Australian Government
Department of Health

phn
An Australian Government Initiative

Updated Activity Work Plan 2016-2018:

Core Funding

After Hours Funding

The Activity Work Plan template has the following parts:

1. The updated Core Funding Annual Plan 2016-2018 which will provide:
    a) The updated strategic vision of each PHN.
    b) An updated description of planned activities funded by the flexible funding stream under the Schedule – Primary Health Networks Core Funding.
    c) An updated description of planned activities funded by the operational funding stream under the Schedule – Primary Health Networks Core Funding.
    d) A description of planned activities which are no longer planned for implementation under the Schedule – Primary Health Networks Core Funding.
2. The indicative Core Operational and Flexible Funding Streams Budget for 2016-2018 (attach an excel spreadsheet using template provided).
3. 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.
4. The updated indicative Budget for After Hours Primary Care funding stream for 2016-2017 (attach an excel spreadsheet using template provided).

Brisbane South

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

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

Overview

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

Table of contents

1. (a) Strategic Vision

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

Activity	**NP 1.1 Refugee Health**
Existing, Modified, or New	Existing
Program Key Priority Area	Other: Vulnerable Population
Needs Assessment Priority Area	1. Appropriate access and usage of health services
Description of Activity	The Brisbane South PHN region has a large culturally and linguistically diverse (CALD) population. The majority of refugees come from African and Middle Eastern backgrounds and are mainly settled in suburbs such as Inala, Acacia Ridge, Marsden and Woodridge. This group has been identified in the Whole of Region Needs Assessment (WORNA) as a target group with high health needs. Refugee Health Connect (RHC) targets this group by linking people from refugee backgrounds to primary health providers to improve health access and engagement with primary care, and mitigate the risk of public health exposure for untreated conditions. RHC aims to improve the health of refugees by increasing the capacity of General Practice and other primary care providers to treat refugees in a culturally and clinically appropriate manner. The service provides a single point of contact for health service providers, schools, community organisations and settlement services for all aspects of refugee health to ensure people of refugee backgrounds are connected with appropriate health care. Healthy Start is a community health literacy program commissioned by Brisbane South PHN, it provides valuable health and health system information for refugees after their arrival and settlement in Australia. The program is delivered in partnership with health and medical students, Settlement services and community leaders to ensure it develops student capability in culturally diverse situations, responds to community need and aligns to settlement activities. This project will require expansion in 2017-18 due to the increased influx of settling refugees - expected to continue at high levels for a minimum of 18 months.
Target population cohort	• General practice and primary care providers • Community organisations with clients of refugee background • Settlement agencies • Refugee population

Activity	**NP 1.1 Refugee Health**

Consultation	• Mater Integrated Refugee Health Services (MIRHS)
	  ○ Provide support to practices/organisations through the provision of nurses, practice visits and over the phone support
	  ○ Updates on Government policies, refugee health environment/ services
	  ○ Involved in allocating RHC referrals
	• Metro South Health Refugee Service (MSHRS)
	  ○ Provide support to practices/organisations through the provision of nurses, practice visits and over the phone support
	  ○ Updates on Government policies, refugee health environment/ services
	• Clinical Leads
	  ○ Provide support and mentoring to clinicians, through the delivery of peer-to-peer education
	  ○ Set any relevant protocols or practices in consultation with Clinical Advisory Council (CAG)
	  ○ Chair and attend CAG
	  ○ Clinical advice and support for the project
	• Refugee Health Connect
	  ○ Provide support to Practices, especially at an administrative level
	  ○ Provide access to MIRHS/MSHRS and Clinical Leads when appropriate
	• Multicultural Development Association (MDA)
	  ○ Newly arrived refugee referrals
	  ○ Forecast of new arrivals
	  ○ Updates from Government departments
	  ○ Feedback about health services from refugee clients
	• ACCESS Community Services
	  ○ Forecast of new arrivals
	  ○ Updates from Government departments
	  ○ Feedback about health services from refugee clients
	• Brisbane North PHN (BNPHN)
	  ○ Identification and provision of support for potential or already refugee ready practices.
	  ○ Collaboration regarding MDA New Farm Hostel
	• Relevant refugee ready practices: Engagement and capacity to see refugee patients
	• Clinical Advisory Group: Advice on training needs, clinical guidance, determination
	• Partnership Advisory Group: Project guidance and leadership

Activity	**NP 1.1 Refugee Health**
Collaboration	RHC is a partnership between Brisbane South PHN, Brisbane North PHN, Mater Health Services (MHS), Metro South Hospital and Health Service (MSHHS), ACCESS Community Services and MDA. It is a model endorsed by the South East Queensland Refugee Health Partnership Advisory Group (RH-PAG) to improve access, quality and care coordination for people of refugee background. Its establishment was a response to the gap in health services, identified by primary care and settlement services. It responds to the increasing numbers of people arriving in Brisbane: humanitarian entrants, people seeking asylum and living in the community on bridging visas. MDA works directly with RHC to connect settling refugees with a local General Practice. RHC supports General Practices to change their business models and improve their capacity to assess and manage these complex patients appropriately. Healthy Start was developed by Hope4Health – with seed funding from Brisbane South PHN and ongoing funding for the delivery of the education to community members. Healthy Start is run by a student organisation– Hope4Health.
Indigenous Specific	No
Duration	Second year of a two year period (2016-2018)
Coverage	Entire Brisbane South PHN region (PHN302) and also supports some of Brisbane North PHN (PHN301), this aligns to the Department of Immigration Settlement Areas – Brisbane LGA (31000) and Logan LGA (34590)
Commissioning method (if relevant)	Direct Delivery of coordination service only. Contracted Clinical Lead time. NB: Partners also play a role in the clinical delivery and support

Activity	**NP 1.2 Clinical Integration & Senior Clinical Advisor**
Existing, Modified, or New	Existing
Program Key Priority Area	Aged Care Digital Health Indigenous Health Health Workforce Mental Health Population Health
Needs Assessment Priority Area	1. Appropriate access and usage of health services

Activity	**NP 1.2 Clinical Integration & Senior Clinical Advisor**
Description of Activity	Brisbane South PHN ensures primary healthcare has local, clinical input into the development of new ways of working to improve services so that they meet the needs of the community and the requirements of local clinicians. Access and coordination, and clinical education have been identified across a number of planning activities as areas for improvement. There is a need for Brisbane South PHN to have clinical subject matter experts with a focus on primary healthcare to support and champion improved integration between services and provide advice on Brisbane South PHN's initiatives. The clinical leads conduct education sessions and/or provide advice and support to a number of activities, including: • NP 1.1 Refugee Health • NP 2.2 Maternal Shared Care • NP 4.2 Optimal Care • NP 6.1 Residential Aged Care Access • NP 10.1 Digital Health • Mental Health (various). Their qualifications include being general practitioners, registered nurses, pharmacists and social workers covering aged care, mental health, perinatal mental health, chronic disease, research, and preventive health (amongst others).
Target population cohort	• General practice and primary care providers • Allied health professionals
Consultation	Not applicable
Collaboration	• Local Primary Health Care providers • Hospital and Health Services • Other NGO and local organisations
Indigenous Specific	No
Duration	Second year of a two year period (2016-2018).
Coverage	Entire Brisbane South PHN region (PHN 302)
Commissioning method (if relevant)	Contracted/Purchased clinical time

Activity	**NP 2.2 Maternal Shared Care**
Existing, Modified, or New	Existing

Activity	**NP 2.2 Maternal Shared Care**
Program Key Priority Area	Health Workforce/ integrated care
Needs Assessment Priority Area	2. Antenatal and perinatal care
Description of Activity	**Joint Maternity service and regional capacity building with MSH** Brisbane South PHN partners with local hospitals to deliver RACGP approved educational events aimed at providing GPs with the most current evidence-based practices in the management of women-centred care in the antenatal period. These events enable GPs to provide high quality antenatal and postnatal care and ensure that all pregnant women have the choice of excellent community care from a Midwife, GP or Obstetrician. Attendees participate in small case-based discussions with expert commentary and feedback. Cases include use of medication in pregnancy (particularly regarding antidepressants, vaccination and hyperemesis), domestic violence and perinatal mental health. Presentations by local experts include combined first trimester screening, nuchal translucency scans, obesity in pregnancy, diabetes management in pregnancy and use of the Pregnancy Health Record.
Target population cohort	• GPs • Midwives • Obstetricians
Consultation	• MSHHS • Mater Mothers Hospital • Clinical Leads
Collaboration	• Mater Mothers Hospital: developed from their Maternity Shared Care Alignment program. • The model has also been expanded across the region for Metro South Health and to other PHN areas.
Indigenous Specific	No
Duration	Second year of a two year period (2016-2018).
Coverage	Entire Brisbane South PHN region (PHN302), with some additional coverage for other PHN regions due to patient flow i.e. some patients and General Practices outside the PHN catchment who are outside the MSHHS / Mater catchment.
Commissioning method (if relevant)	Partner: with local obstetric facilities. Contract/Purchase: Clinical GP Leads to provide education and peer support.

Activity	**NP 3.2 Imago**
Existing, Modified, or New	Existing
Program Key Priority Area	Other: Early childhood
Needs Assessment Priority Area	3. Childhood development
Description of Activity	Imago provides training and education in the use of the Parents' Evaluation of Developmental Status (PEDS) screening tool in childcare centres, not for profit organisations and government services. PEDS provides a platform for developmental and behavioural screening and ongoing surveillance of children from birth through to 8 years of age. It assists with early detection of developmental vulnerabilities which can lead to significant improvement in child outcomes. Children, once identified as developmentally vulnerable, will undergo further developmental screening and are given an opportunity to attend an allied health pop-up intervention clinic.
Target population cohort	• Parents of babies and children (1 year to 8 years) • Culturally and linguistically diverse (CALD) people and communities • Asylum seekers and refugees • Aboriginal and Torres Strait Islander people • Health professionals • Early Childhood Education Centres

Activity	**NP 3.2 Imago**
Consultation	• Provide details of stakeholder engagement and consultation activities undertaken or to be undertaken to support this activity. • Early Education providers, other organisations working with children aged 0-5 years e.g. Schools, Department of Human Services, Intensive Family Support Services, Family Child Connect, Communities for Children, QCOSS • University of Queensland (UQ) • Hear & Say: Provision of Audiology screening program in Early Childhood Education Centres (ECECs) & pop up clinics • Baby Bridges • Royal Far West: Implement & Staff pop-up clinics (Intervention telecare) & Family centred approach • Parents of children in child care: • Queensland Department of Education & Training – Quality Beginnings Quality Futures Strategy: To participate in their early years strategy implementation with ECECs & Schools e.g. Abecedarian Project • Children's Health Queensland & Child Development Services • NGOs – Child Friendly Consortium, Local AEDC Response groups, QCOSS: • Logan Together collective impact initiative: • Federal & State MPs • State & Local Government - Catholic Education & Association of Independent Schools; Local Councils • Primary Health Care Providers • Allied Health Providers • Representatives of: Aboriginal and Torres Strait Islander community, Pasifika Community, CALD/ Refugee community • External Consultants – Science of Knowing: Support for project evaluation
Collaboration	• ECECs and Kindergartens to introduce the PEDS program to improve identification and treatment of children presenting with developmental vulnerabilities • Child developmental service providers and UQ coordinates student-led pop-up clinics functioning as assessment and interventionist child development services. The clinics enables a child to move appropriately from identification to intervention. • Logan Together – a 10 Year collective impact initiative (multi-sectoral) changing the profile of Logan children (0-8 years) • Local GPs and Council
Indigenous Specific	No
Duration	Second year of a two year period (2016-2018).

Activity	**NP 3.2 Imago**

Coverage	• Redlands LGA (36250), Logan LGA (34590) and Beaudesert/Scenic Rim, specifically SA3 – 31101. This is due to the Scenic Rim LGA being shared by 3 PHNs, Brisbane South PHN only services those parts of the Scenic Rim that are in the Brisbane South PHN catchment.
	• Allied Health Intervention (AHI):
	  ○ Jimboomba, Beaudesert and surrounding areas – Jimboomba SA3 31104 and Beaudesert SA3 31101
	  ○ Stradbroke, Russell and Macleay Islands – Redlands Islands SA2 31010.

Commissioning method (if relevant)	Commissioned: • PEDS training and support rollout across ECECs and Kindergartens, and Department of Human Services • Secondary Screening • Pop up clinics (where required).

Activity	**NP 3.3 Allied Health Intervention (AHI)**
Existing, Modified, or New	Existing
Program Key Priority Area	Other: Early childhood
Needs Assessment Priority Area	3. Childhood development
Description of Activity	The Allied Health Intervention service directly targets children who are developmentally vulnerable and reside in rural and geographically isolated areas. In some local government areas within the Brisbane South PHN region, the percentage of children who are developmentally vulnerable is slightly higher than the national average (i.e. Logan and Scenic Rim-Beaudesert). Referrals are made by General Practitioners to approved allied health professionals, who will then provide evidence-based interventions, assessments of childhood developmental milestones, and diagnosis where appropriate. Impacts of service provision will be evaluated within a longitudinal study.
Target population cohort	• Children up to 8 years of age • Children of lower socio-economic groups living in rural or geographically isolated areas, with a registered Health Care Card or experiencing financial hardship, as documented by their GP
Consultation	• GPs: referrals • Allied health providers: service provision
Collaboration	• Local GPs and Councils
Indigenous Specific	No

Activity	**NP 3.3 Allied Health Intervention (AHI)**
Duration	Second year of a two year period (2016-2018).
Coverage	• Jimboomba, Beaudesert and surrounding areas – Jimboomba SA3 31104 and Beaudesert SA3 31101 • Stradbroke, Russell and Macleay Islands – Redlands Islands SA2 31010.
Commissioning method (if relevant)	Commissioned: An EOI was released to the market in Q2 15/16. As a result of the EOI there has been a co-design process in action from Q2-Q3 15/16. Provider commenced this service in Q1 16/17.

Activity	**NP 3.4 Child Health Clinical Leads**
Existing, Modified, or New	Existing
Program Key Priority Area	Other: Early childhood
Needs Assessment Priority Area	3. Childhood development
Description of Activity	There is a need for Brisbane South PHN to have clinical subject matter experts with a focus on childhood development to support and champion improved integration between services and provide advice on Brisbane South PHN's initiatives. They provide effective primary care clinical input into: • The assessment of local needs • Identification of priority actions to address need • Health and service planning • Oversight and evaluation of programs and initiatives.
Target population cohort	• Parents of babies and children (1 year to 8 years) • Culturally and linguistically diverse (CALD) people and communities • Asylum seekers and refugees • Aboriginal and Torres Strait Islander people • Health professionals • ECECs • Children up to 8 years of age • Children of lower socio-economic groups living in rural or geographically isolated areas, with a registered Health Care Card or experiencing financial hardship, as documented by their GP

Activity	**NP 3.4 Child Health Clinical Leads**
Consultation	• Allied health providers • GPs • Medical specialists • Metro South Hospital and Health Service • Steering Committees and network groups • Non-Government Organisations • Clinical Councils • Local primary healthcare providers • Children's Health Queensland
Collaboration	• Local primary healthcare providers • Councils • Hospital and Health Services
Indigenous Specific	No
Duration	Second year of a two year period (2016-2018).
Coverage	Entire Brisbane South PHN region (PHN302)
Commissioning method (if relevant)	Contracted/Purchased: Clinical Lead time

Activity	**NP 4.1 Positive Care**
Existing, Modified, or New	Existing
Program Key Priority Area	Population Health
Needs Assessment Priority Area	4. Prevention and management of chronic disease
Description of Activity	The Positive Care service directly targets patients with complex health needs that frequently present to the Emergency Department (ED) as a result of poorly controlled chronic diseases such as those identified in the WORNA. The service offers chronic disease phone coaching, care co-ordination where required, and navigation or re-orientation to link patients into a general practice. The key aim of the service is to: • Reduce unnecessary ED re-presentations and hospital admissions at Redland hospital • Improve health literacy regarding appropriate use of primary and tertiary healthcare and chronic disease self-management capability • Increase the number of patients navigated to a general practice post ED presentation if not already visiting a GP. Specific patient cohorts who will benefit from this program include target groups identified in the WORNA; such as young people with chronic conditions (e.g. asthma), adolescents (15 years and under), women aged 50-74 years, Aboriginal and Torres Strait Islander peoples, CALD communities and people living in geographical hotspots and/or areas with access and services gaps (e.g. Logan). The specific high priority health needs identified in the WORNA are asthma, diabetes, and COPD. Also included are men aged 50-74 years with chronic disease. Consideration will be given to how this project may contribute to Health Care Home initiatives in the future.
Target population cohort	Patients presenting to hospital ED who meet the criteria for a telephone-based Chronic Disease Self-Management program, and have: • One or more chronic diseases at risk of re-presentation to hospital • One or more chronic diseases who would benefit from the program.
Consultation	• Redland Hospital: Access to ED patient presentation details (Redland Hospital) • Consumers: Participate in service • General Practitioners: Copy of General Practice Management Plan and collaborate in care • Other Primary Care Practitioners: General Practice Management Plan collaboration • Specialists: General Practice Management Plan collaboration • Queensland University of Technology (evaluation): Positive Care report
Collaboration	• The model has been developed and implemented in consultation with Metro South Health's Redland Hospital • This service works alongside Optimal Care (NP 4.2) enabling integration of patients from hospital into an established General Practice "medical home" environment. Through alignment with Optimal Care we are providing an increased likelihood that patients will receive current best practice chronic disease management for their condition.

Activity	**NP 4.1 Positive Care**
Indigenous Specific	No
Duration	Second year of a two year period (2016-2018).
Coverage	Redlands LGA (LGA36250), Southern parts of the Brisbane LGA (31000), mostly comprised of Brisbane – South SA4 (303) and Logan LGA (LGA34590)
Commissioning method (if relevant)	Service is currently commissioned to a private provider to deliver this program at Redland Hospital. Future delivery to any new sites will be commissioned.

Activity	**NP 4.2 Optimal Care**
Existing, Modified, or New	Existing
Program Key Priority Area	Population Health
Needs Assessment Priority Area	4. Prevention and management of chronic disease
Description of Activity	The Optimal Care program targets general practices to improve their management of chronic disease. The practices include those with patients in the Positive Care program and in geographical hotspots and/or areas with access and service gaps. The program provides upskilling in specific priority health needs identified in the WORNA (asthma, diabetes and COPD). The program utilises 3 evidence-based focus areas: • delivery system design • clinician decision support • patient self-management (Wagner Chronic Disease model, APHCRI, 2006) – including opportunities for community-based clinics linked to General Practice. The key aims are to increase the number of patients with a Chronic Disease GP Management Plan and/or Team Care Arrangement/Cycle of Care, increase clinician knowledge of health coaching and improve data management quality, resulting in improved primary care management of patients with chronic disease. Consideration will be given to how this project may contribute to Health Care Home initiatives in the future.

Activity	**NP 4.2 Optimal Care**
Target population cohort	• General practices that have patients enrolled in the Positive Care telephone support program and are eligible for the Optimal Care program • General practices that have enrolled in the Building Digital Health project (i.e. have PenCS system including PENCAT and Top Bar) • General practices in areas of high disease prevalence who are ready to make necessary changes to their system processes to enhance their chronic disease management
Consultation	• General Practitioners: Engagement in initiative, data, evidence of quality improvement • Diabetes Australia: Possible source of clinical educator, information re services for patients • Lung Foundation: Possible source of clinical educator, information re services for patients • Asthma Australia: Possible source of clinical educator, information re services for patients • Other Non-government organisations: Possible source of clinical educator, information re services for patients • Australian Primary Care Nurses Association: Information where relevant • Royal Australian College of General Practitioners: Information where relevant
Collaboration	• General Practice • Allied Health providers • Chronic Disease peak organisations • This service compliments Positive Care (NP 4.1) enabling integration of patients from hospital into an established General Practice "medical home" environment
Indigenous Specific	No
Duration	Second year of a two year period (2016-2018).
Coverage	Entire Brisbane South PHN region (PHN302)
Commissioning method (if relevant)	Not applicable

Activity	**NP 6.1 Residential Aged Care Access (RACA)**
Existing, Modified, or New	Existing
Program Key Priority Area	Aged Care
Needs Assessment Priority Area	6. Aged care

Activity	**NP 6.1 Residential Aged Care Access (RACA)**
Description of Activity	The RACA initiative improves access to allied health services for care recipients across all Residential Aged Care Facilities (RACFs) in the Brisbane South PHN region. Having undertaken a service review and remodelling, RACA provides services where no other funding exists and where support needs have been identified targeting psychological, psychosocial and dementia management support services. There are 7,371 operational RACF beds in the Brisbane South PHN region, with a projected increase of 139% to 17,609 beds by 2050. A range of issues that impact on the health and wellbeing of RACF residents have been identified, and this service fosters collaborative partnerships between allied health providers (AHPs) and RACFs to meet complex care needs.
Target population cohort	Care recipients of RACFs who: • Are not eligible for services through any other alternate funding stream • Have Complex Health Care needs requiring Psychological Support services.
Consultation	• Managers of facilities, operations and clinical areas of RACFs • Consumers/care recipients • Allied Health Providers
Collaboration	• Allied Health Providers • RACFs
Indigenous Specific	No
Duration	Second year of a two year period (2016-2018).
Coverage	Entire Brisbane South PHN region (PHN302)
Commissioning method (if relevant)	Commissioned

Activity	**NP 6.3 Advance Care Planning**
Existing, Modified, or New	Modified
Program Key Priority Area	Aged Care
Needs Assessment Priority Area	6. Aged care

Activity	**NP 6.3 Advance Care Planning**
Description of Activity	Quality of life prior to death in a patient's setting of choice affects the patient and the mental and physical wellbeing of family. In addition to the gains in patient care outcomes, quality palliative and end-of-life care provides efficiencies and cost savings by reducing dependence on the hospital system for end-of-life care. Together with the Advance Health Directive, Resuscitation Plan and Enduring Power of Attorney, Advance Care Planning (ACP) using the Statement of Choices document is a primary component of 'End of Life Planning'. ACPs focus on actively listening and recording the healthcare choices made by or on behalf of patients and residents in our care. By listening well, accurately recording decisions and sharing these decisions with the appropriate people, interventions will be based on informed choices. This minimises the burden of complex decision making in critical situations where time is of the essence. This project is a collaboration between Brisbane South PHN and Metro South Palliative Care Service (MSPCS) to improve ACP in Brisbane South. It aims to increase uptake, improve end of life care, decrease unnecessary hospital admissions in relation to palliative patients in RACFs and build on the evidence base to further support the cost effectiveness of implementing ACP programs. This will include development, education and evaluation across registered RACFs. NP 6.3 – Advance Care Planning (Aged Care) is a continuing (modified) activity, approved as part of the Brisbane South PHN Carryover 2015-16 by DoH in October 2016. As such it was not included in the Activity Work Plan 2016-18 submitted in May 2016.
Target population cohort	• Care recipients of RACFs • Staff of RACFS • GPs providing care at RACFs.
Consultation	• Metro South Palliative Care (MSHPCS): Data participation, collaboration in management and delivery • Local RACFs: Project participation • Local GPs: Project participation
Collaboration	Metro South Palliative Care Service (MSHHSPCS)
Indigenous Specific	No
Duration	Second year of a two year period (2016-2018).
Coverage	Entire Brisbane South PHN region (PHN302)
Commissioning method (if relevant)	Partnership

Activity	**NP 9.1 Practice Nurse Support**
Existing, Modified, or New	Existing

Activity	**NP 9.1 Practice Nurse Support**
Program Key Priority Area	Health Workforce
Needs Assessment Priority Area	9. Health workforce
Description of Activity	This service is designed to provide support to practice nurse roles within general practice by offering training, mentoring and health coaching development. The aim is to up-skill the practice nurse workforce, leading to improved patient wellbeing through prevention, early intervention and self-management of chronic conditions and a reduced burden on acute care. The Practice Nurse Support Program directly addresses a high priority area identified in the WORNA: immunisation, screening, wound management, management of chronic disease and lifestyle factors that lead to chronic disease, and workforce capability development.
Target population cohort	Nurses working in general practices in Brisbane South PHN area that are new, returning or transitioning to general practice, or are new graduates.
Consultation	• GPs, primary care health professionals and support staff: Participate in project • Practice Nurses: Participate in project activities • Program Delivery: Inform knowledge of general practices, collaborate in project activities • Education providers: Deliver education • Marketing and Communications: Document development, education activity promotion and management • External Engagement: Inform knowledge of general practices, collaborate in project activities
Collaboration	• General Practice • Australian Primary Health Care Nurses Association (APNA) • Health Workforce Queensland
Indigenous Specific	No
Duration	Second year of a two year period (2016-2018).
Coverage	Entire Brisbane South PHN region (PHN302)
Commissioning method (if relevant)	Direct delivery as part of General Practice support offering.

Activity	**NP 9.2 Workforce Development**
Existing, Modified, or New	Existing
Program Key Priority Area	Health Workforce
Needs Assessment Priority Area	9. Health workforce
Description of Activity	Workforce Development is designed to build strong and productive partnerships with health (primary, secondary and tertiary) and community service stakeholders through the provision of high quality education services. These services will enable improved integration of care horizontally and vertically between the sectors and, where appropriate, all education will be certified with the appropriate professional governing organisation so that continuing professional development points can be assigned. The aim is to: • Improve communications between all levels of healthcare • Develop networks to increase the collaboration between providers and services • Forecast future education requirements • Proactively deliver education that meets stakeholder needs • Provide a platform for education on Brisbane South PHN initiatives • Promote a change of practice that improves patient outcomes.
Target population cohort	• All primary health care professionals and administrative staff including: General Practitioners, Nurses, Allied Health Professionals, Pharmacists, Aged Care, Community based and Administration Staff. • Any other persons or organisations that provide direct healthcare support to our stakeholders.
Consultation	• Logan Hospital: Provide relevant presenters • GPs, primary care health professionals and support staff: Register and attend education sessions • Key GPs: Advise and support • Australian College of Rural & Remote Medicine: Accreditation for education activities • Royal Australian College of General Practitioners: Accreditation for education activities • Education providers: Deliver education • Marketing and Communications: Document development, education activity promotion and management • Program Delivery: Inform knowledge of primary care organisations, collaborate in project activities • External Engagement: Inform knowledge of primary care organisations, collaborate in project activities

Activity	**NP 9.2 Workforce Development**
Collaboration	• Logan and Redland Hospitals: who provide relevant presenters and venues • GPs, primary care health professionals and support staff: who register and attend education sessions • GP/Primary healthcare Advisors and other organisations: who provide advice and support • Local experts/education providers
Indigenous Specific	No
Duration	Second year of a two year period (2016-2018).
Coverage	Entire Brisbane South PHN region (PHN302)
Commissioning method (if relevant)	Direct delivery of coordination / Commissioned: education providers

Activity	**NP 9.3 Aged Care Workforce Development**
Existing, Modified, or New	Existing
Program Key Priority Area	Health Workforce
Needs Assessment Priority Area	9. Health workforce
Description of Activity	It has been identified in the WORNA that poor access to an appropriately skilled and knowledgeable (including clinically and culturally appropriate) healthcare workforce, as a result of an uneven distribution or insufficient supply, may result in people delaying or not seeking treatment, increased avoidable hospital presentations, and poorer health and wellbeing outcomes. Aged care workforce capability was strongly highlighted at the Brisbane South PHN Aged Care Summit (held in January 2016) as a key contributor to current rates of unnecessary transfers and treatment uncertainty within RACFs. Through a series of co-design workshops, a number of key workforce development activities were identified for action. The aims of these activities were reducing the number of unnecessary transfers from RACFs to hospital, improving the workforce confidence and capability and satisfaction of RACF employees, and assisting with retention issues faced in the Aged Care sector. This is to be achieved with the following activities: • Profile the workforce and skill mix of RACFs– identifying training/information/support needs and identifying factors for skill variation across the region • Leveraging existing support and training resources - including current services – develop a number of workforce strategies (including remote and 'on the job') that will suit the capability and training delivery needs of the regions RACFs • Continue the Brisbane South PHN Aged Integration RACF Working Group that serve to inform/improve care within the Aged Care sector by facilitating communication and interaction between primary care, NGO, acute care and RACFs

Activity	**NP 9.3 Aged Care Workforce Development**
Target population cohort	• RACF staff • Any other persons or organisations that provide direct healthcare support to our stakeholders
Consultation	• Health Workforce training and development providers: Training expertise • Metro South Health: Provision of suitable speakers for education session • Mater Health Service: Provision of suitable speakers for education session • Non-Government Organisations (NGOs): Provision of suitable speakers for education session • GP: Provide feedback • Queensland Ambulance Service (QAS): Provision of suitable speakers for education session • Allied Health providers: Provision of suitable speakers for education session • Local RACFs: Project activity participation • Aged Care Integration Working Group: Inform aged care workforce development project activities • Program Delivery: Inform knowledge of RACFs, collaborate in project activities • Marketing and Communications: Document development, education activity promotion and management
Collaboration	• Health Workforce training and development providers • Local RACFs • Metro South Health, and Mater Health Service • NGOs • GP and Allied Health providers • QAS
Indigenous Specific	No
Duration	Second year of a two year period (2016-2018).
Coverage	Entire Brisbane South PHN region (PHN302)
Commissioning method (if relevant)	Commissioned: Training needs analysis and market investigation, leading to solution development/commissioning

Activity	**NP 10.1 Digital Health**
Existing, Modified, or New	Existing
Program Key Priority Area	Digital Health
Needs Assessment Priority Area	10. eHealth
Description of Activity	Digital Health is a national and Brisbane South PHN priority. Digital Health, as an enabler, has the potential for wide-ranging positive beneficial impacts on the healthcare sector and health outcomes, through improved integration, clinical governance and therefore, better patient care. Changes to the eHealth component of the Practice Incentive Program (ePIP) in May 2016 increased the uptake of the My Health Record system by patients and health professionals. Building on the foundations and relationships built with General Practice, the Building Digital Health project aims to support the adoption and meaningful use of the My Health Record and digital technologies across healthcare sectors within our region. The focus is to change the mindset from only uploading documents to the My Health Record to meet the ePIP requirements, to using the My Health Record as business-as-usual for providing informed decision making and improving patient outcomes. Data quality is of high importance when sharing health information between providers, therefore the project has a strong focus on providing tools, support and training to General Practices to improve and maintain a high level of data quality. As part of Health Care Homes (HCH), this project will be redesigned to realign the scope and style of delivery to optimise the shift in General Practice towards HCH models. These activities will form the foundations needed for General Practice to evolve and commence gradual change.
Target population cohort	The major target group will be primary care, in particular general practices that are eligible and interested in the project. However, other primary care providers and organisations such as aged care, allied health, community pharmacy and specialists will be supported for digital health, if required.
Consultation	• Participating General Practices (and their staff): Participation • Australian Digital Health Agency: Accessibility, information, resources & support • Department of Health: Information, support & resources • Digital Health Data: Connection to other PHNs • Department of Human Services: Accessibility, information & resources
Collaboration	This activity will be implemented by Brisbane South PHN linking with: • Local general practices • Health care professionals • Peak body organisations • Metro South Hospital and Health Service
Indigenous Specific	No

Activity	**NP 10.1 Digital Health**
Duration	Second year of a two year period (2016-2018)
Coverage	Entire PHN region (PHN302)
Commissioning method (if relevant)	Direct Delivery – non-healthcare service

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

Activity Title	**OP 1. Stakeholder Engagement through Account Management**
Existing, Modified, or New	Existing
Description of Activity	To provide key points of contact between our organisation and the local health community, focussing on: • building relationships on all levels • linking the needs of our healthcare providers with those who can deliver cost effective solutions • improving the quality of care for our community. The primary health team supports GPs and the wider health and community service professionals in the adoption of best practice methods in the referral of patients, use of local clinical pathways uptake of accreditation, improved chronic disease management and use of electronic health. The engagement process is based on an account management model that ensures our key stakeholders receive support through regular and targeted contact.
Supporting the primary health care sector	• Creating local connections between providers • Providing active support to primary health providers i.e. referral templates, assistance with eHealth initiatives • Providing information on key State and Commonwealth health initiatives.
Collaboration	The Brisbane South PHN and Metro South Health Engagement teams will collaborate in joint projects, initiatives and stakeholder management to meet the needs of our healthcare community.
Duration	Second year of a two year period (2016-2018)
Coverage	Entire Brisbane South PHN region (PHN302)
Expected Outcome	To achieve and maintain a high level of engagement with our local healthcare community

2. (a) Strategic Vision for After Hours Funding

Access to after hours services is essential in reducing unnecessary ED presentations, and ensuring that all members of the community have access to a health professional. After hours services are also essential in geographic areas where access to services during business hours is already limited, and for at-risk groups who may not seek appropriate care, e.g. people experiencing homelessness.

Despite currently sufficient services across the region, specific areas may be at risk, including certain geographic locations (e.g. Bay Islands, Beaudesert), service providers (e.g. RACFs), and at-risk groups (e.g. homeless). The loss of one service provider may leave a significant gap, warranting ongoing monitoring and maintenance of existing providers.

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

Activity Title	**AH 1. Micah Homeless to Home Health**
Existing, Modified, or New	Existing
Needs Assessment Priority Area	At-risk Homeless
Description of Activity	Nurses work alongside Micah Project Inc.'s existing Street to Home workers to form a care team. These teams visit residences of vulnerably housed people and public locations every night to deliver a range of medical and non-medical services, both planned and opportunistic. The nurses link with a care coordination day hours nurse to effectively link these people into day hours healthcare. A comprehensive economic evaluation commissioned by Brisbane South PHN in 2014 has demonstrated that the net benefits of the Homeless to Home Health (H2H) program are positive i.e. the benefits outweigh the costs whether or not the scope of the evaluation includes only hospital systems costs or is extended to include the monetised benefits of improvements in health related quality of life. The H2H service not only improves health but does so at a lower cost than the alternative. The model is unsustainable without PHN support (salaried nurse-led model with no MBS claiming).
Target population cohort	Homeless and vulnerably housed people of all ages regardless of ethnicity, cultural background, religion, education or health status within the Brisbane inner city and Brisbane City Council boundaries.

Consultation	• Clinical Nurse Manager and Project Manager, Micah Street to Home and H2H projects:
	  ○ After Hours Service delivery
	  ○ Data reports
	  ○ Collaborative relationship
	• Mater Health Services: Employ the nurses, provide clinical governance and oversight of the positions
	• Brisbane North PHN:
	  ○ Brisbane South PHN, Brisbane North PHN, Micah and Mater Health Services form the joint Steering Committee monitoring the project effectiveness.

Activity Title	**AH 1. Micah Homeless to Home Health**
Collaboration	• Mater Health Service • MICAH Projects Inc.
Indigenous Specific	No
Duration	Second year of a two year period (2016-2018)
Coverage	• Brisbane Inner SA3 30302 • Holland Park – Yeronga SA3 30302
Commissioning method (if relevant)	Commissioned: direct engagement – continuation of existing services

Activity	**AH 2. Better Aged Care**
Existing, Modified, or New	Existing
Program Key Priority Area	Aged Care
Needs Assessment Priority Area	1. Appropriate access and usage of health services
Description of Activity	Brisbane South PHN is committed to working with RACFs and the market to prevent unnecessary hospital transfers, and improve patient care outcomes by providing a service that will directly decrease the number of preventable emergency department (ED) presentations from RACFs after hours. To specifically target this health need outlined in the WORNA, Brisbane South PHN commissions a service to provide out of hours clinical support and guidance and mobile clinical outreach to RACFs. It is aimed at improving the patient journey and experience and decreasing the burden on secondary and tertiary care. The aim is to prevent two unnecessary ED presentations from RACFs each night, resulting in a cost reduction to acute care of over $1m and self-funding within the lifetime of the contract.
Target population cohort	Care recipients of RACFs within the Brisbane South PHN catchment urban areas
Consultation	• After Hours Doctors: Service delivery • Care recipients of RACFs: Accessing of the service • RACF staff: Accessing of the service • Queensland Ambulance Service

Activity	**AH 2. Better Aged Care**
Collaboration	• Metro South Health • Local RACFs • Local GPs • Queensland Ambulance Service
Indigenous Specific	No
Duration	Second year of a two year period (2016-2018).
Coverage	Within Brisbane South PHN Region (PHN302)
Commissioning method (if relevant)	Commissioned: direct engagement – continuation of existing services.

Activity	**AH 4. Domestic Violence**
Existing, Modified, or New	Modified. After extensive consultation with providers and consumers, it has been recommended that program modifications to include all hour services and support, in order to improve access to appropriate services, upskill existing services, improve community awareness and streamline with existing providers.
Program Key Priority Area	Other: Domestic Violence
Needs Assessment Priority Area	1. Appropriate access and usage of health services
Description of Activity	The annual cost of domestic & family violence (DFV) to the Queensland economy is estimated to be between $2.7 billion to $3.2 billion. Domestic violence and sexual assault perpetrated against women costs the nation $13.6 billion each year. Without effective intervention, by 2021, the figure is likely to rise to $15.6 billion. Both the Federal and State Governments have made significant policy and funding commitments into DFV. The “Not Now Not Ever” taskforce report includes a focus on PHNs and general practice to ensure primary care providers are upskilled and able to recognise and respond to domestic and family violence. PHNs also have a role in supporting the development of tools and resources for training and education for health professionals. Reduce the impact of DFV through: • Partnering/commissioning services to meet identified gaps • Education and training for primary care providers/community members in the Brisbane South PHN area including the implementation of evidenced-based resources, appropriate referral pathways and legal implications of DFV • Promoting awareness of existing programs and resources including Stepwise Approach for DV Intervention - concise resource aimed at primary care providers highlight levels of intervention required for different levels of risk/severity. Note: The key focus of this proposed activity is to provide improved access to services for victims of domestic and family violence who cannot safely access providers as a result of domestic violence. This would include those who have left their usual residence and are taking temporary refuge in motels, shelters/havens or other short term accommodation.
Target population cohort	• Pregnant women, parents and carers • Culturally and linguistically diverse (CALD) people and communities • Asylum seekers and refugees • Aboriginal and Torres Strait Islander people • Health professionals, including Practice Nurses and GPs?

Activity	**AH 4. Domestic Violence**

Consultation	• General Micah Projects (Safe Lives, Safer Communities), Brisbane Domestic Violence Service, Child Aware & Grow Support: Co-location service provision, Service provision, Evaluations
	• Logan Together Practitioners
	• Primary Health Care & Allied Health Providers:
	  ○ To promote project to relevant stakeholder groups
	  ○ Pass on information on any activities/initiatives which may link/conflict with project
	• Representatives of: Aboriginal and Torres Strait Islander community, Pasifika Community, CALD/ Refugee community
	• Federal & State MPs: To support DFV initiatives being considered by Federal & State Government
	• Department of Communities: To support DFV initiatives
	• Queensland Health: To support DFV initiatives

Collaboration	• Micah Projects (Safe Lives, Safer Communities) • Brisbane Domestic Violence Service • Logan Together
Indigenous Specific	No – but included as target population
Duration	Second year of a two year period (2016-2018)
Coverage	Brisbane South PHN catchment (PHN302) – focus (based on demand) on Kangaroo Point, West End, Inala, Coorparoo, City of Logan
Commissioning method (if relevant)	Commissioned

Activity	**AH 7. Street Doctor**
Existing, Modified, or New	Existing
Program Key Priority Area	Other: Homeless and vulnerable populations
Needs Assessment Priority Area	1. Appropriate access and usage of health services
Description of Activity	A comprehensive evaluation of the “Street Doctor” service including patient data and both patient and stakeholder feedback has been undertaken and has been shown to reduce emergency department presentations. Street Doctor delivers a mobile service that provides a GP-led healthcare service to a vulnerable population in the Brisbane South PHN catchment area.

Activity	**AH 7. Street Doctor**
Target population cohort	• Homeless and vulnerably housed people of all ages • Victims of domestic or sexual violence • Struggling refugees who need to see a doctor to obtain a prescription
Consultation	• Metro South Health • Micah Projects Inc • University of Queensland Centre for the Business and Economics of Health (Professor Luke Connelly - evaluation)
Collaboration	• Street Doctor • Australian After Hours Doctors • Local Pharmacy • Allied Health providers • NGOs • Local General Practice
Indigenous Specific	No – but included in target population.
Duration	One year period (2017-2018) commencing July 2017.
Coverage	Brisbane South PHN catchment (PHN302) – Redlands LGA (36250), Logan LGA (34590), Forest Lake – Oxley Statistical Area 3 – 31001 and Rocklea – Acacia Ridge Statistical Area 3 – 30305.
Commissioning method (if relevant)	Commissioned