Australian Government
Department of Health

phn EASTERN MELBOURNE
An Australian Government Initiative

Updated Activity Work Plan 2016–2018: Core Funding After Hours Funding

The Activity Work Plan template has the following parts:

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.

The updated After Hours Primary Care Funding Annual Plan 2016-2017 which will provide:

e) The updated strategic vision of each PHN for achieving the After Hours key objectives.

f) An updated description of planned activities funded under the Schedule – Primary Health Networks After Hours Primary Care Funding.

g) A description of planned activities which no longer planned for implementation under the Schedule – Primary Health Networks After Hours Primary Care Funding.

Eastern Melbourne PHN

Overview

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

1. (a) Strategic Vision

Our vision: Better primary healthcare for Eastern and North-Eastern Melbourne. An integrated health care system.

Our mission: With our partners, we facilitate health system improvement for people in eastern and north-eastern Melbourne.

Our strategic priorities:

1. **Addressing health inequities and gaps**
2. **Enhancing primary care**
3. **Leveraging digital health, and information technology**
4. **Partnerships for integrated health care**

Enabler:

1. High performing organisation

Our values

- Leadership
- Understanding
- Collaboration
- Outcomes

EMPHN Operating Model and the Commissioning Framework

In its role as a facilitator of primary care system improvement and redesign, EMPHN has adopted an operating model made up of a continuous improvement approach to commissioning, and governance structures geared towards collaboration and co-design.

Commissioning Framework

Commissioning is a cycle. Needs and priorities are assessed through community consultation and solutions designed in partnership with stakeholders. Transparent processes are used to promote the implementation of these solutions, including the identification of providers from whom services may be purchased. Solutions are then evaluated and the outcomes used for further assessment and planning.

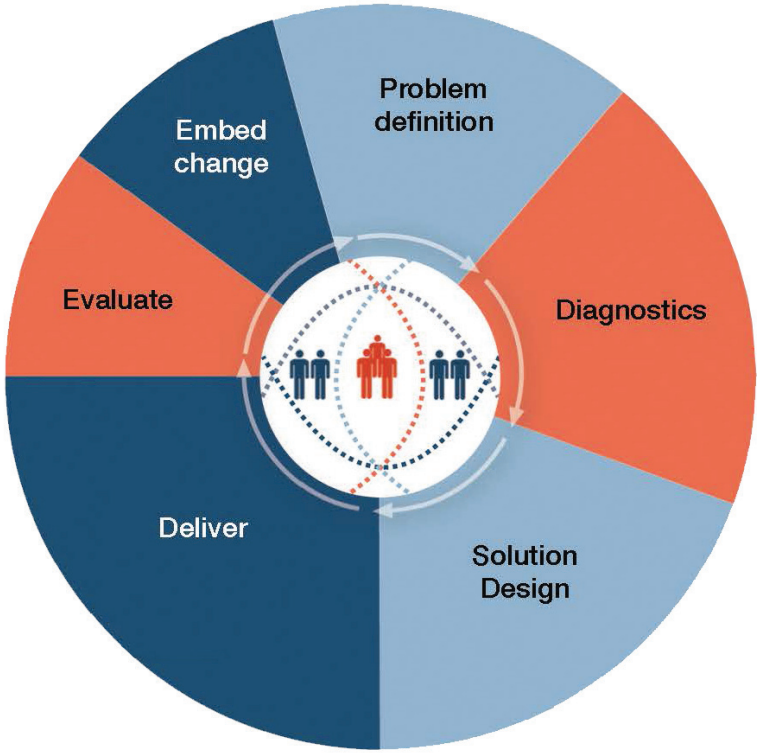

Figure 1. Commissioning cycle

Underpinning the phases of the Commissioning Cycle is a focus on ongoing relationships with consumers, providers and other stakeholders.

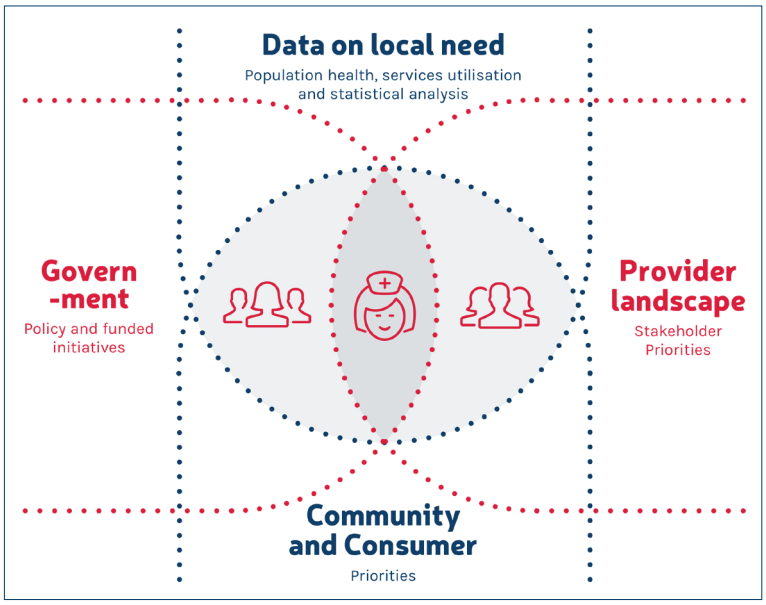

Figure 2. Prioritisation approach

Commissioning principles

1. **Understand the needs of the community** by engaging and consulting with consumer, carer and provider representatives, peak bodies, community organisations and other funders.
2. **Engage potential service providers** well in advance of commissioning new services.
3. **Focus on outcomes** rather than service models or types of interventions.
4. **Adopt a whole of system approach** to meeting health needs and delivering improved health outcomes.
5. **Understand the fullest practical range of providers** including the contribution they could make to delivering outcomes and addressing market failures and gaps.
6. **Co-design solutions;** engage with stakeholders, including consumer representatives, peak bodies, community organisations, potential providers and other funders to develop outcome focused solutions.
7. **Consider investing in the capacity of providers and consumers**, particularly in relation to hard to reach groups.
8. **Ensure procurement and contracting processes are transparent and fair**, facilitating the involvement of the broadest range of suppliers, including alternative arrangements such as consortia building where appropriate.
9. **Manage through relationships; work in partnership**, building connections at multiple levels of partner organisations and facilitate links between stakeholders.
10. **Ensure efficiency and value for money**.
11. **Monitor and evaluate** through regular performance reporting, consumer, community and provider feedback and independent evaluation.

Consultative structures

The EMPHN Board will receive strategic advice on engagement and participation from to key groups:

- Clinical Council
- Community Advisory Committee

Collaborative structures

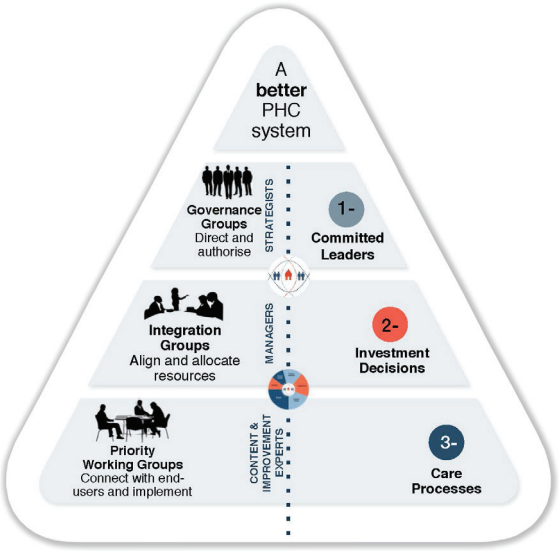

Figure 3. Collaborative Structures

In addition to this, the EMPHN catchment is divided into sub-catchments for the purposes of shared planning and governance. The sub-catchments align with the large public health services boundaries in the catchment:

- Austin Health
- Eastern Health
- Monash Health
- Northern Health

Each sub-catchment will have three similar levels of collaborative structures:

1. **Governance Group**: Strategists who "direct and authorise"
2. **Health System Integration Group**: Managers who "align and allocate resources"
3. **Priority Working Groups**: Content experts who "connect with end users and implement"

These structures provide a shared governance platform to identify, develop and authorise key systems change work that will be committed to in time, support and resources to enact significant systems redesign work. Projects defined by these collaboratives now feature in the 2017–18 Activity Work Plan.

Internal structures

The EMPHN organisational structure includes programs that support and develop primary care practitioners, and that support primary care improvement and integration.

In addition to the formal governance structure, EMPHN staff work across teams within specialty area streams such as Indigenous Health, Aged Care, Refugee Health and Mental Health.

EMPHN staff also work across teams to participate in improvement and innovation initiatives.

Priority & Activity Summary

For 2017-18 a revised set of priorities were devised based upon a refresh of the Needs Assessment in November 2016. These priorities include:

- Improving experience and health outcomes
  - o Keeping people well
  - o Addressing identified risk
  - o Responding to identified chronic illness
- Improving the health system
  - o Workforce
  - o Cultural competence
  - o Consumer engagement
  - o Infrastructure
  - o Appropriate service and system design

Figure 4 below defines how when distributing flexible funds, activities relate to identified priorities captured in the Needs Assessment.

EMPHN Priorities and Activities		
PRIORITY		ACTIVITY
Improving Experience and Health Outcomes	Keeping People Well	NP-1 Immunisation
	Addressing Identified Risk	LP-6 Data Linkages
	Responding to Identified Chronic Illness	LP-3 Chronic Disease Self-Management LP-7 Diabetes Diversion Program LP-8 End of Life Care LP-10 Chronic Disease High Risk Intervention LP-11 Chronic Disease Risking Risk Intervention
Improving the Health System	Workforce	NP-2 Cancer Screening LP-12Primary Care Improvement and Integration
	Cultural Competence	(Integrated Care Schedule)
	Infrastructure	
	Consumer Engagement	LP-5 Consumer Experience and Engagement
	Appropriate Service and System Design	LP-4 Reducing Variations in Care LP-9 Improving Pathways for Planned and Unplanned care

Figure 4. Flexible Fund Activities as they relate to EMPHN priorities

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

Proposed Activities	
Activity Title / Reference	**NP-1: Immunisation** NP1.1 Improve suboptimal childhood immunisation rates NP1.2 Address myths associated with immunisation resulting in ideological conscientious objection NP1.3 Support workforce to respond to demand generated by government immunisation initiatives. NP1.4 Work collaboratively with boarder health care system to increase childhood immunisation rates
Existing, Modified, or New Activity	NP1.1 Modified Activity- As evident in the EMPHN needs assessment there is a rapid shifting of immunisation rates across municipalities, age ranges and quarters due to changes in government policy ("no jab, no pay and no jab, no play"). In response to this EMPHN will not focus specifically in a particular LGA whist the data is still in flux. NP1.2 Existing activity NP1.3-Existing Activity NP1.4 New Activity: AIR data shows that approximately 50% of all childhood immunisations are delivered though municipal providers. EMPHN will establish a collaborative working relationship with municipal providers and DHHA to continue to understand the local data, address systemic barriers to data collection and optimal childhood immunisation.
Program Key Priority Area	Population Health
Needs Assessment Priority Area	Improving Experience & Health Outcomes – Keeping People Well : Possible option 3, page 75)
Description of Activity	Catchment-wide childhood immunisation coverage rates are broadly on par with national rates. SA3 data from 2015 indicated that immunisation coverage rates for children at age 1 were 91.6% (national 91.3%), age 2 were 90.0% (national 89.2%) and age 5 were 92.4% (national 92.2%). Coverage for all children aged 2 was well below the national average at 81.5% (national was 86.7%) and for children aged 5 was 91.3% (compared to a national coverage rate of 93.5%). This indicates that a dual

	approach of ensuring correct data across providers to affirm this, as well as activity that has a focus on the ages with suboptimal rates is necessary. Available June 2016 data shows LGAs with the current lowest coverage rates for 1-year-olds are Boroondara (90.2%), Manningham (91.5%), and Monash (92.3%). The only LGAs meeting the aspirational childhood immunisation rate of 95% in the 5-year age group were the outer metropolitan/semi-rural areas of Nillumbik (95.6%) and Mitchell (95.6%) where crude numbers were somewhat lower than other LGAs in the catchment. Manningham had the lowest proportion of children fully immunised at 5 years of age (90%). Childhood immunisation activities below centre around improvement of the above suboptimal rates in our region and equipping the primary care workforce and partners to address common myths associated with conscientious objection on ideological grounds. 1.1. To improve identified suboptimal immunisation rates across catchment, support: • Support to immunisation providers to maintain current levels. • Deeper dive into levers at systemic and local areas to push immunisation rates towards 95% • Work collaboratively with regional immunisation networks (Eastern and Northern) • Work with other PHNs, Municipal providers and DHHS through VPHNA to address systemic immunisation issues (e.g. cold chain breach reporting). 1.2. To support addressing of ideological conscientious objection, particularly in Nillumbik and Yarra Ranges and deeper dive into levers and drivers for parents deciding not to immunise, support: • Environment scan for innovative models to address community views • Capacity building for general practice in talking about conscientious objections. 1.3. To support providers to respond to demand generated by government initiatives (e.g. 'no jab no pay', 'no jab no play') for improving immunisation rates, support • Sector and community education re 'No jab no pay' policy and how to respond • Capacity building and resources to support immunisation reconciliation. 1.4 EMPHN will establish a collaborative working relationship with municipal providers, other PHNs and DHHS to:

	• Continue to understand the local data, address systemic barriers to data collection and achieving optimal childhood immunisation.
Target population cohort	The target population of this intervention are children 0-5 years of age and their families.
Consultation	Regional immunisation (Northern and Eastern) networks- ongoing membership Immunisation Forum with Municipally providers of immunisations and Vic DHHS-Dec 2016 Victorian PHN Immunisation Community of Practice (PHN and Vic DHHS)– established Dec 2016 and ongoing Stakeholder interviews with local councils.
Collaboration	Activities will be undertaken in collaboration with: GPs, practice nurses, Local Government (immunisation coordinators), parents and community, Vic DHHS Central Branch and regional divisions, RCH (communicable diseases and immunisation specialists), refugee settlement services, migrant resource services and local media.
Indigenous Specific	No
Duration	Anticipated activity start and completion dates (excluding the planning and procurement cycle). 1.1 a) October 2016 - June 2018 b) July 2016 - October 2016 c) July 2016 - June 2018 1.2 a) October 2016 - May 2017 b) October 2016 - June 2018 1.3

	July 2016 - June 2017 1.4 Dec 2016- June 2018
Coverage	Entire PHN Region
Commissioning method (if relevant)	Activities will follow the EMPHN Commissioning process outlined in section 1a, to include: Problem Definition, Diagnostics, Solution Design, Delivery, Evaluation and Embedding Change. The current activities listed fit within the Problem Definition to Delivery components of the methodology.
Approach to market	Open approach EMPHN will undertake an EOI process for small grants to Local Government/Municipal immunisation providers to address issues as identified in co-design workshop.
Decommissioning	Not applicable

Proposed Activities	
Activity Title / Reference	**NP2 - Cancer Screening** NP2.1 Continued roll out of the Screening to Survivorship work package to general practices NP2.2 Building capacity in General Practice for increased uptake of cancer screening in the community. NP2.3 Partner with Integrated Cancer Services leverage off activity to promote the awareness and uptake of Optimal Cancer Pathways and Shared Care in cancer survivorship
Existing, Modified, or New Activity	Modified
Program Key Priority Area	Population Health

Needs Assessment Priority Area	Improving Experience & Health Outcomes: Keeping People Well (possible option 2, page 75) Improving the health system – Workforce (possible option 8, page 77)
Description of Activity	Cancer screening for EMPHN will have a focus on general practice cancer screening rates. Activities will be undertaken in collaboration with subject matter expertise from peak cancer organisations and integrated cancer services and there may be replicability across PHN boundaries. Activities will work to increase capacity and raise local cancer screening participation rates through: 2.1 Continued roll out of a package of supports to General Practice that cover the patient journey from screening to survivorship. This aims to promote cancer screening, referral pathways to services when malignancy is detected, management of cancer and support during remission. Review of appropriate approaches for community engagement to encourage cancer screening 2.2 Capacity building in general practice through education, business and process modelling to encourage a rigorous approach across the catchment for breast, bowel and cervical cancer screening. 2.3 Leverage of activity to promote adoption of Victorian Optimal Cancer Pathways and shared survivorship care models including data collection, education and capacity building. This creates a whole of life focus on the role of primary care in preventing and treating cancers. Activities will aim to increase capacity and raise local cancer screening participation rates through in our community. This approach will complement the work being undertaken in the general practice and integrated cancer service areas
Target population cohort	Women aged 18 + Men aged 50+
Consultation	General Practice Survey Clinical Council & Community Advisory Committee DHHS – Cancer Screening Unit Cancer Screening GP Reference Group
Collaboration	Activities will be undertaken in collaboration with: • Peak cancer bodies

	• LHNs & Integrated Cancer Services • PHN Alliance • DHHS • Diverse Community Support Services Department of Health (State/Federal)
Indigenous Specific	Yes – Broader population approach however working with the Aboriginal Health team to increase breast cancer screening rates in Aboriginal women in our community.
Duration	2.1 Ongoing 2.2 July 2016 –December 2016 2.3 December 2016 – December 2017
Coverage	Entire EMPHN Region.
Commissioning method (if relevant)	Activities will follow the EMPHN Commissioning process outlined in Strategic Vision section 1a.
Approach to market	Not applicable for Activities 2.2 – 2.4 Activity 2.1 – Limited Approach to identified peak cancer organisations for community engagement.
Decommissioning	Not applicable

Proposed Activities	
Activity Title / Reference	**LP-3 Chronic Disease Self-Management Intervention**
Existing, Modified, or New Activity	Existing

Program Key Priority Area	Population Health
Needs Assessment Priority Area	Improving experience and health outcomes – addressing identified risk (option 4, page 84) Improving experience and health outcomes – responding to identified chronic illness (option 7- page 76)
Description of Activity	This activity aims to will implement an evidence based, structured and supportive team based early intervention model for clients recently diagnosed with one or more chronic diseases, and sits alongside other initiatives in a chronic disease stepped model of care. It will ultimately improve outcomes for people living with chronic disease. Clients diagnosed with one or more chronic diseases will, over time, move across the health care continuum as the complexity of their needs fluctuates. Evidence shows that if clients are engaged and supported to self-manage in the early stages after diagnosis of a chronic condition, rates of deterioration are reduced and health outcomes are improved. The activity aims to continue the program funded from 2016-17 Priority 3, Activity 3.3 – Integrated Chronic Disease and activity 3.1 Roll-out of a the POLAR Clinical Audit Tool in general practice for Chronic Disease patient population auditing which will assist across priorities and programs. Please note: Whilst activity LP-8 will focus on populations with established diabetes diagnosis and at risk of hospitalisations due to diabetes complications and progression of their illness, this activity instead focuses on earlier intervention and support for newly diagnosed and a broader range of chronic illness as the potential to increase quality of life and reduce long-term burden of disease.
Target population cohort	Clients in the Northern region of the EMPHN catchment recently diagnosed with chronic disease/s needing support to better self-manage their disease. It is recognised through the Needs Assessment key indicators that the experience of disadvantage is higher in the Northern region and the accessibility of physical locations of services is lower. It was determined a focus on this region would have the highest impact and be addressing the greatest need.
Consultation	Consultation has occurred with a range of stakeholders delivering chronic disease management support programs, such as community health services and Local Hospital Networks.

	Clinical Council and Community Advisory Committee Engagement with the General Practice population will occur as part of program implementation.
Collaboration	The successful bidder for the contract is unknown, but will be responsible for program delivery. General Practitioners in the Northern region will be engaged
Indigenous Specific	No
Duration	18 months (Jan 2017-Jul 2018)
Coverage	Commencing in Whittlesea LGA and broadened out to the wider community if numbers allow.
Commissioning method (if relevant)	EMPHN's commissioning methodology is described in detail in 1a. Strategic Vision.
Approach to market	Procurement via an open approach to market has commenced in 2016-17, the successful tenderer is not yet known.
Decommissioning	Nil

Proposed Activities	
Activity Title / Reference	**LP-4: Reducing Variations in Healthcare**
Existing, Modified, or New Activity	Modified
Program Key Priority Area	Other – system integration, supporting implementation of clinical guidelines, supporting demand management approaches
Needs Assessment Priority Area	Improving the health system – appropriate service and system design (possible option 5, page 76 and possible option 14 page 78))

Description of Activity	The activity enables General Practitioners access to on-line evidence-based guidelines and referral pathways to enable the right care for the patient, in the right place, at the right time. It will improve the health system through the development, design and maintenance of pathways that align with key priority areas and drive system redesign, the promotion of meaningful use of Health Pathways to more General Practitioners, the expansion of pathways to cover the entire EMPHN catchment and through the design and implementation of a workable e-referral solution. It will also continue to support the development of state wide pathways that align with clinical practice guidelines, including paediatrics. EMPHN will also lead the development of mental health pathways across the region. (In Previous AWP this underpinned activity across programs, but will be consolidated into an activity for reporting in this AWP)
Target population cohort	General Practitioners, and clients accessing General Practice.
Consultation	Stakeholder engagement is a core component of this activity and is regularly undertaken with: - Clinical working groups - Events/Training activity - Online feedback mechanisms - Practice demonstrations Key external stakeholders are included in the governance structure.
Collaboration	General Practitioners, subject matter experts and consumers provide input in the problem definition and diagnostics stages, and develop pathways to address identified gaps. Local Health Networks, Community Health Services, nurses and private specialist and allied health provide subject matter expertise to support solution design (agree on management and referral

	guidelines), deliver (promote and encourage use of pathways), embedding change (work towards enforcing agreed referral criteria within their services). Pharmacists and non-general practice team clinicians are secondary users of pathways. State government representatives are kept informed, fund state-wide pathway development and are becoming increasingly involved in pathway development and endorsement of pathways for which they have a responsibility (e.g. out of home care, immunisation). PHNs in other regions are working together to develop more of a coordinated state-wide approach.
Indigenous Specific	No
Duration	Ongoing
Coverage	EMPHN region, NWMPHN region with scoped works for state-wide collaboration with other PHNs.
Commissioning method (if relevant)	Not applicable
Approach to market	Renewal of current contract with Streamliners
Decommissioning	Not relevant,
Funding from other sources	NWMPHN and EMPHN share costs associated with pathways development activities across our catchments. DHHS provides specific funding to progress state-wide paediatric, cancer and hepatitis pathway development.

Proposed Activities	
Activity Title / Reference	**LP-5 Better Health North East Melbourne (BHNEM) Collaborative (priority project) Improving Consumer Experience and Engagement across the North Eastern region**
Existing, Modified, or New Activity	New
Program Key Priority Area	Other – consumer experience and engagement
Needs Assessment Priority Area	Improving the health system - Consumer Engagement (possible option 10, page 77) Improving experience and health outcomes – keeping people well (possible option 1, page 75)
Description of Activity	This activity will measure consumer experiences for residents of the North East Melbourne region using a rigorous community engagement process. The information gathered will inform the future improvement work of BHNEM. The report will be available to members of the BHNEM Collaborative and will help build a picture of the patient journey through the current state of the service system. It will ensure projects are delivered using an evidence base rather than assumption when considering the needs of the consumer in project and service design. An independent provider and facilitator will be engaged to conduct the project, which will ensure impartiality and encourage participants to provide non-biased feedback during the process.
Target population cohort	Consumers/patients who reside in the BHNEM Collaborative region within the Eastern Melbourne PHN catchment. This area covers the same area as covered by Austin Health and includes the catchments of Nillumbik, Banyule and Darebin local Government areas.
Consultation	This project has arisen from the consultation activities already undertaken through the establishment of BHNEM. A workshop with BHNEM members held in October 2016 identified the need to undertake consumer engagement and experience.
Collaboration	Through the Better Health North East Melbourne Collaborative: • Austin Health • Mercy Health • HealthAbility • Banyule Community Health Service • Darebin Community Health Service • Victorian Department of Health and Human Services

	• Darebin Council • Banyule Council • Nillumbik Council • General Practitioners Stakeholders above who are service providers will be involved in assisting with implementation, promoting the activity and as a partner organisation. They will provide access to the consumer cohort, although this won't be the only means by which consumers are recruited for participation. The Department of Health and Human Services (Vic.) are involved as an interested party through their involvement in the Collaborative. Consumers: This activity is aimed at direct consumer engagement for the purpose of ascertaining consumer experience feedback. Consumers in this activity are any person residing in the identified region and will include sub-groups of consumers, including those who are CALD, Aboriginal or Torres Strait Islander, aged, paediatric and have chronic conditions including mental health issues. Service Providers: General Practices, Community Health and Allied Health providers, pharmacy and aged care providers may be involved in identifying consumers and assisting with the collection of data or involved in the hosting or promoting of the activity and face-to-face forums.
Indigenous Specific	No
Duration	- Prior to 1 July 2017 – project planning, procurement process started - 1 July 2017 – project start date - July 2017 – August 2017 – tender out for facilitator and provider - August 2017 – November 2017 - activity commences with chosen provider undertaking forums and collecting consumer feedback as identified in the project plan - January 2018 – report received and disseminated internally - February 2018 – report made available to BHNEM partners - March 2018 – conclusion of project
Coverage	Local Government Areas of Banyule, Darebin and Nillumbik. This is the Austin Health catchment and North Eastern Melbourne sub-region of EMPHN.

Commissioning method (if relevant)	The data collection, engagement and evaluation component of this activity will be commissioned. The solution will require procurement of services for Delivery and appropriate options for procurement will be assessed at that time and advised to the Department. Where services are purchased, a clear brief will be developed, an open tender approach undertaken and performance metrics built into contracts.
Approach to market	Open tender approach
Decommissioning	There is no decommissioning arising from this activity. There are no issues relating to transition and continuity of care, as it is not directly related to service provision.

Proposed Activities	
Activity Title / Reference	**LP-6: Data Linkages Project**
Existing, Modified, or New Activity	New
Program Key Priority Area	Population Health
Needs Assessment Priority Area	Improving experience and health outcomes – addressing identified risk
Description of Activity	The BHNEM and EMPHCC have identified priority projects to commission activity targeting risking risk populations who, unless appropriately identified and supported, are at risk of becoming frequent users of hospital services. A process will be undertaken to further develop predicative data analytics to identify patients within the rising risk cohort, and investigate options for this data to be available across both primary care and the hospital system. Intended outcomes include the development of a system to identify and escalate patients in rising risk groups, and links with more appropriate community supports. It is recognised that whilst NP11 will look at the top 2% of those at risk of readmission that are active frequent flyers in acute services, this activity provides the opportunity to address that cohort one step down who are engaged with General Practice and are at current and rising risk. Further developing the predictive model in the General Practice setting provides the opportunity to integrate

	with acute care to flag these clients and engage them in appropriate interventions within the community. By targeting this group, the intended outcome is to stem the increasing morbidity of disease and demand on acute services, increase capacity for self-management and health literacy for a healthier population.
Target population cohort	Patients at risk and at high risk of unplanned hospital presentation.
Consultation	Significant consultation will be undertaken with the Local Hospital networks and General Practitioners, as well as a range of service providers as part of the market analysis stage of the commissioning process.
Collaboration	Through the Better Health North East Melbourne Collaborative: • Austin Health • Mercy Health • HealthAbility • Banyule Community Health Service • Darebin Community Health Service • Department of Health and Human Services • Darebin Council • Banyule Council • Nillumbik Council • General Practitioners Through the Eastern Melbourne Primary Health Care Collaborative: • Connect 4 Health • Department of Health • and Human Services • EACH • Eastern Health • Eastern Melbourne PHN • General Practitioners

Indigenous Specific	No
Duration	Until June 2018
Coverage	EMPHN catchment
Commissioning method (if relevant)	EMPHN's commissioning methodology is described in Section 1a. Consultation has commenced and the problem has been defined by the EMPHC and BHNEM Collaboratives. The appropriate approach will be identified during the solution design process and the Department will be advised.
Approach to market	Dependent on early commissioning stages
Decommissioning	Nil

Proposed Activities	
Activity Title / Reference	**LP-7 Expanding and Supporting Diabetes Diversion Programs – Phase 2**
Existing, Modified, or New Activity	Modified - Phase 1 from Priority 1 - Avoidable Hospitalisations 16/17 funding
Program Key Priority Area	Chronic Illness
Needs Assessment Priority Area	Improving experience and health outcomes – addressing identified risk (possible option 4 page 75)
Description of Activity	*PHASE 1(2016-17): To expand existing successful Eastern Melbourne PHN catchment service system responses to diabetes, and provide eligible patients with integrated wrap-around support that will reduce hospital outpatient wait lists* PHASE 2(2017-18): EMPHN will be developing the market through a competitive tender process for the establishment of a diabetes hospital diversion program and extrapolation of existing successful clinic models to other areas of the PHN catchment, to address outpatient appointment demand.

	It has been recognised that whilst NP3 will have a focus on early intervention and a broader range of chronic illness, diabetes complications remains as the highest cause of ACSCs in our catchment. Many consumers with an established diagnosis and progressing condition require diversion from long endocrinology outpatient waiting lists for support in the community and primary care setting.
Target population cohort	Patients with poorly controlled Diabetes needing access to an integrated and community based multi-disciplinary service model.
Consultation	Significant consultation will be undertaken with the Local Hospital networks and General Practitioners, as well as a range of service providers as part of the market analysis stage of the commissioning process.
Collaboration	• Local Health Networks • General Practice • Consumers • Community Health Services • Specialist medical staff
Indigenous Specific	No
Duration	Until June 2018
Coverage	EMPHN catchment
Commissioning method (if relevant)	EMPHN's commissioning methodology is described in Section 1a above. Market development has already commenced through a pilot in 2016-17. A clear brief will be developed, an open tender process will be undertaken and performance metrics will be built into contracts. Evaluation findings will be reviewed and reported.
Approach to market	Open tender approach
Decommissioning	Nil

Proposed Activities	
Activity Title / Reference	**LP-8:– End of Life Care- EMPHC Collaborative Project**
Existing, Modified, or New Activity	New
Program Key Priority Area	Aged Care
Needs Assessment Priority Area	Improving experience and health outcomes – responding to identified chronic illness Improving the health system - Appropriate service and system design, page 78
Description of Activity	Problem: This system orientated activity seeks to redesign elements of the service system to ensure more people experience end of life care how, and where, they choose, and that resources and supports across the end of life support system are used more appropriately.
Target population cohort	• End of life care services • Patients at end of life and their families
Consultation	A working group formed from members of the EMPHCC and a range of stakeholders delivering end of life support services together with general practice and consumer representatives will undertake this project. GP's and Consumers will also be involved at all stages of the design and delivery of any intervention developed.
Collaboration	Through the Eastern Melbourne Primary Health Care Collaborative: • Connect 4 Health • Department of Health • and Human Services • EACH • Eastern Health • Eastern Melbourne PHN • General Practitioners

	Additionally, content experts from specific aged care services and networks, such as Eastern Palliative Care, Cemetery Trust, Health Issues Centre will form part of the collaborative working groups.
Indigenous Specific	No
Duration	Planning will commence shortly to further define the priority problems, and undertake rigorous data analytics. Stakeholders will then be consulted with to co-design potential solutions prior to procurement and the commencement of service delivery, which will continue until June 30 2018.
Coverage	Eastern Melbourne region.
Commissioning method (if relevant)	EMPHN's commissioning methodology is described in detail in section 1a. The collaborative entities will undertake diagnostics and solution design activity prior to the procurement phase. A clear brief will be developed, an open tender process to enact the proposed solutions will be undertaken and performance metrics will be built into contracts. Evaluation findings will be reviewed and reported.
Approach to market	Open tender approach
Decommissioning	Nil

Proposed Activities	
Activity Title / Reference	**LP-9: Improving pathways for planned and unplanned care in the community**
Existing, Modified, or New Activity	New
Program Key Priority Area	Other – system infrastructure and redesign
Needs Assessment Priority Area	Improving the health system – appropriate service and system redesign (Possible Option 14, pg.78)

Description of Activity	This activity is in the service planning, solution design phase, in response to the pressures being placed on emergency departments in the EMPHN catchment due to unexpected events (unplanned) and rising acuity in those on ambulatory waiting lists (planned).. 9.1 Currently scoping to identify innovative and effective model of care to divert services away from emergency departments and educating local communities about system redesign efforts. Communities include • Residential Aged Care • General Practices • Community Health • Consumers and Carers **9.2 AH** Determine demand and availability of after-services that can be delivered in primary care settings and procure solutions which facilitate after-hours pathway alternatives to emergency department attendance in targeted areas of need. Activities also underway from 2016-17 that will be reported against this activity include: - Fracture management (previously under NP2 Reducing ED Presentations)
Target population cohort	Patients requiring urgent care across the EMPHN catchment
Consultation	Extensive consultation will be undertaken with health care consumers (a behavioural insights research project) to develop an understanding of consumer behaviours relating to emergency department and primary care service usage. General Practitioners and Hospital networks will also be consulted extensively to inform the development of this activity.
Collaboration	Through the Collaborative: • Local Health Networks • Department of Health and Human Services • Community Health Services • Local Councils

	• Consumers
Indigenous Specific	No
Duration	This activity is entering an extensive planning phase, the results of which will inform future steps.
Coverage	Entire catchment
Commissioning method (if relevant)	This activity will be wholly commissioned. A clear brief will be developed, the appropriate commissioning process will be selected and undertaken and performance metrics built into contracts. Evaluation findings will be reviewed and reported.
Approach to market	Open tender approach
Decommissioning	Nil
Funding from other sources	*Department of Health and Human Services.* *Department of Premier and Cabinet*

Proposed Activities	
Activity Title / Reference	LP-10 Chronic Disease Management high risk intervention .
Existing, Modified, or New Activity	Modified
Program Key Priority Area	Other – development of community based model
Needs Assessment Priority Area	Improving experience and health outcomes – addressing identified risk (Possible Option 7 pg.76) Improving the health system – consumer engagement (Possible Option 10, pg. 77)
Description of Activity	Northern Health, Eastern Health and Austin Health are each involved in varying capacity in Health Links project funded by the Department of Health and Human Services (State Government), a project

	that involves the application of an algorithm to identify patients at high risk of re-presentation to hospital. This activity aims to address the top 2% of clients identified through acute care systems at risk of readmission by the DHHS based algorithm through the Health Links project. Through the collaborative, an integrated approach to developing an appropriate solution to engage and work with this cohort will be developed. A commissioning process will be undertaken to develop and then procure a comprehensive intervention for this cohort, an evidence based model of care in the community, with strong links to General Practice and access to specialty medical services. This activity will provide access to integrated and comprehensive interventions to high risk populations in the EMPHN catchment, ultimately reducing the risk of unplanned hospital presentations and admissions.
Target population cohort	Patients at risk and at high risk of unplanned hospital presentation.
Consultation	Significant consultation will be undertaken with the Local Hospital networks and General Practitioners, as well as a range of providers as part of the market analysis stage of the commissioning process.
Collaboration	DHHS Northern Health Monash Health Barwon Health North Western Melbourne PHN Through the Better Health North East Melbourne Collaborative: • Austin Health (control site in Health Links project) • Mercy Health • HealthAbility • Banyule Community Health Service • Darebin Community Health Service • Department of Health and Human Services • Darebin Council • Banyule Council

	• Nillumbik Council • General Practitioners Through the Eastern Melbourne Primary Health Care Collaborative: • Connect 4 Health • Department of Health • and Human Services • EACH • Eastern Health • Eastern Melbourne PHN General Practitioners
Indigenous Specific	No
Duration	Intervention likely to be implemented January 2017– July 2018
Coverage	LGAs in the EMPHN catchment with higher rates of rising risk and high risk populations. Outer metro North and East likely to be areas of focus but dependent on location or capacity of successful tenderer.
Commissioning method (if relevant)	EMPHN's commissioning methodology is described in detail in Section 1a. Consultation has commenced and the problem has been defined. Stakeholders are currently being engaged to assist with solution co-design. A clear brief will be developed and an open tender process will be undertaken. Performance metrics will be built into contracts. Evaluation findings will be reviewed and reported.
Approach to market	Open tender approach
Decommissioning	Nil

Proposed Activities	
Activity Title / Reference	LP-11 Chronic Disease Management Rising Risk Intervention
Existing, Modified, or New Activity	New
Program Key Priority Area	Chronic Disease
Needs Assessment Priority Area	Improving experience and health outcomes – responding to chronic illness (Possible Option 7-Pg 76)
Description of Activity	Targeting consumers with identified chronic disease and providing tailored service response, including for diabetes, cardiovascular disease, respiratory, disease, Hepatitis, and renal disease. This work is to undertaken in partnership with our collaborative partners, with an expected outcome of reduced hospitalisations.
Target population cohort	Patients with identified chronic disease (Rising Risk) patients
Consultation	Focus groups, quantitative and qualitative surveys will be conducted with providers and consumers. EMPHN needs analysis, POLAR and ABS data will be accessed. A commissioning process will be undertaken to develop and then procure a comprehensive intervention for this cohort, an evidence based model of care in the community, with strong links to General Practice and access to specialty medical services. This activity will provide access to integrated and comprehensive interventions to rising risk populations in the EMPHN catchment, ultimately reducing the risk of unplanned hospital presentations and admissions.
Collaboration	Collaborative agencies will be invited to help define problems and co-design local solutions.
Indigenous Specific	No
Duration	July 2017 – June 2018
Coverage	Across the entire EMPHN catchment
Commissioning method (if relevant)	EMPHN's commissioning methodology is described in detail above.
Approach to market	Open tender approach
Decommissioning	Nil

Proposed Activities	
Activity Title / Reference	**LP-12: Primary Care Improvement and Integration**
Existing, Modified, or New Activity	Modified
Program Key Priority Area	
Needs Assessment Priority Area	Improving the health system - workforce (Possible Option 8, pg. 77) Improving the health system – appropriate service and system design (Possible Option 14, pg.14)
Description of Activity	The development and implementation of innovative activities, integrated with other program areas, which support general practice to add value to the health system and enhance care within their own practice and outer in the wider system. Including a practice benchmarking program to achieve demonstration sites for the practice of the future "Practice 2030", continued quality improvement in the practice and techniques to facilitate integrated and coordinated patient centred care. The activity will include a number of complementary programs of work that all aim to build practices capacity to respond to future directions in health care.
Target population cohort	All
Consultation	Consultation will be ongoing with key groups across the catchment
Collaboration	The program will collaborate with: • General Practice • Community Health • LHNs • DHHS • VPHNA • Clinical specialists

Indigenous Specific	No
Duration	Ongoing
Coverage	Entire PHN region
Commissioning method (if relevant)	Unknown
Approach to market	Unknown
Decommissioning	*Unknown*

Proposed Activities	
Activity Title / Reference	**LP-13 Ageing**
Existing, Modified, or New Activity	Modified
Program Key Priority Area	*Population Health*
Needs Assessment Priority Area	Improving experience and health outcomes – keeping people well (possible option 3, pg.75)
Description of Activity	Healthy ageing is a key issue for the EMPHN region with a high number of RACF beds and an ageing population, particularly in the inner, more densely populated areas. Activities to support healthy ageing have a natural overlap with avoiding hospital presentations by seeking to: increase quality of life and reduce acuity, improve service coordination and information, support general practice

	through Health Pathways and innovative models of early intervention, and increased access to services, including specialist telehealth. Activity includes: LP-13.1 QUM rollout with focus on polypharmacy and falls, and antibiotic resistance LP-13.2 Review evidence on reducing polypharmacy/de-prescribing and develop recommendation
Target population cohort	Aged population across the catchment
Consultation	The program will collaborate with: • General Practice • Community Health • LHNs • DHHS • RACF • Pharmacies
Collaboration	
Indigenous Specific	No
Duration	12 months ongoing
Coverage	All catchment
Commissioning method (if relevant)	Not Applicable at this stage
Approach to market	NA
Decommissioning	NA

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

Proposed activities	
Activity Title / Reference	OP1: Population Health
Existing, Modified, or New Activity	Existing
Description of Activity	The Performance and Planning team has responsibility for equipping the organisation and its programs with: - Continually updating needs assessments to inform program and commissioning activity in health needs, service access trends, service mapping and forecasting - Undertaking deeper dives on issues to inform the organisations and its stakeholders it is collaborating with - Providing the Collaborative Platforms with briefings of the key issues on which to focus through the Collaborative Structure - Assisting and increasing the capacity of the organisation to source an evidence base and appropriately evaluate projects and programs This will ensure the organisation maintains a population health understanding of the health care needs of the PHN communities through analysis and planning, knowing what services are available and helping to identify and address service gaps where needed, including in rural and remote areas, while getting value for money.
Supporting the primary health care sector	The Population Health function will support the primary care sector through the sharing of key data and findings to promote collaborative activity, help provide direction and context to the consolidation of investments and best impact targeting for action. Findings highlight the driving population health needs experienced by the primary care workforce to then influence education, initiatives and supports planned and provided.

Collaboration	This activity will be primarily internal capacity building and assist with our collaborative arrangements. Stakeholder engagement of local government and Primary Care Partnerships will be maintained by the Performance and Planning Team
Duration	Ongoing.
Coverage	Entire EMPHN region
Expected Outcome	Activities are expected to assist in achieving the following EMPHN Strategic Objectives:

Proposed activities	
Activity Title / Reference	OP2: General Practice Engagement & Support
Existing, Modified, or New Activity	Modified
Description of Activity	EMPHN aims to provide support to General Practice to enable a better primary health care system and ensure the programs and projects of EMPHN have strong engagement with General Practice. General Practice Engagement is split into two key functions for EMPHN: General Practice Engagement –by taking a development approach to a caseload of practices, deliver high quality education and support packages in the areas of practice management, practice nursing, vaccine management and immunisation, data quality, MBS, clinical software and accreditation This includes delivery of in-practice education on a range of topics relevant to both the identified priorities and the needs of general practice itself, and supporting practices in quality improvement activities to improve primary health care outcomes based on the available data collection. - These teams will work in collaboration with programs across the organisation and maintain strong connections with General Practice in our region. Whilst activities of support will look to address the priorities identified in the needs assessment, they will also look to support the emerging workforce

	development needs of General Practice and work closely with the Workforce Development and Education team to inform calendars of activity. This activity will support PHN objectives through: Supporting general practices in attaining the highest standards in safety and quality through showcasing and disseminating research and evidence of best practice. This includes collecting and reporting data to support continuous improvement; providing practice support services so that GPs are better placed to provide care to patients subsidised through the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), and help patients to avoid having to go to emergency departments or being admitted to hospital for conditions that can be effectively managed outside of hospitals. General Practice Engagement activities are the mechanism that will enable a range of Flexible Fund activities.
Supporting the primary health care sector	The program will support the primary health sector in attaining the highest standards in safety and quality through showcasing and disseminating research and evidence of best practice. The program will support the development of the primary health care system to be able to respond to the fast changing landscape including changes to policy and funding requirements and community expectations. For example EMPHN will support practices to develop towards being a patient centred Health Care Home (PCHCH) according to the current building blocks identified by the Commonwealth as underpinning the current PCHCH model.
Collaboration	Internal support to General Practice and as enabler for General Practice Engagement and Flexible Funded activity. The program will collaborate with: • General Practice • Community Health • LHNs • Peak bodies (e.g. Cancer Council Victoria, Diabetes Vic) • Accreditation agencies • Medical software vendors • DHHS

	• VPHNA • Clinical specialists
Duration	Ongoing.
Coverage	Entire PHN region
Expected Outcome	Activities are expected to assist in achieving the following EMPHN Strategic Objectives: 1. Investment decisions are targeted for highest impact 2a. Consumers and providers (including GPs) are engaged 2b. Service needs are prioritized and identified gaps are filled PHN objectives providing practice support services so that GPs are better placed to provide care to patients that is based on best practice, subsidised through the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), and help patients to avoid having to go to emergency departments or being admitted to hospital for conditions that can be effectively managed outside of hospitals

Proposed activities	
Activity Title / Reference (eg. OP 1)	OP3: Digital Health/eHealth.
Existing, Modified, or New Activity	*This is an Existing activity (2016-18 Activity Work Plan)*
Description of Activity	Digital Health/eHealth is a key mechanism by which improvements in the primary health care system can be sought by EMPHN.

	The Digital Health Team has expertise to support the following activities relating to eHealth including: - Supporting practices in the uptake of the ePIP - Increasing telehealth capacity in the region - Working in partnership with LHNs and Community Health in eReferral Projects - Internal Information Systems such as CRM and SharePoint that can be used for internal information management and electronic platforms by which to share information with Collaborative Platforms and Committees - Support for the roll out of My Health Record - Support for the roll out of the POLAR GP Clinical Audit Tool The Digital Health team will support a range of internal teams and external organisations by providing practical support and education to understand the processes and systems that underpin the delivery of eHealth services in Australia. This team as the subject experts will build internal capacity and engage directly with external organisations to assist them achieve the required eHealth objectives and provide the primary care interface to ensure a cross-system approach. Promotion and engagement with key national infrastructure and service providers will be critical to enable the effective deployment and expansion of eHealth initiatives across the EMPHN region. This activity will assist general practices in understanding and making meaningful use of eHealth systems, in order to streamline the flow of relevant patient information across the local health provider community.
Supporting the primary health care sector	The Digital Health/eHealth program will support the primary health sector in learning and pursuing the highest standards in quality data capture/ storage and reporting through the education/training and assistance of best practices and workflows. The program will also support the development of the primary health care system to be able to respond to the fast changing landscape including changes to policy and funding requirements and community expectations. An example would include EMPHN supporting practices to develop workflows and practices to ensure compliance with current and future PIP requirements, eReferral, My Health Record uploads-meaningful use and preparations towards being a patient centred Health Care Home.

Collaboration	Whilst this program enables internal capacity across a range of activities, a specific activity in this space will be undertaken in collaboration with: eReferral: General Practice, LHNs – Eastern Health, Austin Health Telehealth: General Practice, Specialists, LHN Outpatients/Specialists Clinical Audit Tool: Outcomes Health, Gippsland and South East Melbourne PHN
Duration	Anticipated activity start and completion dates. ePIP support: July 2016 -June 2018 eReferral: July 2016 – July 2017 Telehealth: July 2017-June 2018
Coverage	Entire PHN region
Expected Outcome	Activities are expected to assist in achieving the following EMPHN Strategic Objectives: 1. Leaders commit to system improvement 1c. Leadership and change capacity is enhanced 2. Investment decisions are targeted for highest impact 2a. Consumers and providers (including GPs) are engaged 3. Care processes designed for need and best use of resources 3a. Design and re-design occurs collaboratively 3b. Services are reoriented to better meet needs 3c. Patients know where to go, when and why 3d. Effective, efficient services are procured PHN objectives will be achieved by: Providing practice support services so that GPs are better placed to provide care to patients

	subsidised through the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), and help patients to avoid having to go to emergency departments or being admitted to hospital for conditions that can be effectively managed outside of hospitals A key metric to assist in improving service coordination across flexible activities includes: All Public LHNs within the region and a minimum of 60% private hospitals registered for My Health Record (2 years), 100% of PIP-registered general practices in the region registered and uploading to My Health Record, 100% of pharmacies with eHealth-capable software registered for My Health Record, 100% of RACFs with eHealth-capable software registered for My Health Record This will be monitored internally through supports provided as currently the PHN does not have access to a centralised listing of organisations registered to upload for My Health Record.
Funding from other sources	DHHS Victorian eReferral Program

Proposed activities	
Activity Title / Reference	OP4: Workforce Education & Clinical Placements
Existing, Modified, or New Activity	Existing
Description of Activity	The Workforce Education and Clinical Placement team aim to provide support and increase the capacity of the primary care workforce through workforce development and education activities. Workforce Development activities include: - Clinical Placements to increase the capacity of the General Practice workforce through attraction of medical graduates to the industry and build the supervisory capacity of General Practice - General Practice (GP, Nurse, Practice Manager) Education through webinars and events relating to areas of workforce development need

	- Primary Care Provider education to Pharmacy and Allied Health - International Medical Graduate preparation to increase General Practice workforce capacity in outer metro areas This aims to meet PHN objectives by providing practice support services so that GPs are better placed to provide care to patients subsidised through the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), and help patients to avoid having to go to emergency departments or being admitted to hospital for conditions that can be effectively managed outside of hospitals.
Supporting the primary health care sector	The above activities help to attract workforce into areas of need, support the current workforce to meet demand and ensure they are upskilled to respond to population health needs.
Collaboration	Collaboration in the development and delivery of education with a range of organisations and services includes at this time: A formal alliance "Eastern Melbourne GO Education alliance with 6 public hospitals to support the delivery of high quality and localised GP education. Additional collaboration with Peak bodies, VPHNA, DHHS, Community Health Centres and other PHNs. Planning will be undertaken with key health organisations in line with identified priorities and related activities that are flexibly funded.
Duration	Ongoing
Coverage	Entire PHN region
Expected Outcome	Activities are expected to assist in achieving the following EMPHN Strategic Objectives: 1. Leaders commit to system improvement 1c. Leadership and change capacity is enhanced 2. Investment decisions are targeted for highest impact 2a. Consumers and providers (including GPs) are engaged 2b. Service needs are prioritized and identified gaps are filled 3. Care processes designed for need and best use of resources

	3b. Services are reoriented to better meet needs PHN objectives will be supported to be achieved Providing continuing professional development and workforce supports so that GPs are better placed to provide care to patients based on best practice, subsidised through the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), and help patients to avoid having to go to emergency departments or being admitted to hospital for conditions that can be effectively managed outside of hospitals.

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

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

Many of these activities noted as not continuing are now being undertaken within new or modified activities within this plan.

Planned activities which will no longer be delivered -	
Activity Title / Reference	Partnering with peak body organisations to develop : (Previously NP10 Cancer Screening in previous AWP – now removed from NP2) 10.1 A work package for roll out in General Practice to support increased cancer screening A diverse community engagement strategy regarding the promotion of cancer screening (CALD, Refugee & ATSI) NP10.4 Reviewing expansion and capacity of peer support networks
Description of Activity	10.1 A work package for roll out in General Practice to support increased cancer screening A diverse community engagement strategy regarding the promotion of cancer screening (CALD, Refugee & ATSI) 10.4 Review/expansion of current peer support networks for cancer survivorship (as part of cancer screening activity from 2016-17 AWP
Reason for removing activity	10.1 The work package has been developed based on collation of existing resources and streamlining to a whole patient journey approach – screening to survivorship. Continued roll out of the package

	will continue via activity 2.1. Community engagement approaches will continue to be explored in collaboration with other PHNs and DHHS. 10.4 Review of activity concluded. Further activity not warranted for peer support networks for cancer survivorship. Cancer survivorship is included in new activity :
Funding impact	Nil impact as new activity has replaced activity no longer delivered

Planned activities which will no longer be delivered -	
Activity Title / Reference from previous plan	NP1: Avoidable hospital admissions from Ambulatory Care Sensitive Conditions NP1.1 Establish collaborative structures NP1.2 Deeper dive into sub-catchment experience of preventable admissions NP1.3 Co-design and delivery of solutions to reduce preventable admissions NP1.4 Review and extrapolate findings of pilot to high risk ACSCs.
Description of Activity	The following activities will be undertaken to look at innovative and collaborative cross-system approaches to addressing potentially avoidable hospitalisations. In recognition of diabetes complications being the clear front runner for Ambulatory Care Sensitive Conditions, activities will commence with diabetes as the pilot model: 1.1 Establish collaborative governance structure in the outer north, the north east and the east. 1.2 Deeper dive into each sub-catchment including: a) Population health data b) Service mapping c) Community attitudes d) Clinician attitudes

	1.3 Co-design and deliver solutions based on findings, including: - Service development - Clinician engagement and resources including clear referral pathways (i.e. HealthPathways) - Community engagement and resources including community mobilisation / activation, health literacy, health system / pathway knowledge 1.4 Review and consider extrapolation for other high risk ACSCs. Cross reference: Activity NP2.7 Trialling of predictive modelling, risk stratification to reduce avoidable hospitalisation.
Reason for removing activity	This activity for 2016-17 provided the foundational activities in establishing the collaborative and exploring further co-design. As a result of this process and the learnings of initial solutions design and in the process of delivery, the Collaboratives have now nominated key projects from their platform that have been incorporated into the 2017-18 AWP.
Funding impact	Funding for 2017-18 redistributed to more targeted collaborative driven projects

Planned activities which will no longer be delivered -	
Activity Title / Reference from previous plan	NP2: Reducing ED presentations for primary care type conditions NP2.1 ED presentation population data deeper dive NP2.2 Data review of ED presentation drivers NP2.3 Support for eReferral and My Health Record uptake (continuing within Digital Health) NP2.4 Alternative care option community education NP2.5 HealthPathways support to increase primary care capacity to reduce ED presentations (continuing as Reducing Variations in Healthcare) NP2.6 Co-design and delivery of pilot programs to reduce ACSCs presenting to ED

	NP2.7 Supporting testing of POLAR DIVERSION Risk Algorithm (Continuing as Data Linkages)
Description of Activity	The following activities will be undertaken to ensure a deeper understanding of the drivers of ED presentations for Category 4 & 5 conditions and develop a collaborative, cross-system approach to addressing potentially avoidable hospital use. 2.1 Agreeing on the problem: Deeper dive with collaborators into **available data** to develop shared understanding and determine what can be learned about complexities, specific issues, demographics and localities, and relationships between them, to support targeted projects (see 1, 3, 4). 2.2 Collaborate with academic research centres to validate and prioritise to address localised drivers for ED presentations e.g. attitudinal beliefs about cost, perception of workforce capacity (especially paediatrics) and convenience (key factors known to be driving some ED presentations for Category 4 & 5 conditions). 2.3 Support for the use of eReferral and uptake of My Health Record within the region. 2.4 Collaborate with academic institutions, PCPs, LHNs to develop a regional plan for **communicating to the public** their care options and health behaviour change messages. 2.5 Improve system navigation knowledge for GPs and other primary care providers--expand and promote access to **HealthPathways**, addressing identified need of part-time, low experience and locum GPs for system pathways and referral information. 2.6 Based on 2.4 (above), co-design specific issue pilot programs aimed at reducing ACSCs presenting to ED and pilot these in key target locales. Examples:

	• Support GPs and practices to manage more target area low acuity and paediatric consultations with specialty education and programs to trial in-practice nurse practitioners. • Investigation of procuring additional diagnostic support for General Practice, so that referral to ED is not necessary. • Investigate trialling a specialist hotline for use by GPs. • Co-develop process and outcome measures specific to determining wins, gaps and learnings from the pilots. 2.7 Partner to validate within general practice the POLAR Diversion project to address GP capacity to prevent avoidable ED presentations by brokering test general practice sites to validate the algorithm and provide input on the reporting process. POLAR Diversion is an algorithm of risk which will be trialled in general practice by analysing their data to highlight a report of at-risk patients and presenting that report to General Practice to validate based on clinical opinion.
Reason for removing activity	This activity for 2016-17 provided the foundational activities in establishing the collaborative and exploring further co-design. As a result of this process and the learnings of initial solutions design and in the process of delivery, the Collaboratives have now nominated key projects from their platform that have been incorporated into the 2017-18 AWP.
Funding impact	Funding for 2017-18 redistributed to more targeted collaborative driven projects

Planned activities which will no longer be delivered -	
Activity Title / Reference from previous plan	NP3: Integrated care for Chronic Disease Prevention & Management NP3.2 Develop a deeper understanding of a proposed Patient-Centred Healthcare Home Model NP3.4 Review of Chronic Disease Health Pathways according to chronic diseases experienced in the EMPHN population

	NP3.5 Increasing uptake of ePIP, eReferral and My Health Record in the EMPHN region NP3.6 Workforce supports for culturally safe practice in primary care NP3.7 Chronic Disease CPD
Description of Activity	A multifaceted approach to chronic disease management will be applied with this suite of activities. This includes working with general practice to build data quality and a population profile of service use in general practice and quality of care in reaching clinical outcomes, developing innovative models with consumers and stakeholders for chronic disease care, ensuring adequate workforce supports through education, eHealth support and Health Pathways and the procurement of services to increase capacity for prevention and early intervention in our region. These activities include: 3.2 Development of a proposed model for the Patient Centred Healthcare Home 3.4 Review/audit of the current HealthPathways developed relating to chronic disease emerging from data 3.5 Workforce supports for culturally safe practice to primary care designed with input from providers and consumers for CALD and ATSI consumers ***Support to Indigenous Australian's Program Activity Workplan 3.6 Chronic Disease continued professional development in line with emerging chronic conditions (Hepatitis B, Diabetes, Asthma, COPD)
Reason for removing activity	Consolidation of activities include: 3.2 An agreed model has been developed by the Department within the PCHCH trial. Supportive activity will continue through the Innovation funding work in 2017-18 3.4 Review of health pathways for chronic disease to be completed in 2016-17 3.5 Cultural safety workforce supports already within the ITC AWP 3.6 into general workforce development CPD planning
Funding impact	Redistributed to NP3 and other targeted collaborative driven projects

Planned activities which will no longer be delivered -	
Activity Title / Reference from previous plan	NP4: Ageing NP4.1 Increasing telehealth capacity for Urology, Geriatrics and Endocrinology NP4.2 Interim Medication Improvement Project with LHNs NP4.3 Develop Palliative Care Health Pathways NP 4.5 Review evidence of falls prevention approaches for recommendations for action NP 4.7 Early Intervention Model for healthy ageing
Description of Activity	Healthy ageing is a key issue for the EMPHN region with a high number of RACF beds and an ageing population, particularly in the inner, more densely populated areas. Activities to support healthy ageing have a natural overlap with avoiding hospital presentations by seeking to: increase quality of life and reduce acuity, improve service coordination and information, support general practice through Health Pathways and innovative models of early intervention, and increased access to services, including specialist telehealth. Activity includes: 4.1 Supporting increased telehealth capacity within the specialties of urology, geriatrics and endocrinology 4.2 Interim Medication Chart improvement projects with LHNs 4.3 Undertake to develop Palliative Care Health Pathways and promote to general practice and locums 4.4 Quality Use of Medicines program roll-out with a particular focus on polypharmacy and antibiotic resistance 4.5 Review findings of current falls programs and Benetas Frailty Research Project to determine recommendations of action to address frailty and falls.

	4.6 Review current research and models of care regarding de-prescribing and reducing polypharmacy in older populations. Develop a model of early intervention for healthy ageing at 45-49 year-old health check to 75 year-old health check to promote healthy ageing and decreased risk of chronic disease, including consideration of commissioning cardiologist access to general practice for ongoing monitoring of patients at risk of heart failure and commissioning community education in the Whittlesea/Wallan region regarding heart health. Activities to be undertaken with the following stakeholders: Northern Hospital and other LHNs, in-reach services, specialists, palliative care services, pharmacies (supply and community), general practice, RACFs, allied health, local councils, Council of the Ageing, Benetas, Heart Foundation, Community Health Services
Reason for removing activity	In recognising the significant overlap in activities that are disease driven versus age cohort driven, a different approach has been taken with this iteration of the AWP. An age cohort lens will instead be applied to activities listed in the plan where the needs assessment indicates the experience of the priority health issue is significant for healthy ageing and the older persons cohort.
Funding impact	Redistributed to targeted collaborative driven projects

Planned activities which will no longer be delivered -	
Activity Title / Reference from previous plan	LP6: Access to Care for Refugee and CALD Communities LP6.1 Support to general practice in better use of interpreters LP6.2 Workforce awareness and preparation to support refugees with a disability LP6.3 Broker supports for CALD carers as per National Ageing and Aged Care Strategy
Description of Activity	As the EMPHN region contains a diverse population, and have existing communities of humanitarian arrivals as well as more settlement incoming, the capacity to delivery culturally appropriate care to engage these populations and address their needs will be key to addressing the increased risks of ill

	health. Activities will be a combination of equipping general practice to respond and working with stakeholders to improve the patient experience for CALD and refugee populations. These include: 6.1. Supporting general practice in better use of interpreters (develop and disseminate in-practice workflows to ensure interpreter bookings, etc.) 6.2. Raising awareness of humanitarian arrival ineligibility for the NDIS to GPs and developing and providing alternative pathways of care 6.3. Supporting general practice services engaged in locating and assisting CALD carers facing cultural and other barriers in accessing carer support services (as per National Ageing and Aged Care Strategy, p. 2).
Reason for removing activity	As a priority project/condition approach versus a cohort approach has been adopted, a refugee lens will be applied to other activities to ensure where the refugee and CALD populations have been identified as at risk (particularly for chronic disease and ED Diversion), the procurement process encourages proposals which include engaging effectively with these populations.
Funding impact	Nil impact as new activity has replaced activity no longer delivered

3. (a) Strategic Vision for After Hours Funding

See Section 1a

After Hours activities retained from the previous AWP are detailed below.

10. (b) Planned PHN Activities – After Hours Primary Health Care 2016–2017

Proposed Activities – After Hours Primary Health Care 2016-17	
Activity Title / Reference	**AH 1 : Increase access to GPs and other primary health care services in the after-hours period**
Existing, Modified, or New Activity	Modified activity (2016-17 Activity Work Plan - Revision approved by DoH Nov 16).
Needs Assessment Priority Area	Improving the health system – appropriate service and system design: Possible option 14. Improving pathways and options for consumers and clinicians to appropriately use and refer to alternatives to emergency departments as clinically appropriate page 78 Improving the health system- infrastructure: Possible option 39. Implement hot spot service solutions to address after hours service shortfalls in the catchment page 86.).
Description of Activity	**AH 1.1** Expansion and development of new service models for the delivery of after-hours care in areas not currently serviced by medical deputising services (MDS). • Commission an expansion of Medical Deputising Service (MDS) beyond the current MDS delivery boundaries. • Scope a new service delivery model (to be developed) in areas where MDS do not operate *Note: As at January 2017 this project is on hold pending outcomes of the Department of Health's After Hours Primary Care Review and the Minister's MDS Taskforce which is reviewing MBS after-hours payments for MDS, the outcome of which may inhibit the cost-versus-benefit EMPHN would seek from an investment in MDSs.* **AH 1.2** Support continuation of after-hours GP clinics in the outer north and outer east, where this is limited or no coverage by the medical deputising services. • Support current after hours GP clinics to continue, and expand hours to meet community demand if required. *Note: A need to extend service hours at the clinic servicing Healesville (outer east) was identified towards the end of 2016. It is proposed that this clinic continue to be funded and with extended hours in 2017-18.*

Target population cohort	• Residents of Residential Aged Care Facilities (RACFs) • Patients requiring diagnostics in after-hours periods. • Communities of EMPHN's outer eastern and outer northern catchments where access to after-hours general practice is limited. • Children aged 0 – 4 years.	
Consultation	• Consultation with general practices, Eastern Health (Yarra Valley Community Medical Service), RACFs, diagnostic services, medical deputising services (MDS), consumers, medical specialties.	
Collaboration	• General practices in targeted hotspots where after-hours diagnostics and fracture/wound management can be delivered from. • Hospital networks may medically diagnose diagnostic images where only technicians are available • Residential aged care facilities (RACFs) Consultation regarding provision of radiology services. • Diagnostic services commissioned to provide services. • Eastern Health: Organisations commissioned to provide after-hours general practice. Consultation regarding after-hours needs. • General practices: Consultation regarding diagnostic imaging accessibility.	
Indigenous Specific	No.	
Duration	Activity scoping and project planning	AH 1.1 March –July 2016
		AH 1.2 March – July 2016
		AH 1.3 December 2016 – January 2017
	Procurement	AH 1.1 On Hold
		AH 1.2 Partially completed June 2016, outer north March 2017
		AH 1.3 May 2017
	Service delivery commencement (Program Execution)	AH 1.1 On Hold
		AH 1.2 : September 2016 and June 2017
		AH 1.3 June 2017

	Service delivery completion	AH 1.1 : On Hold AH 1.2: June 2017 and June 2018 AH 1.3: June 2018
	Cost benefit analysis including evaluation	AH 1.2 : On Hold AH 1.2: May – August 2017 AH 1.2: June – September 2018
Coverage	City of Whittlesea, Shire of Yarra Ranges, Nillumbik Shire, Mitchell Shire, Murrindindi Shire	
Commissioning method (if relevant)	The commissioning method will follow the methodology outlined in section 1a. The current activities listed fit within the Problem Definition to Solution Design components of the methodology. A clear brief will be developed, the appropriate commissioning process will be selected and undertaken and performance metrics built into contracts. Evaluation findings will be reviewed and reported.	
Approach to market	AH 1.1: Open tender approach AH 1.2 Open tender approach AH 1.3 Limited/Restricted approach	
Decommissioning	Not applicable.	

Proposed Activities – After Hours Primary Health Care 2016-17	
Activity Title / Reference	**AH 2 Increase aged care facility residents' access to GPs and other primary health care services in the after-hours period.**
Existing, Modified, or New Activity	Existing activity (2016-17 Activity Work Plan).
Needs Assessment Priority Area	Improving the health system- infrastructure: Possible option 39. Implement hot spot service solutions to address after hours service shortfalls in the catchment, page 86. Improving the health system – system and service redesign, possible option 40. Work in partnership with after-hours service providers providing services to residential care to enhance their capacity to provide afterhours services to residential aged care, page 86.
Description of Activity	Continued activity with funding committed in 2016-17. **AH 2.1** Continuation of the After Hours Visiting GP Service to outer east and north residential aged care facilities (RACFs), undertake a scoping exercise and pilot in hours model of care utilising medical deputising services to provide residents with more timely access to general practitioners. **AH 2.2.** Commission Hospital Residential In-Reach Program staff to provide a targeted education campaign for RACF and MDS staff focussing on ambulatory care sensitive conditions. **AH 2.3** Implement and evaluate St Vincent's RIR/RACF De-prescribing Project at the RACFs whose residents represent the top 5 ED presentations. *Note: depending on evaluation outcomes it is proposed that this project be replicated in 2017-18 in the other 4 LHNs in the catchment.*
Target population cohort	**AH 2.1** Visiting GP Service: Residential Aged Care Facilities and clients in the outer north and outer east. **AH 2.2** RIR Education Commissioned Training: RACFs staff, RIR staff and clients from Eastern Health, Northern Health and Austin Health (LHNs). **AH 2.3** St Vincents Residential Inreach Program and the 5 RACFs whose residents represent the top 5 number of presentations from RACFs in EMPHN and NWMPHN catchment.
Consultation	**AH 2.1** MDS and RACFs. **AH 2.2** Qualitative and quantitative data from Austin Health, Northern Health, Eastern Health and St Vincent's Hospital Networks will be collated to determine areas of need in RACF education.

	AH 2.2 Primary care type presentations will be analysed to determine content of educational modules. RACFs involved in the visiting GP Service will be consulted to discuss availability of service.
Collaboration	**AH 2.1** MDS and Lifelong HealthCare have been commissioned to provide the Visiting GP Service to RACF residents in the outer east and outer north. They are required to market and communicate the service to RACFs. **AH 2.2** Eastern Health, Northern Health, Austin Health, Monash Health and St Vincent's will collaborate to implement identified program including education modules. **AH 2.3** St Vincents Residential In-Reach Program to develop and implement project.
Indigenous Specific	No
Duration	Activity scoping and project planning: July 2016 Procurement: AH 2.1 July 2016 AH 2.2 April 2017 AH 2.3 Sept 16 – April 2017 Service delivery commencement (Program Execution): AH 2.1 June 16, AH 2.2 May 2017 AH 2.3 May 2017 Service delivery completion: November 2017 Cost benefit analysis including evaluation: AH 2.1 and AH 2.2 December 2017 AH 2.3 N/a
Coverage	AH 2.1 Visiting GP Service- LGAs of Yarra Ranges, Nillumbik, Whittlesea AH 2.3 De-prescribing project –LGAs of Boroondara and Whitehorse AH 2.2 RIR – RACFs within hospital networks of Austin Health, Northern Health and Eastern Health
Commissioning method (if relevant)	AH 2.1 Visiting GP Service- Doctor Doctor (MDS) currently provide this service and their contract has been extended until 30 June 2017. Lifelong Healthcare currently provide this service and their contract has been

	extended until 30 June 2017. A review process will be undertaken to determine if a contract renewal or open tender process is most cost effective. AH 2.3 De-prescribing project - St Vincent's is currrently engaged to implement the De-prescribing Project following identification of polypharmacy issues resulting in increase in falls and unnecessary ED admissions. AH 2.2 RIR-EMPHN has conducted scoping to determine educational needs of RACFs within the EMPHN catchment. RIR have been identified as organisations to provide specific training for RACFs therefore were commissioned to provide the training in 2016-17
Approach to market	AH 2.1 Visiting GP Service: Contract extension, sole source AH 2.3 De-prescribing project- Sole Source AH 2.2 RIR- sole source
Decommissioning	Not applicable.

Proposed Activities – After Hours Primary Health Care 2016-17	
Activity Title / Reference	**AH 3 Increase quality and capacity of after-hours primary health care services**
Existing, Modified, or New Activity	Modified activity
Needs Assessment Priority Area	Improving the health system – infrastructure: Possible option 39. Implement hot spot service solutions to address after hours service shortfalls in the catchment Improving the health system – appropriate service and system design: Possible option 14. Improving pathways and options for consumers and clinicians to appropriately use and refer to alternatives to emergency departments as clinically appropriate page 78
Description of Activity	**AH 3.1 Extension of Pharmacy Opening hours in the after-hours period** Target and work with pharmacies to expand their operating hours in areas of identified need. Provide support to pharmacies to enable the provision of after-hours medications to RACFs. **AH 3.2 Targeted Grants Program**

	Implementation of a grants program to maximise after-hours primary care service availability to support the community. **AH 3.3 Improve quality of information provided on the NHSD** Implement a system to assist general practice to regularly update service information on the NHSD. **AH 3.4 Scoping for implementation of proposed 2017/18 commissioning of after-hours emergency department diversion solutions** Completion of scoping exercise to determine gaps in after-hours service provision with the aim of procuring solutions. (New)
Target population cohort	• General practices and pharmacies within the EMPHN catchment. • General community accessing general practices in the after-hours period. • People requiring pharmacotherapy dispensing in the after-hours period.
Consultation	• Consultation conducted with general practices and pharmacies including the completion of a General Practice Survey (75% response rate).
Collaboration	• Extension of pharmacy opening hours – collaboration with community pharmacies, Pharmacy Guild, Area 4 Pharmacotherapy Network. • Targeted grants program – general practices and pharmacies. • NHSD - Health Direct and General Practice
Indigenous Specific	No
Duration	Activity scoping and project planning — October 2016 Procurement — December 2016 Service delivery commencement (Program Execution) — December 2016 Service delivery completion — June 2017 Cost benefit analysis including evaluation — July 2017
Coverage	Areas of geographical need including the Outer East and Outer North of the catchments

Commissioning method (if relevant)	The commissioning method will follow the methodology outlined in section 1a. The current activities listed fit within the Problem Definition to Solution Design components of the methodology. A clear brief will be developed, the appropriate commissioning process will be selected and undertaken and performance metrics built into contracts. Evaluation findings will be reviewed and reported.
Approach to market	Open Tender approach
Decommissioning	Not applicable.

Proposed Activities – After Hours Primary Health Care 2016-17	
Activity Title / Reference	**AH 4 Increased community awareness of after-hours services and options**
Existing, Modified, or New Activity	Existing Activity (2016-17 Activity Work Plan)
Needs Assessment Priority Area	Improving experience and health outcomes – keeping people well, possible option 38. Develop and implement awareness strategies for after hours services and options (including 24/7 crisis phone lines/apps/resources, page 86
Description of Activity	**AH 4.1** Plan and deliver a catchment wide community education campaign to inform the community of available after hours services, through the following activities: • Development of resources, both paper and digital, to be disseminated to community and health organisations. It is anticipated that a comprehensive digital campaign will include e-billboards, television, commercial CSA and apps. • Complete a comprehensive evaluation of the communications strategy including obtaining data from sources such as health direct, google analytics and the community pre and post campaign to identify the effect on a reduction in primary care types to emergency department
Target population cohort	Community within the EMPHN and NWMPHN catchments.
Consultation	Focus groups coordinated to discuss perspectives on accessing after-hours care.
Collaboration	• Collaborate with other metropolitan PHNS to deliver a metro wide media campaign.

	• Collaborate with Victorian Department of Health and Human Services to ensure consistent messaging with their upcoming Ambulance Victoria Diversional Campaign.
Indigenous Specific	No
Duration	Activity scoping and project planning — December 2016 Procurement — March 2017 Service delivery commencement (Program Execution) — April 2017 Service delivery completion — September 2017 Cost benefit analysis including evaluation — November 2017
Coverage	EMPHN and NWMPHN catchments.
Commissioning method (if relevant)	Commission media campaign with NWMPHN The commissioning method will follow the methodology outlined in section 1a. A clear brief will be developed, the appropriate commissioning process will be selected and undertaken in accordance with the commissioning methodology outlined in Section 1a. Performance metrics will be built into contracts. Evaluation findings will be reviewed and reported.
Approach to market	Open tender approach
Decommissioning	Not applicable.

Proposed Activities – After Hours Primary Health Care 2016-17	
Activity Title / Reference	**AH 5 Culturally safe and accessible primary health care services for people from Aboriginal and Torres Strait Islander, culturally and linguistically diverse and refugee backgrounds**
Existing, Modified, or New Activity	This is a modified activity (2016-17 Activity Workplan)
Needs Assessment Priority Area	Improving experience and health outcomes – keeping people well, possible option 38Develop and implement awareness strategies for after hours services and options (including 24/7 crisis phone lines/apps/resources
Description of Activity	**AH 5.1** improve access to after-hours primary care for CALD communities • Work with leaders and representatives of people from culturally and linguistically diverse backgrounds to design community initiated strategies that will improve these groups' access to after-hours primary care. • Build workforce capacity to enable more people to work with CALD communities in the after hours **AH 5.2** Improve access to culturally safe and accessible primary health care services for outer north and outer east Aboriginal communities. • Engage Aboriginal workers in outer north and outer east to include after hours options as part of their education of communities
Target population cohort	People from Aboriginal and Torres Strait Islander, culturally and linguistically diverse and refugee backgrounds residing in the EMPHN catchment.
Consultation	Qualitative and quantitative data collected via interviews with key informants, Aboriginal Community Controlled organisations, elders and a review of the EMPHN CALD/Refugee Service mapping project.
Collaboration	Collaboration with the EMPHN, GPs, MDS and CALD services including Migrant Information Centre, Spectrum Migrant Resource Centre and Community Health Services.
Indigenous Specific	A significant component of the activity supports Aboriginal and Torres Strait Islander people.
Duration	Activity scoping and project planning • AH 5.1 – November 2016 • AH 5.2 – February – March 2017 Procurement • AH 5.1 – January 2017

	• AH 5.2 Service delivery commencement (Program Execution) • AH 5.1 • AH 5.2 Service delivery completion • AH 5.1 • AH 5.2 Cost benefit analysis including evaluation CALD-Refugee	• May 2017 • February 2017 • June 2017 • August 2017 • June 2018 November-December 2017
Coverage	CALD/Refugee and Aboriginal population groups within the LGAS of Yarra Ranges, Whittlesea, Mitchell Murrindindi, Whitehorse, Knox and Boroondara.	
Commissioning method (if relevant)	Not applicable. Direct engagement with stakeholders to collaboratively undertake activities.	
Approach to market	Not applicable	
Decommissioning	Not applicable.	

Proposed Activities – After Hours Primary Health Care 2016-17	
Activity Title / Reference	**AH 6 Increase access to mental health services in the after-hours period ($361,467)**
Existing, Modified, or New Activity	Modified activity (2016-18 Activity Work Plan)
Needs Assessment Priority Area	Improving the health system – infrastructure: Possible Option 38. (page 86) Implement hot spot service solutions to address after hours service shortfalls.
Description of Activity	**AH 6.1** Increase access to after-hours mental health care for young people. • Work with the EMPHN Mental Health Team and Service System Improvement and Integration Team to improve the service system response and access to after-hours mental health care. • Work with community health services, youth-friendly general practitioners and mental health services and practitioners to increase access to after-hours services for young people. • Procure solutions which enhance young people's access to after-hours primary mental health care.

	AH 6.2 Improve general practitioner and medical deputising services knowledge of after-hours mental health service options. • Train general practitioners to assess risk. • Localise Health Pathways mental health care pathways and educate general practitioners accordingly. **AH 6.3** Determine gaps in the capacity of local hospital networks to respond to requests for after-hours urgent mental health care in the community and explore/purchase solutions.
Target population cohort	Young people.
Consultation	• Consultation with internal Mental Health Team. • Consultion with the 3 headspace services in the catchment, Plenty Valley Community Health Service, EACH (community health), Link Health and Banyule Community Health Service. • Further consultation with GPs, Clinical Council and Community Advisory Group and local Mental Health Catchment Planning Groups to be undertaken. • Consultation with mental health consumers to be included in series of EMPHN Stepped Mental Health Co-Design Workshops being conducted February/March 2017. • Consult with Northern Health.
Collaboration	Collaborate with GPs, key mental health agencies (such as headspace), EMPHN's mental health service providers (psychologists, social workers, mental health nurses) and community health services (particularly those in the growth corridor/outskirts of catchment) where there are large populations of young people, fewer service options, poor transport and high socio-economic disadvantage). These services prospectively will be contracted to deliver after hours mental health solutions for young people. Collaborate with internal Mental Health Team to provide clinical guidance and oversight and Service Improvement Team to provide links into Health Pathways and other strategies being progressed by EMPHN that may link with the initiative. Collaborate with Northern Health to determine solutions.
Indigenous Specific	No.
Duration	**AH 6.1**

	February/March 2017 Stakeholder Solution/Co-Design Forums April 2017 Procurement Plan, Request for Tender June 2017 Commencement of service delivery (18 months) December 2018 Completion. **AH 6.2** commissioning/procurement not required. **AH 6.3** Commissioning not required (Northern Health). February/March 2017 Consultation April 2017 Procurement Plan, Request for Tender June 2017 Commencement of service delivery (12 months) June 2018 Completion.
Coverage	AH 6.1 & 6.2 catchment-wide AH 6.3 Whittlesea, Nillumbik, Banyule, Mitchell, Murrindindi.
Commissioning method (if relevant)	The commissioning method will follow the methodology outlined in section 1a. The current activities listed fit within the Problem Definition to Solution Design components of the methodology. A clear brief will be developed, an open tender process undertaken and performance metrics built into contracts. Evaluation findings will be reviewed and reported.
Approach to market	Open tender approach
Decommissioning	Not applicable.

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

Activities included in the May 2016 version of the AWP which are no longer planned for implementation in 2017–18

Planned activities which will no longer be delivered	
Activity Title / Reference (eg. NP 1/OP 1)	**AH 3.1 Quality Service provided by MDS, GPS and RACF Staff, including upskilling in Emergency Decision Making.**
Description of Activity	• Provide education and support to General Practice, locum Doctors and RACF Staff on delivering a primary care response to identified clinical issues in the After Hours period. • Assist RACFs, MDS and General Practice to Implement emergency decision making guidelines at RACFs • Promotion of Diversional and s.ubstitution programs such as Hospital Admissions Risk Program, Hospital in the Home and RIR
Reason for removing activity	No longer a priority following review of refreshed Community Needs Assessment. Training on "emergency decision making" is met, in part, by 6.1 (assessing risk).
Funding impact	The removal of this activity has no impact on the budget as funding was not allocated to the activity.

Planned activities which will no longer be delivered	
Activity Title / Reference (eg. NP 1/OP 1)	**AH 5.2 Explore the viability of transportation support services to after-hours clinics for vulnerable populations**
Description of Activity	Explore the viability of transportation support services such as extending volunteer transportation services after hours or trialling reimbursements for taxi-based transportation to certain after hours clinic for vulnerable groups.
Reason for removing activity	This project was removed as upon further exploration the project was not viable.
Funding impact	The funding was reassigned to the ATSI program.

FOR MORE INFORMATION

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