Australian Government
Department of Health

phn
An Australian Government Initiative

# Updated Activity Work Plan 2016-2018:

# Core Funding

# After Hours Funding

The Activity Work Plan template has the following parts:

1. The updated Core Funding Annual Plan 2016-2018 which will provide:
    a) The updated strategic vision of each PHN.
    b) An updated description of planned activities funded by the flexible funding stream under the Schedule – Primary Health Networks Core Funding.
    c) An updated description of planned activities funded by the operational funding stream under the Schedule – Primary Health Networks Core Funding.
    d) A description of planned activities which are no longer planned for implementation under the Schedule – Primary Health Networks Core Funding.

2. The updated After Hours Primary Care Funding Annual Plan 2016-2017 which will provide:
    a) The updated strategic vision of each PHN for achieving the After Hours key objectives.
    b) An updated description of planned activities funded under the Schedule – Primary Health Networks After Hours Primary Care Funding.
    c) A description of planned activities which no longer planned for implementation under the Schedule – Primary Health Networks After Hours Primary Care Funding.

## *Gold Coast Primary Health Network*

**When submitting this Updated Activity Work Plan 2016-2018 to the Department of Health, the PHN must ensure that all internal clearances have been obtained and that it has been endorsed by the CEO.**

**The Activity Work Plan must be lodged via email to *Qld_PHN@health.gov.au* on or before 17 February 2017**

# 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

### Local Context

On 1 July 2015, the Primary Care Gold Coast commenced as the Gold Coast PHN, establishing its vision and goals aligned with Commonwealth government expectations.

### Strategic Framework

**National PHN Goals**

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

**GCPHN Vision**

*"'Building one world class health system for the Gold Coast"*

**GCPHN Strategic Goals**

| | | | |
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| Increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes | Improving coordination of care to ensure patients receive the right care in the right place at the right time and by the right person | Engage and support General Practice and other stake-holders to facilitate improve-ments in our local health system | Be a high performing, efficient and accountable organisation |

**GCPHN Strategic Outcomes**

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| People are healthier and take responsibility of own health<br><br>People with complex illness have improved health outcomes | An integrated health system across the Gold Coast<br><br>People stay well in their own homes and communities | Strong clinical leadership, capacity and innovation in the Gold Coast primary care sector<br><br>Strong partnerships facilitate service improvement | Strong and highly effective. governance, leadership and decision making<br><br>GCPHN has an integrated business model that ensures success<br><br>GCPHN meets world class commissioning competencies |

## Values


SUSTAINABLE
Efficient, Effective, Viable
COLLABORATIVE
Partnerships, Integrated, Engaged
INNOVATIVE
Flexible, Pioneering, Evolutionary
INFLUENTIAL
Visible, Valued, Courageous
EVIDENCE-BASED
Research, Documenting, Transparent
ACCOUNTABLE
Respect, Responsible, Outcomes

# 1. (b) Planned PHN activities – Core Flexible Funding 2016-18

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|---|---|
| Activity Title / Reference (eg. NP 1) | NP 2017.1 Gold Coast Integrated Care |
| Existing, Modified, or New Activity | Existing activity |
| Program Key Priority Area | Chronic Disease |
| Needs Assessment Priority Area (eg. 1, 2, 3) | Lines 16 and 17 pages 23 - 28<br><br>Section 4 page 56 Chronic disease care coordination<br>Communication and co-ordination to support holistic transition of care for patients; focus on relationships between primary and acute services<br><br>• Gold Coast Integrated Care (GCIC) Program, commence full delivery of integrated care to identify eligible patients<br>• Use digital health platforms<br>• General Practice Liaison Officer (GPLO) - guidelines and templates<br>• Joint training opportunities<br>• Investigate options to co-case conference with GPs/health workers/care coordination in the care of A&TSI patients to ensure everyone involved with the patient is kept abreast of the client progress and care plan. |
| Description of Activity | Aim – the overarching aim of GCIC is to improve health and wellbeing at a lower cost for people accessing health care services within the Gold Coast. GCPHN contribution is:<br>• to ensure care is coordinated through commissioning 4 service navigators<br>• commissioning a nursing service for after hours service delivery including equipment and allied health services<br><br>Addresses needs - The Gold Coast Integrated Care (GCIC) model identifies high risk chronic disease patients and delivers a shared care model supported by health service navigation support, IT infrastructure and enhanced access to specialist services.<br><br>The model - GCPHN contribution to the model is: |

<table>
<tr><td></td><td>In 2016/2017 GCPHN is working in partnership with Gold Coast Health to:<ul><li>Commence first full year of operations</li><li>Participate in governance and evaluation mechanisms</li><li>Commission Service Navigators</li></ul>In 2017/2018 will continue to work in partnership with Gold Coast Health to:<ul><li>Commission Service Navigators to assist identified patients and their families to better navigate the health care system</li><li>Participate in governance and evaluation mechanisms</li><li>Deliver after hours services to GCIC identified patients</li></ul><ul><li>Service Navigators provide non-clinical advice and services. They proactively contact and assist patients to access supplementary services and supports including :<ul><li>Post hospitalisation follow up</li><li>Coordination of non-clinical support and services</li><li>Enrolment of any new patients</li></ul></li></ul>Expected results - for the GCIC overarching program will be detailed in a formal evaluation report to be completed after June 2018. For the components GCPHN contributes to, outcomes will include:<ul><li>non-clinical interventions as identified in the shared plan of care</li><li>reduction in potentially preventable hospital admissions</li><li>number of GCIC patients seen</li><li>number of new GCIC patients accessing services.</li></ul></td></tr>
<tr><td>Target population cohort</td><td>Identified patients with chronic and complex disease profiles within the 15 participating general practices.</td></tr>
<tr><td>Consultation</td><td>This program was developed as a 4-year proof of concept partnership project with Gold Coast Health. Extensive consultation occurred with general practice in the original design of the model and some of its specific components. GCPHN Board and management have representation within the Governance Structure of the project including the Strategic and Clinical Advisory groups and Evaluation Monitoring Committee.</td></tr>
<tr><td>Collaboration</td><td><table><tr><th>Stakeholder</th><th>Role</th></tr></table></td></tr>
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| | Gold Coast Health | Service delivery of overarching GCIC program including direct management of service navigators and nursing services |
| | GCPHN | Representation within the Governance Structure of the project including the Strategic and Clinical Advisory groups and Evaluation Monitoring Committee. |
| Indigenous Specific | No | |
| Duration | Originally commenced in 14/15, implementation commenced 15/16 and will continue until June 2018 | |
| Coverage | Delivered through 15 General Practices across the Gold Coast PHN Region (Gold Coast SA4) | |
| Commissioning method (if relevant) | Contracting – direct approach (originally commissioned in 14/15, this is a continuing contract with Gold Coast Health). | |
| Approach to market | N/A | |
| Decommissioning | N/A | |

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|---|---|
| Activity Title / Reference (eg. NP 1) | NP 2017.2 Transfer of Care |
| | |
| Existing, Modified, or New Activity | Existing activity |
| Program Key Priority Area | Other (system integration) |
| Needs Assessment Priority Area (eg. 1, 2, 3) | Line 33 pages 49 -51<br><br>Section 4 page 59<br><br>Interoperability, General Practice Liaison Officer (GPLO) and My Health Record<br>Poor interoperability, use and understanding of clinical data systems between primary, secondary and other services further inhibits information sharing and care-coordination |

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| | - GPLO to continue to improve referral templates and guidelines. Review quality of referrals and address issues identified through education/information to general practice.<br>- Focus on discharge information to primary care<br>- Support the implementation of Statewide clinical prioritisation criteria |
| Description of Activity | Aim – the overarching aim is to provide care that is patient-centred, accessible, coordinated and delivered in the most appropriate setting. The aim of GCPHN's contribution to this program is to influence clinical practices associated with transfer of care through clinical governance and supporting clinical information across the continuum of care – specifically electronic discharge summaries and referrals<br><br>Address needs - Gold Coast Health (GCH)and GCPHN support a shared vision to deliver seamless patient centred care by exploring, trialling and implementing new models to:<br><br>• improve communication between general practice and Gold Coast Health<br>• support effective patient centred transition of care across primary and acute care settings<br>• improve access to specialist services for patients most in need<br>• build sector capacity and effective clinical relationships across the region through education, joint working groups and sharing of information and expertise.<br><br>Elements of the model include:<br><br>• A jointly funded General Practice Liaison Unit (GPLU) established within the GCH to facilitate cross-sector integration and care coordination<br>• The Unit is staffed by a GPLO (a GP), a program manager, project officer and administrative officer who have joint reporting and accountability to GCH and GCPHN<br>• GPLU will work with GCH and primary care clinicians to:<br>o improve timely communication including discharge summaries and clinical results to primary care<br>o support implementation of The Viewer to allow General Practitioners access to Queensland Health patient information |

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<tr><td></td><td>
<ul>
<li>improve timeliness and quality of discharge summaries and clinical results</li>
<li>reduce unnecessary referrals to specialist outpatients</li>
<li>improve referral templates and guidelines including supporting the implementation of State-wide Queensland Health clinical prioritisation criteria through development of templates, testing and communication with general practice</li>
<li>review quality of referrals and address issues identified</li>
<li>implement an annual education calendar of events for general practice</li>
<li>provide initial advice on implications and requirements of any GCH led workforce redesign and clinical and service changes and support broader consultation if required.</li>
</ul>
Expected results include:
<ul>
<li>improvement in number / percentage of electronic discharge summaries completed</li>
<li>improvement in number / percentage of discharge summaries sent within 48 hours of discharge</li>
<li>increased number / percentage of appropriate e-referrals to GCH.<br>This project also links closely with OP2017.2 Digital Health.</li>
</ul>
</td></tr>
<tr><td>Target population cohort</td><td>Gold Coast residents who access GCH public services</td></tr>
<tr><td>Consultation</td><td>Extensive consultation undertaken with senior GCH staff and other members of the Executive Steering Committee to determine priorities for the GPLU.</td></tr>
<tr><td>Collaboration</td><td>
<table>
<tr><th>Stakeholder</th><th>Role</th></tr>
<tr><td>GCPHN and Gold Coast Health</td><td>Joint management of GPLU through includes bi annual meeting between meetings of the Gold Coast Health and GCPHN Executive Steering the Gold Coast Health and GCPHN Boards, monthly Committee (ESC) which included executive managers, a general practitioner and community provider representatives. This activity is a strong</td></tr>
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| | | collaborative partnership between the Gold Coast Health 's Services and GCPHN. |
| | Lead Clinician Group comprising general practitioners, hospital specialists nursing, allied health professionals (private and public) | Meets monthly to provide support and advice to integration issues and activities that are or need to be addressed to support integrated care for patients and improve quality of care. |
| | Queensland Health<br>CheckUP General Practice Liaison Officer network | CheckUp has a 3-year contract with Queensland Health (2016-2019) to support Queensland Health GPLO Network |
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| Indigenous Specific | No | |
| Duration | Continues to 30 June 2018 | |
| Coverage | Gold Coast PHN Region (Gold Coast SA4) | |
| Commissioning method (if relevant) | Contract – extension | |
| Approach to market | Contract direct approach was used in 16/17 with GCH as this has been an ongoing partnership with joint investment for a number of years. | |
| Decommissioning | N/A | |

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|---|---|
| Activity Title / Reference (eg. NP 1) | NP 2017.3 Immunisation |
| Existing, Modified, or New Activity | Existing |
| Program Key Priority Area | Population Health |
| Needs Assessment Priority Area (eg. 1, 2, 3) | Line 2 pages 9 – 11<br>Line 24 pages 37 – 38<br>Line 15 pages 21 - 23 |

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| | • Very low rates of HPV vaccination (compared to national figures)<br>• Need for practice support and workforce training<br>• Avoidable hospital admissions for people aged over 65<br><br>Section 4 Page 58<br><br>HPV vaccination<br><br>• Develop data system refinements to enable access to, and increase surveillance of HPV vaccine in General Practice<br>• Continue school program and review<br>• Public awareness campaign<br><br>Section 4 Page 58<br><br>Childhood immunisation<br><br>• Joint Gold Coast Health and GCPHN collaboration agreement endorsed<br>• Improved collaboration and partnerships with key primary health care providers including reconstitution of immunisation steering committee.<br>• Scope strategies to improve accuracy and timeliness of vaccination data processing and reporting<br>• Implement pilot vaccine hesitancy project to identify and address hesitancy issues and increase vaccination uptake.<br>• Scope development of using MD Briefcase for GP education<br>• Scope implementation of Smart Vax in 6 GP immunisation clinics<br>• Provide practice support and face to face education to primary care vaccine providers<br><br>Section 4 page 59<br><br>After hours – Support older people …. to stay well at home (linked to reducing avoidable hospital admissions for people aged over 65 see line 14 page 20) |

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| Description of Activity | Aims- The overarching aim of the Gold Coast Immunisation Program (Gold Coast Immunisation Collaborative Agreement) is to:<br>• Exceed national immunisation targets for childhood & HPV immunisation<br>• Reduce vaccine preventable avoidable hospitalisations for older people, infants and people who are or are at risk of homelessness.<br><br>The aim of the GCPHN component of the program is to provide support and education to general practices to increase their childhood vaccination rates and to promote vaccination to community through events and other communication channels.<br><br>Address needs - by working collaboratively with Gold Coast Health (GCH)to ensure effective general practice systems to support immunisation, increased opportunity for immunisation and increased public awareness.<br><br>GCPHN will partner with the GCH's Public Health Unit and general practice to:<br>• review and Implement the Gold Coast Immunisation Strategic Plan addressing HPV, Childhood immunisation and related immunization issues<br>• convene joint forums for health professionals for education and training<br>• continue to implement and evaluate the general practice/PHU immunisation clinics focusing on increasing access to childhood immunization services across the region<br>• analyse and report on immunisation data in partnership with Queensland Health<br>• engage with key facilities including residential aged care facilities and child care centres<br>• develop and implement the State/National Immunisation Forum<br>• develop online training for GPs through MD Briefcase with Zostavax<br>• implement an adverse event reporting (Smart Vax) application in ten immunisation clinics, 4 to include application for recall reminder reporting<br>• Support 5 GP immunisation (walk in) specific clinics in transitioning to business as usual.<br><br>Early Childhood Immunisation program service components will include:<br>• Support in the form of:<br>o Telephone support (answer questions regarding National Immunisation program)<br>o Face to face support (in the event of cold chain breach and assess follow up from workshops)<br>o Resources (delivery of clinician and patient resources though multiple channels) |

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<tr><td></td><td>
<ul>
<li>Education programs (for health professionals)
<ul>
<li>Back to Basics immunisation</li>
<li>Catch up schedule.</li>
</ul></li>
<li>Participation in community activities including those targeting A&TSI and homeless</li>
</ul>
School Immunisation Program focused on HPV service components will include:
<ul>
<li>Marketing and general practice support through:
<ul>
<li>HPV posters</li>
<li>Data cleaning recording and reporting</li>
</ul></li>
<li>Website promotion on Healthy GC and editorial/radio interviews</li>
<li>General practice engagement.</li>
</ul>
Expected results include increased rates of childhood and HPV vaccination and decreased vaccine preventable hospitalisations
</td></tr>
<tr><td>Target population cohort</td><td>
Children aged 0-19 years (to Dec 2017) (for Childhood Immunisation national catch-up program)<br><br>
Children aged 0-7 (Jan 2018 -June 2018) (Childhood Immunisation) Year 7 and 8 high school students for the HPV<br><br>
The homeless community for vaccine preventable avoidable hospitalisations<br><br>
Eligible A&TSI people (in accordance with National Immunisation program)<br><br>
People in residential aged care facilities vaccine preventable avoidable hospitalisations
</td></tr>
<tr><td>Consultation</td><td>GCPHN convenes a bi-monthly Immunisation steering committee comprising of GPs, Registered nurses, epidemiologist, Professor of Public Health, public health nurses and consumers. This group jointly developed the GCH and GCPHN immunisation collaboration agreement which was then endorsed by the GCH and GCPHN Executive Steering Committee.</td></tr>
<tr><td>Collaboration</td><td>
<table>
<tr><th>Stakeholder</th><th>Role</th></tr>
<tr><td>GCH’s Public Health Unit</td><td>o Clinical leadership<br>o Implement schools program</td></tr>
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| | | o Gold Coast Health childhood immunisation clinics<br>o Contribute to education and community events |
| | GCPHN | o Education including event management<br>o Support general practices to implement vaccination program<br>o Project management<br>o Facilitate community events<br>o Promotion and marketing |
| | General practice | o Deliver vaccinations<br>o Deliver specific work in child focussed immunisation clinics |
| Indigenous Specific | No | |
| Duration | July 2016 - June 2018 | |
| Coverage | Gold Coast PHN Region (Gold Coast SA4) | |
| Commissioning method (if relevant) | Direct delivery for key components of the program, including adverse event reporting and online education tool<br>General Practices deliver specific work in child focussed immunisation clinics - memorandum of understanding with each participating practices which details the roles and responsibilities of each party. | |
| Approach to market | Adverse event reporting and the Online education tool are contracted through a direct approach to the market (following market assessment)<br>General practices were recruited 16/17 through an expression of interest process. | |
| Decommissioning | N/A | |

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| Activity Title / Reference (eg. NP 1) | NP 2017.4 Access to health services for the homeless (HealthyGC+) |
| Existing, Modified, or New Activity | Modified |
| Program Key Priority Area | Population Health |
| Needs Assessment Priority Area (eg. 1, 2, 3) | Line 19 page 30 – 34 Social disadvantage and homelessness<br><br>Section 4 page 52<br>Access to health services for people of low socio-economic status, homelessness and social disadvantage |
| Description of Activity | Aim – to utilise podiatry and social work services as a gateway to broader referrals to primary health care services including mental health services for people who are homeless or are at risk of homelessness at St John's Drop-In-Centre.<br><br>Addresses needs - many of the clients who attend the centre do not seek primary health care services due to self-esteem, confidence, and or mental health issues. Known as HealthyGC+ this activity services disadvantaged, homeless and vulnerable clients visiting St John's Drop-In-Centre. is The service is operated as a collaborative, person centred model between GCPHN, Surfers Paradise Crisis Care and Southern Cross University<br><br>This model also utilises supervised student clinics. In 2016/17 Podiatry and Social Work services were provided on-site through contracted arrangements. Podiatry will continue in 2017/18, with services delivered on site by students from Southern Cross University with appropriate clinical supervision. Podiatry students can make referrals to other relevant agencies, including General Practices and subsequently mental health services in the local area. 28 x 4 hour clinics will be delivered in 17/18. The project increases access for vulnerable population groups, as well as provides real world workforce development for Podiatry students.<br><br>This project links very closely with the provision of social work services at the centre which will continue, but be funded under Hard to Reach Psychological Services. From 2017/18, the social work |

<table>
<tr><td></td><td>service will continue and be funded through the broader psychological services for hard to reach groups as part of the mental health reform program.<br><br>Expected results for the project include delivery of podiatry services and referrals to other health services for the target group.</td></tr>
<tr><td>Target population cohort</td><td>People who are homeless or at risk of homelessness</td></tr>
<tr><td>Consultation</td><td>Discussions were held with Southern Cross University around the success of the project to date as well as how to engage hard to reach vulnerable and homeless clients. This included feedback from clients on the value of the podiatry services which had been collected as part of their monitoring and evaluation.<br><br>Surfers Paradise Anglican Crisis Care (SPACC) also confirmed their view that the podiatry services were valued by clients and provided a good method of engaging this hard to reach group.</td></tr>
<tr><td>Collaboration</td><td><table><tr><th>Stakeholder</th><th>Role</th></tr><tr><td>Southern Cross University</td><td>Service delivery (podiatry) through student lead clinics</td></tr><tr><td>Surfers Paradise Anglican Crisis Care (SPACC).</td><td>Provision of venue and logistical support</td></tr></table></td></tr>
<tr><td>Indigenous Specific</td><td>No</td></tr>
<tr><td>Duration</td><td>Project originally established in 2015/16, continuing to June 2018</td></tr>
<tr><td>Coverage</td><td>Surfers Paradise Anglican Crisis Care “St John’s Drop in Centre”, Surfers Paradise SA3</td></tr>
<tr><td>Commissioning method (if relevant)</td><td>Contract variation - GCPHN will renew its existing contract for primary allied health podiatry services with Southern Cross University who provide podiatry students and qualified Podiatry Supervisor.</td></tr>
<tr><td>Approach to market</td><td>Direct approach to Southern Cross University as a part of the existing collaborative</td></tr>
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| Decommissioning | No decommissioning, however slight reduction of services from 32 clinics in 16/17 to 28 clinics in 17/18 |

| **Proposed Activities -** copy and complete the table as many times as necessary to report on each activity | |
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| Activity Title / Reference (eg. NP 1) | NP 2017.5 Turning Pain into Gain |
| Existing, Modified, or New Activity | Existing |
| Program Key Priority Area | Population health - Chronic Disease |
| Needs Assessment Priority Area (eg. 1, 2, 3) | Line 18 pages 29 – 30 Persistent Pain<br>Section 4 Page 61 Persistent Pain<br>Turning Pain into Gain program (identifies and supports self-management strategies that improve patients' ability to live with and access appropriate services for persistent pain)<br>Service Components include:<br>• Turning Pain into Gain patient self-management education program (monthly)<br>• Activity based workshops to support self-management in a practical application.<br>• Individual patient assessment including identification of health care needs, support to navigate to appropriate service providers and recommendations to the patient's GP<br>• Pathways for lower back pain<br>• Advanced allied health services (based on revised eligibility criteria)<br>• General Practitioner education.<br>• One Day Refresher workshops at 6 months, 9 months and 12 months post program. |
| Description of Activity | Aim - to promote self management of pain through education and peer support, with limited allied health services where required.<br><br>Addresses needs– by providing coordinated health services focussed on provision of evidence based interventions, information through a self management model |

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| | Turning Pain into Gain is an innovative primary care model which combines a number of evidence based interventions to deliver a patient centred self management program with the following service components included:<br>• Patient self-management education program<br>• Individual patient assessment including support to navigate to appropriate service providers and recommendations to patient's GP<br>• Access to Additional Allied Health Services where required<br>• GP and Allied Health Education Programs<br>• Peer to peer support group lead by previous participants<br>• Refresher workshops for participants at 6 months, 9 months and 12 months' post program<br>• Evaluation using validated tools for improvement of quality of life in partnership with Griffith University.<br><br>Expected results - As an existing program, Turning Pain into Gain has demonstrated consistent patient outcomes (as evidenced through independent evaluations conducted by Griffith University and patient feedback). |
| Target population cohort | Gold Coast (SA4) residents who comply with the following eligibility criteria:<br>• Have suffered chronic or persistent pain which has lasted for more than 3-6 months<br>• Require improved self-management strategies and skills to optimise ongoing care<br>• Are able to participate in group education<br>• Have an English language capacity sufficient to understand the written and spoken materials being presented<br>• Are able to give voluntary, informed consent for the ongoing collection of audit data. |
| Consultation | Consultation with contractors as part of ongoing contract monitoring processes including specific feedback from:<br>o referring GPs and practice nurses<br>o patients and families<br>o specialists<br>o Griffith University evaluations of program |

<table>
<tr><td></td><td>The youth focussed component of the program (20-35yrs) has been co-designed with patients and health care providers.</td></tr>
<tr><td>Collaboration</td><td>
<table>
<tr><th>Stakeholder</th><th>Role</th></tr>
<tr><td>Contractor</td><td>Delivers the program in collaboration with a range of specifically identified allied health providers (who have undergone an audit process to ensure suitability and alignment to program outcomes)</td></tr>
<tr><td>GCPHN</td><td>Promotion of program</td></tr>
<tr><td>GCH Pain Clinic</td><td>Collaboration with Contractor to ensure alignment of programs and effective use of referral pathways by specialists and general practitioners.</td></tr>
<tr><td>General Practice Liaison Unit</td><td>Involved in patient mapping to further evaluate patient outcomes</td></tr>
<tr><td>Griffith University</td><td>Evaluation</td></tr>
</table>
</td></tr>
<tr><td>Indigenous Specific</td><td>No</td></tr>
<tr><td>Duration</td><td>Continues to 30 June 2018</td></tr>
<tr><td>Coverage</td><td>Gold Coast PHN Region (Gold Coast SA4)</td></tr>
<tr><td>Commissioning method (if relevant)</td><td>Contract variation/extension of existing contract with clinician (who owns the intellectual property) as annual evaluations completed by Griffith University continue to support positive outcomes for patients.</td></tr>
<tr><td>Approach to market</td><td>NA</td></tr>
<tr><td>Decommissioning</td><td>N/A</td></tr>
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|---|---|
| Activity Title / Reference (eg. NP 1) | NP 2017.6 Service Access |
| Existing, Modified, or New Activity | Existing |
| Program Key Priority Area | Digital Health<br><br>System integration |
| Needs Assessment Priority Area (eg. 1, 2, 3) | Line 32 page 47 - 49<br><br>Section 4 page 58<br><br>Access to information to support referrals and service access<br><br>• Identify key target groups as priorities to participate in digital health including A&TSI, people with chronic disease, mental health and the aged<br>• Improving and enhancing the online service directory to ensure that improved collection, validation and updating of service directory data will take place, including data feeds to and from National Health Service Directory.<br>• Increase direct links to local service provider information in health topic areas and health pathways published online to support appropriate and timely referrals.<br><br>• Engage stakeholders to explore options for most effective ways to increase communication, awareness and referral pathways between service providers<br><br>This activity links closely with practice support activities, Integration activity and other program activities. |
| Description of Activity | Aim - The aim is for general practice, primary care sector and community providers to have access to readily available, evidence based resources and service and referral options, tailored specifically to the Gold Coast region.<br><br>Addresses needs - Delivery of patient centred, coordinated services is hampered by fragmented local services that are difficult for providers and the community to navigate. This issue is raised in most sector consultations and features in other priority areas such as aged care, chronic disease, |

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| | mental health and AODs. Access to information to support referral and through a comprehensive web based health and wellbeing information portal has been identified as a way to provide locally tailored and contemporary information to general practice, primary care service providers and the broader community.<br><br>GCPHN will continue to host, develop the I.T. infrastructure, update and market the existing web portal featuring:<br><br>• localised referral guidelines and templates for Gold Coast Health, updated to reflect the new Clinical Prioritisation Criteria protocols being introduced in Queensland<br>• professional resources<br>• patient facing resources<br>• a detailed local service directory.<br><br>In addition, GCPHN will:<br><br>• review and update content to ensure that it is contemporary, evidence based and meets the needs of local stakeholders<br>• increase awareness of the above resources, by promoting web-site and directory through collateral, publications, social media, practice visits and other program areas with General Practice as the primary target audience<br>• facilitate collaboration and integration of services through shared identification and localisation of resources and where possible converting any locally developed pathways to appropriate interactive online formats in key areas (building on existing guidelines and templates and resources) with an aim to deliver evidence based integrated and coordinated pathways, referral templates and resources linked with directory listings to facilitate access and referral options.<br>• Grow service directory listings and encourage self-management of listings<br>• Work cooperatively with National Health Service Directory to ensure most effective information sharing through participation in NHSD PHN telelinks and by offering data downloads to NHSD at least twice a year. |

<table>
<tr><td></td><td>Expected results include achieving increased access to contemporary evidence based resources and localised service and referral information.</td></tr>
<tr><td>Target population cohort</td><td>General practice (primary target group), primary care sector (secondary target group) and community (tertiary target group)</td></tr>
<tr><td>Consultation</td><td>This issue was raised in most sector consultation and features in other priority areas such as aged care, chronic disease, mental health and AODs.</td></tr>
<tr><td>Collaboration</td><td><table>
<tr><th>Stakeholder</th><th>Role</th></tr>
<tr><td>Gold Coast Health</td><td>Advice and input into referral guidelines and templates</td></tr>
<tr><td>General Practice Liaison Unit</td><td>Leadership of implementation of Clinical Prioritisation criteria and support for Gold Coast Health input into review of content</td></tr>
<tr><td>Gold Coast Health specialists, academics and local providers</td><td>Review of content</td></tr>
<tr><td>National Health Service Directory, 13 Health</td><td>Sharing and refining service directory information</td></tr>
</table></td></tr>
<tr><td>Indigenous Specific</td><td>No</td></tr>
<tr><td>Duration</td><td>Continuing to June 2018</td></tr>
<tr><td>Coverage</td><td>Gold Coast PHN Region (Gold Coast SA4)</td></tr>
<tr><td>Commissioning method (if relevant)</td><td>Direct delivery as this is linked closely with core infrastructure and practice support activities</td></tr>
<tr><td>Approach to market</td><td>NA</td></tr>
<tr><td>Decommissioning</td><td>NA</td></tr>
</table>

| Proposed Activities - copy and complete the table as many times as necessary to report on each activity | |
|---|---|
| Activity Title / Reference (eg. NP 1) | NP 2017.7 Cancer Screening |
| Existing, Modified, or New Activity | Existing |
| Program Key Priority Area | Population Health – Cancer screening |
| Needs Assessment Priority Area (eg. 1, 2, 3) | Line 1 pages 7 – 10<br>Line 23 pages 38 - 39<br>Section 4 Page 58<br>Cancer Screening<br>• General practice and public awareness campaign: website, targeted mail out, community groups and bowel cancer screening video<br>• Enhance accuracy in practice data re screening<br>• Advocate for delivery of electronic reporting by Breastscreen and National Bowel Screening<br>• Identify any software enhancement required<br>• GP software options identified, pilot of enhanced reminder processes and messages<br>• Evidenced based management of patients post screening |
| Description of Activity | Aims- The aim is to promote screening programs and activities with general practices and the broader community<br><br>Addresses needs – It was identified that there is low awareness of screening eligibility for national programs. The proposed activities will address this by better embedding infrastructure in the General Practice setting to support uptake of screening in General Practices. This will be coupled with collaborative work with other local stakeholders as part of a public awareness strategy.<br><br>Program service components will include:<br><br>• Advocating for delivery of electronic reporting by BreastScreen and National Bowel Screening that is fully integrated with General Practice clinical software to support effective, proactive models of primary care reminders and recalls for eligible patients. |

<table>
<tr><td></td><td>
<ul>
<li>Identifying appropriate resources for clinicians to promote awareness of risk factors and early detection for other cancers with no formal screening program (for example prostate and skin cancer) to support effective, evidence based services. This may include GP Software options identified, pilot of enhanced reminder processes and messages.</li>
<li>A Public awareness campaign for breast, bowel and cervical screening (with some information on other cancer checks): website, targeted mail out, community groups and cancer screening video to support patient uptake of effective, evidence based proactive screening/checks.</li>
<li>Enhancing accuracy in practice data for screening (including results from all service providers)</li>
<li>Identifying any software enhancement required for General Practice.</li>
</ul>
Expected results to include increased uptake of screening programs
</td></tr>
<tr><td>Target population cohort</td><td>Bowel -women and men 50 – 74 years<br>Cervical- women 20 - 69 years<br>Breast- women 50 -74 years</td></tr>
<tr><td>Consultation</td><td>Gold Coast Hospital and Health Service (GCH) Pubic Health Unit<br>BreastScreen Queensland and BreastScreen Gold Coast<br>Bowelscreen<br>Community Advisory Council and Clinical Council<br>General Practice<br>GCPHN Primary Health Care Improvement Committee</td></tr>
<tr><td>Collaboration</td><td>
<table>
<tr><th>Stakeholder</th><th>Role</th></tr>
<tr><td>A regional group including GCPHN, GCH’s Public Health Unit and local representatives of National screening providers</td><td>o ensure consistent local approach<br>o provide expertise<br>o provide collateral for public awareness activities</td></tr>
</table>
</td></tr>
</table>

| | | |
|---|---|---|
| | Other PHNs | o Currently exploring opportunities to work collaboratively on communication campaigns |
| Indigenous Specific | No | |
| Duration | Continuing to June 2018 | |
| Coverage | Gold Coast PHN Region (Gold Coast SA4) | |
| Commissioning method (if relevant) | Direct delivery with the possible procurement of marketing and education material | |
| Approach to market | To be determined following finalisation of planning against the identified opportunities to work collaboratively with partners | |
| Decommissioning | N/A | |

| Proposed Activities - copy and complete the table as many times as necessary to report on each activity | |
|---|---|
| Activity Title / Reference (eg. NP 1) | NP 2017.8 Workforce |
| Existing, Modified, or New Activity | Existing |
| Program Key Priority Area | Health Workforce |
| Needs Assessment Priority Area (eg. 1, 2, 3) | • Primary Health Care Engagement<br>• Most identified priorities included aspects of training and education including<br><br>Page 9, line 2 Immunisation<br>Page 14, line 5 Mental Health – Youth<br>Page 14, line 6 Mental Health – Indigenous<br>Page 15, line 7 Mental Health – Suicide prevention |

| | |
|---|---|
| | Page 17 line 11 Alcohol and Other Drugs - including consideration of Aboriginal and Torres Strait Islander needs<br>Page 38, line 24 Immunisation<br>Page 46, line 31 Practice Support and Improvement |
| Description of Activity | Aim - to increase workforce capacity through an appropriately skilled and confident primary care workforce<br><br>Addresses needs - Training and education was a component identified in most priorities that emerged through the needs assessment. In particular, there was a focus on developing the primary care workforce through the provision of high quality training to both general practice and those involved in multidisciplinary teams.<br>Program service components that will be progressed in collaboration with stakeholders include:<br>• Producing a detailed current and future workforce profile for primary health care in the region that further informs the needs assessment and identifies key workforce issues and priorities for the region.<br>• Developing and implementing a Primary Health Care workforce plan which will determine priority workforce strategies to address identified gaps.<br>• Continuing to implement current workforce strategies while the needs assessment, planning and co-design phases of the Workforce Plan. These include:<br>o Developing a targeted triennium education and training calendar with a focus on priority topic areas identified through needs assessment (in line with RACGP triennium)<br>o Facilitating Practice Network Forums- including Practice Nurse, Practice Managers and Administration staff<br>o Facilitating Practice Nurse, Practice Managers and GP email chat room forums as required<br>o Engaging GP registrars to attend GCPHN forums<br>o Collaboratively delivering a range of coordinated evidence based workforce strategies to support and enhance primary care workforce across GCPHN region. |

<table>
<tr><td></td><td>Expected results will include development of a collaborative regional workforce plan for the Gold Coast that delivers coordinated, evidence based, training and increased clinician engagement across the GCPHN region.</td></tr>
<tr><td>Target population cohort</td><td>Gold Coast’s primary health care workforce- GPs, practice managers, practice nurses, allied health and administration teams</td></tr>
<tr><td>Consultation</td><td>Gold Coast Health<br>Gold Coast Lead Clinician Group and GCPHN’s Clinical Council<br>General Practices<br>GCPHN Primary Health Care Improvement Committee<br>Education providers including TAFE<br>Australian Primary Health Care Nurses Association<br>RACGP<br>Peak bodies</td></tr>
<tr><td>Collaboration</td><td>
<table>
<tr><th>Stakeholder</th><th>Role</th></tr>
<tr><td>A regional governance group including GCPHN, General Practice Gold Coast, Gold Coast Health and local representatives from universities/TAFE will be established</td><td>o champion and drive the development and implementation of a regional workforce plan<br>o ensure consistent local approach<br>o provide expertise<br>o explore opportunities to collaborate and co-design</td></tr>
</table>
</td></tr>
</table>

| | | |
|---|---|---|
| | Other PHNs | Currently exploring opportunities to work collaboratively |
| Indigenous Specific | No | |
| Duration | Continuing to -June 2018 | |
| Coverage | Gold Coast PHN Region (Gold Coast SA4) | |
| Commissioning method (if relevant) | Direct delivery with the procurement of resources as required. | |
| Approach to market | To be determined following finalisation of planning against the identified opportunities to work collaboratively with partners. | |
| Decommissioning | N/A | |

| | |
|---|---|
| Activity Title / Reference (eg. NP 1) | NP 2017.9 Enhanced Primary Care in RACFs |
| Existing, Modified, or New Activity | Existing |
| Program Key Priority Area | Aged Care<br>Population Health |
| Needs Assessment Priority Area (eg. 1, 2, 3) | • Lines 26, 27 and 28 pages 41-44<br>• Section 4 page 56 Palliative and end of life care planning<br>Develop and implement a regional plan to support uptake of end of life care planning through implementation of the State-wide Strategy for end-of-life care across Gold Coast<br>• Public information campaign<br>• Develop and deliver training and education package for Medical Deputising Services, RACFs, GPs and community. |

| | |
|---|---|
| | This activity links closely with Practice Based Population Health Management activity, which has been approved under the innovation funding. |
| Description of Activity | Aim: The aim is to support GPs to continue to care for patients admitted to RACFs and optimise care management within the RACF setting and to promote patient choice and decision making about end of life care through Advanced care plans.<br><br>Addresses needs – by supporting implementation of end of life planning and supporting effective primary care management within the usual residence, being an RACF<br><br>The model uses data to drive general practices to address the needs of identified population through enhanced education, content development for pathway identification, tools and resources that best meet the needs of their patients residing in RACFs. This involves:<br>• Supporting the sector to efficiently provide improved collaborative model of patient care within existing funding framework within the RACF environment.<br>• Strongly engaging with General Practice and RACFs to promote the utilisation of evidenced based pathways and resources to assist patient inclusive clinical decision making.<br><br>Components of the model:<br>• Embedding RACGP Silverbook guidelines by:<br>o Developing a validated flowchart that is aligned to the Guidelines and<br>o Once the Flowchart is validated it will be promoted to targeted practices with support provided for implementation.<br>• Promoting Advance care planning by:<br>o Using the Respecting Patient Choices “RPC” as the key contemporary program in Australia in relation to advance care planning.<br>o Developing and running a sector wide “Education and Information Plan” jointly developed by GCPHN and Gold Coast Health based on RPC program.<br>o Identifying champions in targeted RACFs for joint training with Gold Coast Health staff. |

<table>
<tr><td></td><td>
<ul>
<li>Delivering and promoting a suite of contemporary evidence based education programs that support the implementation of advance care planning to general practice.</li>
<li>Working collaboratively with Metro South Brisbane Hospital and Health Service regarding administration of advance care planning documentation.</li>
</ul>
<ul>
<li>Providing education and training to the following groups on the ISBAR clinical communication tool to support collaborative patient centred care amongst clinicians when patient conditions deteriorate:
<ul>
<li>RACF staff</li>
<li>General Practice staff including medical deputising services</li>
<li>Gold Coast Health staff.</li>
</ul>
</li>
<li>Resources and pathways
<ul>
<li>Continuing to identify contemporary resources and evidence based tools, practice and service options to support the above and related work.</li>
<li>Exploring opportunities to work with clinicians to develop pathways appropriate to this work.</li>
</ul>
</li>
</ul>
this component links closely with NP 2017.6 “Service Access” activity and AH 1.1 Hospital avoidance – RACFs after hours<br>
Expected results include
<ul>
<li>reduced avoidable hospital admissions</li>
<li>improved adherence to RACGP Silver Book Guidelines</li>
<li>increased uptake of and use of advanced care planning.</li>
</ul>
</td></tr>
<tr><td>Target population cohort</td><td>Those residents of RACFs who are serviced by the four general practices that are participating in the population health management innovation project, who are at risk of poor health outcomes due to geriatric syndromes, complex comorbid chronic disease sets, frailty and barriers to access to timely appropriate health care.</td></tr>
<tr><td>Consultation</td><td>This activity has been developed based on extensive consultation with General Practices, RACFs and Gold Coast Health as well as through the Multidisciplinary Aged Care Service Providers Forum</td></tr>
<tr><td>Collaboration</td><td>
<table>
<tr><th>Stakeholder</th><th>Role</th></tr>
</table>
</td></tr>
</table>

| | | |
|---|---|---|
| | General Practice, RACFs and Multidisciplinary Service Providers | implementing the model |
| | Gold Coast Health | Supporting collaboration and RACF/GP through a range of frail aged strategies including alignment to the QLD State Wide End of Life Strategy and outreach Services offered locally<br><br>Training and support to staff implementing Advance Care Planning. |
| | Multidisciplinary Aged Care Service Providers | enhance delivery of services to the RACFs. |
| | RAGCP | Advice and direction |
| | AUSHI Academic Evaluators | Validating the tool may make additional recommendation to support and refine this and other components of this mode |
| | Metro South Brisbane Hospital and Health Service | administration of advance care planning documentation |
| Indigenous Specific | No | |
| Duration | Continuing to June 2018 | |
| Coverage | Targeted Residential Aged Care Facilities within Gold Coast PHN region and their Regular GPs | |
| Commissioning method (if relevant) | Direct delivery with the procurement of services as required. | |
| Approach to market | N/A | |
| Decommissioning | N/A | |

| | |
|---|---|
| Activity Title / Reference (eg. NP 1) | NP 2017.10 Primary Care (General Practice) Quality Leadership and Clinical Governance for Improving Chronic Disease Management |

| | |
|---|---|
| Existing, Modified, or New Activity | Modified (extension of practice support activity moved from Core Operational as new activity in Core Flexible) |
| Program Key Priority Area | This links closely with and builds on the operational activities in OP1,2,3, 4<br><br>Population health – Chronic disease<br>Workforce |
| Needs Assessment Priority Area (eg. 1, 2, 3) | • Section 4 page 2 – 4 Chronic disease early identification, self-management and medication management |
| Description of Activity | Aim - to enable and support the systems through which general practices will be responsible for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This will include enhancing the capacity of General Practitioners to lead and effect change to improve clinical practice, especially in relation to chronic disease management in general practice.<br><br>Needs Assessment –activity in previous years and a literature review of quality improvement models in primary care indicated that effective clinical governance including GP led quality improvement activity was a key factor in delivering efficient and effective chronic disease management that achieve improved outcomes in primary care.<br><br>Aspects of the model - This activity links closely with and builds on the operational activities in OP1,2,3, 4 and links closely with NP 17.8 Workforce and will be a building block to develop readiness for the expansion of Health Care Home implementation in the future. Components of the planned activity include:<br><br>o Establishment of a clinical governance advisory group including academic and local General Practitioners, Gold Coast Health representatives and other key experts in this area to inform the vision and direction for the change management<br>o Engagement processes specifically targeting GP through peer to peer support with GCPHN contracted GP lead in continuous quality improvement |

| | |
|---|---|
| | o Refinement of and production of practice specific engagement reports that provide up to date data on a timely, as needs basis to support GP engagement<br>o Identification of clinical leaders who will drive clinical governance at the practice level<br>o Development of the identified clinical leads by building knowledge, capability, capacity and confidence to ensure they have the skills to achieve the outcomes<br>o Identifying optimum use of existing incentives to support GP led data driven clinical improvements with a focus on chronic disease<br>o Identifying suitable tools and resources to support this activity and ensure access through the service access platform<br>o Development of a framework for a GP Lead Role within General Practices that will inform an innovative sustainable model to drive data led clinical improvements with a focus on chronic disease.<br><br>Expected results – a sustainable evidence based clinical governance model that:<br>• delivers optimal health and wellbeing outcomes<br>• identifies the systems through which general practices can be responsible for continuously improving the quality of their services and safeguarding high standards of care<br>• creates an environment in which excellence in clinical care will flourish<br>• reduces potentially preventable hospitalisations for patients with specific chronic diseases<br>• delivers high patient and clinician satisfaction<br>• can operate and be implemented within existing resources. |
| Target population cohort | Patients of participating general practices with chronic disease |
| Consultation | GCPHN has a Primary Health Care Improvement Committee with local general practice representation that meets bi-monthly to provide input and advice on GCPHN practice support activities, current issues facing general practice and other projects directly interfacing with General Practice in the Gold Coast.<br><br>The project model has been developed in consultation with and based on significant input from the Chair of the RACGP Expert Committee – Quality Care . |
| Collaboration | |

| | | |
|---|---|---|
| | **Stakeholder** | **Role** |
| | Advisory group including academic and local General Practitioners and Gold Coast Health | Clinical governance |
| | GCPHN staff and General Practice Staff within the targeted General Practices | Implementation |
| Indigenous Specific | No | |
| Duration | Continuing to June 2018 | |
| Coverage | Gold Coast PHN region (Gold Coast SA4) | |
| Commissioning method (if relevant) | N/A | |
| Approach to market | Direct Delivery | |
| Decommissioning | N/A | |
| Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding | | |
| Planned Expenditure **2016-17** (GST Exc) – Funding from other sources | N/A | |
| Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding | $382,438 | |
| Planned Expenditure **2017-18** (GST Exc) – Funding from other sources | N/A | |
| Funding from other sources | N/A | |

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

| | |
|---|---|
| Activity Title / Reference (eg. OP 1) | OP 2017.1 Practice support - Accreditation |
| Existing, Modified, or New Activity | Existing Activity |
| Description of Activity | Aim - to encourage and support general practices to gain and or maintain Accreditation status by providing a clinical audit tool and to support data quality improvement<br><br>Accreditation support for General Practice is a requirement of The Department of Health's funding agreement and has been a long standing component of the Practice Support model on the Gold Coast.<br><br>Accreditation provides a framework for quality care and risk management in Australian general practice. It also supports the continuing development of well performing practice teams to enable them to focus on those things. Supporting General Practice Accreditation is a key priority for GCPHN.<br><br>The 2016/17 activity focussed on:<br>• Identifying those practices on the Gold Coast that were Accredited and those that were not.<br>• Linking with peak bodies that support General Practice Accreditation<br>• Reviewing and providing feedback on the development of the 5th Edition standards.<br><br>2017/18 activity will focus on:<br>• Supporting General Practices to maintain accreditation status as a key component across all 4 tiers of practice support<br>• Working with and encouraging General Practices that indicated they are not currently interested in attaining accreditation status to gain accreditation status, through direct provision of information to highlight importance of accreditation.<br>• Liaising with RACGP and Accreditation agencies with regard to resources to support Accreditation and information sessions to update General Practice staff on 5th Edition Standards<br>• Develop localised processes and resources to align with 5th Edition Standards and introduce the resources to general practices<br>• Aligning practice support activities to the 5th Edition Standards (this activity links closely to other operational activities). |

<table>
<tr><td>Supporting the primary health care sector</td><td>The activity will promote the importance of Accreditation to those practices that do not have Accreditation status and provide localised resources (aligned to 5th edition standards) to support the accreditation process.</td></tr>
<tr><td>Collaboration</td><td>
<table>
<tr><th>Stakeholder</th><th>Role</th></tr>
<tr><td>Peak bodies including RACGP, AGPAL and GPA</td><td>Consultation to ensure activity aligns to the standards.</td></tr>
<tr><td>GCPHN Practice Support Team and General Practice Staff within the targeted General Practices</td><td>Implementation</td></tr>
<tr><td>GCPHN Primary Health Care Improvement Committee comprising local general practice staff</td><td>provide input and advice into the current issues facing general practice, projects directly interfacing with General Practice and GCPHN practice support activities.</td></tr>
</table>
</td></tr>
<tr><td>Duration</td><td>Continuing to June 2018</td></tr>
<tr><td>Coverage</td><td>Gold Coast PHN Region (Gold Coast SA4)</td></tr>
<tr><td>Expected Outcome</td><td>Increased percentage of eligible practices in region to be accredited</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td>Activity Title / Reference (eg. OP 1)</td><td>OP 2017.2 Practice support - Digital health</td></tr>
<tr><td>Existing, Modified, or New Activity</td><td>Existing</td></tr>
<tr><td>Description of Activity</td><td>Aim- to improve access to information across the care continuum through encouraging general practice to utilise the My health record.</td></tr>
</table>

<table>
<tr><td></td><td>Needs assessment identified:<ul><li>Communication and co-ordination to support holistic transition of care for patients; focus on relationships between primary and acute services</li><li>Interoperability, General Practice Liaison Officer and My Health Record<br>Poor interoperability, use and understanding of clinical data systems between primary, secondary and other services further inhibits information sharing and care-coordination</li><li>Access to information to support referrals and service access<br>Hampered by fragmented local services which are difficult to navigate for providers and community</li></ul>GCPHN will achieve this by:<ul><li>providing education and training about all relevant aspects of digital health including the My Health Record, secure messaging and the Queensland Health Viewer</li><li>supporting General practice compliance with ePIP</li><li>enabling the use of e-referrals from primary care to secondary and tertiary care</li><li>adoption of the use of My Health Record by clinicians and patients</li><li>data cleaning and accuracy.</li></ul>GCPHN will monitor key government policy developments including in the areas of digital health, the Health Care Homes program and PIP payments to ensure activities are aligned to support general practice prepare for and implement government initiatives.</td></tr>
<tr><td>Supporting the primary health care sector</td><td>The activity will promote the importance of utilising Digital technology to support timely access to information.</td></tr>
<tr><td>Collaboration</td><td><table><tr><th>Stakeholder</th><th>Role</th></tr><tr><td>GCPHN Practice Support Team and General Practice Staff within the targeted General Practices</td><td>Implementation</td></tr><tr><td>GCPHN Primary Health Care Improvement Committee comprising local general practice staff</td><td>provide input and advice into the current issues facing general practice, projects directly interfacing</td></tr></table></td></tr>
</table>

| | | | |
|---|---|---|---|
| | | with General Practice and GCPHN practice support activities. | |
| Duration | Continuing to June 2018 | | |
| Coverage | Gold Coast PHN Region (Gold Coast SA4) | | |
| Expected Outcome | Increased percentage of practices in region receive the ePIP (My Health Record) | | |

| | |
|---|---|
| Activity Title / Reference (eg. OP 1) | OP 2017.3 Practice support – Information Management |
| Existing, Modified, or New Activity | Existing Activity |
| Description of Activity | Aim - to support general practices to ensure the risk factors (smoking, alcohol use and BMI ) are recorded for their patients through the analysis and provision of data reports<br><br>Information Health Management is a core component of Practice Support under the Department's funding agreement and has been a long standing component of the Practice Support model on the Gold Coast.<br><br>The GCPHN tiered approach to practice support is a contemporary evidence based model that utilises Practice Support Officers to support the general practice team to increase the efficiency and effectiveness of their systems and processes in order to become more self-sufficient in utilising health information to inform quality improvement in health care.<br>Each practice has an allocated Practice Support Officer to support:<br>• Data management including access to and utilisation of a Clinical Audit Tool<br>• Access to resources to support Health Information Management at the General Practice level<br>• Education and training forums aimed at increasing General Practice self-sufficiency in managing data and health information<br><br>In 2016/17 the activity focused on:<br>• Increasing the number of eligible practices having access to and utilising a Clinical Audit Tool to 80% |

<table>
<tr><td></td><td>
<ul>
<li>Improving data quality within General Practices through ensuring effective data entry, data cleaning and quality assurance processes, using markers such as increasing the recording of allergy status recorded in active patient records to >90% as measures of quality.</li>
</ul>
2017/18 activity will focus on:
<ul>
<li>Continuing to increase the number of eligible practices having access to and utilising a Clinical Audit Tool to 95%</li>
<li>Continuing to support the improvement of data quality within General Practices</li>
<li>Improving data quality within General Practices through ensuring effective data entry, data cleaning and quality assurance processes, using markers such as increasing the recording of allergy status recorded in active patient records to >90% as measures of quality.</li>
<li>GCPHN will monitor key government policy developments including in the areas of digital health, the Health Care Homes program and PIP payments to ensure activities are aligned to support general practice prepare for and implement government initiatives..</li>
</ul>
</td></tr>
<tr><td>Supporting the primary health care sector</td><td>The activity will promote the importance of effective utilisation of a Clinical Audit Tool to obtain data to inform quality improvement activity including improving data recording, coding and general quality.</td></tr>
<tr><td>Collaboration</td><td>
<table>
<tr><th>Stakeholder</th><th>Role</th></tr>
<tr><td>GCPHN Practice Support Team and General Practice Staff within the targeted General Practices</td><td>Implementation</td></tr>
<tr><td>GCPHN Primary Health Care Improvement Committee comprising local general practice staff</td><td>provide input and advice into the current issues facing general practice, projects directly interfacing with General Practice and GCPHN practice support activities.</td></tr>
<tr><td>Chair of the RACGP Expert Committee – Quality Care (REC-QC)</td><td>advise on GCPHN tiered approach to practice support model.</td></tr>
</table>
</td></tr>
<tr><td>Duration</td><td>Continuing to June 2018</td></tr>
</table>

| | |
|---|---|
| Coverage | Gold Coast PHN region (Gold Coast SA4) |
| Expected Outcome | Increase in eligible practices accessing practice support (within Tiered approach) and utilising a Clinical Audit Tool |

| | |
|---|---|
| Activity Title / Reference (eg. OP 1) | OP 2017.4 Practice support – Quality Improvement |
| Existing, Modified, or New Activity | Existing Activity |
| Description of Activity | Aim - to encourage best practice management of chronic disease by focusing on associated clinical metrics and keeping those at optimal range<br><br>Following a review of contemporary evidence based approaches to practice support GCPHN refined its model of practice support to focus of each of the tiers is outlined below with supporting adoption of best practice methods to improve quality of care a key component of tier 3:<br><br>• Tier 1 includes access to information and resources, and submission of population level data (where possible)<br>• Tier 2 includes entry level Continuous Quality Improvement (CQI) review of practice profiles and populations to target interventions<br>• Tier 3 incorporates the above plus engages practices in formalised CQI and evidenced based interventions to improve agreed clinical measures. Elements of this component of the model include:<br>o Subsequent tailored data reporting focussing on the agreed areas for improvement<br>o Facilitated peer to peer clinical quality improvement conversations<br>o Touch point meetings with practice staff to review data and monitor progress towards achieving identified outcomes. |

<table>
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- Building a data repository that is growing in both breadth (increasing those submitting data) and accuracy (through data cleaning and data entry activities) to inform current and future GCPHN functions and activities such as needs assessment and service development (particularly targeting most appropriate practices for implementation of further activity)
- GCPHN will monitor key government policy developments including in the areas of digital health, the Health Care Homes program and PIP payments to ensure activities are aligned to support general practice prepare for and implement government initiatives.

</td></tr>
<tr><td>Supporting the primary health care sector</td><td>The activity will promote and support effective utilisation of a continuous quality improvement model to inform quality and drive improvement in health care in the primary care setting.</td></tr>
<tr><td>Collaboration</td><td>
<table>
<tr><th>Stakeholder</th><th>Role</th></tr>
<tr><td>GCPHN Practice Support Team and General Practice Staff within the targeted General Practices</td><td>implementation</td></tr>
<tr><td>GCPHN Primary Health Care Improvement Committee comprising local general practice staff</td><td>provide input and advice into the current issues facing general practice, projects directly interfacing with General Practice and GCPHN practice support activities.</td></tr>
<tr><td>Chair of the RACGP Expert Committee – Quality Care (REC-QC)</td><td>advise on GCPHN tiered approach to practice support model.</td></tr>
</table>
</td></tr>
<tr><td>Duration</td><td>Continuing to June 2018.</td></tr>
<tr><td>Coverage</td><td>Gold Coast PHN region (Gold Coast SA4)</td></tr>
<tr><td>Expected Outcome</td><td>Increase in general practices accessing practice support.<br><br>Improvements in quality of clinical data recorded.<br>Improvement in clinical indicators.</td></tr>
</table>

# 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 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

# 3. (a) Strategic Vision for After Hours Funding

*Please outline, in no more than 500 words, an overview of the PHN's strategic vision for the period covering this Activity Work Plan that demonstrates how the PHN will achieve the After Hours key objectives of:*

- increasing the efficiency and effectiveness of After Hours Primary Health Care for patients, particularly those with limited access to Health Services; and
- improving access to After Hours Primary Health Care through effective planning, coordination and support for population based After Hours Primary Health Care.

In 2016-17 and onwards, your organisation is required to:

- Implement innovative and locally-tailored solutions for after hours services, based on community need; and
- Work to address gaps in after hours service provision.

Please note, although PHNs can plan for activities in the 2017-18 financial year, at this stage, current funding for PHNs After Hours is confirmed until 30 June 2017 only. PHNs must not commit to spend any part of the funding beyond 30 June 2017.

Due to the revision of the PHN Performance Framework, performance information relating to the After Hours Schedule for this update to the 2016-18 Activity Work Plan deliverable is not required. Further information will be provided separately.

### Local Context

On 1 July 2015, Primary Care Gold Coast commenced as the Gold Coast PHN, establishing its vision and goals aligned with Commonwealth government expectations.

## Strategic Framework

### National PHN Goals

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

### GCPHN Vision

*"'Building one world class health system for the Gold Coast"*

### GCPHN Strategic Goals

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|---|---|---|---|
| Increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes | Improving coordination of care to ensure patients receive the right care in the right place at the right time and by the right person | Engage and support General Practice and other stake-holders to facilitate improve-ments in our local health system | Be a high performing, efficient and accountable organisation |

### GCPHN Strategic Outcomes

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| People are healthier and take responsibility of own health<br><br>People with complex illness have improved health outcomes | An integrated health system across the Gold Coast<br><br>People stay well in their own homes and communities | Strong clinical leadership, capacity and innovation in the Gold Coast primary care sector<br><br>Strong partnerships facilitate service improvement | Strong and highly effective. governance, leadership and decision making<br><br>GCPHN has an integrated business model that ensures success<br><br>GCPHN meets world class commissioning competencies |

### Values

A needs assessment looked at population profile, service mapping and identify gaps and issues in the afterhours. Initial service mapping identified:

- Overall, the Gold Coast Region is well serviced in relation to afterhours general practice services, with one of the highest rates of service delivery by General Practitioners nationally; and
- Availability of pharmacies in the afterhours was also well serviced including on public holidays.

The needs analysis identified a high level of accessibility for general practice and pharmacy after hours services in the Gold Coast region generally. Subsequently, GCPHN has investigated other more specific after hours needs on the Gold Coast, with a focus on the priority areas identified by the government including the frail aged and chronic disease. GCPHN will focus more on these vulnerable populations with the particular aim of reducing avoidable hospitalisations.

## 3. (b) Planned PHN Activities – After Hours Primary Health Care 2016-17

| **Proposed Activities** - copy and complete the table as many times as necessary to report on each activity | |
|---|---|
| Activity Title / Reference (eg. NP 1) | AH 1.1 Hospital avoidance – RACFs after hours |
| Existing, Modified, or New Activity | Modified |
| Needs Assessment Priority Area (eg. 1, 2, 3) | • Lines 26, 27 and 28 pages 41-44<br><br>Section 4 Aged Care pathways and coordination page 58<br>• System navigation for older people and primary care providers supporting them with a focus on Dementia<br>• Agreed pathways developed and evaluated that provides triage, consultancy, clinical support, and advice for Residential Aged Care Facilities (RACF) staff and GPs, so that care for patients can be delivered in the facility where appropriate, and transfer to hospital is avoided. Training and education for implementation of pathways to RACFs, GPs and MDS<br>• Detailed service mapping to identify current services in acute and community to identify duplicates and gaps within the system that supports older person.<br>• Support for older patients returning home sooner |

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| | • Develop a regional solution through pathways and process that can be implemented regionally<br>• Up to date information to support access and referral online |
| Description of Activity | The original aim of this activity 2016/17 was to work in collaboration with Gold Coast Health (GCH) to reduce need for transfer of frail aged patients to hospital in after hours by extending the GCH's Geriatric Evaluation and Management (GEMITH) team to include clients in their own home which then provides flexibility to treat older patients in their place of residence. The GEMITH service design work was to be completed collaboratively with all stakeholders and focus primarily on RACF clients to achieve:<br>• Agreed evidenced based integrated and coordinated pathways developed and evaluated that provides triage, consultancy, clinical support, and advice for RACF staff and GPs, so that care for patients can be delivered in the facility where appropriate, and transfer to hospital is avoided<br>• In collaboration with GCH, establishment of position in ED to support afterhours advice to RACFs and General Practice including Medical Deputising Services.<br><br>The activities above commenced in the 2015/16 however were unable to continue into 2016/17 successfully as a result of a significant re-structure within GCH and the resignation of the GCPHN Program Manager responsible for this program in August 2016. A subsequent review of both aged care and chronic disease services was undertaken by GCH after they had completed the restructure which meant GCH was not in a position to commit to or work in collaboration with GCPHN in any service design activities during the planned period.<br><br>As key components of this activity (the ED position and associated work) could only be progressed successfully in partnership with the GCH and as GCH was not in a position to progress these activities it was not of value for GCPHN to continue to invest in service co-design at this point in time. Subsequently with the GCH review of Aged Care and Chronic Disease Services that was completed in November 2016 discussions have been occurring at Joint Board and Executive Management levels to explore mechanisms and opportunities to plan more integrated approaches across these service areas into the future. |

<table>
<tr><td></td><td>Preparation for other components of this activity are continuing in 2016/17 as detailed above and are planned for 2017/18 including:<br><br>• Opportunities to further educate Medical Deputising Services, after hours general practitioners and regular general practitioners to ensure RACF client records are up to date at all times.<br>• Improve capacity of after hour GP services to support frail aged patients living in RACFs through:<br>o Education and training<br>o More effective communication with general practice<br>o Advanced care planning<br>o Use of My Health Record<br>o Telehealth<br>• Review outcomes of current local project being completed by BlueCare to design a model of care which can support palliative and end of life care in RACFs to avoid hospital admissions particularly in after hours.</td></tr>
<tr><td>Target population cohort</td><td>People living in RACFs</td></tr>
<tr><td>Consultation</td><td>As a key component of this activity could only be progresses successfully in partnership and collaboration with the GCH and as GCH was not in a position to progress these activities it was not of value for GCPHN to proceed to investment at this point in time. Subsequently with the GCH review of Aged Care and Chronic Disease Services that was completed in November 2016 discussions have been occurring at Joint Board and Executive Management levels to explore mechanisms and opportunities to plan more integrated approaches across these service areas into the future.</td></tr>
<tr><td>Collaboration</td><td><table><tr><th>Stakeholder</th><th>Role</th></tr><tr><td>GCH</td><td>Support for training and coordination of services</td></tr><tr><td>General Practice, RACFs and Multidisciplinary Service Providers</td><td>Implementing the model</td></tr></table></td></tr>
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| Indigenous Specific | No |
| Duration | Continues to June 2018 |
| Coverage | Gold Coast PHN Region (Gold Coast SA4) |
| Commissioning method (if relevant) | NA |
| Approach to market | NA |
| Decommissioning | NA |

| **Proposed Activities -** copy and complete the table as many times as necessary to report on each activity | |
|---|---|
| Activity Title / Reference (eg. NP 1) | AH 1.2 COPD After hours |
| Existing, Modified, or New Activity | Existing |
| Needs Assessment Priority Area (eg. 1, 2, 3) | After Hours – Chronic Disease |
| Description of Activity | **COPD After hours**<br>Aim - to provide urgently required after-hours services for patients with COPD through referral from Gold Coast Health (GCH), to reduce avoidable hospital admissions.<br><br>The services will be:<br>• Delivered across the Gold Coast region in an appropriate, timely way that supports COPD patients discharged or referred from hospital in the after-hours period.<br>• Delivered in patients' homes and may include:<br>- Allied health<br>- Nursing services<br>- Personal care<br>- Home oxygen<br>- Transport |

<table>
<tr><td></td><td>- Social support.</td></tr>
<tr><td>Target population cohort</td><td>Gold Coast residents with COPD</td></tr>
<tr><td>Consultation</td><td>This service has been established through a partnership with GCPHN, local non-government provider and GCH Chronic Disease Wellness Program. A service components of the service is to ensure there are timely and clear referral and management pathways between the GCH Chronic Disease Services and the provider to ensure coordinated and effective clinical handover and continuity of care for the patient and family.<br><br>There is a service agreement in place between GCPHN and the non-government provider for the delivery of the afterhours service until 30 June 2017.</td></tr>
<tr><td>Collaboration</td><td><table><tr><th>Stakeholder</th><th>Role</th></tr><tr><td>GCH Chronic Disease Services</td><td>Ensure there are timely and clear referral and management pathways between the GCH Chronic Disease Services and the provider to ensure coordinate and effective clinical handover and continuity of care for the patient and family</td></tr></table></td></tr>
<tr><td>Indigenous Specific</td><td>No</td></tr>
<tr><td>Duration</td><td>Service will cease after 30 June 2017</td></tr>
<tr><td>Coverage</td><td>Gold Coast PHN region (Gold Coast SA4)</td></tr>
<tr><td>Commissioning method (if relevant)</td><td>N/A</td></tr>
<tr><td>Approach to market</td><td>N/A</td></tr>
<tr><td>Decommissioning</td><td>An 18 month review of the service model and utilisation demonstrated that physiotherapy was the only service required after hours for the patients with COPD. A review of the patients accessing the physiotherapy was also completed and it was determined that the patients could all have received services in hours either through their aged care package or access to community physiotherapy.</td></tr>
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| | It has been agreed between GCH, GCPHN and the provider that the service can be discontinued without a negative impact for clients. Therefore, a decision has been made for the GCPHN to decommission the program from the 30 June 2017.<br>A transition plan will be implemented from the end of February to ensure all patients have an exacerbation plan in place with their General Practitioners and have timely access to in-hours physiotherapy when required to minimise the likelihood of an avoidable hospital admissions. |
| Planned Expenditure **2016-17** (GST Exc) – Commonwealth funding | $180,000 |
| Planned Expenditure **2016-17** (GST Exc) – Funding from other sources | $0 |
| Planned Expenditure **2017-18** (GST Exc) – Commonwealth funding | $0 |
| Planned Expenditure **2017-18** (GST Exc) – Funding from other sources | $0 |
| Funding from other sources | NA |

| **Proposed Activities -** copy and complete the table as many times as necessary to report on each activity | |
|---|---|
| Activity Title / Reference (eg. NP 1) | AH 1.3 GCIC After hours |
| Existing, Modified, or New Activity | Existing |
| Needs Assessment Priority Area (eg. 1, 2, 3) | Chronic Disease |
| Description of Activity | **Gold Coast Integrated Care (GCIC)** |

<table>
<tr><td></td><td>The aim of the Gold Coast Integrated Care (GCIC) Program is to provide urgently required After Hours services for patients through referral from the GCIC or Royal District Nursing Service, to reduce avoidable hospital admissions. GCPHN is funding the afterhours component of the program. The service will be:<ul><li>Delivered to patients who are referred in the after-hours period across the Gold Coast region in an appropriate, timely way .</li><li>These services will be delivered in the patients home and include:<ul><li>Allied Health</li><li>Nursing Services.</li></ul></li></ul>Establish referral and handover systems to coordinate service provision and provide ongoing patient care once after hours service has been completed.</td></tr>
<tr><td>Target population cohort</td><td>GCIC identified patients</td></tr>
<tr><td>Consultation</td><td>Extensive consultation took place with Gold Coast Health (GCH)</td></tr>
<tr><td>Collaboration</td><td><table><tr><th>Stakeholder</th><th>Role</th></tr><tr><td>GCH</td><td>Delivers the overarching program</td></tr><tr><td>Royal District Nursing Service</td><td>Delivers the after hours services</td></tr></table></td></tr>
<tr><td>Indigenous Specific</td><td>No</td></tr>
<tr><td>Duration</td><td>Continuing to June 2018 as part of NP 2017.1 Gold Coast Integrated Care</td></tr>
<tr><td>Coverage</td><td>Delivered through 15 General Practices across the GCPHN region</td></tr>
<tr><td>Commissioning method (if relevant)</td><td>Renewal of existing contract with GCH</td></tr>
<tr><td>Approach to market</td><td>Direct Engagement</td></tr>
<tr><td>Decommissioning</td><td>NA</td></tr>
</table>

# (c) Activities submitted in the 2016-18 AWP which will no longer be delivered for After Hours Funding

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.

| Activity Title / Reference (eg. NP 1/OP 1) | AH 1.1 Hospital avoidance – RACFs after hours |
|---|---|
| Description of Activity | The original intent of this activity 2016/17 was to work in collaboration with Gold Coast Health (GCH) to reduce need for transfer of frail aged patients to hospital in after hours by extending the GCH's Geriatric Evaluation and Management (GEMITH) team to include clients in their own home which then provides flexibility to treat older patients in their place of residence. The GEMITH service design work was to be completed collaboratively with all stakeholders and focus primarily on RACF clients to achieve:<br>• Agreed evidenced based integrated and coordinated pathways developed and evaluated that provides triage, consultancy, clinical support, and advice for RACF staff and GPs, so that care for patients can be delivered in the facility where appropriate, and transfer to hospital is avoided<br>• In collaboration with GCH, establishment of position in ED to support afterhours advice to RACFs and General Practice including Medical Deputising Services.<br><br>The activities above commenced in the 2015/16 however were unable to continue into 2016/17 successfully as a result of a significant re-structure within GCH and the resignation of the GCPHN Program Manager responsible for this program in August 2016. A subsequent review of both aged care and chronic disease services was undertaken by GCH after they had completed the restructure which meant GCH was not in a position to commit to or work in collaboration with GCPHN in any service design activities during the planned period.<br><br>The aspects of the 2016/17 activity that are in progress and will be embedded in 2017.9 Enhanced Primary Care in RACFs into the future are: |

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| | • Opportunities to further educate Medical Deputising Services, after hours general practitioners and regular general practitioners to ensure RACF client records are up to date at all times.<br>• Improve capacity of after hour GP services to support frail aged and palliative patients living in RACFs through:<br>o Education and training<br>o More effective communication with general practice<br>o Advanced care planning<br>o Use of My Health Record<br>o Telehealth<br>• Review outcomes of current local project being completed by BlueCare to design a model of care which can support palliative and end of life care in RACFs to avoid hospital admissions particularly in after hours. |
| Reason for removing activity | As the key component of this activity could only be progresses successfully in partnership and collaboration with the GCH and as GCH was not in a position to progress these activities it was not of value for GCPHN to continue to invest in service co-design at this point in time. Subsequently with the GCH review of Aged Care and Chronic Disease Services that was completed in November 2016 discussions have been occurring at Joint Board and Executive Management levels to explore mechanisms and opportunities to plan more integrated approaches across these service areas into the future.<br><br>Other components of this activity are continuing in 2016/17 as detailed above and will be embedded in 2017.9 Enhanced Primary Care in RACFs in 2017/18. |
| Funding impact | The aspects of this work to improve capacity of after hour GP services to support frail aged and palliative patients living in RACFs through:<br>o Education and training<br>o More effective communication with general practice<br>o Advanced care planning<br>have been taken forward and will be embedded in 2017.9 Enhanced Primary Care in RACFs |

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| Activity Title / Reference (eg. NP 1/OP 1) | AH 1.2 COPD Afterhours |
| Description of Activity | **COPD Afterhours**<br>The aim of the COPD after hours project was to provide urgently required after-hours services for patients with COPD through referral from Gold Coast Health (GCH), to reduce avoidable hospital admissions.<br><br>Services were to be:<br>• Appropriate, timely support services across the Gold Coast region for patients with COPD that are discharged/referred from hospital in the after-hours period.<br>• These services will be delivered in patients' homes and include:<br>- Allied health<br>- Nursing services<br>- Personal care<br>- Home oxygen<br>- Transport<br>- Social support |
| Reason for removing activity | An 18 month review of the service model and utilisation demonstrated that physiotherapy was the only service utilised. A review of the patients accessing the physiotherapy was also completed which determined that the patients could all have received services in hours either through their aged care package or access to community services physiotherapy.<br><br>It has been agreed between GCH, GCPHN and the provider that the service can be discontinued without a negative impact for clients. Therefore, a decision has been made for the GCPHN to decommission the program from the 30 June 2017.<br><br>A transition plan will be implemented from the end of February to ensure all patients have an exacerbation plan in place with their General Practitioners and referral pathways in place to ensure timely access to in-hours physiotherapy when required to minimise the likelihood of an avoidable hospital admissions. |

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| Funding impact | The aspects of this work to improve capacity of after hour GP services to support frail aged and palliative patients living in RACFs through:<br>o Education and training<br>o More effective communication with general practice<br>o Advanced care planning<br>have been taken forward and will be embedded in 2017.9 Enhanced Primary Care in RACFs. |