Australian Government
Department of Health

phn
An Australian Government Initiative

Primary Health Networks Core Funding

Primary Health Networks After Hours Funding

Updated Activity Work Plan 2016-2018:

- **Core Funding**
- **After Hours Funding**

Adelaide PHN

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

This Updated Activity Work Plan has been endorsed by the CEO.

Submitted on 17 February 2017.

Contents

Introduction

Overview

The key objectives of Primary Health Networks (PHN) are:

- Increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- Improving coordination of care to ensure patients receive the right care in the right place at the right time. Each PHN must make informed choices about how best to use its resources to achieve these objectives.

Together with the PHN Needs Assessment and the PHN Performance Framework, PHNs will outline activities and describe measurable performance indicators to provide the Australian Government and the Australian public with visibility as to the activities of each PHN.

Thus far, PHNs have completed two Needs Assessments – the Baseline Needs Assessment (BNA), completed in March 2016 and an update to the BNA was completed in November 2016.

This document, the updated Activity Work Plan template, captures those (existing, modified and new) activities addressing needs identified in the updated BNA.

This updated Activity Work Plan covers the period from 1 July 2016 to 30 June 2018. To assist with PHN planning, each activity nominated in this work plan can be proposed for a period of 12 months or 24 months.

This updated 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.

1. (a) Strategic Vision

The Adelaide PHN (APHN) is a membership based and driven organisation, committed to honest and genuine community involvement and input into improving the health outcomes of people living in metropolitan South Australia. Our Strategic Plan reflects the key objectives and priority areas from the Commonwealth Government and incorporates our core local priority areas determined by our APHN membership groups. It is a truly collaborative and integrated Strategic Plan (endorsed by the APHN Board).

Our Vision (our aspirations for the future)
Connecting you to health

Our Purpose (our reason for existence)
Facilitating a collaborative and responsive health care system for metropolitan Adelaide

Our Values
Communication, Commitment, Respect, Quality, Transparency, Equity, Accountability and Trust

Our strategic objectives are:

Strategy 1

Have a sound understanding of the health and service needs of our communities.

Strategy 2

Develop, implement, review and improve system wide approaches and activities within our priority areas.

Strategy 3

Support primary health care providers to deliver quality, efficient and effective services (right care, right place, and right time).

Strategy 4

Ensure engagement and involvement of community members in development of health promotion, prevention, early intervention and empowerment.

Strategy 5

Commission services that are high quality, efficient, effective, integrated and innovative.

Strategy 6

Be an efficient and effective organisation.

For further information on our Strategic Framework, please see our website:
http://adelaidephn.com.au/assets/APHN_Strategic_Framework_and_Plan.pdf

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

Proposed Activities – NP1.1 South Australia (SA) PHNs Immunisation Hub	
Activity Title / Reference (eg. NP 1)	NP 1.1 South Australia (SA) PHNs Immunisation Hub
Existing, Modified, or New Activity	Existing Activity
Program Key Priority Area	Population Health
Needs Assessment Priority Area (eg. 1, 2, 3)	10. Immunisation rates for Aboriginal and Torres Strait Islander children are lower than non-Aboriginal and Torres Strait Islander children 12. The CALD community are disproportionally affected by Hepatitis B 14. Identified areas of the Adelaide PHN (APHN) region have childhood immunisation rates below the national average 33.Prevention and early intervention strategies for childhood and youth health conditions
Description of Activity	The Adelaide and Country SA PHNs have jointly implemented the SA PHN Immunisation Hub, a multi-faceted approach to bridge gaps in immunisation service provision, support the skill base of immunisation providers, improve accessibility to after-hours immunisation services and promote the need for a well immunised community. The Hub will provide education, mentoring and networking for service providers, engagement, advocacy and resources for the community, and will facilitate nurse led clinics in areas where low immunisation coverage and service delivery gaps are identified. Through increased immunisation service delivery, especially in areas with identified low childhood immunisation coverage or high prevalence of vaccine preventable disease (VPD'S) such as influenza, childhood immunisation rate will increase and hospital presentations and admissions from VPD's will decrease. The Champion Nurse Immunisation Program (CNIP), one of five elements of the SA PHN Immunisation Hub program will use specialist Nurses to provide: • immunisation program support and education to providers • support and information to the community

	• identify barriers to vaccine uptake • address vaccine hesitancy • promote and advocate for immunisation at local community events • address immunisation requirements for CALD and new emerging communities With practice based support available to providers and expert immunisation nurses accessible to communities, it is anticipated increased immunisation program awareness will lead to improved immunisation coverage. The program will be evaluated to determine its success and the potential to expand further into rural regions. The Hub engages with SA Health to monitor Aboriginal childhood immunisation rates and with Aboriginal Health organisations to ensure communities are assisted to overcome barriers leading to under-immunisation. The Hub is represented on the Hepatitis Action Plan Implementation Group – Hep B, to work with key stakeholders to ensure appropriate information is communicated and appropriate resources developed and to develop strategies to improve awareness of hepatitis B treatment and pathways.
Target population cohort	All children overdue for immunisation
Consultation	• ACIR data for Aboriginal and Torres Strait Islander children under 7 years of age is actively monitored and cleaned by the SA Health Immunisation Section. The Hub will engage regularly with SA Health to develop strategies to respond to identified data and/or provider issues. • The Hub has engaged and consulted with the Local Government Association, SA Health, Country Health SA, State Department of Education and Child Development (DECD), (State) Migrant Health Service, (State) Child and Family Health Service (CaFHS), Aboriginal Community Controlled Health Organisation(s) (ACCHO), Aboriginal Health Council SA, Hepatitis SA, General Practitioners and Local Councils in targeted areas of both APHN and Country SA PHN regions to enable sharing of information, resources and innovative ideas across the State. • The activity has engaged and consulted with the 280 members of the South Australian Immunisation Provider Network (IPN) by providing secretarial support to enable facilitation of meetings with stakeholders and relevant partners.

Collaboration	• Australian Immunisation Register (AIR) - to effectively manage the childhood immunisation data through (AIR) data cleaning activities to accurately reflect the current immunisation status of children. • The organisation commissioned to deliver the Champion Immunisation Nurse project – this co-designed activity will ensure all key elements of the Champion Immunisation Nurse project are undertaken in a timely manner and objectives met. • Immunisation service providers, including General Practice, Aboriginal Health Organisations, Local Councils, Child and Family Health Services and Hospitals – this activity will collaborate and support providers through providing clinical advice, face to face education and information through newsletter articles. • Country SA PHN (CSAPHN) – a partner in the SA PHN Immunisation Hub. CSAPHN will support delivery of provider education, AIR data cleaning activities, community engagement activities to increase awareness of the immunisation program and networking with key stakeholders to ensure there remains a united focus on immunisation across the state. • SA Health Immunisation Section – will meet regularly with the Hub to ensure consistent messaging, monitoring of Aboriginal children immunisation data and ensure providers receive appropriate support • SA Health – this activity will require hospital presentation and admission data for vaccine preventable diseases to be articulated to the APHN. Analysing this data will enable targeted activities with providers and communities This activity will collaborate with specific Local Health Networks (LHNs) to investigate opportunities for the identification of children and adults in target groups in areas with low immunisation rates who present to Emergency Departments or on discharge summaries (after hospitalisation) as under-immunised. • Country Health SA – will assist the Hub to recognise service delivery gaps and requests for support in rural SA. This group enlists representation from General Practice, Aboriginal Health, Department of Education and Child Development, Migrant Health, SA Health, Country Health SA and the Women's and Children's Hospital and focusses on ensuring a cross sector approach to increasing immunisation rates and decreasing vaccine preventable disease. • SAHMRI (South Australian Health and Medical Research Institute) – The Hub is represented on the SA Immunisation Strategic Alliance

	• Hepatitis SA – continues collaboration to ensure Hepatitis B disease rates reduce and the community receives appropriate advice, resources, treatment and support. Migrant Health – along with the Hub, this collaboration will ensure CALD and emerging communities are aware of immunisation recommendations and services. Local Government Association – collaboration continues with Local Councils delivering immunisation programs including the School Based Immunisation Program (SBIP). The majority of these providers are members of the IPN
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	The five elements of the SA PHN Immunisation Hub are in various stages of development and implementation (all elements expected to complete by June 2018): Element 1: AIR data interrogation: due to commence in March 2017 Element 2: Champion Immunisation Nurse Network: due to commence in January 2017 (contract to June 30th 2017) Element 3: Service Delivery (identifying gaps): due to commence in March 2017 Element 4: Stakeholders: commenced July 2015 Element 5: Provider support: commenced July 2015
Coverage	• The SA PHN Immunisation Hub covers the entire APHN and CSAPHN regions • The Champion Immunisation Nurse Program (CNIP) covers the entire APHN region
Commissioning method (if relevant)	• Immunisation Hub – APHN providing direct project coordination. • Champion Nurse Incentive Program – Open approach to market; Expression of Interest; Commissioned in whole.
Approach to market	• Immunisation Hub – APHN providing direct project coordination. • Champion Nurse Incentive Program – Open approach to market; Expression of Interest.
Decommissioning	N/A

Proposed Activities – NP2.1 Culturally and Linguistically Diverse (CALD) and New Emerging Communities Health Project	
Activity Title / Reference (eg. NP 1)	NP 2.1 Culturally and Linguistically Diverse (CALD) and New Emerging Communities Health Project
Existing, Modified, or New Activity	Existing Activity
Program Key Priority Area	Population Health
Needs Assessment Priority Area (eg. 1, 2, 3)	12. The CALD community are disproportionally affected by Hepatitis B 13. Accessibility to and appropriateness of primary health care services, particularly for CALD and new and emerging communities, Aboriginal and Torres Strait Islander people, LGBTIQ and older people. 24. Early screening of selected cancers (cervix, bowel, and breast) can assist in intervention measures which can help reduce mortality as part of a wider cancer control strategy. 35. Access and information to Breast, Cervix and Bowel cancer screening services for Aboriginal and Torres Strait Islander people, CALD, and those in low socio economic areas. 36. Awareness and timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.
Description of Activity	CALD and newly emerging communities have ongoing challenges in accessing appropriate primary health care services in the APHN region. The health project will address access to appropriate primary health care for CALD and Refugee Communities by: • improving the capacity of mainstream primary health care services to work effectively with CALD and newly emerging communities, • supporting CALD and new emerging communities to access information, training, tools and education to make informed decisions regarding their health and health care • reduce potentially preventable hospitalisations of this group, and • providing • care coordination.

	NP2.1 will support the delivery of a range of services and activities to be commissioned across the PHC system to meet the community needs, as identified through the APHN baseline needs assessment. A model of care which clearly articulates the scope of work being undertaken by the PHN is under development and will support the commissioning approach for NP2.1. The APHN's role will be to ensure all components of the model are connected, integrated and promoted to community, service providers and the broader primary health care system. Additionally, to ensure a multi-pronged approach, CALD and Emerging Communities considerations will also be supported and embedded in other activities such as immunisation, education and training. The APHN strives to be culturally safe and culturally appropriate in all activities undertaken.
Target population cohort	CALD and Newly Emerging Communities
Consultation	Engagement and consultation has occurred with key stakeholders working with CALD and emerging communities including: • Migrant Health Service, SA Health • Australia Migrant Resource Centre SA • Multicultural Communities Council • STTARS • Red Cross • Federation of Ethnic Community Councils of Australia Initial discussions with these organisations identified that refugees and emerging communities have greater challenges in accessing appropriate primary health care services. Main issues impacting this cohort include: • Poor health literacy • Lack of cultural competency skills of primary health care providers • A poor systemic approach to address primary health care need of this cohort A workshop will be facilitated Feb/March 2017 with primary health care providers and organisations in the multicultural sector to develop an approach to improve the health outcomes for refugees and emerging communities. APHN will also be part of a working group convened by STTARS to update and further develop national refugee health resources for general practices and other primary care providers. The

	resources will include new website-based referral information for South Australia and print publications, based on the existing publication: Promoting Refugee Health: a guide for doctors, nurses and other health care providers caring for people from refugee background and related desk top guide.
Collaboration	• Collaborate with general practices in target areas to increase their knowledge and capacity to provide culturally appropriate services to CALD and new emerging communities. • Collaborate with Local Health Networks (LHNs) to coordinate and support referral pathways of identified population groups and or those with health condition(s) presenting at Emergency Departments and discharge summaries (after hospitalisation) in target areas. • Collaborate with pharmacies and allied health services in target areas to support general practices and patients in managing health condition(s). • Collaborate with relevant NGOs to provide additional support, educational and or promotional services. • Establish a network of appropriate agencies, organisations and community groups to support and guide the delivery of this activity • Collaborate with SA Health to ensure the sector is provided with information and resources to assist their work with refugees and new arrivals - as recommended by the Settlement Services Advisory Council for PHNs • Undertake effective needs analysis with refugee communities to ensure targeted support for new arrivals – as recommended by the Settlement Services Advisory Council for PHNs
Indigenous Specific	No
Duration	• Planning for Activity N.P 2.1 commenced in September 2016. • Consultation is being undertaken (due for completion in February 2017) • Procurement and Commissioning to be undertaken March – May 2017 • Expected service delivery to commence June 2017 • Ongoing beyond 30th June 2018 subject to project evaluation outcomes and funding availability
Coverage	Entire APHN region with specific focus on areas of high CALD populations and refugee settlement in the north, south and central West of our region
Commissioning method (if relevant)	The commissioning method will be dependent on the finalised model developed.

Approach to market	The Approach to market will be dependent on the finalised model developed.
Decommissioning	N/A

Proposed Activities – NP 3.1 Adelaide Respiratory Health Project	
Activity Title / Reference (eg. NP 1)	NP 3.1 Adelaide Respiratory Health Project
Existing, Modified, or New Activity	Existing Activity
Program Key Priority Area	Other: System integration
Needs Assessment Priority Area (eg. 1, 2, 3)	11. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people. 15. Selected areas of the APHN region have high rates of smoking which correlates with areas of high prevalence of COPD. 22.Selected APHN regions have higher rates of PPH resulting from a range of chronic (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, diabetes complications, angina, iron deficiencies) and acute conditions (dental issues, urinary tract infections, cellulitis). 36. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers. 37. A coordinated approach to improve navigation and pathways for patients to manage their conditions.
Description of Activity	The Adelaide Respiratory Health Project (ARHP) will support the development and/or delivery of solutions which aim to improve outcomes for people living with Chronic Obstructive Pulmonary Disease (COPD) and Asthma, build the capacity of service providers to deliver safe and effective care and demonstrate reductions in preventable hospitalisations for COPD and Asthma in the APHN region. The model will focus on interventions which support people living with COPD and/or Asthma across the continuum with a focus on vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, Palliative Care patients, people with multi-morbidities and people not able to access services due to frailty or disability. The ARHP involves an integrated approach to respiratory health prevention and management across the continuum (acute care, primary health care services and population health programs) across agencies and across the Adelaide region. A stepped model of care will enable service providers to

	focus on areas of expertise, whilst considering the connection and integration with other service providers for step up or step down care. The APHNs role will be to ensure that the steps of the model are connected, integrated and promoted to both clinicians and consumers. The results of this activity will aim to improve collaborative working across sectors (with particular focus on clinical handover and shared ways of working); Implementation of evidence best practice models that are practice and patient centred (such as Asthma/COPD action plans); increase the availability, efficiency and effectiveness of respiratory health care and increasing workforce capacity and capability.
Target population cohort	People living with COPD and/or Asthma across the care continuum with a focus on vulnerable population groups (particularly, Aboriginal and Torres Strait Islander people, Children and Youth, Palliative Care patients, people with multi-morbidities and people not able to access services due to frailty or disability).
Consultation	In 2013 The Northern Adelaide Medicare Local was successful in securing grant funding through the Australian National Health Prevention Agency (ANPHA) to undertake an 18-month project (2013/15) working in partnership with Asthma SA, Lung Foundation Australia, the Pharmaceutical Society of Australia (SA/NT Branch), Drug and Alcohol Services SA [DASSA], Cancer Council (Quitline), Northern Region GP Council and the Northern Adelaide Local Health Network [NALHN]. The Northern Respiratory Project (NRP) focused on an integrated approach to respiratory health in northern Adelaide and aimed to raise community awareness of the relationship between smoking rates and respiratory conditions. Adelaide Primary Health Network (APHN) continued to fund the project as a transition activity during 2015/16. The project was re-named the Adelaide Respiratory Project (ARP) and expanded to include all of metropolitan Adelaide - the focus and partnership arrangements remained the same. Learnings from evaluation of stakeholder feedback from both the NRP and ARP highlighted the benefit of organisations working collaboratively in targeted populations and areas of need and this approach has informed the development of the service model for the ARHP.

	A workshop was undertaken with members from the steering group involved in previous projects to determine key learning and issues encountered. The findings from this workshop assisted in refining the scope of the project.
Collaboration	Consistent with the co design concept the actual detailed role of each party will be determined by the ATM and the resultant co design process with each of the stakeholders. • Ongoing collaboration with Asthma SA will continue to raise community awareness and support primary health care practitioners (especially GPs) with Asthma resources available to assist with management of the condition. • Ongoing collaboration with Asthma SA will continue to raise community awareness and support primary health care practitioners (especially GPs) with Asthma resources available to assist with management of the condition. • Ongoing collaboration with Lung Foundation Australia will continue support primary health care practitioners (especially GPs) with COPD resources available to assist with management of the condition. • Ongoing collaboration with Pharmaceutical Society of Australia [SA/NT Branch] to support increased interventions and management at the pharmacy level to support smoking cessation and patient medication compliance. • Ongoing collaboration with Drug and Alcohol Services SA [DASSA], Cancer Council [Quitline] to support the community and primary health care practitioners (especially GPs) with the increasing referrals to Quitline and other smoking cessation resources and programs. • Engage with APHN Regional GP Councils for input and advice on ongoing program development and implementation. • Continue to collaborate with Northern Adelaide Local Health Network [NALHN]; Southern Adelaide Local Health Network [SALHN]; Central Adelaide Local Health Network [CALHN]; Women's and Children's Health Network [WCHN] to assist in consistent, improved clinical pathways for appropriate patient management of respiratory conditions. • All relevant stakeholders will be invited to provide representation on the project working group
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	The APHN will issue an ATM by March 2017 seeking an organisation(s) to provide the ARHP service model from mid-2017 to 30th June 2018.

Coverage	Entire APHN region with preference given to (services that support residents of the) Local Government Areas of Playford and Onkaparinga.
Commissioning method (if relevant)	Open approach to market; Request for Proposal; Commissioned in whole.
Approach to market	Open approach to market; Request for Proposal.
Decommissioning	N/A

Proposed Activities – NP4.1 Care Connections (ICH)	
Activity Title / Reference (eg. NP 1)	NP4.1 Care Connections
Existing, Modified, or New Activity	Modified activity
Program Key Priority Area	Other: System integration
Needs Assessment Priority Area (eg. 1, 2, 3)	11. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people. 13. Accessibility to and appropriateness of primary health care services, particularly for CALD and new emerging communities, Aboriginal and Torres Strait Islander people, LGBTIQ and older people. 16. Selected areas of the APHN region have high rates of obesity and overweight and correlate with areas of low physical activity and poor nutrition. 17. Selected APHN LGAs have higher rates of a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease, musculoskeletal) and multi-morbidities. 19. Higher rates of multimorbidity among the aged population lead to increased utilisation of health care services. 22.Selected APHN regions have higher rates of PPH resulting from a range of chronic (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, diabetes complications, angina, iron deficiencies) and acute conditions (dental issues, urinary tract infections, cellulitis) 25. A need to increase the ease of navigation and visibility of the health care system in selected APHN regions, population groups and for particular health issues. 26. Lack of easily understood and accessible referral pathways across systems and settings. 29. Lack of person-centred care and responsiveness to individual circumstances, including co-morbidities. 36. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.

	37. A coordinated approach to improve navigation and pathways for patients to manage their conditions.
Description of Activity	Care Connections is a response to the Primary Health Care Advisory Group Final Report, designed to improve chronic condition management in primary care through supporting better coordination of care and integration across the health system. The aims of Care Connections are: 1. connect 2. and integrate local primary health care systems in the APHN region, and 3. improve chronic condition management in identified population groups through implementation of elements of a patient-centred medical home model. The three main elements of Care Connections: • *Integrated Care Hubs (ICH):* These are targeted general practices who will undertake activities designed to improve chronic condition management, including participation in local medical neighbourhoods, and leadership development education and support. Activities will be chosen by the practices and will align with their demographic data and patient needs and populations (addressing Needs Assessment Priority Areas (NAP): 11, 13, 16, 17, 19, 22, 29, see above). • *Local Area Coordination (LAC) Services*: Dedicated support services to the ICH practices to assist with implementation of improvement activities and to integrate them with the local medical neighbourhood (NAP: 17, 19, 22, 25, 26, 37, see above). • *Local Medical Neighbourhood*: The formal relationships between and within ICHs and other key health providers considered necessary and appropriate for care pathways. These relationships encourage collaboration and communication including the flow of information across and between clinicians and patients, to include specialists, hospitals, home health, long term care and other clinical providers (NAP: 17, 19, 22, 25, 26, 34, 36, 37, see above).
Target population cohort	Vulnerable populations with demonstrated high prevalence of chronic conditions and poorer health outcomes.
Consultation	Initial consultations were undertaken with APHN Clinical Councils for feedback to inform preliminary design. Further consultations were then conducted with general practices in the identified areas (see coverage for reference) to refine the activity model and ensure consistency with on-the-ground workforce concerns.

	Future consultations may include: • Specific • Local Health Networks (LHNs) to coordinate referral pathways of identified population groups and or those with health condition(s) presenting at Emergency and/or Outpatient Departments and discharge summaries (after hospitalisation) in target areas. • Pharmacies and allied health services in target areas to support general practices and patients in managing health condition(s). • Aboriginal Community Controlled Health Organisation(s) (ACCHO) to support culturally appropriate services for Aboriginal and Torres Strait Islander people. • NGOs to provide additional support, educational and or health promotion services and activities.
Collaboration	Collaboration on this activity is evolving and it is expected that the LAC service providers will engage with: • Local Health Networks • Allied health • Pharmacies • Community Health and social support providers These engagements will build targeted relationships in the local geographic regions, to support the development of the Local Medical Neighbourhood. This work may include clarifying referral pathways, identifying capacity and capability issues, and supporting linkages between these organisations and the Integrated Care Hubs. The Care Connections project is complementary to the Health Care Home roll out and will enhance chronic disease care coordination with the targeting and provision of specific resources in areas of identified high need.
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people (note: one ICH is an Aboriginal medical service).
Duration	• Expressions of Interest for the Integrated Care Hubs gathered during April 2016 • Request for Proposal for LAC Services undertaken in November 2016 • LAC Services to start March-April 2017 and funded to June 2018

	• Ongoing beyond 30th June 2018 subject to project evaluation outcomes and funding availability
Coverage	Public Health Information Development Unit (PHIDU) Population Health Areas (PHAs) (based on ABS Statistical Area Level 2): Davoren Park, Elizabeth East, Elizabeth/ Smithfield - Elizabeth North, Parafield/ Parafield Gardens/ Paralowie, Salisbury/ Salisbury North, Dry Creek - South/ Port Adelaide/ The Parks, Largs Bay - Semaphore/ North Haven, Christie Downs/ Hackham West - Huntfield Heights, Christies Beach/ Lonsdale, Morphett Vale - East/ Morphett Vale – West.
Commissioning method (if relevant)	• Integrated • Care Hubs – Direct/targeted approach to market; Expression of Interest; Commissioned in whole • Local Area Coordination and Local Medical Neighbourhood - Open approach to market; Request for Proposal; Commissioned in whole
Approach to market	• Integrated Care Hubs – Direct/targeted approach to market; Expression of Interest. • Local Area Coordination and Local Medical Neighbourhood - Open approach to market; Request for Proposal. •
Decommissioning	N/A

Proposed Activities – NP5.1 Living Well with Persistent Pain Program	
Activity Title / Reference (eg. NP 1)	NP5.1 Living Well with Persistent Pain Program
Existing, Modified, or New Activity	Modified activity
Program Key Priority Area	Population Health
Needs Assessment Priority Area (eg. 1, 2, 3)	18. Services for people living with persistent pain are limited with long delays to access hospital-based services. 33. Prevention and early intervention strategies for childhood and youth health conditions. 37. A coordinated approach to improve navigation and pathways for patients to better manage their conditions.
Description of Activity	Evidence shows that multidisciplinary biopsychosocial interventions, such as pain management programs are successful in assisting people to manage ongoing or persistent pain. Based on the successful PainWise® Turning Pain into Gain Program, activity NP5.1 is a comprehensive pain management program. The aim of the activity is to provide a multi-disciplinary, collaborative primary care-based northern Adelaide persistent pain management network, which: • supports individuals to better understand their condition; • equips them with the necessary tools to improve their quality of life; and • minimises the burden of pain on the individuals and the wider community. With a particular focus on people who are currently waiting for hospital-based pain management services, the program will aim to provide an accessible local service which has been designed with the patient at the centre of their own healthcare. The activity includes a holistic self-management course, case coordination and extended allied health services. A GP with a particular interest in managing persistent pain is available to access. A care coordinator undertakes an initial assessment and supports the patient and GP through the process of both group sessions and one-on-one allied health services through a skilled multi-disciplinary team.
Target population cohort	People living with persistent pain

Consultation	Prior to the development of the program, consultations were undertaken with: • Royal Adelaide Hospital Pain Management Unit (PMU) in the Central Adelaide Local Health Network to establish the level of need in the community, through examining the waiting lists for access to the PMU, establishing links between the pain specialists and the Program GP. • Northern Adelaide Local Health Network to support the location of a pain management program in northern Adelaide • PainWISE® Turning Pain into Gain Program operators to understand the program procedures, impacts and outcomes. • Identified general practice and allied health to develop the local program implementation guidelines. During the early stages of the program implementation, program leaders participated in the SA Health Transforming Health Chronic Pain Model of Care consultation process as part of both the Working Group and Steering Committee. This participation assisted to align the activity with the State model and ensure integration across the sectors.
Collaboration	Northern Adelaide Local Health Network: - Partnering as a delivery partner - Referral of appropriate patients Central Adelaide Local Health Network (specifically Pain Management Unit, Royal Adelaide Hospital): - Support development of the activity - Referral of appropriate patients General Practices in target areas: - Service delivery to support them to manage patients' persistent pain condition alongside any chronic condition(s). - Referral of appropriate patients Allied health services, including pharmacies: - Building capacity of these providers to support patients to manage their persistent pain
Indigenous Specific	Not specific but includes Aboriginal and Torres Strait Islander people

Duration	• Planning and development was undertaken in 2014-15 • Service delivery commenced in 2015 • Program redesign undertaken in 2016 • Evaluation data is being collected through 2016-17 • Ongoing beyond 30th June 2018 subject to project evaluation outcomes and funding availability
Coverage	Local Government Areas of Playford, Salisbury, Tea Tree Gully
Commissioning method (if relevant)	Direct engagement; Commissioned in whole
Approach to market	Direct engagement
Decommissioning	Two organisations were previously delivering this activity in partnership. However, in early 2017 transition management of the service to one organisation has been undertaken - a general practice employing a GP with a special interest in pain management. Implications considered included: - Potential delay in service provision (minimal) - Potential conflict of interest in accepting referrals from other general practices - Capacity of a general practice to deliver wider services such as waiting list management and education sessions The Care Coordinator will be transitioned to the single provider along with all required data and IP. Delays in service provision are expected to be minimal as the single provider is already contracted to provide a level of service provision and has a well-developed prior understanding of this activity. Referral point has not changed.

Proposed Activities – NP5.2 Paediatric Chronic Pain Model of Care	
Activity Title / Reference (eg. NP 1)	NP5.2 Paediatric Chronic Pain Model of Care
Existing, Modified, or New Activity	New Activity
Program Key Priority Area	Population Health
Needs Assessment Priority Area (eg. 1, 2, 3)	18. Services for people living with persistent pain are limited with long delays to access hospital-based services. 33. Prevention and early intervention strategies for childhood and youth health conditions. 36. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers. 37. A coordinated approach to improve navigation and pathways for patients to manage their conditions.
Description of Activity	This Model of Care is designed to support children and young people with ongoing pain to be managed in primary care. The key aim of the Paediatric Chronic Pain Model of Care is to implement a dedicated, coordinated multidisciplinary pain management service for children in South Australia. The model of care will deliver: • Holistic care that enables children and young people experiencing chronic pain to develop their greatest potential and experience their best quality of life. • An integrated understanding of the child's physical and mental experiences, and promote awareness of systemic factors contributing to their experience of pain. • A state-wide referral pathway to improve collaborative and effective working relationships between the primary, secondary and tertiary health systems. • Treatment options that are consistent with up-to-date clinical evidence and promote these options across all health care sectors while improving access to specialist advice for the primary health care sector to better manage children with chronic pain.

	• Education in order for children, and their care givers to develop greater capacity to self-manage their condition, as appropriate, and ease the impact of chronic pain on their daily life The Model of Care will include the recruitment of a Clinical Coordinator to support the multi-disciplinary pain team and coordinate care across the sectors.
Target population cohort	Children and young people who experience chronic pain
Consultation	A Working Group, including Women's and Children's Hospital Network clinicians and directors and APHN staff, was formed to explore and develop the Model of Care. The Working Group for the Paediatric Chronic Pain Model of Care consulted with: - Women's and Children's Health Network Community of Practice (meetings) - Tertiary pain units in Central and Southern Adelaide Local Health Networks (review of model) - Paediatricians from Southern Adelaide Local Health Network (review of model) - Paediatricians from Women's and Children's Health Network (review of model) - Pain Australia (email and phone communication, one face to face meeting) - Paediatric Pain Units interstate (email and phone communication) Consultation with these groups highlighted the need to investigate potential activities to address the fact that there is currently no dedicated paediatric pain management service in South Australia (the only mainland State not to have one). Consultations also identified that an option that incorporated both tertiary and primary care would be preferred to one in tertiary care only.
Collaboration	This activity will be delivered in partnership with the Women's and Children's Health Network. It is anticipated that the following WCHN parties will collaborate as part of the activity: - WCHN Specialist Pain Medicine Physician – assist with multidisciplinary assessments - WCHN Allied health staff (physiotherapy, Occupational therapy, Psychologist, Social Worker, Pharmacist) – participate in the multidisciplinary assessment, deliver allied health services as required, deliver education sessions as required - WCHN Administration – to support the administration of the program and the Clinical Coordinator - WCHN Nursing (Pain Nurse) - support the Specialist Pain Medicine Physician As the activity progresses, further collaboration will be sought from community based allied health and their peak organisations, including:

	- Australian Physiotherapy Association - Occupational Therapy Australia - Australian Psychological Society - Australian Association of Social Workers - Australian Association of Consultant Pharmacy to identify community-based allied health professionals who can participate as part of the primary care pathways of the Model of Care.
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	• Planning has been undertaken in 2016-17 • Recruitment for Clinical Coordinator in first half of 2017 • Activity to be undertaken during 2017-18 • Evaluation of the activity will be undertaken during the activity period • Ongoing beyond 30th June 2018 subject to project evaluation outcomes and funding availability
Coverage	Entire APHN region
Commissioning method (if relevant)	The commissioning method will be dependent on the finalised model developed.
Approach to market	The Approach to market will be dependent on the finalised model developed.
Decommissioning	N/A

Proposed Activities – NP6.1 Coordinated Cancer Screening	
Activity Title / Reference (eg. NP 1)	NP6.1 A coordinated approach to increase cancer screening participation
Existing, Modified, or New Activity	Existing activity
Program Key Priority Area	Population Health
Needs Assessment Priority Area (eg. 1, 2, 3)	24. Early screening of selected cancers (cervix, bowel, and breast) can assist in intervention measures which can help reduce mortality as part of a wider cancer control strategy. 35. Access and information to Breast, Cervix and Bowel cancer screening services for Aboriginal and Torres Strait Islander people, CALD, and those in low socio economic areas.
Description of Activity	This activity will support a collaborative approach to increasing participation in cervix, breast and bowel cancer screening programs for target groups in the APHN region. Strategies will include: • Promotion of cervix, bowel and breast cancer screening programs through General Practice and other primary health care settings as appropriate • Promotion of and support for culturally appropriate cervix, bowel and breast cancer screening services for Aboriginal and Torres Strait Islander and CALD population groups • Commissioning of small projects in general practice and other primary health care settings that take an innovative and combined approach to increasing participation rates of cervical, bowel and breast cancer screenings to target population groups in APHN region
Target population cohort	• Population groups who reside in areas of higher areas of lower participation rates in cancer screening programs • Aboriginal and Torres Strait Islander population groups • Culturally and Linguistically Diverse population groups
Consultation	APHN is participating in the strategic SA State-wide Screening Advisory Committee chaired by Dr Paddy Philips, Chief Medical Officer for SA, and as a result, a working group has been established to form practical strategies to improve screening uptake in SA. Representation on this group includes: • Public Health Partnerships, Public Health Services, Public Health & Clinical Systems – Department of Health and Ageing SA Health • SA Cervix Screening Program

	• BreastScreen SA • South Australian Cancer Service • National Bowel Cancer Screening Program • Cancer Council SA • Country SA PHN This group has met three times and will meet regularly throughout the duration of the activity. Additional to already planned activities below, the APHN plans to consult with this working group on potential joint co resourced activities in 2017-18.
Collaboration	Planned collaborative activities with the stakeholders listed above include: • Working with Public Health Partnerships, Public Health Services, Public Health & Clinical Systems – Department of Health and Ageing SA Health, Country SA PHN and Primary Care Providers – specifically General Practice to integrate and collaborate statewide efforts. • Partnering with BreastScreen SA, National Bowel Cancer Screening Program, Cancer Council, SA Cervix Screening Program to promote cancer screening along with other early intervention and health promotion strategies.
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	September 2016 -June 2018.
Coverage	Targeted areas within the APHN region include: PHIDU Population Health Areas (PHAs) with lowest national bowel cancer screening program participation rates: • Elizabeth/Smithfield – Elizabeth North • Adelaide • Davoren Park • Beverley/Hindmarsh/Brompton • Charles Sturt –North PHIDU PHAs with lowest breast cancer screening participation rates: • Davoren Park

	• Elizabeth/Smithfield – Elizabeth North • Adelaide • Dry Creek – South/Port Adelaide/The Parks • Windsor Gardens PHIDU PHAs with lowest cervix screening participation rates: • Adelaide • Playford • Port Adelaide Enfield • Salisbury • West Torrens PHIDU PHAs with highest percentage of Aboriginal and Torres Strait Islander women aged 50 years and over: • Dry Creek-South/Port Adelaide/The Parks • Largs Bay – Semaphore/North Haven • Elizabeth/Smithfield-Elizabeth North • Parafield/Parafield Gardens/Paralowie • Salisbury/Salisbury North PHIDU PHAs with highest percentage of recently arrived women aged 50-74 years: • Salisbury/Salisbury North • Dry Creek-South/Port Adelaide/The Parks • Brighton/Glenelg • Marion-South • Adelaide
Commissioning method (if relevant)	Not yet finalised – potential for commissioned services.
Approach to market	The Approach to market will be dependent on the finalised model developed.
Decommissioning	N/A

Proposed Activities – NP7.1 SA PHNs and Women's and Children's Hospital (WCH) General Practice Liaison Unit (GPLU)	
Activity Title / Reference (eg. NP 1)	NP 7.1 SA PHNs and Women's and Children's Hospital (WCH) General Practice Liaison Unit (GPLU)
Existing, Modified, or New Activity	Existing Activity
Program Key Priority Area	Other: System integration
Needs Assessment Priority Area (eg. 1, 2, 3)	27. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover. 37. A coordinated approach to improve navigation and pathways for patients to manage their conditions.
Description of Activity	APHN, Country SA PHN (CSAPHN) and the Women's and Children's Health Network (WCHN) have partnered to establish a General Practice Liaison Unit (GPLU) within the Paediatric Medicine Unit of the Women's and Children's Hospital (WCH) in Adelaide. The GPLU is focused on improving the care of children and young people aged 1-18 years of age with chronic conditions such as asthma and type one diabetes who have frequent contact with the hospital. The GPLU team which includes a General Practitioner, registered nurse and administrative support officer commenced operation in February 2017. The aim of the activity is to: • Improve patient care by facilitating and strengthening health care collaboration, communication and integration between general practice and the hospital • Improve access to and navigation of hospital services for general practice • Ensure systems and processes support the quality and timeliness of clinical handover The activity will be evaluated to establish the potential for future roll out to other hospitals in South Australia as a co-funded model with SA Health, APHN and CSAPHN.
Target population cohort	Children and young people (aged 1-18 years of age) with type one diabetes, asthma or other chronic conditions who are frequent attendees at the hospital and their general practitioners, carers and significant others.
Consultation	• This activity was established in consultation with general practitioners and clinicians and administrative staff from WCHN

	• This activity is governed by a Steering Group, involving participants from APHN, Country SA PHN, WCHN to oversee the performance monitoring and evaluation functions of the unit.
Collaboration	• This activity is jointly implemented in collaboration with Country SA PHN and the Women's and Children's Health Network and will be undertaken at the Women's and Children's Hospital. • This activity will engage and collaborate with general practice and clinicians and administrative staff from WCH to improve communication and build sustainable working relationships to ensure systems and processes support the quality and timeliness of clinical handover and the coordination of care for patients across the hospital/community interface.
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	This activity commenced in February 2017 and finish June 30 2018, inclusive of a three-month evaluation process. The contract process includes the ability to review and redesign as necessary with contracts continuing in line with funding received by APHN under this schedule.
Coverage	Entire APHN and CSAPHN regions
Commissioning method (if relevant)	Direct approach with the WCHN
Approach to market	Approach to market by direct engagement
Decommissioning	N/A

Proposed Activities – NP8.1 Preventative health care and community health literacy	
Activity Title / Reference (eg. NP 1)	NP8.1 Preventative health care and community health literacy
Existing, Modified, or New Activity	Existing Activity
Program Key Priority Area	Population Health
Needs Assessment Priority Area (eg. 1, 2, 3)	16. Selected areas of the APHN region have high rates of obesity and overweight and correlate with areas of low physical activity and poor nutrition. 28. Lack of community awareness about existing health care services for different population groups, consumers and providers. 30. Need to improve effectiveness of health information to consumers and professionals across the health sector to encourage the take-up and application of self-management preventive health measures. 33. Prevention and early intervention strategies for childhood and youth health conditions. 34. Accessibility to primary health services for Aboriginal and Torres Strait Islander people. 35. Access and information to Breast, Cervix and Bowel cancer screening services for Aboriginal and Torres Strait Islander people, CALD, and those in low socio economic areas. 36. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.
Description of Activity	The APHN considers that health promotion, early intervention and increasing health literacy are essential elements of good coordinated primary health care. This activity will advocate for greater understanding and emphasis on preventive health and health literacy across all primary health care services and community and consumer organisations. The activity aims: • To increase health literacy and knowledge of primary health care services system and preventative health choices available. • To increase the capacity of primary health care providers to promote evidence-based preventative health activities.

	• To strengthen the capacity of NGOs and LGAs to support consumers to make healthy lifestyle choices through the provision of collaborative approaches focussed on improving population health literacy and access to health information and services. • Resource for data access and analysis.
Target population cohort	The project will target vulnerable groups including: • Communities from Culturally and Linguistically Diverse Background. • Aboriginal and Torres Strait Islander community groups • People from low socio-economic backgrounds • People living with more than one chronic disease
Consultation	Consultations with the Cities of Onkaparinga, Salisbury, Playford and Port Adelaide Enfield have been completed. From the Needs Assessment process, these Councils have been identified as areas with the greatest health needs in regards to health promotion/prevention/literacy. Consultations with the non-government health organisations focusing on chronic disease prevention and management will be the next stage of the project.
Collaboration	The APHN will collaborate with the following stakeholders: • SA Health, Public Health Branch, responsible for the State Public Health Plan 2013 which is mandated by the Public Health Act 2011 and guides the preparation of Council Public Health Plans. • The Local Government Association SA, peak body for Councils • City of Onkaparinga, City of Salisbury, City of Playford, City of Port Adelaide and Enfield whose Public Health Plans reflect health promotion as a key activity • Non-government health organisations to explore joint approaches to building the capacity of population groups at risk of hospitalisation to better navigate, understand, manage and coordinate multiple services, lifestyle changes and treatment regimes, in collaboration with Country SA PHN • Key stakeholders will be invited to attend a working group to develop a collective approach to address health prevention and promotion for their local area.
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people

Duration	• The activity commenced September 2016 with the implementation of a consultation strategy. • Working • groups of the key stakeholders identified above will be called in March 2017 Activities to roll out in 2017-2018. • Ongoing beyond 30th June 2018 subject to project evaluation outcomes and funding availability.
Coverage	Entire APHN region and some activities specifically with the Local Government Areas of Onkaparinga, Salisbury, Playford and Port Adelaide/Enfield and non-government health agencies state-wide
Commissioning method (if relevant)	Not yet finalised – potential for commissioned services.
Approach to market	The Approach to market will be dependent on the finalised model developed.
Decommissioning	N/A

Proposed Activities – NP9.1 Workforce, education, networking, capacity building and quality improvement	
Activity Title / Reference (eg. NP 1)	NP 9.1 Workforce, education, networking, capacity building and quality improvement
Existing, Modified, or New Activity	Existing activity
Program Key Priority Area	Health Workforce
Needs Assessment Priority Area (eg. 1, 2, 3)	4. Disproportionate quantities of mental health related medicines prescribed in women, disadvantaged areas and population groups such as people aged 75 and over. 23. Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations. 31. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity. 32. Minimise instances of poor quality and unwarranted variations of care and follow up.
Description of Activity	The APHN will provide a range of education and quality improvement supports for primary health care providers to enhance their ability to work as part of a primary health care system to provide the right care in the right time and the right place. The aim of this is develop focussed and co-ordinated quality improvement action across the primary health care sector, utilising the expertise of Drug And Therapeutics Information Service (DATIS), quality improvement organisations, professional development providers, health professional organisations and standards (e.g. RACGP Standards) and to integrate these areas in all primary health care programs and services Education, networking and quality improvement actions and methods of disseminating best practice will focus on identified areas of need including empathic system and service level responses to health care consumers/patients, culturally diverse consumers, and quality use of medicines. Aspects of this activity will be integrated in the General Practice support activities. The intended outcomes are: • Increased participation of primary health care providers in workforce education • Adoption and effective use of best practice approaches to improve clinical outcomes and delivery of care

	• High satisfaction by attendees in educational service delivery with learning outcomes consistently met • Interprofessional and inter-disciplinary sharing of best practice and leadership development
Target population cohort	All Primary Health Care practitioners/providers
Consultation	Engagement with various Medical, Pharmacy, Allied Health Professional Associations/Peak Bodies; Feedback via previous education service delivery providers; APHN membership groups. Collect Needs assessment survey of primary health care providers.
Collaboration	To ensure high-quality, evidence based educational and capacity building methods are used in delivering this activity, the activity will collaborate with: • Professional organisations representing general practice, GPs and other allied health – to ensure the mode of delivery and topic content is relevant to various disciplines • Local Health Networks (LHNs) – to assist with the development of appropriate clinical pathways and referral management guidelines. • Drug and Therapeutic Information Service (DATIS) – to assist with the latest updates on medication management for chronic conditions and to deliver education in the form of academic detailing • General Practices – for feedback on most relevant topics for education • Pharmacies and Allied Health providers for feedback on most relevant topics for education • Organisations working with Culturally and linguistically diverse communities such as Migrant Health Service – to assist in the provision of resources and delivery of culturally appropriate sessions such as cultural safety, cultural competence. • Development of partnerships with health professional, allied health, pharmacy, dental, medical organisations and collaborative work including information sharing and networking. Collaboration and consultation with the Aboriginal Community via the metropolitan ACCHO, Aboriginal Health Councils of SA and appropriate community forums tot in the development of education to support culturally appropriate services for Aboriginal and Torres Strait Islander people.
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people

Duration	The activity will commence from 01 January 2017 (with an 18 month evaluation and review process) and be completed in June 2018 – the contract process will include the ability to review and redesign as necessary contracts continuing in line with funding received by APHN under this schedule.
Coverage	Entire APHN region
Commissioning method (if relevant)	Open approach to market, Request for Proposal, Education services delivery has been totally commissioned (under OP1.1 – Primary Health Care provider support). Interdisciplinary Networking undertaken as a partnership activity with Mental Health Professionals Network Small grants to be offered to primary health care providers who wish to facilitate local networks.
Approach to market	Open approach to market; Request for Proposal
Decommissioning	N/A

Proposed Activities – NP10.1 Mental Health Clinical Internship (MHCI) Program	
Activity Title / Reference (eg. NP 1)	NP 10.1 Mental Health Clinical Internship (MHCI) Program
Existing, Modified, or New Activity	Existing activity
Program Key Priority Area	Health Workforce
Needs Assessment Priority Area (eg. 1, 2, 3)	26. Lack of easily understood and accessible referral pathways across systems and settings. 27. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover. 31. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity.
Description of Activity	This activity addresses workforce capacity and skills development, in clinical therapeutic intervention in mental health. The Mental Health Clinical Internship (MHCI) program will continue to be offered as a targeted 2-year program in regions with high need and offered to post graduate students to develop their skills and expertise in clinical practice. Upon completion of the program the Intern will have fulfilled the requirements for application for registration as an accredited Clinical Mental Health Social Worker, or in the case of other disciplines, two years post graduate clinical experience. The program will consist of: • Professional Development • Community Development, Education and Engagement • Observing Direct Clinical Practice • Co-facilitation of Clinical Practice • Supervised Practice • Clinical Supervision Due to workforce shortages, particularly for experienced Mental Health Clinicians capable of working with hard to reach populations (particularly Aboriginal people and emerging communities), the APHN is seeking to offer 2 intern positions in the 16/17-18/19 years. 2 Additional positions will also be scoped to assist with Country SA Mental Health workforce attraction and retention and Aboriginal

	workforce capacity building. It is anticipated that the costs of 2 additional positions will be shared with CSAPHN.
Target population cohort	Post-graduate students looking to develop their skills in clinical practice and can work towards credentialing suitable for delivering clinical mental health services.
Consultation	The MHCI program has been informed by workforce requirements in the APHN region (particularly with hard-to-reach populations) and community/stakeholder consultation.
Collaboration	The APHN has funded the MHCI as a transition program via Northern Health Network, with 2 interns who completed their internship in July 2016. They have been retained by the organisation as Mental Health Clinicians which demonstrates the worth of this project in attracting, building, retaining and sustaining suitably qualified clinical staff. Two further MHCI positions were funded to ensure continuity of this program and these were successfully recruited in August 2016. The program model will be shared across other identified regions and providers to build provider capacity to offer these positions within their provider workforce. The APHN, NHN and SA Health Mental Health community teams are keen to provide an opportunity for the MHCI positions to spend some time working with and alongside State Community Mental Health teams to further the integration and collaboration of both State and primary care service delivery. Further NHN will mentor the other large PMHCS provider Links to Wellbeing to commence a MHCI program in the Southern and Centre East region.
Indigenous Specific	Not specific but will include skills development in the provision of clinical mental health services to Aboriginal and Torres Strait Islander people.
Duration	1 July 2016 to 30 June 2018
Coverage	APHN region and targeted to areas of need
Commissioning method (if relevant)	A successful applicant from the Primary Mental Health Care Services (Stepped-care) request for proposal was selected directly.
Approach to market	To be determined based on evaluation.
Decommissioning	N/A

Proposed Activities – NP11.1 Child and Youth Wellbeing in Schools Project	
Activity Title / Reference (eg. NP 1)	NP11.1 Child and Youth Wellbeing in Schools Project
Existing, Modified, or New Activity	Existing activity
Program Key Priority Area	Population Health
Needs Assessment Priority Area (eg. 1, 2, 3)	33.Prevention and early intervention strategies for childhood and youth health conditions.
Description of Activity	Literacy under-achievement has high social and economic costs in terms of health. The Australian Government National Inquiry into the Teaching of Reading (AGNITTOR, 2005) Committee received evidence indicating that the overlap between under-achievement in literacy (especially in reading) and poor behaviour, health and wellbeing, is a major issue to the extent that what should be an 'education issue' has become a major health issue. This project provides a consultant who works with teachers, school support officers and parents/carers of children who need different teaching strategies to enhance their wellbeing and outcomes. The project addresses behaviour and emotional wellbeing for children in schools that have very low literacy rates and has been undertaken for the past two years in the Medicare Local setting and the last 12 months under APHN. Focusing on early (health) literacy skills to children will enable ease of navigation and awareness of health care system/services during adulthood. The aims of the activity are to: • Improve behaviour and emotional wellbeing for children in schools with very low literacy rates • Increase awareness and understanding by staff in preschools, schools, and childcare centres in target areas in the APHN region of the needs of, and strategies to assist, children with Specific Learning Difficulties, • Provide support to children with learning difficulties in preschools and schools in the target areas in the APHN region.
Target population cohort	Staff (teachers and school support officers), school leadership team, students, parents/carers in selected schools and pre-schools.
Consultation	The APHN Child and Youth Health Priority Group (55 members across 43 agencies) has identified child wellbeing as a priority including early identification of learning needs. This will include mapping the various health and wellbeing assessments across a child's development and sharing this data.

Collaboration	This existing activity collaborates with the selected preschools and schools to increase awareness and understanding by staff, leadership team and parents/carers of the needs and strategies to assist, children with Specific Learning Difficulties. This activity collaborates with Dyslexia SA to advocate and support the well-being and success of children with dyslexia and dyslexia type learning needs.
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	May 2016 – 31 December 2017 (including evaluation process)
Coverage	Local Government Area of Onkaparinga
Commissioning method (if relevant)	Direct approach, commissioned in whole
Approach to market	Direct approach
Decommissioning	The contract for the activity in the northern area of the APHN region concluded in December 2016. The activity delivered training sessions to staff. Evaluation indicates the skill level and knowledge of staff increased as a result of the training and will continue to support student learning. In addition, recent discussions with DECD have occurred to explore opportunities for transition and/or partnership.

Proposed Activities – NP12.1 Digital Health Support	
Activity Title / Reference (eg. NP 1)	NP12.1 Digital Health Support
Existing, Modified, or New Activity	Existing activity
Program Key Priority Area	Digital Health
Needs Assessment Priority Area (eg. 1, 2, 3)	27. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover. 32. Minimise instances of poor quality and unwarranted variations of care and follow up. 37. A coordinated approach to improve navigation and pathways for patients to manage their conditions.
Description of Activity	The Digital Health project aims to engage with health care providers from all sectors across APHN region to promote and facilitate the use of the My Health Record and appropriate digital health technologies in an effort to increase the communication and collaboration between service providers, improve clinical hand over, and improve timely accessibility to consumer health information. The project aims are: • Work with health care providers to increase their understanding and utilisations of secure messaging technologies to assist with timely and secure sharing of information between health care providers. • Provide assistance and access to data extraction tools and importance of correct clinically coded records. • Assist consumers and health care providers to have access to timely information and assist with coordination of health care services to ensure the best possible outcomes for the consumer. • Work with local hospitals, hospital networks and the private hospital sector to increase the uptake of My Health Record and assist with utilising digital health technologies such as the My Health Record and Secure Messaging Delivery. The APHN will focus on public hospitals and private hospitals to increase the uptake of sending discharge summaries and information pertinent to a consumer health care needs direct to their health care providers utilising

	digital health technologies such as the My Health Record and Secure Messaging and as such ensuring timely and secure transfer of consumer health information. • Increase • the use of digital technology's in a health care setting such as secure messaging delivery, data extraction tools and ongoing support with clinical applications and templates. Provide access and support for practices around the PenCS Clinical Audit tool to help facility improved practice data quality, the completeness of patient records and provide a means to recall patients in a timely manner. • Increase the use of clinical audit tools in a health care setting to assist in analysis of patient cohorts to improve population health outcomes. • Assist administrative staff to understand digital health and assist consumers with sign up and how to access their health care information through the My Health Record.
Target population cohort	All health care providers and health care provider organisations working across all sectors of health care.
Consultation	Stakeholder engagement and consultation are currently ongoing with the following peak bodies; • Digital Health Agency – ongoing consultative process with Webinars to assist with ongoing changes that are needed, feedback and advice. • Pharmacy Guild – ascertain barriers to access of Digital Health specifically the My Health Record and electronic sending of prescriptions. • Primary Health Group – advice on the best way to implement digital health technologies across services and systems run by the Primary Health Group, to ensure uptake and consistency across the Primary Health Care practices. • Pen Computing Systems – implementation, roll out and ongoing support of the PenCS clinical audit tool to General Practices across the APHN region. • Enhance OT - ascertaining the barriers to Allied Health providers in accessing digital health, ongoing discussion and assistance to the APHN around digital health systems and implementation of Digital Health to Allied Health Providers. • Referral Net (Global Health secure messaging system (SMD)) – Roll out and assistance of SMD to those interested in sending and receiving information via SMD platform, ongoing discussions to engage further providers.

Collaboration	• Digital Health Agency - to provide ongoing consultation with PHN staff to ensure consistent messaging across the PHN's, access to resources, data sources and a point of call to assist PHN's with addressment of issues, feedback and advice as needed. • All Health Care Providers and peak organisations - to gather ongoing feedback, issues and what's working well and what's not, to inform where the PHN can support General Practice, Pharmacy, Specialists of all specialities, Allied Health Providers etc. located with the APHN region • Peak organisations - to advise the APHN on how to best engage this cohort of health professionals also to advise on the barriers that effect access to Digital Health uptake for both the providers and consumers.
Indigenous Specific	No
Duration	1 July 2016 – 30 June 2018
Coverage	Entire APHN region
Commissioning method (if relevant)	N/A
Approach to market	N/A
Decommissioning	N/A

Proposed Activities – NP13.1 General Practice Outreach Project – Aboriginal Health	
Activity Title / Reference (eg. NP 1)	NP13.1 General Practice Outreach Project – Aboriginal Health
Existing, Modified, or New Activity	New Activity
Program Key Priority Area	Aboriginal and Torres Strait Islander Health
Needs Assessment Priority Area (eg. 1, 2, 3)	11. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non-Aboriginal and Torres Strait Islander people. 34. Accessibility to primary health services for Aboriginal and Torres Strait Islander people. 36. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.
Description of Activity	The Project is a joint partnership between the APHN and the Southern Adelaide Local Health Network (SALHN) who fund and manage the Aboriginal Family Clinic, and a local GP Practice, The Health Hub Adelaide. The Project has piloted the sustainability of the GP outreach model to improve access to culturally appropriate medical services for Aboriginal and Torres Strait Islander people living in the southern metropolitan Adelaide region. The aim of the Project includes: • providing access to a consistent GP service at the Aboriginal Family Clinic (AFC) sites; • testing the potential for a sustainable outreach GP service business model within a nurse led clinic environment which utilizes MBS claimable options; and • improving patient outcomes by ensuring consistency and clinical compliance surrounding the management of Aboriginal people with acute and chronic disease.
Target population cohort	Aboriginal and Torres Strait Islander people living in southern APHN region
Consultation	A Project Oversight Working Group has been established with the partnership that works collaboratively to support and assist with implementation issues, monitor progress of the Project including the service model and evaluation.

	The working group supports activities to ensure more regular and reliable medical service at AFC able to meet patient needs. The evaluation of the project includes consultation with clients with a client survey on the service and their experience, and a staff survey on service modelling and workforce education and training.
Collaboration	The APHN collaborates with 2 partners, the Aboriginal Family Clinic (SALHN) and the Health Hub private practice. We share a vision to improve the delivery of chronic condition management, and support integration across health to improve access to primary health care for local Aboriginal and Torres Strait Islander people living in the Southern region of Adelaide. We have established a partnership working group who have designed a participatory evaluation plan and process. The Aboriginal Family Clinic (SALHN) has an Aboriginal and non-Aboriginal workforce that provide service delivery and support the GP outreach practice. The Aboriginal Family clinic facilitate all client information management, clinical systems and facility management at AFC Noarlunga and Clovelly Park clinic. They provide funded services that support an integrated team approach with the GP outreach service. The Health Hub Adelaide provides a GP outreach service to the SALHN Aboriginal Family Clinic Noarlunga and Clovelly Park comprising Vocational GP and a GP Registrar. The practice works within the Aboriginal Family Clinic working collaboratively with the workforce to promote and support best practice approaches and improve access to the local community. The Health Hub also participates in the Partnership Working Group.
Indigenous Specific	Yes
Duration	List the anticipated activity start and completion dates, and key milestones including planning, procurement, and commencement of service delivery. Start Date: 23/6/2016 The Project will be conducted in 2 phases. Phase 1: Activities to construct the business and clinical models required by HHA and AFC to support the outreach GP service. Phase 1 will be for a six (6) week period.

	Phase 2: HHA provision of an outreach GP service to AFC, and clinical service and business model evaluation. Phase 2 began so that there is a seamless transition of existing services, and will continue for twenty-four (24) weeks — i.e. ending on 17 February 2017. There has been an overlap of Phases 1 and 2 in July – August 2016. APHN will be working with the partnership to commit to a phase 3 of the project – which expands service provision due to successful review and evaluation of the pilot project. The APHN and SALHN will continue to support the expansion which will be self-sustaining by June 2018.
Coverage	LGAs of Mitcham, Holdfast Bay, Marion and Onkaparinga
Commissioning method (if relevant)	Direct engagement; Commissioned in whole
Approach to market	Direct engagement
Decommissioning	N/A

Proposed Activities – NP14.1 Supporting Palliative Care in the community	
Activity Title / Reference (eg. NP 1)	NP14.1 Supporting palliative care in the community through enhanced planning and access to the Core Medicines List through community pharmacies
Existing, Modified, or New Activity	New Activity
Needs Assessment Priority Area (eg. 1, 2, 3)	23. Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations 29. Lack of person-centred care and responsiveness to individual circumstances, including co-morbidities 31. Need to improve the aptitude/attitude and consistency of empathetic responses of a variety of health care staff across a range of sectors and setting as well as increase workforce capacity. 32. Minimise instances of poor quality and unwarranted variations of care and follow-up. 36. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly Aboriginal and Torres Strait Islander people, children and youth, people with a disability, older people, palliative care patients and their carers.
Description of Activity	This activity will aim to • increase prescriber and community pharmacy knowledge and collaboration across metropolitan Adelaide, with a focus on a previously developed Core Medicines List (CML) to improve medication access and enable death at home. It is anticipated that this will be undertaken through a number of activities. It is anticipated that it will include identifying and working with community pharmacies who currently do or will stock the CML and other end-of-life (EoL) medicines, developing and implementing on-the-ground support to build or improve existing relationships between general practitioners and community pharmacists where someone is requiring medicines as part of EoL care and developing and delivering training, information and support to strengthen the role of community pharmacies/pharmacists in the provision of medicines for EoL care. Expected outcomes include:

	• Carers have increased options and are supported to easily locate the core medicines. • Community pharmacies and pharmacists understand and support carers with improved access to provision of medicines for EoL care • Community pharmacists understand and support general practitioners to undertake anticipatory prescribing. • General practitioners understand the importance of and practice anticipatory prescribing • General practitioners and pharmacists work in collaboration to improve consistency around the provision of medicines as part of EoL care.
Target population cohort	People with life-limiting conditions nearing the end of life
Consultation	Consultation on this activity has been undertaken through working party meetings attended by the following organisations: • Country SA Primary Health Network • GP Partners • Palliative Care SA • Pharmaceutical Society of Australia (SA Branch) • Pharmacy Guild of Australia (SA Branch) • Silverchain (RDNS) • SA Ambulance Services • Specialist Palliative Care Services Pharmacists (SALHN, CALHN, NALHN)
Collaboration	It is anticipated that the successful service provider will collaborate with the APHN and the following organisations to ensure system integration. They are: • GP Partners – locate GPs who participate in the Palliative Care Shared Care Program; linking with these GPs and existing resources; understanding GP issues • Palliative Care SA – Resources and links around advocacy • Pharmaceutical Society of Australia (SA Branch) – training and education of pharmacists • Pharmacy Guild of Australia (SA Branch) – engagement with pharmacies; understanding pharmacy issues • Silverchain (RDNS) – links with current services • SA Ambulance Services – links with Extended Care Paramedics

	• Specialist Palliative Care Services Pharmacists (SALHN, CALHN, NALHN) – specialised knowledge and services; links to specialists • Decision Assist/Care Search – research and resources on palliative care
Indigenous Specific	Not specific but may include Aboriginal and Torres Strait Islander people
Duration	• Planning was undertaken in 2016 • Procurement process early 2017 • Service delivery to start mid-2017 • Evaluation data to be collected through 2017-18 • Ongoing beyond 30th June 2018 subject to project evaluation outcomes and funding availability
Coverage	The following LGAs in the Central Adelaide Local Health Network region: Port Adelaide Enfield, Campbelltown, Norwood, Payneham St Peters, Burnside, Walkerville, Prospect, Adelaide, Charles Sturt, West Torrens and Unley.
Commissioning method (if relevant)	The commissioning method will be dependent on the finalised model developed.
Approach to market	The Approach to market will be dependent on the finalised model developed.
Decommissioning	N/A

Proposed Activities – NP15.1 Northern Adelaide General Practice Liaison Unit	
Activity Title / Reference (eg. NP 1)	NP15.1 Northern Adelaide General Practice Liaison Unit (NAGPLU)
Existing, Modified, or New Activity	New Activity
Program Key Priority Area	Other: System integration
Needs Assessment Priority Area (eg. 1, 2, 3)	27. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover. 37. A coordinated approach to improve navigation and pathways for patients to manage their conditions.
Description of Activity	The aim of this activity is to improve patient care by facilitating and strengthening health care collaboration, communication and integration between general practice and the Lyell McEwen Hospital in the Northern Adelaide Local Health Network. The activity will achieve this by delivering programs of work across the following domains: Engagement and Relationship Building • Identifying and engaging general practices with patients in the cohort group Communication and Collaboration • Working between inpatient and outpatient services and general practice to ensure patient information is exchanged in a timely and appropriate manner as part of the clinical handover process Access and Navigation • Promoting and disseminating referral and management guidelines and resources as part of HealthPathways Capacity and Capability Building • Supporting general practice and hospital clinicians to enable improved management of the patient cohort in primary care through peer to peer mentoring and education Integration • Linking relevant hospital specialist areas, staff and resources and liaison services with general practice to support management of the patient cohort. The activity will be jointly funded by APHN and the Northern Adelaide Local Health Network (NALHN) and undertaken at the Lyell McEwen Hospital. The activity will employ a 0.6FTE General

	Practitioner and a 0.6FTE care coordinator in the hospital. Additional in-kind funding will be provided by the hospital to cover administrative and accommodation related expenses.
Target population cohort	The target population will be adults and/or children with chronic conditions who have frequent contact with hospital services.
Consultation	• This activity was established in consultation with general practitioners and clinicians and administrative staff from Lyell McEwen Hospital • This activity is governed by a Steering Group, involving participants from APHN, Lyell McEwen Hospital to oversee the performance monitoring and evaluation functions of the unit.
Collaboration	• This activity is jointly implemented in collaboration with NALHN and will be undertaken at the Lyell McEwen Hospital. • This activity will engage and collaborate with general practice and clinicians and administrative staff from the Lyell McEwen Hospital to improve communication and build sustainable working relationships to ensure systems and processes support the quality and timeliness of clinical handover and the coordination of care for patients across the hospital/community interface.
Indigenous Specific	Not specific but may include Aboriginal and Torres Strait Islander people
Duration	• Planning to commence in August 2017 • The activity will start in January 2018 – January 2019 (including evaluation and review process).
Coverage	Northern Adelaide Local Health Network region
Commissioning method (if relevant)	Direct approach with Northern Adelaide Local Health Network
Approach to market	Direct engagement
Decommissioning	N/A

Proposed Activities – NP16.1 Southern Adelaide General Practice Liaison Unit	
Activity Title / Reference (eg. NP 1)	NP16.1 Southern Adelaide General Practice Liaison Unit (SAGPLU)
Existing, Modified, or New Activity	New Activity
Program Key Priority Area	Other: System integration
Needs Assessment Priority Area (eg. 1, 2, 3)	27. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover. 37. A coordinated approach to improve navigation and pathways for patients to manage their conditions.
Description of Activity	The aim of this activity is to improve patient care by facilitating and strengthening health care collaboration, communication and integration between general practice and the Flinders Medical Centre in the Southern Adelaide Local Health Network. The activity will achieve this by delivering programs of work across the following domains: Engagement and Relationship Building • Identifying and engaging general practices with patients in the cohort group Communication and Collaboration • Working between inpatient and outpatient services and general practice to ensure patient information is exchanged in a timely and appropriate manner as part of the clinical handover process Access and Navigation • Promoting and disseminating referral and management guidelines and resources as part of HealthPathways Capacity and Capability Building • Supporting general practice and hospital clinicians to enable improved management of the patient cohort in primary care through peer to peer mentoring and education Integration • Linking relevant hospital specialist areas, staff and resources and liaison services with general practice to support management of the patient cohort. The activity will be jointly funded by APHN and the Southern Adelaide Local Health Network (SALHN) and undertaken at the Flinders Medical Centre. The activity will employ a 0.6FTE General

	Practitioner and a 0.6FTE care coordinator in the hospital. Additional in-kind funding will be provided by the hospital to cover administrative and accommodation related expenses.
Target population cohort	The target population will be adults and/or children with chronic conditions who have frequent contact with hospital services.
Consultation	• This activity was established in consultation with general practitioners and clinicians and administrative staff from Flinders Medical Centre. • This activity is governed by a Steering Group, involving participants from APHN, Flinders Medical Centre to oversee the performance monitoring and evaluation functions of the unit.
Collaboration	• This activity is jointly implemented in collaboration with SALHN and will be undertaken at the Flinders Medical Centre. • This activity will engage and collaborate with general practice and clinicians and administrative staff from the Flinders Medical Centre to improve communication and build sustainable working relationships to ensure systems and processes support the quality and timeliness of clinical handover and the coordination of care for patients across the hospital/community interface.
Indigenous Specific	Not specific but may include Aboriginal and Torres Strait Islander people
Duration	• Planning to commence in August 2017 • The activity will start in January 2018 – January 2019 (including evaluation and review process).
Coverage	Southern Adelaide Local Health Network region
Commissioning method (if relevant)	Direct approach with Southern Adelaide Local Health Network
Approach to market	Direct engagement
Decommissioning	N/A

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

OP1.1 Primary Health Care provider support	
Activity Title / Reference (eg. OP 1)	OP1.1 Support services for primary health care providers in the APHN region.
Existing, Modified, or New Activity	Modified activity
Description of Activity	The APHN will undertake communication and engagement with the general practice and broader primary health care sector and provide education and quality improvement support for primary health care providers to enhance their ability to work as part of a primary health care system to provide the right care in the right time and the right place. The aim of the activity is to: • Increase the awareness by the general practice and primary health care sector of the APHN and increase the capacity of general practices and primary health care providers to engage and participate in primary health care reform and thereby provide quality health services to their communities. • Increase primary health care providers understanding and actions to improve population health outcomes including immunisation, cancer screening, and targeting high risk/vulnerable populations and groups • Increase the capacity of the primary health care sector to understand, respond to and better meet the needs of their communities
Supporting the primary health care sector	Outline how the activity will support the primary health care sector General practice and primary health providers in the APHN region will be offered: • Enquiries line: an enquiries support model, which facilitates the timely response to requests from general practice and other primary health care providers • Provision of updates and information: various mediums utilised (website, regular primary health care e-Newsletter called Primary Links, bi-monthly newsletter, direct mail, emails and face-to-face) to meet needs of the primary health care sector Support to commissioned service providers: work with commissioned service providers to support their engagement and communication with primary health care providers

	• Education, engagement and networking events: Attend events as support, networking and engagement opportunities by staff and build partnerships with health professional organisations • Capacity building support: engagement of primary health care providers in reform programs • Needs assessment: survey of primary health care providers • Access to a clinical audit tool to enable extraction of relevant data from general practice support software for business and service planning, with Digital Heath Officer support to utilise the software
Collaboration	• Primary health care providers - to facilitate continued provision of quality care to their patients • Primary health care provider organisations – to engage and facilitate reform activities • Integrated Team Care (ITC) program; collaborate with Aboriginal Community Controlled Health Organisation(s) (ACCHO) to support culturally appropriate services for Aboriginal and Torres Strait Islander people. • PHC accreditation providers - promotion and support for quality improvement and best practice Health Care Home initiative (HCH) – promotion and assistance
Duration	This activity commenced from 01 July 2016 (with a 12 month evaluation and review process) and will continue until July 2018.
Coverage	Entire APHN region
Expected Outcome	Outline the expected outcome of this activity as it relates to the PHN objectives. • Increased awareness by general practices and primary health care providers of the APHN role and functions and the reform agenda • Build a strong collaborative relationship with general practices and primary health care providers in the APHN region to achieve the PHN strategic vision. • Increase the efficiency and effectiveness of general practices and primary health care providers to provide best practice services for patients, particularly those at risk of poor health outcomes. Improve the coordination of care for patients particularly those with chronic conditions and multi-morbidity to reduce potentially preventable hospitalisations and improve health outcomes.

OP1.2 South Australian PHNs Conference	
Activity Title / Reference (eg. OP 1)	OP1.2 South Australian PHN Conference / SA PHN Conference
Existing, Modified, or New Activity	New Activity
Description of Activity	The APHN in conjunction with Country SAPHN will run the South Australian Primary Health Care Conference for all Primary Health Care Professionals with a focus on multidisciplinary teams, chronic disease and integrated care. The conference will run over two days on the 1st and 2nd of April 2017. The key aim of the activity is to engage Primary Health Care Professionals (General Practitioners and Practice Teams, Allied Health Professionals, Pharmacy, Mental Health Professionals and SA Health staff etc.) in innovative conversations around different models of care, integrated teams and referral pathways. The conference will include national priority areas such as: Mental Health, Alcohol and other Drugs, Aboriginal Health, Population Health including immunisation and cancer screening, Workforce, Aged Care and End of Life Care.
Supporting the primary health care sector	Outline how the activity will support the primary health care sector The activity will provide: • An opportunity for primary health care providers to engage in knowledge sharing, collaboration and partnership building to enhance their ability to work collaboratively within our primary health care system • Quality education, professional development, referral pathways and linkages on a range of topics over a 2-day intensive period. • General Practitioners with one Category 1 RACGP accredited activity and one Category 2 RACGP accredited CPR session. • A session on wellbeing and self-care for primary health care professionals
Collaboration	This activity has and will continue to collaborate with: • General Practitioners, Practice Teams, Allied Health Professionals and other Primary Health Care Professionals to provide targeted education and facilitation of collaboration and partnerships

	• Royal Australian College of General Practitioners (RACGP) to facilitate/approve accredited education for General Practitioners • Australian Medical Placements Health Education and Training (AMPHEaT) to offer conference management support in the way of speaker and exhibitor management • SA Health, Cervix Screening Program • SA Health clinical staff This activity will also collaborate with commissioned service providers to promote their programs and services to Primary Health Care Professionals.
Duration	Planning period: Oct 2016 – April 2017 Event Date: 1st and 2nd April 2017 Follow up and expected completion date: May 2017
Coverage	Outline coverage of the activity. Where area covered is not the whole PHN region, provide the statistical area as defined in the Australian Bureau of Statistics (ABS), or LGA. Entire APHN and Country SA PHN regions
Expected Outcome	Outline the expected outcome of this activity as it relates to the PHN objectives. • To improve the partnerships and collaboration between the disciplines of Primary Health Care Professionals so that they can provide more efficient and effective health services to the South Australian Community • Provide high quality workforce education to increase the knowledge and skills of primary health care professionals, improving integrated and co-ordinated care to our health care consumers • Increased awareness by PHC professionals of the Adelaide and Country SA PHN roles, functions and commissioned services to enhance and strengthen collaboration and partnership between providers and the PHNs. • Increased knowledge about new resources and current best practices, changes, updates and reform within primary health care

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

There are no activities included in the May 2016 version of our AWP which are no longer planned for implementation in in 2017-18.

Planned activities which will no longer be delivered - copy and complete the table as many times as necessary to report on each activity	
Activity Title / Reference (eg. NP 1/OP 1)	N/A
Description of Activity	N/A
Reason for removing activity	N/A
Funding impact	N/A

2. (a) Strategic Vision for After Hours Funding

The Adelaide PHN (APHN) 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.

The APHN will undertake initiatives for the After Hours which aim to support and enhance existing services whilst building new and more flexible mechanisms of service navigation and service innovation for people in the community, primary health care providers including general practice and Residential Aged Care. These initiatives will engage and collaborate with key stakeholders to build sustainable working relationships and models which promote integration and coordination between service providers and optimise outcomes for people in the community. It is anticipated these initiatives will lead to improved access and knowledge of after-hours services and a reduction in potentially preventable hospitalisations in the targeted areas of activity of the APHN region in the after-hours period.

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

Proposed Activities – AH1.1 After Hours Consumer Awareness Resource	
Activity Title / Reference (eg. NP 1)	AH1.1 After Hours Consumer Awareness Resource
Existing, Modified, or New Activity	Existing activity
Needs Assessment Priority Area (eg. 1, 2, 3)	20. Lack of community awareness about appropriate after hours health care services leading to increased potentially preventable hospitalisations. 28. Lack of community awareness about existing health care services for different population groups, consumers and providers. 36. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.
Description of Activity	APHN will develop and commission a community awareness raising tools of after-hours medical services to ensure that residents in the outer fringes of the APHN region will have access to, or information to support self-triage, whilst raising awareness of available and appropriate after hours services, to support better health that are appropriate and accessible. The development of the tools involves working with organisations such as medical deputising services [MDS], general practice and other primary health practitioners i.e. Dentist and pharmacy, providing after hours services within the APHN region, to ensure that appropriate information is provided to community whilst raising awareness about the most appropriate and available services. Strategies involve the use of information technology, consumer resource development and expanded care options. The intended outcomes are a reduction in preventable hospitalisations and improvements in the delivery and management of care to all community members in order to receive the right care at the right time in the right place. A hard copy flip chart will be developed for Playford City Council residents only – in response to high emergency department presentation based on most current data; a consumer tri-fold brochure will be developed for use in Lyell McEwin and Modbury Hospital Emergency Departments for patients triaged

	as level 4 or 5; and a mobile optismised website for the whole APHN region, that is searchable for after hours health service options, during business hours, allowing for planned approaches to care.
Target population cohort	The hard copy resource will be developed for Playford City Council residents only; tri-fold brochure for anyone attend the Lyell McEwin and Modbury Hospital Emergency Departments classified as triage 4 or 5; and the website for the whole APHN region.
Consultation	Consultation with relevant LGAs, LHNs and membership and community groups.
Collaboration	• Northern Local Health Network (NALHN) will actively promote the hard copy resource and ED specific resource to encourage Playford City Council residents receiving the right care from the right place at the right time. • Playford LGA will promote the hard copy resource to constituents via publications, community centres and other mechanisms defined by them • The website will be promoted by APHN website and regular publications, membership groups and via other partner organisations with mechanisms defined by them.
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	• Hard copy resources dissemination Feb/March 2017 – completion April 2017 • Website design, development and launch April 2017 – completion May 2017
Coverage	• Hard copy flip chart resource to be distributed to Playford LGA in APHN region • Emergency Department (ED) tri-fold brochure to be distributed to Lyell McEwin (Playford LGA) and Modbury Hospital (Salisbury LGA) to ED attendees (triaged level 4 or 5) • Website is targeted to the entire APHN region
Commissioning method (if relevant)	Website design component - Direct engagement, commissioned in whole.
Approach to market	Website design component - Direct engagement.
Decommissioning	N/A

Proposed Activities – AH2.1 After Hours Innovation Grants	
Activity Title / Reference (eg. NP 1)	AH2.1 After Hours Innovation Grants
Existing, Modified, or New Activity	Existing Activity
Needs Assessment Priority Area (eg. 1, 2, 3)	20. Lack of community awareness about appropriate after hours health care services leading to increased potentially preventable hospitalisations. 21. RACFs have a low capacity to support their residents in the afterhours setting leading to increased transportation to emergency departments and medical deputising services. 28. Lack of community awareness about existing health care services for different population groups, consumers and providers. 36. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.
Description of Activity	The APHN has a responsibility to maintain continuity of after-hours services that are out of scope of the new After Hours Practice Incentive Program (PIP) administered by Medicare. In this regard the APHN 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. The purpose of the grants is to provide financial incentive to support General Practices and other primary care providers to implement innovative approaches to after-hours care that reduce demand on the after-hours period or solutions within the after-hours period. The aims of the grants areas re to: • Support and promote innovation in after-hours primary care services to meet identified community needs • and enable providers to deliver innovative solutions that will address one or more of the identified priority gaps within the APHN region as described below: : o residents of Residential Aged Care Facilities (RACFs)

	o migrants (including refugees and international students) o people requiring immediate mental health treatment o people requiring palliative care treatment o people not able to access after-hours care due to frailty or disability o Aboriginal and Torres Strait Islander Health and Wellbeing o other service gaps identified by providers, supported by sound evidence of community need. Applicants should consider a number of factors when demonstrating community need, as follows (but not limited to): ▪ Population affected ➢ Surrounding health infrastructure (eg availability of a medical deputising service, locum service, local hospital) ➢ Level of socio-economic disadvantage in the region ➢ Proximity to existing after hours services • Evidence that the proposal is available to the wider community, not just existing practice clientele • Alignment with Digital Health and My Health Record • Potential impact of the proposal is tangible and measurable.
Target population cohort	Targeted cohorts within the APHN region with a focus on: • residents of Residential Aged Care Facilities (RACFs) • migrants (including refugees and international students) • people requiring immediate mental health treatment • people requiring palliative care treatment • people not able to access after-hours care due to frailty or disability • Aboriginal and Torres Strait Islander Health and Wellbeing And Other population groups supported by sound evidence of community need
Consultation	The APHN has undertaken a series of community and health care professional consultations as part of the needs assessment process. Based on this feedback and analysis of population health data, hospital emergency department presentation data and After Hours intelligence and reporting from the three South Australian Medicare Locals, the APHN has identified gaps in After Hours service provision and developed a strategic focus for After-Hours funding.
Collaboration	List stakeholders that will be involved in implementing the activity, including Local Hospital Network or state/territory government. Describe the role of each party.

	To provide innovative after hours services that meet identified community needs, the activity collaborated with: • General Practices • Pharmacies • Allied health
Indigenous Specific	No
Duration	Planning for the activity commenced February 2016, an invitation to apply was released 15 April 2016 with implementation of services from 01 July 2016 (with an evaluation and review process) to 30 June 2017.
Coverage	Entire APHN region.
Commissioning method (if relevant)	Open approach to market, Request for Proposal, commissioned in whole.
Approach to market	Open approach to market, Request for Proposal, commissioned in whole
Decommissioning	N/A

Proposed Activities – AH3.1 After Hours Extension of Mental Health Clinical Services	
Activity Title / Reference (eg. NP 1)	AH3.1 After Hours Extension of Mental Health Clinical Services
Existing, Modified, or New Activity	Existing Activity
Needs Assessment Priority Area (eg. 1, 2, 3)	20. Lack of community awareness about appropriate after hours health care services leading to increased potentially preventable hospitalisations. 28. Lack of community awareness about existing health care services for different population groups, consumers and providers. 30. Need to improve provision of education to consumers and professionals across the health sector to encourage the take-up and application of preventive health measures. 36. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.
Description of Activity	This activity will enable selected APHN commissioned providers of primary mental health care services to provide services in the after-hours period. Selected commissioned providers will provide mental health care services in these hours, adjusted according to population health needs and in agreement with the APHN. This flexibility in the provision of primary mental health care services aims to maximise the availability of services to targeted communities and ensure timely access to primary mental health treatment and care.
Target population cohort	Under-serviced/hard to reach population groups
Consultation	The APHN has consulted widely with stakeholders, representative bodies, professional and community organisations, providers, membership groups, consumers and carers regarding primary mental health and alcohol and other drug reform. The APHN has consulted specifically with Aboriginal and Torres Strait Islander communities regarding wider reforms to primary mental health care services. These consultations have provided strategic input in to the activity planning process, forming an important collaborative role with the APHN. The APHN will continue to collaborate with Aboriginal Community Controlled Health Organisation(s) (ACCHO) and Aboriginal specific reference groups to support culturally appropriate services for Aboriginal and Torres Strait Islander people. For a comprehensive

	summary of this engagement please refer to the relevant document on our website: http://adelaidephn.com.au/publications-resources/consultation-findings-mhaod/ This engagement has highlighted the importance of flexible service provision in mental health care and treatment.
Collaboration	The APHN will collaborate with selected APHN-commissioned providers servicing areas of need and/or working with hard-to-reach populations.
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	The activity commenced on the 01 July 2016 (with a 12 month evaluation and review process) – the contract process will include the ability to review and redesign as necessary with contracts continuing in line with funding received by the APHN under this schedule.
Coverage	Entire APHN region with focus on the following Local Government Areas (LGAs) (with high prevalence of need and people who are not able to access Medicare funded mental health services): Playford, Salisbury, Port Adelaide-Enfield and Onkaparinga.
Commissioning method (if relevant)	Direct approach to market using commissioned providers for APHN Primary Mental Health Care Services (Stepped-care approach), commissioned in whole.
Approach to market	Direct approach to market using commissioned providers for APHN Primary Mental Health Care Services (Stepped-care approach).
Decommissioning	There is no decommissioning commenced or planned regarding this activity.

Proposed Activities – AH4.1 Mental Health After Hours Services	
Activity Title / Reference (eg. NP 1)	AH4.1 Mental Health After Hours Services
Existing, Modified, or New Activity	New Activity
Needs Assessment Priority Area (eg. 1, 2, 3)	1. High prevalence of mental health/behavioural issues and psychological distress in selected areas across the region. 2. Provision of psychological services comparatively low in areas of high need. 3. Comparatively high numbers of people attempting to access psychological services in areas with minimal psychological service provision. 20. Lack of community awareness about appropriate after hours health care services leading to increased potentially preventable hospitalisations. 28. Lack of community awareness about existing health care services for different population groups, consumers and providers. 30. Need to improve provision of education to consumers and professionals across the health sector to encourage the take-up and application of preventive health measures. 36. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.
Description of Activity	Mental Health Community After Hours Services will provision the APHN region offering a stepped accessible, responsive and personalised adult mental health service which is able to offer support advice and/or treatment options to consumers and carers. The service will also act as a referral gateway relevant to the presenting mental health condition. The Service will be based on a stepped integrated model approach with clear escalation and e-escalation procedures intrinsic at all levels. The aim of the activity is to; • Provide points of contact for consumer and carer centric, proactive, responsive and supportive services to people requiring mental health support and/or advice at time of crisis. • These services will operate in targeted hours after those of mainstream services.

	• Provide a stepped approach to mental health crisis that is in keeping with the need of the presenting mental health crisis. • To provide potential options for managing the mental health crisis until access to main stream services are available. • To enable access to mainstream assessment, treatment and support for mental health that is appropriate to the mental health crisis presentation. • To provide a follow up service to ensure that the consumer or carer has resolved the crisis or accessed services as required.
Target population cohort	• Adults in mental health crisis aged 18-65 • Adults 18-65 as having potentially preventable hospital admissions
Consultation	• Consultation will occur with the all accessible stakeholders Adelaide Local PHN's • Consultation, with additional state services SAAS and SAPOL • Consultation, with NGO's. • Consultation with Consumer and Carer groups including ATSI and CALD representatives.
Collaboration	• The activity will collaborate with commissioned services across the APHN region whom can support consumers seeking advice and guidance for mental health presentations when access to mainstream mental health services are unavailable. • Collaboration will additionally occur with secondary and tertiary specialist services within the 5 Local Health Networks in the APHN region in order to ensure that consumers receive a stepped approach which is appropriate to the presentation, seamless in regards to access to relevant services and timely to prevent deterioration or increase in risk.
Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	Planning, Consultation, Collaboration and model development; January 2017 –March 2017 Procurement of new services; March – June 2017 Integration of existing services into a seamless stepped approach; March – June 2017 Commencement of Integrated Services; July 201 Review of effectiveness; January 2018 Evaluation of stepped model; April 2018 Ongoing beyond 30th June 2018 subject to project evaluation outcomes and funding availability

Coverage	• Local Government Areas of Playford, Salisbury, Tea Tree Gully and Statistical Local Areas (SLAs) of Port Adelaide Enfield (East) and Port Adelaide Enfield (Inner).
Commissioning method (if relevant)	The commissioning method will be dependent on the finalised model developed.
Approach to market	The Approach to market will be dependent on the finalised model developed.
Decommissioning	N/A

Proposed Activities – AH5.1 Australian Disability Medical Services Primary Health Care Services Enhancement Project	
Activity Title / Reference (eg. NP 1)	AH5.1 Adelaide Disability Medical Services Primary Health Care Enhancement Project
Existing, Modified, or New Activity	New Activity
Needs Assessment Priority Area (eg. 1, 2, 3)	36. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.
Description of Activity	Adelaide Disability Medical Services (ADMS) provides "in home" general practitioner services in Adelaide's north, north east and western metropolitan areas to people with an intellectual disability (ID) who are unable to access mainstream general practice due to severe behavioural challenges. This activity will provide seed funding for the set-up and establishment of a fixed location general practice including employment of nursing and administrative support, IT infrastructure and services, practice lease and clinic equipment. This will enable ADMS to expand and diversify to a mixed model of home visits and a fixed location general practice, extend its chronic disease capacity and capability and enable more patients to receive timely access to an appropriate service able to meet their specific needs. It is also expected that as a sustainable model into the future ADMS will further expand its service to provide a multidisciplinary allied health and specialist model of care which would provide advice and support to other GPs and primary care providers in the APHN region to assist with their management of people with ID.
Target population cohort	People with intellectual disability living in Adelaide's north, north east and western metropolitan areas.
Consultation	This activity has consulted with APHN's Disability Health Priority Group (HPG) as part of the needs assessment process. The following points were raised as issues to address: • Need of a primary health service model for people with disabilities which is interagency and interdisciplinary • Access to primary health services across disability health and community • Training for GPs, nurses, allied health professionals in disability and health needs of people with disability
Collaboration	ADMS general practitioners will provide medical and primary care services ADMS extend services to identified patients

Indigenous Specific	Not specific but will include Aboriginal and Torres Strait Islander people
Duration	The activity will commence in March 2017. The contract will be for 12 months. The contract process will include the ability to review and redesign as necessary with contracts continuing in line with funding received by APHN under this schedule.
Coverage	North, north east and western suburbs of the APHN region
Commissioning method (if relevant)	Unsolicited Proposal, Direct Engagement, Commissioned in whole
Approach to market	Unsolicited Proposal, Direct engagement
Decommissioning	N/A

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

There are no activities included in the May 2016 version of our AWP which are no longer planned for implementation in in 2017-18.

Planned activities which will no longer be delivered	
Activity Title / Reference (eg. NP 1/OP 1)	N/A
Description of Activity	N/A
Reason for removing activity	N/A
Funding impact	N/A