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WESTERN QUEENSLAND PHN

Activity Work Plan 2016-2018:

Core Funding

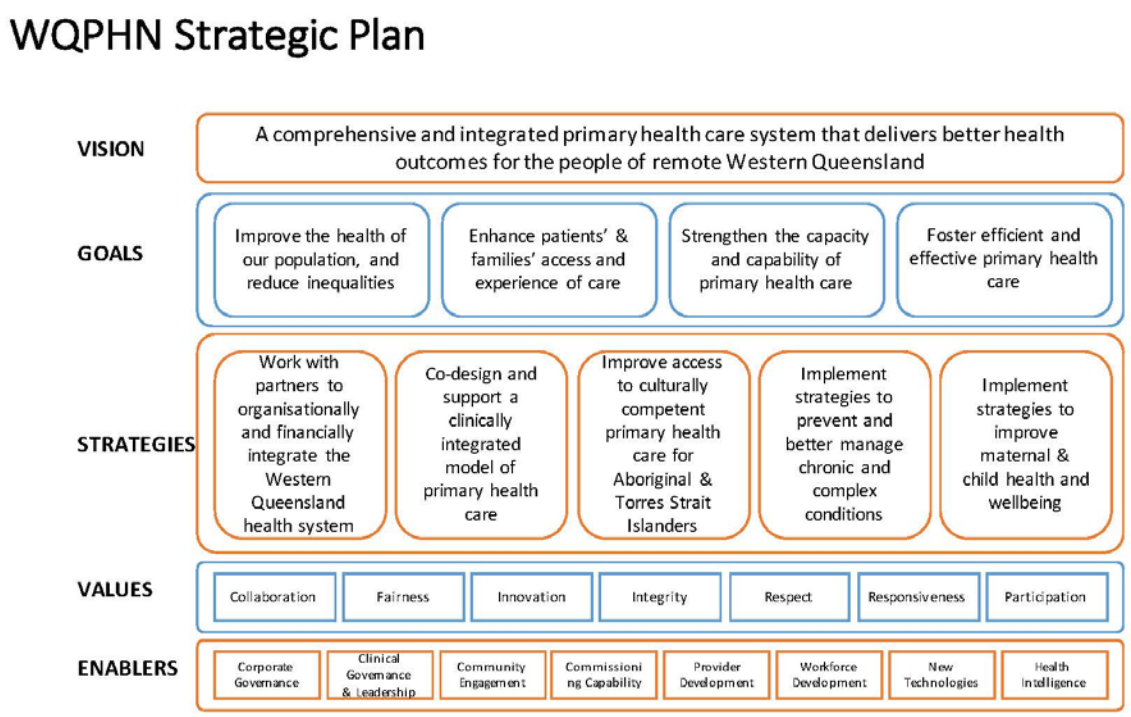
After Hours Funding

Overview

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

During 2016 - 2018 the WQPHN will continue to develop systems and capabilities to ensure effective corporate, clinical and program governance and provide a better system of care for the states most remote and isolated populations. Whilst 2015-2016 was essentially a year of transition from the ML program to the new PHN program, 2016-2017 represents a year for the transitioning of current services provider organisations with the gradual implementation of a new commissioning framework that aims to improve performance, create greater market responsiveness, build meaningful health intelligence and move to a more patient centred and outcomes focused paradigm. In 2017-2018 the WQPHN commissioning approaches will be increasingly implemented including a greater emphasis toward outcomes and practice-based population health approaches.

Strategic Vision



The WQPHN Vision is high level, ambitious and underscored with greater clarity around program and provider priorities and critical transformational and transactional enablers designed to drive performance and innovation. The vision has been directly informed by the Health Needs Assessment and provides a contemporaneous worksheet through which to develop the capacity, strategic intent and primary health care leadership of the WQPHN within its vast and challenging landscape.

The capacity of provider organisations and networks within the catchment is extremely limited and considerable support will be required to build the capabilities necessary to enable greater integrated primary health care performance and competency. This is especially the case in many general practice structures which are relatively underdevelopment from against contemporaneous Australian comparisons and not positioned to provide the needed clinical leadership and systemisation to support comprehensive primary health care.

Central to supporting the integrity and effectiveness of the Commissioning framework is further planning and health intelligence. This will better support design and collaborative service delivery opportunities between the WQPHN and its partners and guide investment and change management efforts. A number of pilot projects to trial innovation and yield evidence to support change and adoption will be pursued over the two years. The WQPHN will develop evidence based models of care to drive whole of system alignment in the management of chronic conditions and child and maternal health. Using models of care the WQPHN will be able to better align commissioning frameworks, consumer and provider engagement, and guide clinical quality improvement activities and greater team based care.

Overall, the Flex Fund will progressively transform the centrality of general practice within a more comprehensive local primary health system of care that is underpinned by well-coordinated, integrated and technologically enabled provider networks. More importantly activities undertaken within the Flex Fund will be patient centric and target critical National and local priorities including better prevention and management of chronic conditions, child and maternal health and prioritise deliberate efforts to improve the health of the catchments Aboriginal and Torres Strait Islander populations.

Planned PHN activities – Core Flexible Funding 2016-18

Proposed Activities	
NP1.	Commissioning and evaluation of primary health care services in WQPHN towns
Existing, Modified, or New Activity	Existing activity (2016-18 Activity Work Plan)
Program Key Priority Area	Primary Health Care – Commissioned PHC services
Needs Assessment Priority Area	1. Organisational Integration 2. Clinical Integration 3. Improved Access to PHC for ATSI people 4. Improved Chronic Disease Prevention & Management 5. Improved Child and Maternal Health & Wellbeing

Description of Activity	The current service environment has evolved over the last 5-10 years. As such, the commissioning activities to reorient current contracted services in a way that better supports general practice centred multidisciplinary team-based care and constructively change manage a fragile service environment will take a number of annual commissioning cycles to be achieved. The WQPHN's focus over the 2016-2018 period will be to orientate existing contracted services toward a general practice-based population health model of care by applying a number of commissioning levers to better integrate currently funded services with general practice. Additionally, from July 2017 new services will be incrementally introduced as a result of the reconfiguration of procurement approaches in line with the WQPHN's Commissioning and Development Framework, due to be finalised in April 2017. Where possible, new services will be a jointly designed and commissioned with WQ general practices, QAIHC & WQ ACCHOs and the WQ HHSs. Clearly, given the remote environment and the scarcity of local services, the commissioning and development approach needs to be incremental in scope, and done in a manner that develops the existing workforce and services to support the new model of care rather than causing the dissipation of long standing well regarded service providers as an unintended consequence.
Target population cohort	The entire WQPHN population
Consultation	The WQPHN has a formal protocol with the three WQ HHSs that provides for greater collaboration and joint planning of primary health care services. The WQPHN also maintains close working ties with QAIHC and the WQ ACCHOs and is actively developing a formal co-commissioning agreement to inform joint planning, data sharing and joint commissioning.

	The WQPHN regional Clinical Chapters (SW, CW, NW) and network-wide Clinical and Consumer Advisory Councils enable effective clinical leadership and community engagement in planning and policy making.
Collaboration	The review of services under contract will be undertaken in collaboration with current service providers and the relevant General Practices, ACCHOs and HHSs.
Indigenous Specific	Although not specifically targeted, services are provided for significant Indigenous populations in the region.
Duration	2016-18
Coverage	The current flexible funded services cover the entire PHN region The full list of services include: • RFDS S&EWB services to multiple towns in CWHHS (Alpha, Aramac, Barcaldine, Blackall, Isisford, Jericho, Longreach, Muttaburra, Tambo, Winton and Yaraka) (2016-17 Only) • CWHHS Diamantina program contributing to nurse-led health services at Birdsville & Bedourie • Blackall-Tambo Council health program coordinating allied health services and delivering health promotion/community development activities to Tambo • Quilpie Council health program providing health promotion/community development activities to Quilpie • SWHHS Healthy Ageing program providing healthy ageing and allied health services to Charleville, Cunnamulla, Morven and Augathella • Cripps podiatry services to St George and Cunnamulla • Matthew Edwards podiatry services to Dirranbandi • Outback Physical Bodyworx exercise physiology services to Cunnamulla • Vital Health - allied health services to Augathella, Morven, Mitchell, Injune, Roma and St George • SWHHS physiotherapy services to Cunnamulla and Wallumbilla

	• CWAATSICH dietitian services to Charleville • North West Remote Health allied health services to multiple towns and communities in CWHHS and NWHHS • WQPHN Diabetes Chronic Disease collaborative • WQPHN New Child and Family Health services
Commissioning method	A consistent approach to the commissioning and development of services will be taken across all current flexible funded services: 1. Re-contract existing flexible funded services from 2016-17 contingent on agreement to the new Commissioning and Development approach and adherence to a stricter reporting framework. 2. Better monitor delivery of services, improve and actively manage reporting of current contracted services during 2016-18 3. Finalise the WQPHN's Commissioning and Development Framework to guide the gradual reorientation of existing services and introduction of new services to align with WQPHN Health Needs Priorities and WQPHN Strategic Plan from 2017-18 onwards. 4. Commisioning of selected new Child and Family services and Diabetes Management Services
Approach to market	WQPHN will use a variety of procurement approaches including direct engagement, open tender, and EOI in the establishment of new services.
Decommissioning	While the WQPHN does not foresee the decommissioning of any existing service providers in 2017-18 it will continue to intensively work with a number of service providers, namely NWRH, the RFDS, the SWHHS and CWHHS to better orientate their funded services toward a general practice-based population health model of care, ensure their services better align with WQPHN Health Needs Priorities and WQPHN Strategic Plan and maximise their services in terms of value for money. As such while it is not anticipated any service providers

	will be defunded, it is likely that some contracts will be significantly modified in terms of content and budget. Note RFDS Mental health services will be funded directly from the MHS Program funding in 2017-18

Proposed Activities	
NP2.	Primary Health Care - Chronic Disease Model of Care
Existing, Modified, or New Activity	Existing activity (2016-18 Activity Work Plan)
Program Key Priority Area	Chronic Disease Prevention and Management
Needs Assessment Priority Area	1. Organisational Integration 2. Clinical Integration 3. Improved Access to PHC for ATSI people 4. Improved Chronic Disease Prevention & Management
Description of Activity	According to the WQPHN's HNA the region has disproportionately high numbers of people with chronic and complex conditions such as heart disease, diabetes, cancers, respiratory diseases and mental illness. Furthermore these conditions are the leading causes of illness, disability and death in the PHN. Lastly, the region's current health system is not optimally set up to effectively prevent and manage these chronic diseases. Services for this patient cohort are fragmented and poorly integrated. The majority of patients receive treatment from multiple providers, most of them working in different locations, and are often working in different parts of the health system (social, primary and acute). As a result, effective communication between the health 'team' is challenging and inconsistent resulting in concerns about the quality and safety of patient care.

	The objective is to create the environment to support greater partnership across all the key health providers in the region (e.g. HHSs, ACCHOs, CheckUp, private General Practice, RFDS, allied health professionals, NGO social care providers) to develop a PHN-wide strategic framework for a new model of primary health care for patients with chronic and complex conditions that is aligned closely with the key features of the Health Care Home. The WQPHN will commission the development of a Chronic Disease Strategic Framework that clearly defines a model of care through which to articulate the adoption of systems and services, roles and responsibilities, and outcome measures to support the management of complex conditions within a Health Care Home construct. There has been good progress with stakeholder in garning support for codesign of a new chronic disease model of care and the current timeline is identified as December 2017, allowing a more consultative methodology,. A WQ Chronic Disease Strategic Framework will inform commissioning and quality improvement priorities in 2018-19.
Target population cohort	The entire WQPHN population
Consultation	The WQPHN has a formal protocol with the three WQ HHSs that provides for greater collaboration and joint planning of primary health care services. The WQPHN also maintains close working ties with QAIHC and the WQ ACCHOs and is actively developing a formal co-commissioning agreement to inform joint planning, data sharing and joint commissioning. The WQPHN regional Clinical Chapters (SW, CW, NW) and network-wide Clinical and Consumer Advisory

	Councils enable effective clinical leadership and community engagement in planning and policy making.
Collaboration	General Practice, WQ ACCHOs & QAIHC, HHSs, CheckUp, RFDS, James Cook University and other private and not-for-profit services (eg Anglicare, Blue Care, Lifeline, CentaCare)
Indigenous Specific	Yes. Although not specifically targeted, services are provided for significant Indigenous populations in the region.
Duration	2016-18
Coverage	Entire WQPHN region.
Commissioning method	A WQ Chronic Disease Strategic Framework will inform commissioning and quality improvement priorities in 2017-18.
Approach to market	WQPHN will use a variety of procurement approaches including direct engagement, open tender, and EOI in the establishment of new services that align with WQ Chronic Disease Framework.

Proposed Activities	
NP3.	Primary Health Care - Child & Maternal Health Model of Care
Existing, Modified, or New Activity	Existing activity (2016-18 Activity Work Plan)
Program Key Priority Area	Child Health & Wellbeing
Needs Assessment Priority Area	1. Organisational Integration 2. Clinical Integration 3. Improved Access to PHC for ATSI people 4. Improved Child and Maternal Health & Wellbeing
Description of Activity	According to the WQPHN's HNA the region has very poor child development and well-being outcomes compared with Queensland and Australian children. The origins of many chronic diseases are set in utero and early childhood, most notably through low birth weight, growth retardation and repeated childhood infections. Furthermore chronic diseases are also inextricably linked with the broader social determinants of health and quality of life, particularly education and employment. Early child development, including the physical, social/emotional and language/cognitive domains, has a determining influence on subsequent life chances and health through skills development, education, and occupational opportunities. The cost of not intervening in the early years is too great. For example, for every $1 spent per child on the (Olds) nurse home visiting program, at 15-year follow-up, $5 is returned to society; for every $1 spent on the (Perry) preschool program, at 40-year follow-up, $17 is returned to society.

	With the high rates of chronic diseases in the Aboriginal adult population and the disproportionally poor early years outcomes in the Aboriginal child population, proactively addressing the needs of Aboriginal children and young people is of particular importance given the WQPHN's large A&TSI population. Nationally and internationally there has been increased focus on child development and wellbeing from a primary prevention, promotion and early intervention perspective. This research would inform the evidence-based best buys in our proposed regional strategy. The WQPHN will commission the development of a Child Health & Wellbeing Strategic Framework that clearly defines a model of care through which to articulate the adoption of systems and services, roles and responsibilities, and outcome measures to improve the development and wellbeing of children in western Queensland. The deliverable is to work in partnership with all the key health providers in the region (i.e. QH, HHSs, QAIHC, ACCHOs, Education Qld, schools, other organisations that have an influence on child development and well-being) to develop a WQPHN-wide strategic framework. There has been considerable progress gaining key stakeholder engagement and support for a unique child and maternal health model of care, particularly in the Lower Gulf. To ensure a broad-based consultative methodology and to enable co-design outcomes, the completion date for this activity is December 2017. Early work is currently underway in the Lower Gulf that will inform a whole-of-catchment framework to be developed collaboratively. A WQ Child Health & Wellbeing Strategic Framework will inform commissioning and quality improvement priorities in 2017-18.
Target population cohort	The entire WQPHN population

Consultation	The WQPHN has a formal protocol with the three WQ HHSs that provides for greater collaboration and joint planning of primary health care services. The WQPHN also maintains close working ties with QAIHC and the WQ ACCHOs and is actively developing a formal co-commissioning agreement to inform joint planning, data sharing and joint commissioning. The WQPHN regional Clinical Chapters (SW, CW, NW) and network-wide Clinical and Consumer Advisory Councils enable effective clinical leadership and community engagement in planning and policy making.
Collaboration	The aim is to develop a collaborative strategic framework that is supported by the WQPHN, General Practice, QH, the HHSs, QAIHC, the ACCHOs, EQ, the schools and other early childhood services, Queensland Department of Communities, Child Safety & Disability Services, other public and private health professionals, other non-government and community organisations, and consumer representatives.
Indigenous Specific	Although not specifically targeted, services are provided for significant Indigenous populations in the region.
Duration	2016-18
Coverage	Entire WQPHN region.
Commissioning method	A WQ Child Health & Wellbeing Strategic Framework will inform commissioning and quality improvement priorities in 2017-18.
Approach to market	WQPHN will use a variety of procurement approaches including direct engagement, open tender, and EOI in the establishment of new services.

Proposed Activities	
NP4.	Primary Health Care - Joint Planning & Health Intelligence
Existing, Modified, or New Activity	Existing activity (2016-18 Activity Work Plan)
Program Key Priority Area	Integrated Care
Needs Assessment Priority Area	1. Organisational Integration 2. Clinical Integration 3. Improved Access to PHC for ATSI people 4. Improved Chronic Disease Prevention & Management 5. Improved Child and Maternal Health & Wellbeing
Description of Activity	A challenging characteristic of Western Queensland's healthcare environment is the borderline viability and continued decline of general practice in the region over the last 20 plus years. Traditional models of independent general practice as characterised by private ownership and the rural GP with hospital and after-hours responsibilities, have become less attractive for many younger doctors. This has seen the emergence of other GP models such as the Central West One Practice Model underpinned by the Queensland Health Rural Generalist Program, Aboriginal Community Controlled Health Organisation-operated general practice and RFDS run general practice. As such the current general practice environment in the region is distinguished by marginal sustainability, notable diversity and limited primary care capacity. While many of these alternate general practice models have been crucial in maintaining essential services in the region's communities, the driver for these new models has understandably meant the

	focus has been on a general practitioner's acute skills in dealing with accidents and emergencies, and clinical procedures such as general surgery, anaesthesia and operative obstetrics. The challenges now facing some of these new general practice models will be the need to deliver more comprehensive primary care services, clinical leadership, and refine a more robust business model, with a greater emphasis on care coordination and GP led team based outcomes. While there are a number of Aboriginal Community Controlled Health Services in the region, the sizable A&TSI population dictates that the sector should have a greater role in the delivery of primary care services to Indigenous people. Like mainstream general practice the challenge facing the sector and individual services will be delivering sustainable general practice services. The WQPHN recognises the evolving general practice models within the region. As such it will be crucial to support the many existing general practice models – both traditional and subsidised, non-Indigenous and Indigenous – as well as extend capacity to improve access to comprehensive general practice services for its many remote communities. Added to the deterioration in general practice over the last couple of decades and the growing difficulty in recruiting and retaining a stable medical workforce, has been the lack of integration of other primary care and specialist services with general practice, resulting in poorly coordinated and often duplicated care. While there has been an increased investment in allied health and specialist services in the region in the last ten years, the design of these services has, to some extent, been disconnected from general practice and evolved in parallel.

	The WQPHN recognises the central role of the general practitioner in the design of health services and views general practice as the gateway to other primary care and specialist providers via referral pathways. To this end, primary care services need to be developed in a manner that supports general practice-centred multidisciplinary team-based care. The Baseline HNA process identified a number of possible joint planning exercises focusing on revitalising a general practice model of care to support comprehensive primary health care both in mainstream and Aboriginal Community Controlled settings. These included: 1. The development of a Lower Gulf Strategy in partnership with Gidgee Healing and NWHHS; 2. The development of an independent General Practice support entity for the Charleville cluster (Charleville, Cunnamulla & Quilpie) in partnership with SWHHS, CACH and CWAATSICH; 3. The development of a Western Corridor Strategy (Birdsville, Bedourie & Boulia) in partnership with CWHHS and RFDS; 4. The trialling of a 'primary care for mental health' service model in a variety of General Practices in WQPHN (St George, Cunnamulla, Cloncurry, Balcaldine) in partnership with privately and ACCHO operated General Practice; and 5. The support for CWHHS's one regional general practice model in partnership with CWHHS The last 12 months has seen significant progress made in terms of joint planning for all these projects with the exception of number 2 (eg joint agreements in place, joint development of QH ICIF project plans, piloting of mental health general practice based collaboratives, joint development of a Lower Gulf Needs Analysis & Plan, etc) however the 2017-18 year will see this planning work intensify and

	the early implementation of these joint plans. In addition, over the last 12 months a number of new collaborative planning opportunities have been identified and will be proactively pursued in 2017-18. Key items of interest are the three approved Integrated care and Innovation Fund projects within the WQPHN and an emerging data sharing collaborative with QAIHC and Q health. Finally, in 2016-17 the WQPHN has built its internal capacity and capability to support the ever-increasing joint planning exercises and shared health intelligence work (eg recruitment of key staff, PEN CAT4 roll-out to GPs/ACCHOs, trialling of Qlik Sense as a health intelligence system). Once again, the 2017-18 year will realise further growth in the shared health intelligence capability of the WQPHN and its key partners.
Target population cohort	The entire WQPHN population
Consultation	The WQPHN has a formal protocol with the three WQ HHSs that provides for greater collaboration and joint planning of primary health care services. The WQPHN also maintains close working ties with QAIHC and the WQ ACCHOs and is actively developing a formal co-commissioning agreement to inform joint planning, data sharing and joint commissioning. The WQPHN regional Clinical Chapters (SW, CW, NW) and network-wide Clinical and Consumer Advisory Councils enable effective clinical leadership and community engagement in planning and

	policy making.
Collaboration	General Practice, WQ ACCHOs & QAIHC, HHSs, RFDS and James Cook University
Indigenous Specific	Although not specifically targeted, services are provided for significant Indigenous populations in the region.
Duration	2016-18
Coverage	Entire WQPHN region.
Commissioning method	Through partnerships with the HHSs and QAIHC whole-of-system co-commissioning across the region will be pursued.
Approach to market	WQPHN will use a variety of procurement approaches including direct engagement, open tender, and EOI in the establishment of new services.

Proposed Activities	
NP5.	Primary Health Care - Continuous Quality Improvement
Existing, Modified, or New Activity	Existing activity (2016-18 Activity Work Plan)
Program Key Priority Area	Continuous Quality Improvement
Needs Assessment Priority Area (eg. 1, 2, 3)	1. Clinical Integration 2. Improved Access to PHC for ATSI people 3. Improved Chronic Disease Prevention & Management
Description of Activity	The Australian Primary Care Collaborative is a recognisable feature of the contemporary Australian General Practice quality improvement landscape. Within the WQPHN context, few quality activities have been undertaken beyond the general practice accreditation and associated activities and isolated training and development provided under the Medicare Locals program. As Practice-based and provider capability increases and with the adoption of systems, clinical pathways and networks, processes and technology; the WQPHN will introduce a catchment-wide diabetes collaborative in identified high performing general practices in 2016-18 to promote multidisciplinary team based collaboration, build clinical leadership in and adoption of PDSA methodology, to assist change management and quality improvement within practices and across visiting provider networks. It is anticipated subsequent collaborative topics will be progressively introduced including mental health and other vascular illnesses.
Target population cohort	Identified high performing general practices within the WQPHN catchment.

Consultation	The WQPHN has a formal protocol with the three WQ HHSs that provides for greater collaboration and joint planning of primary health care services. The WQPHN also maintains close working ties with QAIHC and the WQ ACCHOs and is actively developing a formal co-commissioning agreement to inform joint planning, data sharing and joint commissioning. The WQPHN regional Clinical Chapters (SW, CW, NW) and network-wide Clinical and Consumer Advisory Councils enable effective clinical leadership and community engagement in planning and policy making.
Collaboration	General Practice, WQ ACCHOs & QAIHC, HHSs, James Cook University and other PHNs
Indigenous Specific	No. But ACCHOs will be provided the same opportunities as mainstream general practices.
Duration	2016-18
Coverage	Entire WQPHN region.
Approach to market	General practices will be directly enrolled.

Proposed Activities	
NP6.	Primary Health Care - Workforce Support & Training
Existing, Modified, or New Activity	Existing activity (2016-18 Activity Work Plan)
Program Key Priority Area	Health workforce
Needs Assessment Priority Area	1. Clinical Integration 2. Improved Access to PHC for ATSI people 3. Improved Chronic Disease Prevention & Management 4. Improved Child Health & Wellbeing
Description of Activity	Given the relative isolation and underdeveloped nature of a large number of the general practices, particularly those operated by the three HHSs, combined with the many smaller and remotely located visiting service provider organisations, there is a significant body of work required to bring individuals and systems in line with primary health care contemporary standards. Funds will be made available to cover individual clinician training costs and resource practice-based and visiting service provider training and education opportunities. WQPHN will deliver a range of products and services specifically targeting practice-based and service provider capability development. As competency and capability increases, the performance and adoption of systems, clinical pathways and service networks, processes and technology will increase in the general practices.

	Examples of practice staff competencies: family planning, Immunisation, triage, mental health first aid, diploma of practice management, PenCAT & population health data training, eHealth enablement, phlebotomy, practice accreditation, CQI & PDSA, and cultural competency. Provider competencies: e-referral, my health record, videoconferencing, CQI & PDSA, commissioning & contracting awareness, tender and report writing, population health and data interpretation skills, formative evaluation, mental health first aid, cultural competency, motivational interviewing.
Target population cohort	General practice staff and PHN contracted visiting service providers.
Consultation	The WQPHN has a formal protocol with the three WQ HHSs that provides for greater collaboration and joint planning of primary health care services. The WQPHN also maintains close working ties with QAIHC and the WQ ACCHOs and is actively developing a formal co-commissioning agreement to inform joint planning, data sharing and joint commissioning. The WQPHN regional Clinical Chapters (SW, CW, NW) and network-wide Clinical and Consumer Advisory Councils enable effective clinical leadership and community engagement in planning and policy making.
Collaboration	General Practice, WQ ACCHOs & QAIHC, HHSs, PHN contracted visiting service providers.
Indigenous Specific	No. But ACCHOs will be provided the same opportunities as mainstream general practices.

Duration	2016-18
Coverage	Entire WQPHN region.
Approach to market	General practices and visiting service providers will be directly approached.

Planned PHN activities – Core Operational Funding 2016-18

Proposed Activities	
OP1	Primary Health Care - General Practice Systems & Capability Support
Existing, Modified, or New Activity	Existing activity (2016-18 Activity Work Plan)
Program Key Priority Area	General Practice Support
Needs Assessment Priority Area	1. Clinical Integration 2. Improved Access to PHC for ATSI people 3. Improved Chronic Disease Prevention & Management 4. Improved Child Health & Wellbeing
Description of Activity	The Baseline and Updated HNAs identified a need to better support general practices and the fragile service delivery environment to deliver quality primary care through: IT support; training of practice staff; adoption of e-Health technology and systems to streamline the flow of patient information across the health provider community; accreditation support; the collection and use of clinical data to implement improvements in patient care through audit and CQI, and so on. Furthermore the HNA noted the general lack of practice systems to support best practice care, for example secure messaging and e-referral services, patient data management systems, disease registers, care pathways, and evidence based guidelines, and the need for greater practice systemisation and enablement.

	The WQPHN has established three regional practice and visiting provider support positions - North-West, Central West and South-West – to build general practice capacity. These positions will increase practice capacity and systemisation by providing: • Accreditation assistance • Continuous Quality Improvement (CQI) • Uptake of eHealth technologies • My Health Record • Revenue maximisation • Data quality • Practice management systems and expertise • Culturally informed practice • Innovating workforce Similar to other QPHNs, the WQPHN has developed a practice support framework which differentiate the capacity, function and readiness of practices throughout the catchment against contemporaneious measures to guide Practice Support and engagement efforts. A range of scored questions over 8 program areas determines the practice tier. The system will enable Coordinators to gauge what type and intensity of support is needed for each individuals practice in each program area.

	Tier 1 - Practice is not engaged with WQPHN Primary Health Care Support Team or Programs Tier 2 - Practice receives visit and information from Coordinators but doesn't engage in any Programs Tier 3 - Practice is signed up for Data Management Program and uploads data monthly, receives visit and information from Coordinators but is not enrolled in QI programs Tier 4 - Practice does all Tier 3 activities and also is enrolled and making improvements through QI programs The objectives of the system are: 1. Provide a tiered level for each WQPHN general practice regardless of how it is managed 2. Provide a strategic level view of WQPHN general practice to allow engagement in programs at the correct level e.g readiness for QI program enrollment 3. Provide coordinators with knowledge of each general practice and what is needed to support them 4. Allow coordinators to "move" a general practice to the next tier through providing access to the correct resources and knowledge During 2016-17 the WQPHN will be working to harmonise Practice Support and Data management activities with QAIHC (and its affiliates) and also where dedicated practice support positions have been established in HHS organisation. There will be structural efficiency in these efforts and potentially shared investment in activities linked to pratice support, digital health enablement, and health intelligence.

	With the planned cessation of the After Hours program in 2017-18, current practice support staff have been accommodated within the FLEX activities. Work undertaken to assist Practices provide better access to after hours, initiatives arising from the clinical chapter working in examining Emergency Department non-urgent presentations, and improving digital connectivity betwacute, primary and social care settings.
Target population cohort	General practice staff and PHN contracted visiting service providers.
Consultation	The WQPHN has a formal protocol with the three WQ HHSs that provides for greater collaboration and joint planning of primary health care services. The WQPHN also maintains close working ties with QAIHC and the WQ ACCHOs and is actively developing a formal co-commissioning agreement to inform joint planning, data sharing and joint commissioning. The WQPHN regional Clinical Chapters (SW, CW, NW) and network-wide Clinical and Consumer Advisory Councils enable effective clinical leadership and community engagement in planning and policy making.
Collaboration	General Practice, WQ ACCHOs & QAIHC, HHSs, PHN contracted visiting service providers.
Indigenous Specific	No. But ACCHOs will be provided the same opportunities as mainstream general practices.
Duration	2016-18
Coverage	Entire WQPHN region.
Approach to market	General practices and visiting service providers will be directly approached.

Strategic Vision for After Hours Funding

The WQPHN Vision is high level, ambitious and underscored with greater clarity around program & provider priorities and critical transformational and transactional enablers designed to drive performance and innovation. The vision has been directly informed by the Health Needs Assessment and provides a contemporaneous worksheet through which to develop the capacity, strategic intent and primary health care leadership of the WQPHN within its vast and challenging landscape.

Across the WQPHN catchment, potential After Hours activities have been difficult to develop largely as a result of the limited capacity of provider networks and high prevalence of general practice services being provided through the HHS Senior Medical Office Model, often based in the 24 hour hospital and emergency department. Whilst all existing private practices actively participate in the AH PiP, the majority of practices operate mutually exclusive of hospital and emergency departments with poorly defined relationships and after hours protocols.

During the 2016-17 period, the WQPHN will be working to break down barriers across primary and acute provider systems and explore opportunities to innovate a more connected and robust after hours framework for communities, including a number of specific proof of concept trials in a number of sites to examine system improvement. Increasing access to General Practitioner services and better uptake and adoption of virtual and technologically enabled approaches will feature in these efforts, especially for the more remote populations. Creating the capacity to better identification of people most at risk of needing after hours support (especially frail aged, people with complex conditions, people with disabilities, people with a severe mental health condition) is a priority for the WQPHN and in 2016-17 a range of provider and practice support activities will build the capacity and linkages necessary to better assist these vulnerable segments of the population.

Residents and families of remote and isolated RACF facilities often also experience a disconnect from appropriate and consistent general practice and specialist care services, resulting in sub-optimal care, unnecessary acuity and potentially avoidance after-hours activity. The WQPHN will be examining options to improve both the connectivity, clinical support and a consistent General Practice after hours program of support to ensure facilities, staff and importantly residents experience better access.

The health intelligence and after hours data is poor and more work will need to undertaken, in collaboration with each of the 3 HHS organisations across the catchment to develop a more cohesive, efficient and transparent set of local and regionally based solutions that can respond to the challenges of distance, health literacy, technology constraints and transient populations within the NW and western corridor.

A key focus area will be the uptake and adoption of systems that better support sharing of clinical information around individual patient needs, such as the *myHealth record*, better care planning for identified individuals at risk of potentially avoidable emergency support during after hours, home monitoring assistance and telehealth. The relative isolation, varying degrees of workforce and system capacity across the various parts of the health system in remote areas, and the health literacy of populations will require investment from the WQPHN to build the capacity within individuals, organisations and systems to better provide a robust after hours system of care in WQ.

Planned PHN Activities – After Hours Primary Health Care 2017-18

Proposed Activities **NP1.** Primary Health care capacity - effective use of eHealth technology and systems, including My Health Record	
After Hours Priority Area	Increased access to Primary Health Care for A&TSI people Regional leadership Integrated planning Workforce Chronic disease
After Hours Activity Title / Reference	Improved health information exchange between after-hours services and primary care services
Description of After Hours Activity	People living in Western Queensland increasingly seek healthcare from multiple services/professionals for a variety of reasons. The process of requesting and retrieving clinical information from these disparate providers is cumbersome, time-consuming, and often unsuccessful, especially when patients do not recall the variety of locations in which they have received care. This situation is exacerbated in an after-hours setting. While there has been earlier work done to promote the PCEHR (now My Health Record) and some services and consumers within the region have registered, and we acknowledge the opt-out trials currently being conducted in Far North Qld and NSW, there is the real opportunity to promote the My Health Record across the WQPHN and improve the health information exchange between hospitals and primary care services, and in turn the access to patient information and continuity of care in the after-hours setting.

	The PHN will establish three regional eHealth officer positions - North-West, Central West and South-West. These positions will: • Build working relationships with General Practices, ACCHSs, hospitals, pharmacies and other health professionals; • Promote awareness around the My Health Record; • Assist services to register or renew and upload information; • Educate and assist consumers to register, and encourage services to do the same; and • Support the uptake of other eHealth technology and systems in General Practices and ACCHSs This Activity aligns the second After Hours objective – improving access to After Hours Primary Health Care through effective planning, coordination and support for population based After Hours Primary Health Care
Collaboration	Yes with General Practices, ACCHSs, hospitals, pharmacies and other health professionals
Duration	24 months
Coverage	Entire PHN region
Commissioning approach	Based on WQPHN's Commissioning and Development Framework, the Activity would 'Enhance' the health system by using a broad range of commissioning levers including: System leadership, Clinical engagement, Community engagement, Provider collaboration and Primary care capability building
Performance Indicator	% Percentage of HHS Practices with formal after hours PiP registration %persons who have registered for My Health Record % services who actively use My Health Record % general practices/ACCHSs who are eligible for eHealth Practice Incentive Payment

Local Performance Indicator target	After 24 months % of practices that have adopted an after-hours patient discharge and referral pathways / protocols from EDs back into general practice for at-risk patients 50% of persons registered 90% of services registered 90% general practices/ACCHSs
Data source	My Health Record Emergency Departments (EDIS) Medicare Local providers

Proposed Activities **NP2.** GP capacity - effective use of eHealth technology and systems, including My Health Record	
After Hours Priority Area	Increased access to Primary Health Care for A&TSI people Regional leadership Integrated planning
After Hours Activity Title / Reference	Planning to examine potential after-hours service gaps identified in the HNA, namely: • after-hours services in Mt Isa. • after-hours services to Residential Aged Care Facilities. • after-hours services to some very remote towns.

Description of After Hours Activity	The HNA found that in general the after-hours services to most towns in the region was satisfactory. However, the HNA did identify potential gaps requiring further examination over the next 12-24 months. These included a need for the: (a) after-hours services in Mt Isa. (b) after hours integrated pilot in St George (ED and RACF) (c) after-hours services to Residential Aged Care Facilities. (d) after-hours services to some very remote towns. (a) Mt Isa has more than 50% of the total admissions within WQ and currently experience significant after-hours activity with up to 50 patients presenting daily seeking non-urgent assistance. The majority of these presentations are occurring in the after hours period with many patients Aboriginal from the lake Nash and NT region. This strategy will support collaboration between the ACCHO and private general practices, Mt Isa hospital and nominated social care providers to build better systems to divert ED activity and repatriate patients into general practice based programs, including consideration for better access to social services for homeless people. (b) The St George medical centre current provides a largely unfunded service to the RACF and after hours support for private patients of the St George hospital. The Practice is also assisting better management of patients with severe and persistent mental health conditions including assisting patients in residential programs locally. This project will support greater collaboration between the ED, General Practice and RACF to adopt new protocols and innovation to provide a more

	sustainable framework for after-hours including VMO privileges at the hospital, training and protocol development for the RACF and new team care arrangements and connectivity. (c) RACFs within the WQ are dispersed across a vast geography and can experience a wide variation in the skill and capacity of staff and systems, consistency of support from General Practitioners, and a lack of clarity around escalation protocols for higher triage events in residence. This project will identify priority facilities (including St George and Mt Isa) and develop a range of systems, training and referral protocols including uptake and adoption of technology enable support and improved connectivity across referral and specialist networks. (d) WQPHN has a number of very remote and isolated small communities located in the Western periphery if the catchment. Recognised as a western corridor, these communities are services via fly in fly out services and supported via virtual clinical consultations in the after hours. This project will support key stakeholder including QAIHC, CW and NWHHS, and RFDS to examine systems to better support those people most at risk of after hours support requirements, especially Aboriginal people, people aging in place and people with disabilities. Strategies will include enhancing current team care arrangements, home monitoring and virtual networks and enrolment in shared care and information platforms, including the myHealth record. This Activity aligns the second After Hours objective – improving access to After Hours Primary Health Care through effective planning, coordination and support for population based After Hours Primary Health Care
Collaboration	Yes with General Practices, ACCHSs, hospitals, RACFs, other health professionals and consumers.

Duration	12 months
Coverage	- Mount Isa - St George - Residential Aged Care Facilities in region - Very remote towns in the Western Corridor
Commissioning approach	Based on WQPHN's Commissioning and Development Framework, the Activity would 'Modify' and 'Enhance' the health system by using a broad range of commissioning levers including: System leadership, Clinical engagement, Community engagement, Provider collaboration and Primary care capability building
Performance Indicator	Planning undertaken for each of the (four) identified needs Recommendations made to address the (Four) identified needs
Local Performance Indicator target	Plans completed
Data source	Local providers and consumers