Sydney Dementia Strategy Implementation group (WSDSIG) – advisory on dementia issues in primary care , tender selection panel members, invited speakers at GP events Healthy Older People Partnership – development of tender specifications and selection of tender proposals, engagement with consumers and health professional of health promotion and falls prevention activities to increase uptake strength and balance exercise opportunities. Ambulance NSW – advisory role
Indigenous Specific	No
Duration	2 year period (2016-2018) commencing July 2016

Coverage	Entire Western Sydney PHN Region
Commissioning method (if relevant)	For the 2016-17 funding period, WSPHN will commission services to address - falls risk factors - integrated care for residents in Residential Aged Care Facilities Initiatives will commence in March 2017
Approach to market	Open tender
Decommissioning	Not relevant

Child and Family – SALSA / HealthOne / Thrive@5

Proposed Activities	
Activity Title / Reference	NP 8.1 **Improved health of children and their families.**
Existing, Modified, or New	Modified
Program Key Priority Area	Population health (child and family)
Needs Assessment Priority Area	Child and Family (page reference 150)
Description of Activity	The WSPHN will continue to support programs and initiatives which aim to address and improve health factors such as chronic disease, transitional care, as well as medical and psychosocial factors, and supporting the capacity of primary secondary and tertiary health care providers through the HealthOne program. The SALSA program and the SCOOP initiative address issues of overweight, obesity, healthy exercise and healthy lifestyle through the SALSA and SCOOP initiatives.

	The WSPHN collaborate with the Chief Executives of the Sydney Children's Hospital Network, Westmead (SCHN), the Western Sydney Local Health District and the Sydney West Aboriginal Health Service and other organisations to develop, implement and evaluate a Child and Family Health Strategic Plan for western Sydney 2016-2018.
Target population cohort	Children and young people families within the WSPHN catchment area
Consultation	WSPHN has consulted with the SCHN Western Sydney Local Health District (WSLHD), local GPs, local schools and sports clubs and the Primary Health Care Education and Research Unit, University of Sydney and young people and families. WSPHN consulted extensively with the Clinical Advisory Council and the Consumer Advisory Council which provided advice on the planning of health care in the region and on patient experiences and expectations. This consultation informed commissioning decisions.
Collaboration	WSLHD, SCHN, local GPs for HealthOne. WSLHD, SCHN, Primary Health Care Education and Research Unit (PERU), local sporting clubs for SALSA
Indigenous Specific	No
Duration	Two year period (2016-2018)
Coverage	Entire WSPHN region.
Commissioning method (if relevant)	SALSA is 100% commissioned. HealthOne is a partnership activity, funded by the LHD and supported by WSPHN. SCOOP is a partnership activity, funded by the LHD and supported by WSPHN.
Approach to market	Services for HealthOne already operating and funded by the LHD. SALSA is by direct contribution to the LHD.
Decommissioning	Not relevant.

Proposed Activities	
Activity Title / Reference	NP 8.2 **Thrive@5 project**
Existing, Modified, or New	**Modified**

Program Key Priority Area	Other (Child and Family)
Needs Assessment Priority	Child and Family (page reference 150)
Description of Activity	Thrive@5's goal is to address the health needs of children aged 0-5 and their families and respond to the social and health-related precursors to poor health and/or developmental delay. The initiative builds on partnerships between families, community leaders, primary health care providers, government agencies and non-government organisations. Participating agencies will agree on shared KPIs, support partners in implementing and evaluating soft entry points to improve engagement with primary health providers for improved screening and any required responses, with a focus on vulnerable families facing adversity. There will be a focus on trauma informed care including continuing *professional development* to build the capacity of service providers to respond to the social, emotional and mental health needs of children aged 0-5 years and their families. Trauma support groups will be provided to vulnerable sub-populations in partnership with Cara House (Centre for Resilience and Recovery). Should evaluation of the first cycle of the group be positive, a second cycle will be commissioned and a comprehensive research plan with a University partner will be submitted. Developmental surveillance will occur through implementation of the Tiny Tots Soccer/Baby Rhyme Time initiative in terms 2 and 3 each year. The aim is to identify children that are not meeting developmental milestones, ensure intervention occurs where required and promote activities that improve developmental progress to the child's family and care givers. An Allied Health Partnership Initiative, funded partly by the 16/18 PHN Innovation Grant, will build provide greater access to screening for gross and fine motor skills and speech and communication delays, provide responses and build the capacity of centres children attend in a place-based, capacity-building manner in Doonside to better provide an environment that stimulates language development. The partnership will involve the appointment of a speech pathologist to respond to the overwhelming need identified through implementation of the Thrive@5 initiative. The speech therapist will be commissioned to a partner provider, Relationships Australia, who have been working with the community as part of Thrive@5 since its inception. THE WSLHD will provide clinical support and resourcing from the LHD Allied Health Clinical Lead.

Target population cohort	Children and families within the Doonside area of the WSPHN region
Consultation	Extensive and ongoing consultation with Doonside community members and all participating agencies, community health, paediatricians and University of Sydney staff.
Collaboration	Early Childhood Education Centres and kindergartens participate in planning and delivery and introduce children to the Thrive@5 program and improve identification of children with developmental delays Child development service providers and Relationships Australia coordinate Mini Tots soccer and Baby Rhyme Time, which function as soft entry points for assessments and referrals. LHD HealthOne nurses provides referral and liaison for children requiring developmental assessments Cara House (Centre for Resilience and Recovery) run the trauma support groups to vulnerable sub populations. Blacktown Council and Wesley Mission provide the *Paint Doonside REaD* initiative, contributing to building an environment in Doonside that better stimulates early language development and provides an excellent, discrete neighbourhood from which the research and evidence-base on interventions such as these can be greatly enriched. Murdoch Children's Research Institute to participate in evaluation.
Indigenous Specific	No, except for the trauma-informed support groups
Duration	Two year period (2016-2018) with quarterly steering committees overseeing implementation and evaluation
Coverage	Doonside area (Blacktown LGA)
Commissioning method (if relevant)	Activities in Thrive@5 are commissioned to Relationships Australia, a foundation member of the Thrive@5 initiative and Cara House for their specialised trauma support work. Governance and management of Thrive@5 is resourced through a partnership activity, jointly funded by the LHD and WSPHN, hosting agencies that will provide the best value for money in this foundational period.
Approach to market	Not relevant
Decommissioning	Not relevant

Proposed Activities	
Activity Title / Reference	NP 8.3 **Allied Health Partnership initiative**
Existing, Modified, or New	New Activity (Innovation Funding) and roll-over funding from previous year
Program Key Priority Area	Other (Child and Family)
Needs Assessment Priority	Child and Family (page reference 150)
Description of Activity	Allied Health Partnership Initiative – Please refer to NP 8.2 Thrive@5 project
Duration	Two year period (2016-2018) commencing January 2017

Proposed Activities	
Activity Title / Reference (eg. NP 1)	NP 8.4: **Increase the capacity for both private and public providers to respond to the mental health needs of children, young people and their families or carers.**
Existing, Modified, or New	Modified
Program Key Priority Area	Mental Health
Needs Assessment Priority Area (eg. 1, 2, 3)	Children and Families: Strategies to address social, emotional, developmental and spiritual wellbeing of children and their families (page 150)
Description of Activity	The WSPHN are a participating partner in the Western Sydney interagency initiative of the Child and Youth Mental Health Co Design team. Other key agencies including Education, Police, the WSLHD, the SCHN and FaCS. These agencies are working collaboratively to assist with common goal of assisting children, young people and their families to better navigate the system, regardless of where they first present, and ensure they receive better care. Initiatives in this activity will include an educational, capacity-building approach across primary, secondary and tertiary health providers, together with those from sectors that can influence help-seeking behaviour of families and their children, including services that cater for children 0-5, schools, community services and relevant NGOs. Investment in activities that augment services to children and young people and their families deemed most in need will also be explored.
Target population cohort	Children and young people with mental health issues, their families and/or carers, and the service providers with responsibility for assisting them.
Consultation	Extensive consultation has occurred with over 43 services relevant to this target population in the WSPHN region. A rigorous process was undertaken and documented, which included a specific focus on early involvement of young people and their families during the early stages.
Collaboration	WSLHD, SCHN, Community Services, local GPs, local mental health services and other relevant NGOs – development of the project options, design of tender specifications for chosen projects and members of steering groups overseeing implementation.
Indigenous Specific	No

Duration	Planning for the activity began late in the 15/16 FY, planning is currently underway, education and capacity-building activities have been occurring since the beginning of this Activity Plan period and it is anticipated that service delivery will commence early in the 17/18FY.
Coverage	Entire PHN region.
Commissioning method (if relevant)	This activity will be wholly commissioned.
Approach to market	Activities will be procured through a blend of direct engagement and EOI.
Decommissioning	N/A.

Population Health Community Projects

Proposed Activities	
Activity Title / Reference (eg. NP 1)	NP 9.1 **Improve Antenatal care coverage and health outcomes.**
Existing, Modified, or New	Existing
Program Key Priority Area	Population Health: Antenatal Care
Needs Assessment Priority Area (eg. 1, 2, 3)	Children and Family (page reference number 150)
Description of Activity	WSPHN will continue to support the Antenatal shared care approach to care within western Sydney. Maternity, antenatal and gynaecological care pathways will be developed and reviewed

	Professional development: WSPHN will support educational opportunities for GPs across Western Sydney to participate in the *Antenatal Shared Care Program.* ANSC is the division of care of pregnant women between the general practitioner and the hospital antenatal clinic. Antenatal Shared Care (ANSC) is an option for pregnant women with no adverse maternal or foetal pregnancy risk factors. If a pregnant woman becomes infected with some diseases, her unborn baby can be harmed. Newborn children can also be harmed if their mothers have an infection. The WSPHN will therefore support General Practice in the health promotion of immunisation and pregnancy including influenza and whooping cough vaccines.
Target population cohort	244 GPs in WSPHN Region
Consultation	Registration
Collaboration	1. WSPHN 2. WSLHD 3. SCHN 4. Primary Care
Indigenous Specific	No
Duration	Two year period (2016-2018)
Coverage	Pregnant women receiving services from registered General Practice
Commissioning method (if relevant)	Direct approach by the registered GPs.
Approach to market	Direct approach by the registered GPs.
Decommissioning	Not relevant

Proposed Activities	
Activity Title / Reference	NP 9.2 **Address the low rates of Cervical, Breast and Bowel Cancer Screening**
Existing, Modified, or New	Modified activity
Program Key Priority Area	Population Health
Needs Assessment Priority	PA. 3. Strategies to improve screening rates for breast, cervical & bowel cancer (page reference number 151).
Description of Activity	One of the four national health priorities determined by the Australian government is to increase cancer screening rates. Cancer screening is proven to reduce mortality and morbidity attributable to cancer. High participation in cancer screening programs is needed to reap the greatest benefits in terms of reducing illness and death from these cancers. The WSPHN population has one of the lowest cancer screening rates in the State. The WSPHNs role is to work closely with clinicians and communities to improve the access to, and coordination of health services to support better health outcomes. WSPHN will continue to work with the Cancer Institute NSW of the NSW Cervical Screening – Never Screeners Invitation Project to increase participation. Work will also continue on the implementation of the new NSW Primary Care Strategy to increase participation in breast, bowel and cervical screening programs, with specific emphasis on priority populations. WSPHN will continue to work with BreastScreen NSW Sydney West, the Australian Cervical Screening Foundation and local communities to develop and implement localised prevention strategies and raise awareness around the importance of cancer screening, targeting low screening postcodes within the region. This involves co-designed community level interventions. WSPHN will continue to partner with the Local Health District and integrated cancer treatment centres to deliver RACGP approved educational events to GP's to update them on current cancer screening and management and treatment of cancer.

	WSPHN will prepare for upcoming changes to Cervical Screening, which will commence 1 May 2017. This includes provision of support and information for health providers and the general public. In addition to this, the PHN will partner with Family Planning NSW to deliver training to Practice Nurses within the WSPHN region in cervical cancer screening.
Target population cohort	Entire WSPHN region in particular, Cervical Screening: Women aged 20-69 years, Breast Screening: Women aged 50-74 years, Bowel Screening: Men and Women aged over 50 years.
Consultation	• Local Primary Health Care providers to introduce cancer screening programs • Western Sydney Local Health District • BreastScreen NSW Sydney West planning meetings to discuss strategies • Health Pathways development working group meetings • Consumer Advisory group meetings • University of Western Sydney • Agency for Clinical Innovation (ACI) • PHN Cancer Screening Network
Collaboration	• WSPHN: Education provider for general practitioners, health promotion provider, HealthPathways development • Cancer Institute NSW: initiative partner, policy development • Australian Cervical Cancer Foundation: Pap Text registration • Local Government: Strategic direction, policy development and advocacy. • Non-government organisations: Pathway to community engagement. • General Practitioners: Provide screening, referrals and health education. • Communities: Partners in consumer engagement • Women's Groups • Family Planning NSW • PHN Cancer Screening Network to discuss partnering on joint cancer screening strategies • Bowel Cancer Australia: Service delivery • Referrals and health education • Communities • Consumer Advisory Groups consultation • BreastScreen NSW Sydney West: Service delivery • WSLHD Strategic direction, policy development and advocacy
Indigenous Specific	No

Duration	Two year period (2016-2018) commencing January 2016, with review of strategies at 12 months.
Coverage	Entire WSPHN region
Commissioning method (if relevant)	Partner with local screening facilities. Clinical GP Leads to provide education and peer support
Approach to market	Not relevant
Decommissioning	Not relevant

Proposed Activities	
Activity Title / Reference	NP 9.3 Hepatitis B
Existing, Modified, or New	**Modified**
Program Key Priority Area	Population Health
Needs Assessment Priority Area	PA3 - Strategies to address the high prevalence of Hepatitis B (page reference 151) This includes building capacity of the workforce, improving health literacy of priority at-risk populations and reorientating health services
Description of Activity	Aligning with NSW Hepatitis B Strategy 2014-2020, WSPHN will collaborate with the WSLHD and other peak bodies to develop local strategies to identify and work with vulnerable groups within western Sydney to reduce Hepatitis B infections and improve the health outcomes of people living with hepatitis. **Activities to be undertaken will include**: • Commissioning the Multicultural HIV Aids and Hepatitis C Service (MHAHS) and Hepatitis NSW to provide community educational sessions in partnership with local community groups

	• Developing culturally appropriate health promotion messages and resources for targeted communities, in particular the Asian community where prevalence is high • Promote the Clinical Audit for Viral Hepatitis (CAViH) Project – to implement engagement strategies with Western Sydney GPs and practices supporting the correct use of hepatitis B indicators on their Clinical Management Software, enabling GPs to use data to drive improvements in screening, management and follow up on at risk patients. • Explore extension of the CAViH project to extend to other, often co-occurring, infectious diseases such as Hepatitis C and Sexually Transmitted Infections • Increase number of GP practices engaged with the WSLHD Hotter West program to access support by the Clinical Nurse Consultant • Provide a series of professional education/training sessions to GPs and their practice support staff to improve awareness and management. Provide local training opportunities to increase the number of GP community prescribers for Hepatitis treatment in Western Sydney • Promote the use of Hepatitis B care pathways (HealthPathways) to medical professionals
Target population cohort	Populations at risk of Hepatitis B including People from at risk, culturally and linguistically diverse backgrounds, priority language groups being Chinese, Arabic, Vietnamese and Korean speaking groups and Aboriginal Torres Strait Islanders
Consultation	Along with compelling data indicating need, feedback has been received from consumers and health professionals in Western Sydney about the need to improve in this area. Western Sydney Local Health District - Storr Liver Clinic / Hotter West Program / Jade Fan Working Group/Centre for Population Health Australasian Society for HIV Medicines (ASHM) Further consultation will be undertaken with medical professional bodies who work with Asian communities' e.g. Australian Vietnamese Health Professionals Association NSW
Collaboration	1. GP Education – ASHM to provide education to local GPs and practice nurses, including advanced prescriber training 2. The Clinical Audit for Viral Hepatitis (CAViH) Project – South Western Sydney SPHN/CESPHN, WLSHD, Sydney and Sydney East Local Health District and other possible partners in the NSW/ACT network 3. Community education and mobilisation - Western Sydney Local Health District – Centre for Population Health, HIV & other related disease Program, Multicultural Health, Jade Fan Working group, Multicultural HIV Aids and Hepatitis C Service (MHAHS) and Hepatitis NSW, Sydwest, MECCA , Auburn Diversity.
Indigenous Specific	No

Duration	One year period (2017-18) commencing July 2017
Coverage	Entire Western Sydney PHN region
Commissioning method (if relevant)	Not relevant
Approach to market	Direct engagement with Hepatitis NSW , Multicultural HIV Aids and Hepatitis C Service (MHAHS) ,PEN CS software developer
Decommissioning	Not relevant

Proposed Activities	
Activity Title / Reference	NP 9.4 **Improve immunisation coverage in 1, 2 years age group.**
Existing, Modified, or New	Existing
Program Key Priority Area	Population Health
Needs Assessment Priority Area	Population Health PA 2.2.3 (page reference number 151)
Description of Activity	The WSPHN is working in partnership with the Public Health Unit on the project for 'Improving childhood immunisation in western Sydney through overdue children follow-up'. The project entails identifying children five years and under within the boundaries of the WSPHN and WSLHD, who are overdue for vaccination and follow up through immunisation providers, or by contracting their parents with the aim of bringing them up-to-date with immunisation. The project will also support general practices in planning, providing and reporting catch-up immunisations for overdue children (especially those born overseas) and help practices who have large numbers of overdue children to clear their backlog. This project will indirectly assist parents to access payments for CCB, CCR and FTB Part A end of year supplement. Approaches involve:

	Step 1 • Import 2,509 overdue immunisation data from Australian Childhood Immunisation Register (ACIR). • Communicate with general practices the database that includes overdue status of individual children of the practice. • Train identified staff of general practices on database use. **Step 2** • Agree on the number of practices that will be targeted within the identified LGAs per download. • Establish communication with the targeted providers, explain the aims of the project, provide details of the overdue immunisations and offer support. • Establish reminder systems for parents of children with overdue immunisations. • Resolve data cleansing and uploading issues. • Provide training to general practice staff on reporting history of overseas vaccination to ACIR. Assist general practices with clearing the back-log of the overdue children by organising 'Immunisation Catch-up Workshop' for GPs and general practice staff.
Target population cohort	2509 overdue children of western Sydney region
Consultation	Parents of the overdue children, respective GPs
Collaboration	• WSPHN: To establish reminder systems for parents of children with overdue immunisations, assist with ACIR reporting, resolve data transmission issues, provide training on data cleansing and reporting histories of overseas vaccinations to ACIR, assist with cleansing the back-log of the overdue. • WSLHD Centre for Population Health: Will download ACIR overdue children report once every 2 months initially and identify high priority providers and practices in Auburn and Parramatta LGAs. • WSLHD Epidemiology Department: To design, develop and test a dataset to import overdue immunisation data from ACIR; design, generate and test letters for general practices from the database that includes overdue status of individual children of the practice. • Selected General Practices as per identified high rate overdue data • Parents and Carers
Indigenous Specific	No
Duration	2017-2018
Coverage	Auburn and Parramatta LGA in initial phase. Entire PHN region in year two.

Commissioning method (if relevant)	Not relevant
Approach to market	Direct engagement
Decommissioning	Not relevant

Proposed Activities	
Activity Title / Reference	NP 9.5 **Maintain and ensure adequately skilled immunisation workforce and provider's confidence in participating in the National Immunisation Program through effective communication strategies, capacity building and resource allocation.**
Existing, Modified, or New	Modified
Program Key Priority Area	Population Health
Needs Assessment Priority Area	Population Health PA 2.2.5 (page reference number 151)
Description of Activity	The WSPHN will;- • Organise periodic training on 'Strive for 5' for practices. • Provide training on data cleansing, reporting and uploading to ACIR to practices. • Ensure availability and proper distribution of the Immunisation Enrolment Toolkit for Child Care centres and Primary Schools and availability of IEC materials for bilingual community educators (BCE). • Ensure immunisation IEC materials in multiple languages for CALD community. • Continuously support practices through training on 'Cold Chain Management' in practice and eLearning. • Assist with accreditation of GP practices through compliance with 'Strive for 5' guidelines and encourage practices to follow national vaccine storage guidelines to maintain safety and viability of vaccines. • Provide data logging services including thermometers to detect and identify cold chain breach. • Organise 4 Year Old Immunisation Bike Competition in 2016/2017 with a view to raise community awareness on NIP and improve vaccination coverage in the 1 year age group. •

Target population cohort	All <5 years children of western Sydney PHN
Consultation	GPs, Parents
Collaboration	• WSLHD will support WSPHN Practice Support team with IEC materials • WSPHN will organise the 4 year old Bike Competition Practice Sites will be involved in Bike Competition
Indigenous Specific	No
Duration	Two year period (2016-2018)
Coverage	All WentWest general practices will be covered by receipt of communication materials and training/orientation.
Commissioning method (if relevant)	No.
Approach to market	Direct engagement
Decommissioning	Not applicable

Proposed New Activities	
Activity Title / Reference	NP 9.6 **Homelessness and Health**
Existing, Modified, or New	**New activity**
Program Key Priority Area	Population Health – vulnerable groups
Needs Assessment Priority Area	Page 17 of needs assessment
Description of Activity	The WSPHN will work in collaboration with the local homelessness interagency networks GP's and ED's to identify and address health service gaps. The PHN will work with partner agencies to respond to some of the barriers in accessing health services and look to extend existing or new services via commissioning. The PHN will leverage off agencies and programs who are already have existing rapport with, and understanding and knowledge of this vulnerable and hard to reach group. GPs and other primary health practitioners will also be integral to this initiative
Target population cohort	People who are linked to, or encounter homelessness support services in western Sydney
Consultation	Ongoing consultation with the Western Sydney District Homelessness Implementation Group, LHD, NSW FaCS, Local GP's.
Collaboration	Western Sydney District Homelessness Implementation Group (members agencies please) Specialist Homeless Services Interested GPs and other primary care providers.
Indigenous Specific	No
Duration	commencing March 2017 – December 2017
Coverage	To be determined through consultation
Commissioning method (if relevant)	Wholly commissioned
Approach to market	EOI
Decommissioning	Not relevant

Proposed Activities	
Activity Title / Reference	NP 9.7 **Healthy Lifestyle Project**
Existing, Modified, or New	**New Activity**
Program Key Priority Area	Population Health (Vulnerable Groups)
Needs Assessment Priority	Chronic Diseases (page reference number 151)
Description of Activity	The WSPHN will work in collaboration with relevant stakeholders to explore opportunities to facilitate low or no cost activities that support lowering the BMI of western Sydney GP's patients where there is a heightened risk of exacerbated health conditions.
Target population cohort	Overweight or obese patients of participating GP's.
Consultation	Clinical Advisory Council, LHD's, FaCs and Local GP's
Collaboration	GP Practices, Heart Foundation, LHD
Indigenous Specific	No
Duration	March 2017 – December 2017
Coverage	Entire WSPHN region
Commissioning method (if relevant)	Wholly commissioned
Approach to market	EOI
Decommissioning	Not relevant

Culturally and Linguistically Diverse Population

Proposed Activities	
Activity Title / Reference	NP 9.8 **Improving health of culturally and linguistically diverse communities through Healthy Western Sydney TV**
Existing, Modified, or New	**New**
Program Key Priority Area	Population Health
Needs Assessment Priority Area	PA 5 - Strategies to address health needs including the needs of people from refugees, newly arrived migrants and asylum seeker migrants (page reference 152)
Description of Activity	WSPHN will continue to undertake strategies to improve access to culturally appropriate primary care services and health literacy to meet the needs of the culturally diverse population. This will include: - "Healthy Western TV" Phase 2 – the implementation and evaluation of commissioned project to upload CALD multimedia health information into the Healthy Western Sydney portal, with possible extension to other groups including Aboriginal and Torres Strait Islanders (ATSI), Lesbian, Gay, Bisexual, Transgender and intersex (LGBTI) population (resources permitting). - Engage in a range of strategies to promote knowledge of and access to GPs and other primary health service staff who speak another language, and improve access to resources such as NHSD and Health pathways. - Establish and support a network of refugee friendly GP practices in western Sydney - Actively participate in the newly established Western Sydney Refugee Health Coalition in partnership with the LHD and Refugee Health Services - Participate in the PHN Refugee Health Network to continue build capacity of PHN to plan and deliver strategies which are sensitive to the needs of Refugee population - Partner with organisations which work with CALD groups to deliver health promotion events
Target population cohort	People from CALD, refugee backgrounds and newly arrived migrants
Consultation	Western Sydney LHD - Health Promotion Officers, Multicultural Health NSW Refugee Health Services

	Consumers from a CALD background.
Collaboration	Health promotion officers – to assist in disseminating information to the communities they work with Multicultural Health- to assist in disseminating information to the communities they work with Refugee Health Services - to assist with providing refugee health resources to GPs and providing support to Practice support team
Indigenous Specific	No
Duration	Two year period (2016- 18) commencing March 2016
Coverage	Entire WSPHN region
Commissioning method (if relevant)	Request for tender to implement and evaluate 'Healthy Western Sydney TV'
Approach to market	EoI
Decommissioning	Not relevant
Funding from other sources	

Aboriginal Health (New)

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference	NP 10.1 **Aboriginal Health**
Existing, Modified, or New	New Activity
Program Key Priority Area	Indigenous Health
Needs Assessment Priority Area (eg. 1, 2, 3)	Aboriginal and/or Torres Strait Islander Health (Page reference 82-97)

Description of Activity	The WSPHN will expand its Aboriginal health focus to improve the overall health of Aboriginal and/or Torres Strait Islanders whilst ensuring culturally appropriate and safe environments within western Sydney by targeting six key areas as identified in the needs assessment: 1. Improving overall health literacy of Aboriginal and/or Torres Strait Islanders through education and community health, closely related to influencing better lifestyle choices in nutrition, substance abuse and exercise; 2. Promote affordable and culturally appropriate health services through education, resources and community engagement opportunities to support navigation through the health system; 3. Improve maternal health and parenting by decreasing the number of Aboriginal mothers smoking during pregnancy through resources and promoting joint care coordination for antenatal care; 4. Progress priority health improvement strategies by the development of an Aboriginal Health Plan between WSPHN, WSLHD, Sydney West Aboriginal Health Service and The Sydney Children's Hospital Network; 5. Work in partnership to strengthen social and emotional wellbeing of Western Sydney Aboriginal and Torres Strait Islander communities. 6. Linking aboriginal and Torres Strait Islander and community members to culturally appropriate primary health providers, improving access and engagement and mitigating the risk of untreated existing or developing chronic health conditions.
Target population cohort	Aboriginal and/or Torres Strait Islanders
Consultation	WSLHD, SCHN, Aboriginal Health staff, Local Aboriginal elders, SWAHS Staff, Aboriginal NGO's in Western Sydney.
Collaboration	• WSLHD • The Children's Hospital Westmead • Sydney West Aboriginal Health Service • NGO's • Local Community
Indigenous Specific	Yes
Duration	Two year period (2016 – 2018) commissioned services 2017
Coverage	WSPHN region
Commissioning method (if relevant)	Projects will be commissioned with local Aboriginal Leaders
Approach to market	EOI

Alcohol and Other Drugs

Proposed Activities	
Activity Title / Reference (eg. NP 1)	NP 11.1 **Facilitating the development of an integrated and diverse service system to respond to the needs of people affected by alcohol**
Existing, Modified, or New Activity	New activity
Program Key Priority Area	- Other –AOD facilitating supportive responses for members of the community not already receiving treatment.
Needs Assessment Priority Area (eg. 1, 2, 3)	Population Health (Alcohol related harm) p 57 Reducing hospitalisations attributed to alcohol
Description of Activity	*Provide a short description of the activity, including a clear aim, how the activity will address the Needs Assessment Priority and what results the activity is expected to achieve within the planning period (no more than 300 words).* Social inclusion is a key determinant of health. People experiencing harm from alcohol use become increasingly socially isolated from family and community and experience multiple barriers to seeking help in primary health settings and directly from drug and alcohol services. This delay in seeking help results in harm from alcohol becoming evident at the time of presentation to ED and hospitalisation. To facilitate early help seeking we will commission services for WSPHN residents affected by alcohol related harm. We will commission services to: • Facilitate early help seeking by providing an online evidence-based support source with immediate access for western Sydney residents experiencing alcohol related harm that are referred by their GP • support and inform families that are in turn supporting family members affected by alcohol in our region • increase skills of people accessing western Sydney drug and alcohol services to facilitate their social inclusion and economic participation • build consumer voices in drug and alcohol service design and delivery through governance training and support

	• build drug and alcohol services capacity to meet the needs of highly marginalised priority populations currently under-serviced or not accessing services. These services align with activities in the Drug and Alcohol Activity Plan that do not have funds allocated from the specific Drug and Alcohol funding pool.
Target population cohort	Western Sydney residents affected by alcohol dependence including consumers and family and carers.
Consultation	WSPHN consulted extensively with the Clinical Advisory Council, Consumer Council, GP leaders group and current service providers, all of whom provided advice on the planning of health care in the region and on patient experiences and expectations. This consultation informs commissioning decisions.
Collaboration	These activities require collaboration with the Local Health District, primary care providers and NGO service providers in the drug and alcohol and community sectors.
Indigenous Specific	NO
Duration	December 2016-June 2018
Coverage	Whole PHN region
Commissioning method (if relevant)	Commissioning is via direct approach to reputable providers identified via the AOD Activity Work Plan main enhancing services open tender that closed in November 2016.
Approach to market	Direct engagement
Decommissioning	Not relevant
Funding from other sources	N/A Aligned services are described in the AOD Activity Work Plan

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

Proposed general practice support activities -	
Activity Title / Reference (eg. OP 1)	**OP1.0. Development and implementation of a sustainable and scalable Commissioning Framework to align with national guidelines and support the delivery of commissioned and co-commissioned activities (expanded)**
Existing, Modified	Existing
Description of Activity	IWSPHN commissioning framework has been developed in consultation with a number of stakeholders including commissioning experts, mental health organisations, GPs, allied health professionals and consumers, and designed to align to national guidelines and applied to a local setting The WSPHNCF will form the basis of all commissioning activities conducted through WSPHN and be complemented by a number of systems and processes to facilitate its implementation, including a performance management and decommissioning framework, TenderLink and Folio, along with a number of standardised templates and reporting tools. The performance management and decommissioning frameworks will provide WSPHN with a range of levers to help providers maximise their performance and boost their capability and capacity. The WSPHNCF has been circulated amongst the LHD and other stakeholders including consumers and other NGOs. The framework has been embedded into our processes and has become our point of reference for all commissioning activities. We will begin planning co-commissioning opportunities in mental health. Other key initiatives will include the rollout of the medical home lead sites. With the work currently underway with the Patient Centred Medical Home, WSPHN has commenced priming GP practices for the implementation of such a model and payment structures. Current and ongoing training of program managers will continue to ensure they are equipped to effectively manage providers.
Supporting the primary health care sector	This activity aligns with part 1 of our quadruple aim (Improved Health Outcomes) With a solid commissioning framework in place, WSPHN will be able to conduct commissioning in a fair, transparent and defensible manner that allows for a robust and data driven approach supported by expert and consumer engagement through independent selection panels.

Collaboration	Collaboration with WSLHD and a wide range of NGO parties and allied health to co-design the commissioning framework. WSPHN will continue to collaborate with appropriate stakeholders to identify opportunities for co-commissioning.
Duration	It is anticipated that the WSPHNCF will be further revised and approved by the WSPHN Board by July 2017. Supporting templates and infrastructure will be updated on a continual basis, taking into consideration feedback and opportunities for improvement. Co-commissioning will occur on an ongoing basis where opportunities present both internally and with key external partners.
Coverage	The WSPHNCF will cover all commissioning activities conducted by WSPHN, hence it will cover the entire western Sydney area
Expected Outcome	The WSPHNCF will allow WSPHN to effectively and efficiently commission services to meet the needs of western Sydney residents. By implementing the framework across all departments within WSPHN who will be undertaking commissioning activities, there will be a streamlined understanding of the requirements and processes involved. The WSPHCF will be the overarching framework that informs all commissioning activities across the organisation. The standardised systems and processes will enhance the effectiveness and efficiency of the WSPHN commissioning activities. They will ensure that all commissioned work, regardless of the business area involved, will follow the same processes and quality checks. The introduction of TenderLink and Folio as electronic procurement, contract and reporting systems will significantly reduce the manual work involved in what were previously heavily resource intensive tasks. Co-commissioning is a key strategy to enhance system integration, foster partnerships and capitalise on existing experiences, relationships and resources. Co-commissioning will also enhance stakeholder buy-in and acceptance of commissioned activities and ensure needs are being met via appropriate strategies. At this time payment systems will be based primarily on output measures identified during contract negotiation. It should be noted that WPHN has a strong commitment to move towards outcome-based payments as we move towards best practice in commissioning. . In 2017-18 it is planned that WSPHN will contract/commission service providers as required by DoH.
Funding from other sources	

Proposed general practice support activities	
Activity Title / Reference (eg. OP 1)	OP2.0 **Partnerships and Engagement**
Existing, Modified, new	Modified
Description of Activity	Primary objectives of the WSPHN cannot be achieved in isolation. Partnering with local GPs, the LHD and services from other agencies that impact on both the physical and social determinants of health is the only mechanism to achieve the objectives of the WSPHN. With input from the Consumer Advisory Council, WentWest will continue to engage with a wide range of groups and organisations to identify opportunities to broaden current partnerships and identify new possibilities to achieve the priorities included in the Needs Analysis. Opportunities to partner with corporate or philanthropic organisations to enhance strategies and programs, particularly in the area of maternal and child health will be pursued in this funding period.
Supporting the primary health care sector	The sector in WSPHN is very diverse and has a number of challenges, including high levels of chronic and complex care needs. The area is also home to the largest urban Indigenous population in Australia and has numerous areas of disadvantage and one of the most culturally diverse populations in the nation. Partnering and engaging with various parts of the sector will facilitate the development of mutually beneficial activities and initiatives that will contribute to the quadruple aim. They will also ensure education, support, resources and initiatives designed to meet the diverse needs of the community are utilised and maximised.
Collaboration	WSPHN will collaborate in joint projects, initiatives and stakeholder management to meet the needs of the western Sydney community, including; • WSLHD: partner in planning, delivery and evaluation of initiatives, co-funder of some initiatives • Sydney Children's Hospital Network: partner in planning, delivery and evaluation of initiatives, co-funder of some initiatives • Sydney West Aboriginal Health Service: partner in planning, delivery and evaluation of initiatives, co-funder of some initiatives • NSW Government Services including, but not necessarily limited to, NSW Department of Family and Community Services (incorporating community services, education, housing and disability services), NSW Department of Justice (incorporating NSW Police, Corrective Services and Juvenile Justice): partner in planning, delivery and evaluation of initiatives • Relevant Non-Government Organisations including those addressing the needs of children and families, Aboriginal and Torres Strait islander and CALD communities, drug and alcohol services, mental health social support and disability services and services or groups supporting ex-prisoners: partner in planning, delivery and evaluation of initiatives. • Corporate and Philanthropic Organisations: potential partner in planning, delivery and evaluation of initiatives
Duration	2016-2018, commencing July 2016 with regular review.

Coverage	Entire PHN region
Expected Outcome	• Increasing the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes; and • Improving coordination of care to ensure people receive the right care in the right place at the right time.

Proposed general practice support activities	
Activity Title / Reference (eg. OP 1)	OP 2.1 **Support mechanisms for Consumer and Stakeholder Engagement**
Existing, Modified,	Modified
Description of Activity	Consumer engagement is a whole of organisation activity in accordance with the WSPHN Consumer and Community Engagement Framework. The majority of WSPHN programs have consumer and carer engagement embedded into their work. \. This includes training and development activities for WSPHN consumer representatives to assist health consumers to increase their confidence and effectiveness and to assist them in carrying out their role. Consumer Advisory Committee and Consumer Working Group participants are reimbursed for their participation in shared decision making around the plan, design, delivery and evaluation of health services. The WSPHN will continue to partner with Health Consumers NSW (HCNSW) to ensure best practice community engagement and partner with The LHD and SCHN on joint consumer and stakeholder engagement activities to support shared service planning and delivery of health services, at a regional level. WSPHN will continue to develop and/or disseminate stakeholder information more broadly via the WSPHN website, HealthPathways, Healthy Western Sydney, e-newsletters and fact sheets. We will also continue to host community and stakeholder forums to engage key stakeholders and encourage them to have their say by exchanging information about health issues. To facilitate more integrated primary, secondary and tertiary health systems, WentWest will convene or participate in interagency planning and implementation mechanisms across a broad range of portfolios. These include; Healthy Ageing Health care for people from culturally and diverse backgrounds Child and Family Aboriginal health

	Chronic and complex care Mental health, suicide prevention, AoD and After Hours Health Care Homes Practice Support HealthPathways Digital health and Data management Homelessness NSW Government Service delivery reform across healthy Public Health and Population Health, Human Services and Justice •
Supporting the primary health care sector	**Outline how the activity will support the primary health care sector** Research consistently demonstrates that consumer input improves quality of care. Initiatives that support health literacy can also help adjust lifestyle factors and prevent onset or escalation of chronic conditions. General practitioners report that they welcome assistance with the provision of evidence-based support for the patients.
Collaboration	**List stakeholders that will be involved in implementing the activity, including Local Hospital Network or state/territory government. Describe the role of each party.** • Consumer Advisory Committee: Service planning and recommendations and direction into WSPHNs activities. • Consumer Working Group: Ongoing feedback, service planning and recommendations. • Health Consumers NSW (HCNSW): joint project partner, education and training. • WSLHD and SCHN: Local Community Partnerships. • Parents and Carers: consumer consultations • Community sector: partnerships, Consultations • GP, Nurses, Practice Managers, Community sector, Allied health, Local government
Duration	Two year period (2016-2018)
Coverage	Entire WSPHN region
Expected Outcome	

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

Please use the table below to outline any activities included in the May 2016 version of your AWP which are no longer planned for implementation in in 2017-18.

Planned activities which will no longer be delivered - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. NP 1/OP 1)	**Reduce hospitalisation rates from Influenza/Pneumonia in western Sydney residents by improving Influenza and Pneumococcal disease immunisation in 65+ year's age group. QAim 1 & 2- Population Health, cost sustainability. NP 2.2.1**
Description of Activity	From 2001-02 to 2013-14, the trend of hospitalisation for influenza and pneumonia is increasing in the WSPHN with the majority in the population of people 65 years and over, which were 33.7 and 28.5 more hospitalisations per 100,000 population per 2 year period in males and females, respectively for the specific time period. In 2014 -2015, total 18 Influenza outbreaks were reported in western Sydney. To improve this situation, the following activities are planned to improve vaccination coverage of 65+ years age group: • Raise awareness on Influenza and Pneumococcal vaccines through different consumer forums. • Assist practice sites to send recall letters to eligible cohorts and utilise missed opportunity to improve vaccination coverage. • Organise 20 mobile vaccination cart in 5 LGAs (4 sessions per LGAs). • Organise 4 ATSI vaccination session in Blacktown LGA.
Reason for removing activity	Limited workforce capacity and no available funding option
Funding impact	No

Planned activities which will no longer be delivered - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. NP 1/OP 1)	**Ensure vaccine supply and efficient use of vaccines for the NIP and continue to enhance vaccine safety monitoring system. QAim 2- Cost sustainability. NP 2.2.2**
Description of Activity	There is no method of calculating vaccine wastage at a national level. Through stakeholder consultations it has been identified that power failure represents 46% of the reasons of vaccine wastage within western Sydney. The total value of vaccine wastage reported in the Sydney West Immunisation Strategy 2010-2013 was approximately $274,000 in 2008 and $299,000 in 2009. Lack of awareness regarding the cost of vaccines and reluctant attitude towards cold chain maintenance triggered the situation. Causes behind vaccine wastage reported to Parramatta office 2009-2009 are equipment failure (36%) followed by human error (35%) and power failure (29%). To overcome the situation: • The WSPHN will continuously support practices through training on 'Cold Chain Management' in practice and eLearning. • The WSPHN will assist with accreditation of GP practices through compliance with 'Strive for 5' guidelines and encourage practices to follow national vaccine storage guidelines to maintain safety and viability of vaccines. • The WSPHN is currently providing data logging services including thermometers to detect and identify cold chain breach. • The WSPHN will regularly review the indicators for wastage and leakage of vaccines and organise need based orientation sessions for practices. • The WSPHN will review the factors that impact on vaccine wastage and leakage to better understand and, if required, identify opportunities to minimize wastage and leakage equal to or less than 10% (self-reported KPI). • The WSPHN will assist with new vaccine account requirements. • The WSPHN will encourage use of vaccine specific fridges.
Reason for removing activity	Limited resources. Merged with NP 2.2.5
Funding impact	No

Planned activities which will no longer be delivered - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. NP 1/OP 1)	**Ensure an adequately skilled immunisation workforce through promoting effective training for immunisation providers. QAim 4- Improved providers' satisfaction. NP 2.2.4**
Description of Activity	Data cleansing activities of overdue children on ACIR, have stopped the cessation in 2013 of general practice immunisation incentive GPII, and its accompanying report of overdue children. This was compounded by the removal of ACIR field officers who provided technical support to general practices to manage ACIR issues. **To improve the situation, following supports has been extended for the practice sites:** • The WSPHN will organise periodic training on 'Strive for 5' for practices. • The WSPHN will provide training on data cleansing, reporting and uploading to ACIR to practices. • The WSPHN will organise Immunisation update workshops for GPs, PNs and PMs. • As a member of WSIC, the WSPHN will undertake regular review of ACIR and the HPV Register to assess their potential for expansion, identify a list of overdue children and provide the feedback to respective practice sites. • The WSPHN will use data on immunisation coverage in ACIR and the HPV register and other sources to better understand and identify groups at risk and/or gaps in immunisation coverage compared to the NIP Schedule. • The WSPHN has developed an online information portal Healthy Western Sydney, which is aimed at general practitioners and other health professionals to provide information on how to assess and manage medical conditions. Currently HealthPathways has localised 12 pathways for immunisation including management and the referral system for AEFI. WSPHN promotes the usage of HealthPathways in all practice sites. The WSPHN will explore opportunities to improve and strengthen the immunisation system using eHealth and other technological initiatives.
Reason for removing activity	Limited resources. Merged with NP 2.2.5
Funding impact	No