Perth North PHN Activity Work Plan

Core Funding

Summary View
2023/2024 – 2026/2027

Presented to the Australian Government Department of Health and Aged Care

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Contents

CF 1000 – Managing Chronic Conditions

Activity Title

Managing Chronic Conditions

Activity Number

1000

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

The Managing Chronic Conditions Program aims to improve patient access to primary health care, provide coordinated care, reduce potentially preventable hospitalisations, and strengthen patient self-management for people with chronic conditions.
The key objectives are to:

- Improve patient experience
- Improve health outcomes
- Improve health literacy and self-management
- Increase interagency /cross sector connection, integration, and collaboration
- Strengthen chronic conditions management in primary care
- Minimise chronic conditions preventable hospitalisations and Emergency Department presentations
- Improve health equity and primary health care outcomes for priority populations
- Locate place-based services in priority community locations.

The chronic conditions targeted by this program include diabetes; respiratory conditions such as Chronic Obstructive Pulmonary Disease (COPD) and asthma; obesity, chronic pain, and cardiovascular conditions, such as Chronic Heart Failure (CHF).

Description of Activity

Background

Almost half of Australians (47 per cent, or 11.6 million people) were estimated to have one or more of 10 selected chronic conditions in 2020–2021.
In Western Australia, chronic conditions and injury cause the highest burden of disease than any other diseases.

The Health and Wellbeing of Adults in Western Australia 2021 survey indicated for

adults over the age of 16 years residing in WA North Metropolitan region, the prevalence[1] of the following chronic conditions were

Chronic Condition	% population diagnosed in East Metro	% population diagnosed in North Metro	Priority areas in Perth North PHN (WAPHA Needs Assessment)
Asthma (lifetime	19.7%	16.8%	Target whole of PHN
Diabetes	9.8%	7.9%	Swan, Bayswater-Bassendean, Stirling
Respiratory Diseases other than Asthma	4.4%	5.3%	Swan SA3 Bayswater -Bassendean SA3
Heart Disease	7.9%	7.7%	Swan SA3 Bayswater – Bassendean SA3
Stroke	2.0%	2.4%	Swan SA3 Bayswater SA3
Obesity	34.2%	34.2%	Target whole of PHN

The survey indicated that there were also high incidences of lifestyle behaviours, increasing individual risk of developing chronic diseases, such as high cholesterol, high blood pressure and lower levels of physical activity.

While nine out of ten (90.2%) adults in WA used primary health services within the past 12 months (2021), only 15% or people had accessed a GP chronic disease management plan (WAPHA needs assessment), identifying significant opportunities to improve chronic conditions care and manage risk factors in general practice and other primary health care services commissioned by WAPHA.

Rationale

Chronic disease is a major contributor to health burden in Australia and some people are disadvantaged due to inequitable access to resources needed to address risk to health and/or have an increased susceptibility to adverse health outcomes. This includes regional, rural, and remote residents, LGBTIQA+ and multicultural community members, older adults and Aboriginal people who experience higher risk of chronic health conditions.

People who live in lower socioeconomic circumstances face much poorer health outcomes, with diabetes 2.6 times as high and coronary heart disease and stroke 2.2

[1] East and North Metropolitan regions reflect the WA Health Service Provider area health service jurisdictions.

times as high compared to people in the highest socioeconomic group. Perth North PHN has pockets of significant disadvantage including Swan, Wanneroo and Perth City SA3.

The WA Sustainable Health Review 2019 noted that:

- Approximately 190,000 of the one million attendances to WA Emergency departments (ED) in 2017–18 could have been potentially avoided with treatment in primary care or community settings.
- Seven per cent of all hospital admissions in 2017–2018, costing an estimated $368 million, were potentially preventable with appropriate care and management outside of hospitals.
- Chronic diseases were responsible for 73 per cent of deaths in Australia with $715 million of hospital costs in WA attributed to chronic conditions in 2013.

Some regions in Perth North PHN have had high rates of lower urgency Emergency Department presentations such as Swan and Mundaring SA3s.

This suggests that there are opportunities to support primary health care providers to manage chronic conditions in priority Perth North PHN communities and build capacity for patient self-management (WAPHA Needs Assessment 2022-2024).

Key Activities

The Managing Chronic Conditions Program provides care coordination and nursing and allied health services, tailored to the needs of those members of the community experiencing disadvantage through the following activities:

- COPD Supported Discharge works in collaboration with Asthma WA's COPD Community Based Care service, to provide clinical care coordination to individuals with chronic obstructive pulmonary disease (COPD), who are non-oxygen dependent, within one week of discharge from hospital due to a COPD related admission. The service connects the patient to primary care including facilitated connection to general practice, with the aim of establishing more effective care in the community and reduced hospital admissions. The service recruit's patients from eight metropolitan hospitals.
- COPD Community Care works in collaboration with the Silver Chain COPD Supported Discharge service, to provide community support and education to individuals with COPD recently discharged from hospital due to a COPD related admission. The service supports clients to engage with primary care including facilitated connection to general practice, with the aim of establishing more effective care in the community and reduced hospital admissions.
- Primary Care at Home provides primary health care to people at risk of poor health outcomes and who have difficulty accessing appropriate primary health care services, including those currently engaged with community and social services. The service takes healthcare into the homes of some of Perth's more

disadvantaged communities, whether that be a house, hostel, or community residential facility. The service provides health assessment, treatment, development of an individualized care plan and connection to a general practitioner.

- Street Doctor provides the services of a conventional primary care practice. The service is staffed by a doctor and a nurse, with outreach workers and a mental health outreach worker providing support to those accessing the clinic services. The clinic operates on a drop in/walk in basis from different locations covering the CBD and eastern metropolitan region of Perth. Other commissioned services may be considered to support the needs and health issues of the target group. The service provides six monthly evaluation reports that contain the number of clients contacting the service, the number who return for contact and whether they consider the service improved their condition.
- Persistent Pain Program aims to help persistent pain sufferers improve self-management of their pain through expert education, individual case management, support, goal setting and improved use of community healthcare services. The program also aims to build the capacity of the primary health sector in identified locations to provide improved chronic pain management. The program is designed so that participants can explore a range of different strategies for living well leading to:
    - reduced reliance on medication for pain management
    - reduced requirements for emergency care, and
      participants not requiring referral to a higher level of hospital-based care.
- Country to City – Improving Patient Transitions Project focuses on the coordination of health and other care elements and to improve the health journey of Integrated Team Care clients across WA and support providers to apply continuous quality improvement to the Country to City – including but not limited to the service model, standardised processes and improving communication, information sharing and discharge planning.

The PHN will continue to develop and maintain close working relationships with contracted service providers and will formally review services to determine:

- how well targeted and efficient services are
- how effective services and systems are in relation to patient reported experiences and patient reported health outcomes service/system integration;
- service sustainability including provider experience/governance/formal accreditation against industry standards (including financial support required) and service cost effectiveness.

The PHN uses a diverse range of data collection methods to evaluate the performance of services and inform any necessary actions, including:

- Patient level episode and service contact data. Using the WA Primary Health Alliance Performance Management Framework (PMF), the PHN measures and tracks providers' performance against specified PMF indicators relating to health

equity, patient-reported experiences and outcomes and cost effectiveness
- Provider reports formally reviewed at 6 month and 12-month intervals
- Referral agency feedback
- Commissioned Services Reporting Portal for nominated managing chronic condition service providers.

A comprehensive review of all PHN chronic conditions activities has commenced, due for completion in late 2024. This review will inform service planning for future chronic conditions services. Performance indicators for chronic condition services have been implemented from 1 July 2023 along with improved frequency and depth of activity and outcome reporting.

Collaboration

Stakeholders will be provided with an opportunity to:

- Provide feedback on barriers and opportunities and priorities to be addressed in relation to chronic care conditions primary care services in Perth North PHN.
- Identify opportunities to enhance person and family centred care, integration and collaboration between the primary care, acute health systems and other sectors.
- Recommend activities for future commissioning and workforce development.

Consultation

Ongoing consultation with service providers occurs through contract management, the chronic conditions care community of practice, service providers connect newsletters and meetings.

A review of the chronic conditions care program may also include engagement with following key stakeholders where recent, relevant consultation hasn't occurred to inform any changes to the activity:

- WAPHA staff members
- General practitioners and general practice staff
- Other relevant primary care providers including allied health professionals and commissioned service providers
- Australian Government Department of Health (including other PHNs)
- State Departments of Health and Health Service Providers,
- Aboriginal Community Controlled Health Services
- Other key service providers e.g. Silver Chain, Asthma Foundation, Diabetes WA, Heart Foundation
- Cohorts of possible service users

Perth North PHN Needs Assessment

Priorities	Page reference
Reduce non-urgent emergency department attendances and improve access to alternative services. (Metro)	12
Increase access to best-practice management for people with chronic heart failure. (Metro)	11
Support Primary Health Care providers to implement effective health interventions for those living with overweight and obesity. (Metro)	11
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11

Target Population Cohort

People who require primary care services and who may be disadvantaged and require additional support to manage their chronic condition/s.

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Work Plan as amended and agreed by the Department, as appropriate.	100%

Activity Milestones	Due Date
Activity Work Plan and Budget	30 April 2024, 30 April 2025
Annual Activity Needs Assessment	15 November 2024
Twelve-month Performance Report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025
Final Report	30 September 2025

Coverage

Swan, Wanneroo and Perth City local government areas in the Perth North PHN

Activity Start Date	Activity End Date
1 July 2019	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
Core Flexible	$1,706,462.18	$1,845,604.79	$0.00

CF 2000 – Developing System Capacity/Integration

Activity Title

Developing System Capacity/Integration

Activity Number

2000

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

The key aim of the Developing System Capacity and Integration is to support the primary health care sector by:

- Providing general practitioners and primary health care clinicians with an online health information portal (HealthPathways) to assist with management and appropriate referral of patients when specialist input is required.
- Facilitating integrated holistic services to reduce the impact of chronic disease by providing enablers for service and patient level integration.
- Providing general practices with access to a platform (license) to support patient centred care through the extraction and analysis of general practice data.

Description of Activity

Background

WAPHA Strategic Plan 2023-2026 commits the organisation to ensuring the best value for money through commissioning integrated primary health services that build capacity, capability and sustainability and measurably improve health outcomes. To meet this commitment, WAPHA supports the provision of tools to support secure digital enable health care, continuous improvement and development of integrated primary health care services.

Key principles for an integrated health system include:

- Comprehensive services across the care continuum from health promotion to primary to tertiary level care as well as cooperation between health and social care organisations.
- A patient centred approach, accessibility, minimal duplication of key services.
- Standardisation with a focus on multidisciplinary care.
- Performance management.
- Efficient information systems.

Rationale

Australia is facing an ageing and growing population with an increasing prevalence of complex chronic conditions and higher expectations for quality care. Health budgets are limited and require healthcare to be delivered equitably and be cost effective. An integrated health system that builds capacity is critical to ensuring sustainability and a focus on flexibility and adaptation to the local context. There is no one size fits all model or process, that guarantees success however literature reviews indicate the above key principles build an integrated health system over time.

Key activities

To support the overarching aim of this AWP, WAPHA delivers the following activities:

- **HealthPathways License and Support**
  HealthPathways is a web-based tool designed to guide general practitioners (GPs) and other health professionals in making appropriate, patient-focused decisions, particularly regarding the management of a variety of patient presentations and the local referral process. It offers primary care clinicians locally agreed information to make the right decisions, together with patients, at the point of care.

  It is designed and written for use during primary care consultation. It provides detailed clinical pathways which are locally agreed upon and evidence-based guidance for assessing and managing patient presentations. HealthPathways is tailored to specific regions, providing localized information about referral options, services available in the area, and local management guidance. The development of HealthPathways often involves collaboration between GPs, specialists, and other health professionals. The content is regularly reviewed and updated to reflect the latest research and changes in clinical practice.

  Perth North PHN also purchased the license to access the GPBook Specialist Directory via a widget embedded within the service referral pages of HealthPathways. This provides up to date, accurate information to general practitioners about private specialists within the PHN region, with the ability to search by practitioner name, specialty, gender, language, telehealth availability, and billing.
- **My Community Directory**
  WAPHA, in partnership with the WA Mental Health Commission, has provided funds to Community Information Support Services, which is a registered Health Promotion Charity that manages My Community Directory.

  My Community Directory is an online directory of local health, social and community services. It acts as a single source of information that has provided WAPHA with a platform to showcase and display all our commissioned services to external stakeholders. The partnership with My Community Directory

assisted WAPHA by:

- Mapping a broad range of services within a search area,
- Enabling localisation - making data available on what people search for and where they are searching from to inform service mapping and identify gaps,
- Gaining insights into the combination of categories and types of services that are searched,
- Providing reports and data to help services for continuous quality improvement.

Following a review, WAPHA ceased the funding agreement with My Community Directory on 7 March 2024. WAPHA continues to develop sustainable mechanisms to provide information to stakeholders on local community assets including health and social service, within WAPHA communication channels.
WAPHA will also encourage commissioned service providers to continue to list their services on the platform, to provide consumers with relevant information about primary health care services available to them.

- **Commissioned Services Reporting Portal (CSRP)**
  WAPHA aims to develop a comprehensive data set and create performance dashboards for commissioned services. This will enable access to accurate, timely and high-quality chronic disease performance data which will enable:
  - Data-driven decisions that will provide better value for money commissioning and improved provider performance management
  - Deliver better value services in line with WAPHA's Performance Management Framework
  - Improved data security and governance
  - Monitoring and evaluating standards and capabilities to ensure that commissioned services are effective and efficient, and meet the needs of the community

The CSRP was launched in June 2023, with the first reports received in October 2023.

- **Primary Care Reporting Portal**
  WAPHA is investing into the development of the Primary Care Reporting Portal. This will be an encrypted platform with validated access control enabling a safe and secure method of delivery and access for all general practices sharing data. With access to real-time reporting of practice information, key reports, insights, and other data, WAPHA is developing and providing performance dashboards to general practices, supporting the monitoring and improvement of their performance as well as ensure the delivery of value-based services.

- **Primary Sense Installation and ongoing management and continuous improvement**
  Primary Sense is a population health management, clinical decision support and data extraction tool that helps GPs deliver the right care to patients at the right time. WAPHA has purchased the Primary Sense license, managed implementation across the PHN and developed continuous improvement strategies. The license allows WAPHA to extract general practice data for practice analysis and aggregates general practice data for service planning, reporting and population health needs.

As WAPHA's data extraction tool of choice, the cost of Primary Sense will be fully subsidised for all general practices in WA and WAPHA continues a roll out of Primary Sense software to all general practices in the region.

Perth North PHN Needs Assessment

Priorities	**Page reference**
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Goldfields, Midwest, Wheatbelt, North West,)	15
Improve the rates of cancer screening and reduce avoidable deaths from cancer. (Metro)	11
Increase access to best-practice management for people with chronic heart failure. (Metro)	11
Increase childhood immunisation rates for regions not meeting national immunisation targets. (Metro)	11
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11

Target Population Cohort

WAPHA's priority community groups such as Aboriginal, LGBTIQA+ and multicultural community members, those experiencing homelessness, those experiencing family domestic sexual violence, those with a disability and older people.

Consultation

The PHN will continue liaison with the following stakeholders:

- General practices
- General practitioners

- Community and commissioned service providers
- WA Health Service Providers
- Residential Aged Care Facilities
- Aboriginal Community Controlled Health Services

Collaboration

Ongoing engagement with key stakeholders to ensure that the services/activities are meeting the needs of the community and service providers.

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Work Plan as amended and agreed by the Department, as appropriate.	100%

Activity Milestones	Due Date
Multiyear Activity Work Plan and Budget	30 April 2024, 30 April 2025
Annual Needs Assessment	15 November 2024
Twelve-month performance report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025
Final Report	30 September 2025

Coverage

Perth North PHN

Activity Start Date	Activity End Date
1 July 2019	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
Core Flexible	$535,243.97	$588,591.99	$0.00

CF 2010 – PHN Clinical Referral Pathways

Activity Title

PHN Clinical Referral Pathways

Activity Number

2010

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

This activity will:

- Develop, enhance and maintain clinical referral pathways (HealthPathways) relevant to the PHN
- Enhance linkages between primary health care services, other providers, and relevant services
- Improve the patient journey and health outcomes
- Increase clinician capabilities and the quality of care provided

This activity aims to:

- Develop, review, enhance and maintain HealthPathways
- Maintain the license of the HealthPathways software and technical writing services provided by Streamliners
- Increase the awareness of, engagement with, and utilisation of HealthPathways by primary care clinicians in the region
- Provide and increase awareness of current best practice guidance for a wide range of primary care patient presentations
- Enhance clinician awareness of and access to local referral options and services for patients
- Improve collaboration with and integration across health care and other systems

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Description of Activity

HealthPathways are developed, reviewed and enhanced as appropriate to the health needs of the Perth North PHN. Pathways are for use by clinicians during consultation with patients, supporting patient assessment and management, and referral to local services and supports.

Clinical and referral (request) HealthPathway development, enhancement, review and maintenance will include the following activities:

- Consultation with subject matter experts, peak bodies, and clinicians.
- Mapping, documenting and maintaining currency of local support and referral service information
- Engaging with Streamliners (who provide technical writing and editorial services) to publish HealthPathways content.
- Literature review, drafting and editorial activities.
- Monitoring, reviewing, and improving existing HealthPathways to ensure currency, accuracy and consistency with best practice.
- Identification of information gaps in the HealthPathways library and subsequent consideration for new pathway development or incorporation of information into existing pathway/s as required.
- Identification and escalation of gaps in care/service availability, for consideration to support health system improvements.
- Identification of reputable resources suitable for health professionals and patients to include in HealthPathways.
- Development and delivery of targeted educational activities, supporting the awareness of HealthPathways and how to maximise user experience.
- Promoting newly published and/or reviewed pathways, in addition to audience specific pathways, to a wide range of health professionals.

Perth North PHN Needs Assessment

Priorities	**Page reference**
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management	15
Support the mental health of older people and assist primary care providers to identify older people who may need additional support or referrals to services.	23
Improve the management of chronic conditions for ageing populations and promote healthy ageing at home.	46
Promote early intervention and monitoring activities to support older adults to live at home and reduce early entry into residential care.	46

Target Population Cohort

WAPHA's priority community groups such as Aboriginal, LGBTIQA+ and multicultural community members, those experiencing homelessness, those experiencing family domestic sexual violence, those with a disability and older people.

Consultation

Consultation will occur with the following key stakeholders:

- General practitioners and other primary health professionals
- Consumer representatives or people with lived experience (if applicable to the topic)
- Health Service Providers
- WA Department of Health
- WA HealthPathways Users (GPs practicing in WA; other registered clinicians and some non-clinicians (approved case by case))
- Other PHN regions across Australia

The PHN promotes WA HealthPathways to specific audiences at conferences (e.g., Rural Health West Conference), through internally and externally produced written communications and articles (e.g., WAPHA publications GP Connect and Practice Connect; Medical Journal of Australia; Medical Forum).

The PHN delivers education and training to those working in general practice (and other clinicians) to:

- Provide an overview of the WA HealthPathways platform and maximise user experience.
- Launch new and newly reviewed HealthPathways in conjunction with other PHN initiatives and in collaboration with SMEs, HSPs and peak bodies (e.g., Dementia Care in General Practice, Eating Disorders event, Transgender health and gender diversity webinar series).

Collaboration

Developing relationships and collaborating with key stakeholders including peak bodies and provider organisations improves coordination, integration, and continuity of care at the aged care, health, primary care interfaces.

Key stakeholders, in addition to those listed above, include:

- Royal Australian College of General Practitioners
- Subject Matter Experts (SMEs) Including hospital clinicians, non-GP medical specialists, allied health practitioners, nurses etc.)
- Consumer representatives, GPs, Peak Bodies (e.g., Diabetes WA, Australasian Society of Clinical Immunology and Allergy (ASCIA)) to:
    - Inform clinical and referral pathways
    - Provide representation and specialist expertise in working groups related to HealthPathways development and/or review
- Streamliners NZ
    - The PHN administers the WA HealthPathways platform, which is owned

by Streamliners NZ. The PHN develops and authors new clinical (and non-clinical) HealthPathways and Request (referral) pages and maintains and updates existing HealthPathways in line with the style guide provided by Streamliners. Streamliners provide technical writing and editorial services to standardise and publish the provided content to the WA HealthPathways platform

- Other stakeholders as they are identified

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Work Plan as amended and agreed by the Department, as appropriate.	100%
Total pathway views and top five most viewed pathways (clinical and referral)	100%
Total and type of education events or activities related to HealthPathways delivered to local health professionals	100%

Activity Milestones	Due Date
Multiyear Activity Work Plan and Budget	30 April 2024, 30 April 2025
Annual Needs Assessment	15 November 2024
Twelve-month performance report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025

Coverage

Perth North PHN

Activity Start Date	Activity End Date
1 July 2022	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
HealthPathways	$230,887.80	$285,939.24	$0.00

CF 2011 – Aged Care Clinical Referral Pathways

Activity Title

Aged Care Clinical Referral Pathways

Activity Number

2011

Activity Status

Modified

PHN Program Key Priority Area

Aged Care

Aim of Activity

In response to the Royal Commission into Aged Care Quality and Safety, Primary Health Networks (PHNs) have been funded to undertake clinical referral pathways activities specific to aged care, including:

- Developing, enhancing, and maintaining clinical referral pathways (HealthPathways) content specific to aged care and the PHN region.
- Enhancing linkages between primary health care services, other providers, and relevant services.
- Improving the patient journey and health outcomes.
- Increasing clinician capabilities and the quality of care provided.

Within the Perth North PHN (PNPHN), the activity aims to:

- Develop, review, enhance and maintain aged care related HealthPathways.
- Maintain the license for the HealthPathways software and technical writing services provided by Streamliners NZ.
- Increase the awareness of, engagement with, and utilisation of aged care related HealthPathways by primary care practitioners in the region.
- Increase awareness of and promote current best practice care for older adults.
- Enhance clinician awareness of and access to local referral options and services.
- Improve collaboration and integration across health care and other systems.

Description of Activity

Background

Clinical and referral pathways are developed, reviewed, and enhanced, as appropriate to meet the health needs of the PHN. Pathways are for use by clinicians during consultation with patients, supporting patient assessment and management, and referral to local services and supports.

Nineteen older adult and sis Dementia pathways are live and localised for WA and the PNPHN region. One pathway was localised, and six pathways were reviewed in 2022.

Eleven pathways were reviewed in 2023 (two pathways were reviewed and merged into another pathway and the two standalone pathways were decommissioned). The review of the remaining seven pathways is planned for completion by 30 June 2025. In late 2023 there were 320 general practices and four Aboriginal Community Controlled Health Service (ACCHS) sites in the PHN region.

Rationale

Today's Western Australians aged 65 and over are generally living longer and healthier lives than previous generations, and the population of older people is growing. Age is an important determinant of health and people aged 65 years and over are more likely to have complex and/or chronic conditions as well as comorbidities. Moreover, geriatric syndromes later in life (usually after the age of 85 years) including pressure ulcers, incontinence, falls, and delirium have substantial implications for quality of life as well as health care utilisation.

In 2021, there were over 170,000 people aged 65 years and over in Perth North PHN, representing about 16% of its population, similar to the state rate (Australian Bureau of Statistics, 2021a). This population is expected to increase by approximately 36% to 218,258 in 2030.

Roles and responsibilities

WAPHA's Clinical Insights Team within the Primary Care Innovation and Development Portfolio, which works across the three WA PHNs, is responsible for the delivery of the Aged Care Clinical Referral Pathways initiative. An executive sub-committee oversees all PNPHN aged care activity including the Aged Care Clinical Referral Pathways initiative to ensure it aligns with funding requirements, guidance, and WAPHA's Strategic Plan 2023-2026.

In addition to demonstration and education sessions led by the Clinical Insights Team, place-based integration managers and practice navigation and quality improvement teams also promote the use of the HealthPathways with general practice and relevant ACCHS staff. A program logic guides the initiative.

Key activities

This activity will:

- Increase the awareness of, engagement with, and utilisation of aged care related HealthPathways by primary care practitioners in the region.
- Increase awareness of and promote current best practice for the care of older adults.
- Enhance clinician awareness of and access to local referral options and services.
- Improve collaboration and integration across health care and other systems.

Clinical and referral pathways development, enhancement, review, and maintenance will include the following activities:

- Consultation with subject matter experts, peak bodies, and clinicians.
- Mapping and documenting local support and referral services for the target population.
- Engaging with Streamliners NZ (who provide technical writing and editorial services) to publish pathway content.
- Monitoring, reviewing, and improving existing clinical and referral pathways, ensuring currency, accuracy, and consistency with best practice.
- Identification of any information gaps in the clinical and referral Pathways library and consideration of new pathway development or incorporation of information into existing pathway/s as required.
- Identification of relevant resources to include in the pathways for GPs and health professionals to share with patients.
- Promoting newly published and/or reviewed pathways to other health professionals, in addition to delivering demonstrations and education to support the uptake of clinical and referral pathways.
- Maintaining the license of the HealthPathways software and technical writing services provided by Streamliners NZ.

Perth North PHN Needs Assessment

Priorities	**Page reference**
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11
Promote early intervention and monitoring activities to support older adults to live at home and reduce early entry into residential care. (Metro)	41
Improve the management of chronic conditions for ageing populations and promote healthy ageing at home. (Metro)	41

Target Population Cohort

The activities will focus primarily on general practitioners, in addition to other health professionals including primary care clinicians and allied health professionals.

Consultation

Consultation has and will continue to occur with the following key stakeholders:

- General practitioners and other primary health professionals.
- Consumer representatives or people with lived experience (if applicable to the topic) limited

- Health Service Providers
- WA Department of Health
- WA HealthPathways users via HealthPathways feedback mechanisms.
- Other PHN regions across Australia.

PHN promotes WA HealthPathways to specific audiences at conferences (e.g., Rural Health West Conference) and through internally and externally produced written communications and articles (e.g., WAPHA publications GP Connect and Practice Connect; Medical Journal of Australia; Medical Forum).

The PHN delivers education and training to those working in general practice (and other clinicians) to:

- Provide an overview of the WA HealthPathways platform and its use.
- Launch new and newly reviewed HealthPathways, in conjunction with other PHN initiatives and in collaboration with subject matter experts, Health Service Providers and peak bodies (e.g., Dementia Care in General Practice).

Collaboration

Developing relationships and collaborating with key aged care stakeholders including peak bodies and provider organisations improves coordination, integration, and continuity of care at the aged care, health and primary care interfaces.

Key stakeholders, in addition to those listed above include:

- Royal Australian College of General Practitioners
- Subject Matter Experts, including hospital clinicians, non-GP medical specialists, allied health practitioners, nurses, peak bodies (e.g., Diabetes WA, Trans, Gender Diverse and Non-Binary Health) to:
    - o Collaborate on clinical and referral pathways
    - o Provide representation and specialist expertise in working groups related to HealthPathways development and/or review
- Streamliners NZ
    - The PHN administers the WA HealthPathways platform, which is owned by Streamliners NZ. The PHN develops and authors new clinical (and non-clinical) HealthPathways and Request (referral) pages and maintains and updates existing HealthPathways in line with the style guide provided by Streamliners. Streamliners provide technical writing services to standardise, draft and publish the provided content to the WA HealthPathways platform
- Other stakeholders as they are identified.

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Work Plan as amended and agreed by the Department as appropriate.	100%
The PHN reports on all published aged care pathways, including when they were published or last updated whichever is the most recent).	100%
The PHN reports on the count of total page views for each of the PHNs aged care pathways.	100%

Activity Milestones	Due Date
Publication of promotional materials specific to aged care and dementia related HealthPathways including demonstrational video and brochures.	October 2023
Publication of Nutrition and Weight Management in Older Adult's clinical feature article in GP Connect in collaboration with an Accredited Practicing Dietitian.	September 2023
Seven Aged Care specific request (referral) HealthPathway reviews completed in 2023.	One outstanding for completion in 2024
Multiyear Activity Work Plan and Budget	30 April 2024, 30 April 2025
Annual Needs Assessment	15 November 2024
Twelve-month performance report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025
Final Report	30 September 2025

Coverage

Perth North PHN

Activity Start Date	Activity End Date
1 July 2022	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
HealthPathways	$61,570.08	$76,250.46	$0.00

CF 2012 – Dementia Support Pathways

Activity Title

Dementia Support Pathways

Activity Number

2012

Activity Status

Modified

PHN Program Key Priority Area

Aged Care

Aim of Activity

In response to the Royal Commission into Aged Care Quality and Safety, Primary Health Networks (PHNs) are funded to undertake clinical referral pathways activities specific to aged care and dementia.

The Dementia Clinical Referral Pathways activity will develop and enhance Western Australia's Primary Health Network's (PHNs) HealthPathways content specific to dementia; enhance linkages between primary health care services; other providers and relevant services; improve the patient journey and health outcomes; and increase practitioner capabilities and the quality of care provided in the Perth North PHN (PNPHN) region.

The activity aims to:

- Improve dementia awareness within the PHN local community, including risk reduction strategies.
- Improve dementia knowledge within the primary care workforce to support clinicians in diagnosing and referring people for diagnosis and/or providing ongoing supports at all stages of the dementia journey.
- Facilitate more timely diagnosis, including referral to diagnostic services.
- Enable earlier consumer access to post-diagnostic supports and services.
- Increase referrals from GPs to relevant post-diagnostic supports, such as Alzheimer's WA, Dementia Australia, My Aged Care, Carer Gateway, community support programs and services and allied health.
- Ensure that people with dementia, their family, and carers are supported throughout the dementia journey.
- Maintain (where possible, improve) the quality of life for people with dementia, their family, and carers.

Description of Activity

Background

Clinical and referral pathways are developed, reviewed, and enhanced as appropriate

to meet the health needs of the PHN. Pathways are for use by clinicians during consultation with patients, supporting patient assessment and management, and referral to local services and supports.

The development and review of the WA Primary Health Alliance's Dementia Clinical and Referral Pathways (HealthPathways) stream was completed on 20 December 2022. Pathways will be maintained, publishing ad hoc updates as required, until their next scheduled formal review.

In late 2023 there were 320 general practices and four Aboriginal Community Controlled Health Service (ACCHS) sites in the PNPHN region.

Rationale

In 2021, there were over 170,000 people aged 65 years and over in Perth North PHN, representing about 16% of its population, similar to the state rate (Australian Bureau of Statistics, 2021a). This population is expected to increase by approximately 36% to 218,258 in 2030.

It is estimated that in 2021, 37,963 people were living with dementia in WA, 15,640 lived in the PNPHN region. The population of people with dementia is expected to continue to grow, it is estimated that the number of people with dementia in Australia will more than double from 2022 (401,300) to 2058 (849,300).

Dementia is the second leading cause of death in Australia, and leading cause of death in women.

Early dementia diagnosis is essential in assisting people to live their best life through treatment of symptoms, early access to relevant health and support services, and planning. Evidence shows that early intervention can delay disease progression, minimise hospitalisations by coordinating care, improves the quality of life of the person living with dementia (and their carers/family) and delays entry to residential care.

Roles and responsibilities

WAPHA's Clinical Insights Team within the Primary Care Innovation and Development Portfolio, which works across the three WA PHNs, is responsible for the delivery of the Dementia Clinical Referral Pathways activity. An executive sub-committee oversees all PNPHN aged care activity including the Dementia Clinical Referral Pathways activity to ensure it aligns with funding requirements, guidance, and WAPHA's Strategic Plan 2023-2026.

In addition to demonstration and education sessions led by the Clinical Insights Team, place-based integration managers and practice navigation and quality improvement

teams also promote the use of the HealthPathways with general practice and relevant ACCHS staff. A program logic guides the initiative.

Key activities
From 2024 onwards PNPHN will:

- Maintain the clinical dementia HealthPathways until next formal review.
- Update and maintain existing referral content, as new services for dementia care are established.
- Engage with Streamliners NZ (who provide technical writing and editorial services) to maintain currency of HealthPathways content.
- Continue to promote and increase the awareness of, engagement with, and utilisation of dementia HealthPathways and relevant consumer resources by local health care practitioners.
- Continue to work with Dementia Australia and Alzheimer's WA to ensure HealthPathways reflect emerging best practice and appropriate services and supports within the region.
- Continue to collaborate across PHN regions in support of the development, maintenance and sharing of pathway information.

Perth North PHN Needs Assessment

Priorities	**Page reference**
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11
Support people living with dementia and their carers to navigate the aged care system and access appropriate services. (Metro)	41
Promote early intervention and monitoring activities to support older adults to live at home and reduce early entry into residential care. (Metro)	41
Improve the management of chronic conditions for ageing populations and promote healthy ageing at home. (Metro)	41

Target Population Cohort

The activities will focus primarily on general practitioners, in addition to local primary care clinicians and allied health professionals.

Consultation

Consultation from 2024 onwards will occur with the following key stakeholders (as required):

- General practitioners and other health professionals

- Dementia Australia
- Dementia Australia WA
- Older Adults Health Network
- Alzheimer's WA
- Health Service Providers
- WA Department of Health
- WA HealthPathways users via HealthPathways feedback mechanisms
- Other PHN regions across Australia.

The PHN promotes WA HealthPathways to specific audiences at conferences (e.g., Rural Health West Conference) and through internally and externally produced written communications and articles (e.g., WAPHA publications GP Connect and Practice Connect; Medical Journal of Australia; Medical Forum).

The PHN delivers education and training to those working in general practice (and other clinicians) to:

- Provide an overview of the WA HealthPathways platform and its use.
- Launch new and newly reviewed HealthPathways, in conjunction with other PHN initiatives and in collaboration with subject matter experts, Health Service Providers and peak bodies (e.g., Dementia Care in General Practice).

Collaboration

Developing relationships and collaborating with key aged care stakeholders including peak bodies and provider organisations improves coordination, integration, and continuity of care at the aged care, health, primary care interfaces.

Key stakeholders, in addition to those listed above include:

- Royal Australian College of General Practitioners
- Subject Matter Experts, including hospital clinicians, non-GP medical specialists, allied health practitioners, nurses etc.), Consumer representatives, other peak bodies (e.g., Dementia Support Australia) to:
    - Collaborate on clinical and referral pathways
    - Provide representation and specialist expertise in working groups related to HealthPathways development and/or review
- Streamliners NZ - The PHN administers the WA HealthPathways platform, which is owned by Streamliners NZ. The PHN develops and authors new clinical (and non-clinical) HealthPathways and Request (referral) pages and maintains and updates existing HealthPathways in line with the style guide provided by Streamliners. Streamliners provide technical writing services to standardise, draft and publish the provided content to the WA HealthPathways platform
- Other stakeholders as they are identified.

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Work Plan as amended and agreed by the Department as appropriate.	100%
The PHN reports on consultation activities to inform development and/or enhancement of dementia Clinical Referral Pathways.	100%
The PHN reports on educational activities undertaken to support the uptake of dementia Clinical Referral Pathways.	100%
The PHN reports on the count of total page views (and increase in views) for each of the PHNs dementia pathways.	100%

Activity Milestones	Due Date
Publication of promotional materials specific to dementia related HealthPathways including demonstration video and brochures	October 2023
Multiyear Activity Work Plan and Budget	30 April 2024, 30 April 2025
Annual Needs Assessment	15 November 2024
Twelve-month performance report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025

Coverage

Perth North PHN

Activity Start Date	Activity End Date
1 July 2022	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
HealthPathways	$15,392.52	$19,062.62	$0.00

CF 2020 – Dementia Consumer Pathway Resource

Activity Title

Dementia Consumer Pathway Resources

Activity Number

2020

Activity Status

Modified

PHN Program Key Priority Area

Aged Care

Aim of Activity

In response to the Royal Commission into Aged Care Quality and Safety, Primary Health Networks (PHNs) are funded to undertake a range of activities specific to aged care. This includes the development of Aged Care and Dementia Clinical Referral Pathways and the development and maintenance of dementia consumer resources.

This Activity Work Plan describes Perth North Primary Health Network's (PNPHN) approach to delivering the Dementia Consumer Resource activity.

The aim of the Dementia Consumer Resource activity is to enhance the ongoing care and support to people living with dementia, their carers and families to support them to plan ahead and better navigate living with dementia, ultimately to support people living with dementia to live well in the community for as long as possible.

The PNPHN will develop and maintain consumer focused dementia resources which detail the post-diagnostic care and support available for people living with dementia, their carers, and families, including local, state, and federal government, private sector, and community-driven support, in the PHN region.

This activity will be undertaken with input from Dementia Australia to ensure the Dementia Consumer Resources are both nationally consistent at a high level and reflective of individual services and supports within individual PHN regions.

Description of Activity

Background

In partnership with My Community Directory, WA Primary Health Alliance established the Dementia Community Services and Support Finder for the three WA PHNs. This resource informed by a targeted engagement process and tailored for individual regions, was published on 18 December 2022.
This activity was informed by consultation with local primary care clinicians, allied

health, aged care providers and consumers to determine the current gaps and opportunities in the model of care for people living with dementia with further consultation and promotion of the resource during 2023/24.

In March 2024, the Dementia support and services related information hosted by My Community Directory was moved to a WA Primary Health Alliance (WAPHA) Dementia consumer resources webpage. National, state, and local resources and service links continue to be available.

Rationale

In 2021, there were over 170,000 people aged 65 years and over in PNPHN, representing about 16% of its population, similar to the state rate (Australian Bureau of Statistics, 2021a). This population is expected to increase by approximately 36% to 218,258 in 2030.

The Australian Institute of Health and Welfare reports:

- the rate of dementia rises quickly with age – from less than 1 person with dementia per 1,000 Australians aged under 60, to 71 per 1,000 Australians aged 75–79, and then to 429 per 1,000 Australians aged 90 and over.
- approximately 67% of people with dementia live in the community.

It is estimated that in 2021, 37,963 people were living with dementia in WA, 15,640 lived in the PNPHN region and around 60% were female. The population of people with dementia is expected to continue to grow, it is estimated that the number of people with dementia in Australia will more than double from 2022 (401,300) to 2058 (849,300).

Carers of people with dementia have consistently reported not knowing where to get assistance or what is the next practical step following a dementia diagnosis.

Roles and Responsibilities

WAPHA's Primary Care Innovation and Development Portfolio, which works across the three WA PHNs, is responsible for the delivery of the Dementia Consumer resources via delegated activity leads. An executive sub-committee oversees all CWAPHN aged care activity including the Dementia Consumer resources activity to ensure it aligns with funding requirements, guidance, and WAPHA's Strategic Plan 2023-2026.

Place-based regional integration managers and practice navigation and quality improvement teams promote the use of Dementia Consumer resources with clinicians and their local networks. A program logic guides the initiative.

Key activities

From 2024 onwards PNPHN will:

- Evaluate, maintain and where necessary improve / update relevant consumer resources.
- Monitor the use of the webpage.
- Continue to promote and increase the awareness, engagement, and utilisation of dementia relevant consumer resources by local health care practitioners.
- Continue to promote the resource to people living in the PHN region and relevant forums.
- Continue to work with Dementia Australia and other PHNs to ensure:
    - Resources are updated in a nationally consistent manner, and
    - Access to Dementia Australia resources, via the WAPHA Dementia consumer resources webpage.
- Continue to collaborate across PHN regions in sharing of consumer resource information.

Perth North PHN Needs Assessment

Priorities	**Page reference**
Support people living with dementia and their carers to navigate the aged care system and access appropriate services. (Metro)	41
Improve the management of chronic conditions for ageing populations and promote healthy ageing at home. (Metro)	41

Target Population Cohort

The activities will focus on:

- general practitioners, local primary care clinicians and allied health professionals.
- people seeking advice about Dementia and the resources and services that are available to assist them.

Consultation

Consultation has occurred with and will continue to occur with the following key stakeholders (as required):

- Consumer representatives
- Carers Australia
- General practitioners and other health professionals
- Dementia Australia
- Dementia Australia WA
- Older Adults Health Network
- Alzheimer's WA
- Health Service Providers

- WA Department of Health
- Other PHN regions across Australia
- Linkwest
- The Dementia Community Resources are promoted at relevant forums and via social media

Collaboration

Developing relationships and collaborating with key aged care stakeholders including peak bodies and provider organisations improves coordination, integration, and continuity of care at the aged care, health, primary care interfaces.

Collaboration has and will continue to occur (as relevant) with:

- My Community Directory
- Dementia Australia
- Dementia Australia (WA)
- Alzheimer's WA
- Other stakeholders providing relevant services

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Work Plan as amended and agreed by the Department as appropriate.	100%
The PHN reports on consultation activity to inform development and/or enhancement of dementia Clinical Referral Pathways.	100%
The PHN reports on information on education activity to support the use of dementia Clinical Referral Pathways.	100%
The PHN reports on the count of total page views (and increase in views) for each of the PHNs dementia pathways.	100%

Activity Milestones	Due Date
Multiyear Activity Work Plan and Budget	30 April 2024, 30 April 2025
Annual Needs Assessment	15 November 2024
Twelve-month performance report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025
Final Report	30 September 2025

Coverage

Perth North PHN

Activity Start Date	Activity End Date
1 July 2022	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
Dementia Consumer Pathway Resource	$10,258.06	$5,032.26	$0.00

CF 4000 – Healthy Weight

Activity Title

Healthy Weight

Activity Number

4000

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

To build knowledge, skills and confidence of primary healthcare professionals in the early detection and primary care interventions to prevent chronic disease. This will be achieved through a targeted strategy to improve how overweight, and obesity are identified and addressed with patients through early intervention and management in general practice.

Early intervention and management pathways for overweight and obesity have been developed to support general practitioners and other primary health care professionals and their patients, with innovative, scalable, and sustainable approaches, programs, and tools for weight management.

Primary healthcare practitioners are encouraged to identify, engage, and regularly communicate with members of the multidisciplinary team to provide coordinated support for their patients with weight related health concerns. This includes dietitians, practice nurses, exercise physiologists and psychologists as well as evidence based and accessible healthy lifestyle programs.

The project encourages primary healthcare professionals to take a sensitive and supportive approach, free from weight stigma when communicating with patients about weight. WA Primary Health Alliance will focus on creating sustainable behaviour change for general practitioners, other practice staff and allied health professionals and patients.

This work aligns to the WA Healthy Weight Action Plan 2019-2024 in partnership with WA Department of Health and the Health Consumers' Council WA, from a primary care perspective.

Description of Activity

The overweight and obesity management strategy in general practice includes the following strategies and actions:

1. The provision of evidence-based tools for the management of weight and prevention of obesity for general practice, including:
    - Surveys conducted with general practitioners, practice nurses and allied health professionals working in general practice regarding gaps, barriers, and opportunities for better management of overweight and obesity in general practice.
    - Development of a practice toolkit for general practitioners including synthesis and applicability of current guidelines.
    - Implementation of a general practitioners led, evidence-based weight management program (e.g., ANU Change program which is available free to Primary Health Networks (PHN) for use within general practices).
    - The use of Chronic Disease Management Plans via MBS for people with complex obesity, where clinically appropriate.
    - General practitioners and General Practitioner Registrar education regarding prevention, identification, and guidance of support options for people living with obesity. Awareness of the impact of weight bias, stigma and inequity is also addressed, and information is provided on how to reduce this in practice.
    - The use of PDSA (Plan, Do, Study, Act) cycles of continuous quality improvement (coaching and support from WA Primary Health Alliance practice support staff).
2. The provision of information and advice on referral pathways in general practice. including:
    - Up-to-date information on local programs and services for general practices.
    - Further development and promotion of HealthPathways, referral and management pathways for weight management for adults, childhood obesity and bariatric surgery.
3. General practice support includes:
    - Information on new eating disorder MBS item numbers.
    - Training in difficult conversations – scripting and support for general practitioners using the Australian National Health Service and WA Health resources.
    - Assistance with uptake of MBS items that can assist in weight management and obesity.
    - General practitioner training event (informative and academic), focused on general practice continuous professional development (CPD) streams on sensitive conversations, empowering behaviour change, reducing

weight stigma and care management including multidisciplinary team care.

4. WA Healthy Weight Action Plan 2019-2024
    - Provision of funding support for the ongoing implementation of WA Healthy Weight Action Plan (WAHWAP) activities.
    - In alignment with Strategy 1 of the WAHWAP, ensure the successful operation of The Weight Education and Lifestyle Leadership (WELL) Collaborative through enabling a dedicated project coordination and secretariat function, which aims to allow integrated, coordinated overweight and obesity associated planning and action across WA.

The PHN recognises the impact COVID-19 had on the community, primary health care and commissioned service activity. With services having returned, monitoring and service impact assessment will continue, to ensure the PHN continues to meet the aims of the activity and the needs of the priority target groups.

Perth North PHN Needs Assessment

Priorities	**Page reference**
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.	14
Support Primary Health Care providers to implement effective health interventions for those living with overweight and obesity.	14

Target Population Cohort

WA Primary Healthcare Professionals (GPs, practice nurses, allied health professionals and general practice staff), who work with patients with weight related health issues and chronic conditions.

Stage 2 of the project will involve the development of resources to add to the existing SHAPE website to assist healthcare professionals to support Aboriginal patients. This activity includes consultation with Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Healthcare workforce and general practices. Collaboration with Diabetes WA for the development of educational videos to support general practice in addressing weight management in Aboriginal populations across WA.

Consultation

Phase 1 of the project consulted general practice clinicians, such as GPs, practice nurses, dietitians, and exercise physiologists to understand the barriers to weight management in general practice. The results of this consultation indicated that

clinicians would benefit from evidence-based tools and resources in one accessible location.
The project convened a clinical content working group to contribute to guiding development of the clinical content and formulation of messaging for the branding campaign. The working group comprised of general practitioners, a psychologist, dietitians, the WA Department of Health and the Health Consumers' Council. Stages 2 and 3 of the project includes the addition of material to support healthcare professionals to assist Aboriginal patients, people experiencing food insecurity and children with higher weight and their families. Consultation with a variety of stakeholders has been completed, to inform Stage 2 deliverables. Consultation for Stage 3 will commence in July 2024.

Development and maintenance of relationships with key stakeholders in the planning and delivery of the healthy weight related initiatives, has been ongoing throughout the duration of the project, including, but not limited to:

- WA Department of Health
- WA Health Consumers' Council
- Health Service Providers (i.e. East Metropolitan Health Service)
- WA General Practices
- Royal Australian College of General Practitioners WA
- Cancer Council WA
- Aboriginal Community Controlled Health Organisations
- Curtin University
- WA Centre for Rural Health
- Diabetes WA

Collaboration

Stakeholders with direct involvement in the design and implementation of the project deliverables include, but are not limited to:

- WA Department of Health
- WA Health Consumers' Council
- Health Service Providers (i.e., East Metropolitan Health Service)
- WA General Practices
- Royal Australian College of General Practitioners WA
- Diabetes WA
- Cancer Council WA
- Aboriginal Community Controlled Health Organisations
- Curtin University
- Benchmarque Group RTO

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Work Plan as amended and agreed by the Department as appropriate.	100%

Target Population Cohort

WA Primary Healthcare Professionals (GPs, practice nurses, allied health professionals and general practice staff), who work with patients with weight related health issues and chronic conditions.

Stage 2 of the project will involve the development of resources to add to the existing SHAPE website to assist healthcare professionals to support Aboriginal patients. This activity includes consultation with Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Healthcare workforce and general practices. Collaboration with Diabetes WA for the development of educational videos to support general practice in addressing weight management in Aboriginal populations across WA.

Activity Milestones	Due Date
Multiyear Activity Work Plan and Budget	30 April 2024, 30 April 2025
Annual Needs Assessment	15 November 2024
Twelve-month performance report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025
Final Report	30 September 2025
Stage 1 – Build infrastructure and develop resources (SHAPE website; launched in August 2022) to assist health care professionals to support patients aged 18-65 years with concerns related to weight and health. This stage is complete and supplementary activities are underway to promote SHAPE and these resources within primary health care and general practices.	
Stage 2 – Develop and add resources to the existing website to assist health care professionals to support patients living in Western Australia who identify as Aboriginal and Torres Strait Islander has continued through to June 2024. (Sept 2022 – July 2024).	
Stage 3 – Add resources to existing website to assist health care professionals to support children and families living in Western Australia (July 2024 – June 2025).	

Coverage

Perth North PHN

Activity Start Date	Activity End Date
1 July 2019	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
Core Flexible	$57,427.00	$57,427.00	$0.00

CF 5000 – Strengthening General Practice; Comprehensive Primary Care

Activity Title

Strengthening General Practice; Comprehensive Primary Care

Activity Number

5000

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

The *Strengthening General Practice in WA; Comprehensive Primary Care (Strengthening General Practice)* activity aims to strengthen and improve the primary care response and access to general practice using the foundations of the Comprehensive Primary care (CPC) program aligned with the Quintuple Aim for Healthcare Improvement and the Bodenheimer Building Blocks for high performing primary care. The activities delivered will utilise data driven quality improvements with a focus on enhanced leadership and team-based care which is:

- Patient centred – shared decision making that respects personal goals and provides support to patients to self-manage.
- Skilled, integrated and multi-disciplinary, where teams work to the top of their scope, in partnership with patients.
- Data informed, with embedded continuous quality improvement and best practice decision making to improve population health and access to care.
- Integrated wherever possible with allied health and the public and private hospital sector; Improved models of care and customer service encourage patient loyalty to their general practitioner and the practice maximising their care outcomes.
- Sustainable, utilising business models which are adaptable to changes in the health system and patient needs.

This activity complements the existing practice support offered through the Primary Health Network (PHN) Core Operational funding stream activities for HSI 1010 – Health General Practice Support.

Description of Activity

Background

In 2018 the Australian Government funded PHN's to support general practice staff and clinicians to provide high quality care for patients, particularly those at risk of poor health outcomes. Perth North PHN provided support through a variety of modalities including a practice assist helpdesk, practice visits from Primary Health Liaison staff and access to subject matter experts on a range of topics, with the aim of building capability and capacity within general practice. The ongoing Commonwealth funding to support general practice has seen activities becoming iterative in nature, adapting to the maturation of general practices, and in response to the changing Australian primary health environment.

The Australian Primary Health Care 10 Year Plan 2022-2032 and the Strengthening Medicare Taskforce Report (2022) have both informed how WA Primary Health Alliance (WAPHA) continues to support general practices, with a focus on the ability of practices to adapt and respond to current and emerging health policy and reform in an effective and sustainable manner, that aligns with the Quintuple Aim.

Key Activities:
The *Strengthening General Practice* funding enables WAPHA to continue to deliver and expand Comprehensive Primary Care and Enhanced practice support initiatives within the Perth North PHN.

Utilising the Bodenheimer model *10 Building Blocks of high performing primary care* to provide targeted, efficient activities, general practices will be supported to:

- Lead and develop practice teams to successfully undertake an evidence based and staged process of practice transformation using QI processes.
- Improve continuity of care with allied health, tertiary and secondary services through integrated models of multidisciplinary team-based care, data sharing, integrated care plans and specialist in-reach programs.
- Have an opportunity to influence, co-design and trial general practitioner-led models of care and incorporate existing local services that:
  - are integrated, local and supported by a multi-disciplinary team.
  - are tailored to meet the needs of individual practices and patients.
  - build on existing and/or introduce new and innovative models of care that reflect national and international best practice.
  - are scalable, sustainable, and adaptive to future changes.
  - improve continuity and coordination of care to improve health and social outcomes for patients.
  - build practices' capacity and capability to deliver responsive patient-centred care, which empowers patients to take an active role in the management of their own health.
- Facilitate networking opportunities, both formal and informal, to encourage knowledge sharing, professional development, problem solving and collegiality.

Perth North PHN Needs Assessment

Priorities	Page reference
Reduce non-urgent emergency department attendances and improve access to alternative services. (Metro)	12
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11

Target Population Cohort

Primary health provider organisations (including private general practice, ACCHO's, AMS's, allied health entities) located in Perth North PHN, and the primary healthcare professionals engaged within these organisations.
Organisations located in geographical areas with a large proportion of vulnerable population groups or areas of high need will be prioritised.

The Aboriginal population are not specifically targeted within this activity, however primary health providers who service a high percentage of Aboriginal people or other vulnerable populations will be prioritised.

Consultation

- Previous Naïve Enquiry with Primary Care workforce
- Consultation with Health Service Provider
- Consultation with GP Advisory Group

Collaboration

- Private general practices, Aboriginal Medical Services
- General practitioners
- Practice Managers
- Practice Nurses
- Allied Health providers
- Pharmacists
- Data Officers – administrators
- Regional Integration Managers
- Health Service Provider - Director Community Engagement

Activity Key Performance Indicators

Performance Indicator Description
Data driven improvements using Primary Sense.
Quality improvement activities including PDSAs using the Bodenheimer Building Blocks as foundation.
Navigation of practices to appropriate resources.
Improved use of digital health.
Achievement of the Quintuple Aim – patient satisfaction, improved patient outcomes, improved worker satisfaction, sustainability of services and improved health access and equity.
Improvement in Performance Quality Framework indicators.

Activity Milestones	Due Date
Activity Work Plan and Budget	30 April 2024, 30 April 2025
Twelve Month Performance Report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025
Needs Assessment	15 November 2024
Final Report	30 September 2025
Implementation of Primary Sense – by June 2023	
Embedding of QI processes for chronic conditions	
Contemporary Medicare Reform communications (at least fortnightly as per Commonwealth communications)	
Improved rates for PIP QI measures	
Increased use of digital health systems	

Coverage

Perth North PHN

Activity Start Date	Activity End Date
1 July 2018	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
Core Flexible	$191,410.38	$238,385.84	$0.00

CF 5050 – PHN Collaborative Data and Analytics Centre of Excellence

Activity Title

PHN Collaborative Data and Analytics Centre of Excellence

Activity Number

5050

Activity Status

Modified

PHN Program Key Priority Area

Digital Health

Aim of Activity

The aim of this activity is to:

- Bolster the primary care data analytics capability across all Primary Health Networks (PHN) by establishing centralised data and analytics quality and management standards and frameworks.
- Build on the existing investment in Primary Health Insights and enhance PHNs' ability to leverage the platform to deliver consistent and collaborative analytics and reports.
- Enhance PHNs' ability to generate insights, deliver national policy agendas, and plan and evaluate value-based care initiatives locally, regionally and nationally.

Description of Activity

Funded Activity Scope

WA Primary Health Alliance, as Lead PHN for Primary Health Insights, will:

- Research and maintain knowledge of current and future technology trends that support data quality, security, management and analytics.
- Develop data and analytics models on service utilisation, activity modelling and other aspects of PHN services which inform government decisions about resource allocation.
- Develop uniform data and reporting standards and frameworks for PHNs' performance reporting and analysis which then enables bench marking across the network.
- Lead communities of practice across PHNs and enable peer collaboration on analysing primary healthcare data which supports the sharing and update of health care innovations and improvements across the network.
- Managed and delivered within the Primary Health Insights Services team, a

detailed Work Plan that identifies and prioritises key needs, gaps and opportunities in PHN data and analytics will be developed and maintained. This detailed Work Plan will be approved by a Steering Committee with a Departmental delegate as a decision maker, while operational governance and oversight will be incorporated into the existing PHI governance structure.

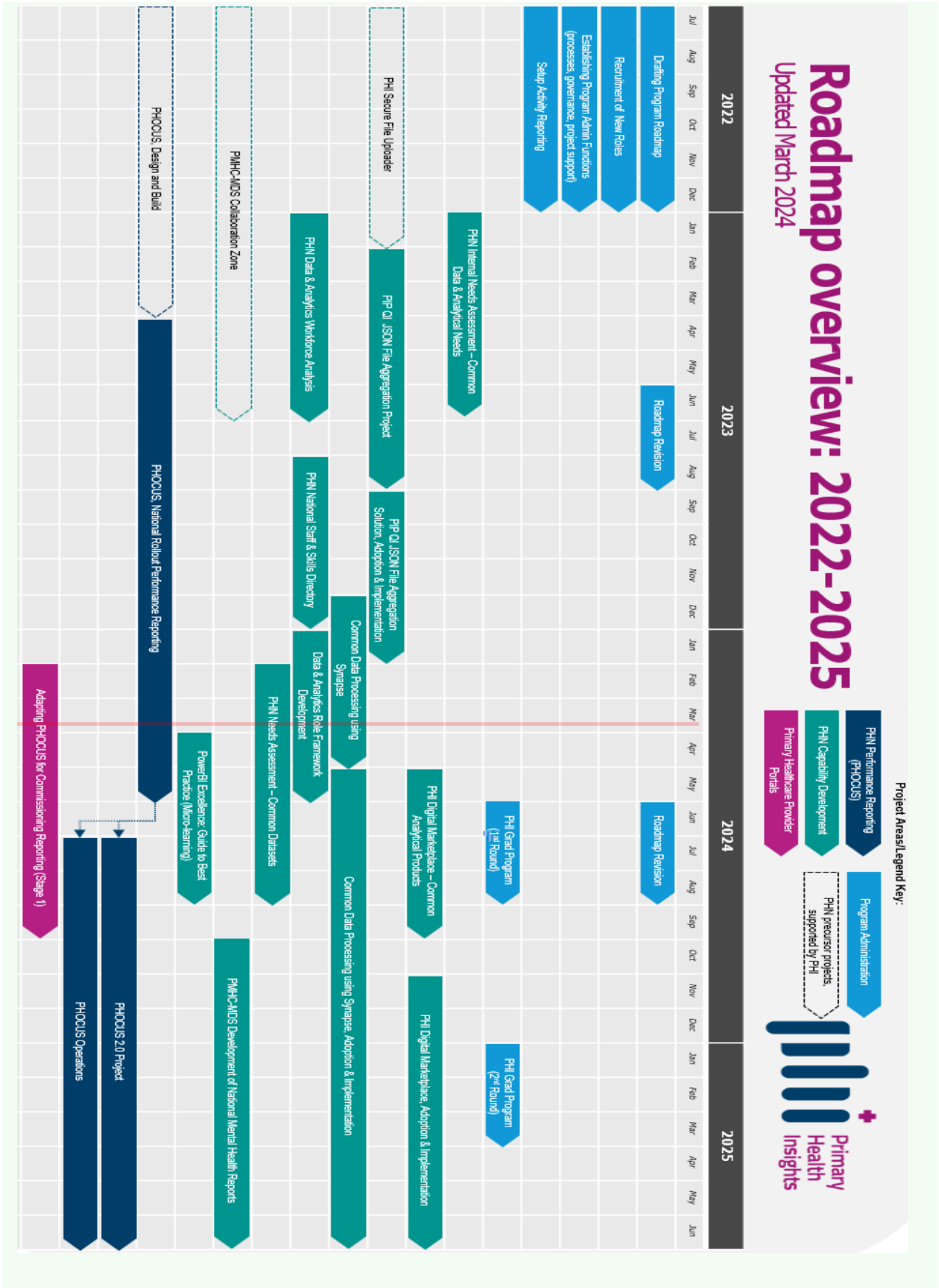
WAPHA will work collaboratively with other PHNs to resource and staff individual projects and activities within the detailed Work Plan, as a way of ensuring that any increased capability or capacity generated through upskilling and knowledge acquisition remains within the network.

The following outputs are expected to be delivered as an outcome of this activity:

- New or improved tools and systems within PHI that enable more, easier and quicker collaboration among PHN data and analytics staff.
- Standard data models for common sources or types of data (e.g., GP data, aged care data) that can be created and used by and across PHNs independent of the source systems or technologies used.
- Standard algorithms and analytics processes for common business needs that can be easily adopted and adapted by and across PHNs.
- Standard reporting and visualisation formats and templates for common requirements that enable data consumers (e.g., the Department of Health and Aged Care) to more quickly, easily and accurately aggregate data provided by PHNs at regional and national levels.
- Increased data and analytics capability and capacity within all PHNs through reduced effort required to deliver common requirements, increased skills and process maturity, and a greater ability for PHNs to resource and process sharing across PHNs.

Governance Update:
In 2023, this work was formalised as the DataLeap Program, and began reporting through to the Primary Health Transformation Coordination Committee (PHTCC) and its sub-group, the Insights Steering Committee, to ensure that the national work being undertaken through this Program was properly coordinated against other nationally funded activities. This is in addition to reporting to the Centre of Excellence Steering Committee chaired by the Department.

Work Plan Update
The Program Roadmap has been updated to reflect the latest work approved and planned work:


Roadmap overview: 2022-2025
Updated March 2024
Project Areas/Legend Key:
PHN Performance Reporting (PHOCUS)
PHN Capability Development
Primary Healthcare Provider Portals
Program Administration
PHN precursor projects, supported by PHI
Primary Health Insights
2022
2023
2024
2025
Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
Drafting Program Roadmap
Recruitment of New Roles
Establishing Program Admin Functions (processes, governance, project support)
Setup Activity Reporting
Roadmap Revision
Roadmap Revision
PHI Secure File Uploader
PHN Internal Needs Assessment – Common Data & Analytical Needs
PIP QI JSON File Aggregation Project
PIP QI JSON File Aggregation Solution, Adoption & Implementation
PHI Grad Program (1st Round)
PHI Grad Program (2nd Round)
PHN Data & Analytics Workforce Analysis
PHN National Staff & Skills Directory
Common Data Processing using Synapse
Data & Analytics Role Framework Development
PHI Digital Marketplace – Common Analytical Products
PHI Digital Marketplace, Adoption & Implementation
PHN Needs Assessment – Common Datasets
Common Data Processing using Synapse, Adoption & Implementation
PHN-MDS Collaboration Zone
PowerBI Excellence: Guide to Best Practice (Micro-learning)
PHN-MDS Development of National Mental Health Reports
PHOCUS, Design and Build
PHOCUS, National Rollout Performance Reporting
Adapting PHOCUS for Commissioning Reporting (Stage 1)
PHOCUS 2.0 Project
PHOCUS Operations

Project / Activity	Description
PHN Common Data & Analytics Needs Analysis / Common Data Needs Analysis	Extensively engage with PHNs to undertake the first-ever comprehensive collection and analysis of current data & analytics tasks and gaps. The desired outcomes include a prioritised list of data & analytics tasks that are similar enough across all PHNs to easily be replaced with various common standardised processes. Status: • Initial consultation complete. A prioritised list of work was developed through extensive consultation with PHNs, which informed the remainder of the Roadmap. • A second round of consultation relating to common data sets used by all PHNs commenced in early 2024 and will target updating or obtaining datasets used by all or most PHNs as a single process (rather than by each PHN). Data sets used for the PHN Needs Assessments are being prioritised.
Primary Care GP common data model, design and build / Primary Care GP common reporting & analytics	There are currently up to 31 different ways in which PHNs process general practice data for analysis and reporting. Many PHNs may be reporting on the same metrics or reporting to the same standards (PIP QI, RACGP 5th standard for accreditation) but in different ways. The intended outcome of this project is a single data model that can be populated by PHNs using any GP data source or extraction tool, and then used as a common basis for developing further standardised analytics scripts or reports. Status: Cancelled before commencement due to duplication of work being undertaken by Western Sydney PHN (WentWest) under their Centre of Excellence funded Digital Intelligence Capability Program.
PHMC-MDS Collaboration Zone	Currently there is no standardised process for storing, analysing and reporting on the PMHC-MDS data across PHNs. This project leverages the first PHI Collaboration Zone for the pooling and analysis of Primary Mental Health Care Minimum Data Set (PMHC-MDS) data from up to 12 PHNs to identify and standardise ways to generate improved insights when PHNs can share non-aggregated data, and develop standard data models, analytics scripts and report templates to facilitate this. Status: Commenced and underway

	• The PHN Mental Health Data Collaborative is currently supported by 19 PHNs, 12 of which have already provided data. • The project has developed standard analytics code run across the data, feeding into a national Power BI dashboard that allows PHNs to see and compare their results across program areas. • Several new insights have been generated from the dataset, which are being investigated to determine their usefulness to program planning and evaluation, among other uses.
PHN Data & Analytics Workforce Analysis	PHNs have varying degrees of data & analytical skillsets and team structures. There is a growing need to align staff skillsets and knowledge with PHI technology. As PHI continues to grow and expand, the skillsets and knowledge of PHNs should also grow with it. PHNs require some direction as to what the future workforce would look like to inform recruitment and professional development, and to enable PHNs to better identify and share these skills with each other. This project will develop role-based learning and development pathways, recommended minimum skill sets against common data & analytics role types, and a national PHN staff and skills directory. Status: Commenced and underway • 19 PHNs participated in detailed consultation, which has led to the development of the National Staff and Skills Directory. Final work is underway on the visualisation to make this accessible, and finalising the processes to ensure the data is sustainably kept up to date. • A series of Position Description templates for a range of data and analytics roles (e.g. data engineer, data analyst, etc.) have been drafted and are undergoing final review before publishing. • Targeted, peer-driven learning modules are also being developed to help PHN data & analytics staff improve their skills and capabilities in using modern tools. The "Power BI Excellence" micro-learning module has been commenced and is due to be made available to PHNs by the end of June 2024.
Develop PHMC-MDS National	Using the newly developed common PHMC-MDS data model this project aims to support PHNs to develop a new "national report

Mental Health Report	card" based on this data and do so in a way that will establish process, policy and agreement standards that can be leveraged by future projects to develop similar national-level reports based on other PHN priority service delivery areas. Status: Originally scheduled to commence in mid-FY24, this work has been deferred to start in Q2 of FY25.
PHN Performance Reporting (PHOCUS)	The current process undertaken by PHNs to collect and report on performance data to the Department of Health and Aged Care through PPERS as part of the AWP process is manual, cumbersome, and does not enable the Department of Health and Aged Care to do any useful analytics, comparisons or reporting. This project will deliver a new national platform to collect, collate, approve, submit and report on statistical performance data from all PHNs for the Department of Health and Aged Care, as well as work with PHNs and the Department to expand the metric set to be reported and simplify and improve the Department's ability to access and use this information. Status: Commenced and underway • PHOCUS was delivered and operational before the targeted deadline of 30 June 2023. All 31 PHNs provided data against the initial set of performance metrics by September 2023. • PHOCUS has also been used to collect data on the rollout of UCCs and has metric sets for Aged Care (Healthy Aging) and ISO 27001 compliance work being implemented. • The project stage of PHOCUS 1.0 will be completed in June 2024, and funding is being sought for ongoing operational support outside of this AWP. • An expanded scope of work to extend the scope and nature of performance data that can and is being collected is being discussed with the Department of Health and Aged Care, and funding for PHOCUS 2.0 will be sought outside of this AWP.
Workforce Planning and Prioritisation General Practice Workforce Placement	PHNs are now responsible for developing needs assessments to inform the placement of Commonwealth-funded GP trainee positions under the Workforce Planning and Prioritisation (WPP) service. This project is intended to develop and support a process and platform to facilitate this activity.

	Status: Cancelled due to a lack of clarification of larger WPP program scope, and whether this work is required. Initial scoping of potential solutions only undertaken. Output has been stored in case needed in future.
AIHW PIP QI Reporting Process Improvement	Currently PHNs are requested to submit their quarterly PIP eligible dataset (based on data collated from individual GP PIP QI submissions) via an Excel file template which is then uploaded to the AIHW Portal. Whilst AIHW provides a technical reporting specification to PHNs, there is still a considerable amount of data cleansing and validation required both before and after the file is submitted to AIHW. This project will develop a more consistent and streamlined process for PHNs to prepare the PIP submission files and provide improved quality to AIHW. Status: Completed • The first major "common analytics process" identified by PHNs was a way to aggregate JSON files submitted by practices for PIP QI in the proper format without relying on a 'black box' third-party tool. • During 2023 this project was developed collaboratively by bringing in data analysts from several PHNs to work on the project. The result is now managed through the PHI GitHub environment and has been used by numerous PHNs. • Note that AIHW announced in late 2023 that PHNs should stop processing JSON files until data quality issues were addressed by the practice software vendors.
PHI Digital Marketplace (New)	This project aims to create an easily searchable online directory of analytics solutions created by both DataLeap projects and individual PHNs. A key goal of this project is to make the improvements in PHN collaboration delivered through the DataLeap Program sustainable without program funding, so that PHNs can continue to create and share methods and code with each other in a secure, managed service that would be managed as part of PHI. Status: Commenced and underway.
Common Data Processing (New)	This project aims to develop a solution that goes one step beyond PHNs being able to access and use 'common data and analytics products' code from GitHub and provides a mechanism for one user of PHI (either the Lead PHN as a

	'common service', or any individual PHN as a shared service) to actually run the data processing for other PHNs, without needing to hold their data. Azure Synapse Analytics is being used to create an automated process to allow PHNs to simply drop input files into a designated folder in their own lockbox's 'Transient Out' storage area, and then receive the fully processed results into a matching folder in their 'Transient In' storage. Status: Commenced and underway.

Perth North PHN Needs Assessment

Priorities	**Page reference**
Reduce non-urgent emergency department attendances and improve access to alternative services. (Metro)	12
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11
CGP1.5 Promote the effectiveness of digital health technologies to optimize patient care (telehealth).	106

Collaboration

WAPHA is delivering the outputs and outcomes of this Activity as a Lead PHN working with other stakeholders, particularly other PHNs:

- Primary Health Networks – both consultations to identify and prioritise needs, but also engagement and participation of staff from other PHNs in planning and developing the solutions to meet those needs. PHNs engagement includes governance and broad community of practice involvement
- Australian Commonwealth Department of Health and Aged Care (Department) - Key staff within the Department have been engaged as key consumers of PHN data and analytics products to ensure that PHN data submissions can more effectively support national policy agendas and programs. The DataLeap Program team engage with the PHN Data and Reporting Branch at least monthly on the design and progression of PHOCUS
- Australian Institute of Health & Welfare – as a key stakeholder in the PIP QI process, the AIHW is being engaged as a collaborator in developing improved approaches for PIP QI submission, as well as other projects where capability and capacity exist

Consultation

WAPHA continues to consult broadly in supporting PHNs to use and enhance the PHI platform to deliver improved data and analytics capabilities. Key stakeholders that are being engaged in the development and implementation of the detailed Work Plan, and the individual projects within it, include:

1. Australian Commonwealth Department of Health and Aged Care – engaged in the development and review of the purpose and role of this funding, the Department continues oversight through the Steering Committee on an at-least-quarterly basis in approving, reviewing and updating the detailed Work Plan and progress against it.
2. Australian Institute of Health & Welfare – as the national data custodian for a range of data collections such as PIPQI, AIHW have been engaged to inform, support and give feedback on any data and analytics improvement activity under the detailed Work Plan that relates to PIP QI, and through established communities of practice and user groups are providing feedback on other common data and analytics processes. WAPHA as Lead PHN has been engaging with the AIHW to help identify areas for improvements since late 2020.

PHN Cooperative – As part of developing a PHI Strategic Plan, WAPHA engaged with all PHNs through both a national workshop in August 2022 and provision of a Consultation Draft Strategic Plan, that included (but was not limited to) the activity to be funded through the CoE within its scope. This enabled PHNs to examine the proposed work within its larger context alongside existing PHI work. In addition, PHNs have established a new national cross-PHN governance framework under a Primary Health Transformation Coordination Committee (PHTCC) to help ensure that national projects support and do not conflict with each other – this group is now providing closer governance of this work through the DataLeap Program.

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Work Plan as amended and agreed by the Department, as appropriate.	100%

Activity Milestones	**Due Date**
Activity Work Plans and Budgets	30 April 2024, 30 April 2025
Annual Activity Needs Assessment	15 November 2024
Twelve Month Performance Report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025

Coverage

The activity has been funded through the Perth North PHN and will be delivered statewide and nationally.

Activity Start Date	Activity End Date
1 July 2022	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
PHN Collaborative Data and Analytic centre of Excellence	$1,627,284.67	$1,356,268.29	$0.00

CF-PHI 5060 – Integrated Digital Enhancement Program (leveraging PHI)

Activity Title

Integrated Digital Enhancement Program (leveraging PHI)

Activity Number

5060

Activity Status

New Activity

PHN Program Key Priority Area

Digital Health

Aim of Activity

Please note: The PHN has named this activity Integrated Digital Enhancement Program (leveraging PHI), which is the activity name in the PHNs Core Funding Schedule Item C Funding and Payment - C.20.

WA Primary Health Alliance (WAPHA), as the lead PHN, will continue to enhance and develop digital capability, improved service delivery and transparency across the Primary Health Networks (PHN) leveraging Primary Health Insights (PHI) as its secure backbone.

The aim of this activity is for WAPHA to continue to be a leader in the:

- Enhancement and support of Primary Health Network's (PHN) ability to provide quality, integrated, secure and seamless digital service offerings to health service providers, including commissioned services providers, general practices and eventually allied health care providers.
- Identification and monitoring of clinical outcomes to reliably assess the impact and effectiveness of commissioned services and other funded programs.
- Ability to work more closely with the state health systems and provide more integrated digital service offerings including analytics, data linkage and clinical pathways for practitioners, including change management programs and support.
- Implementation of PHOCUS (Primary Health Operational and Commissioning Unified System) across all 31 x PHN's including the qualitative and quantitative measures, support, change management and reporting at a national level.
- Development of flexible and adaptable digital solutions that can be easily adopted or adapted by other Primary Health Networks (nationally) if desired.

- Drive greater efficiencies across PHN's in the delivery of services and support to its key stakeholders.
- Continuously mitigate cyber risk in the storage and use of primary care data across the Primary Health Networks.

Description of Activity

As the lead PHN, WA Primary Health Alliance will:

- Improve the usability and accessibility of digital services by providing streamlined and easier-to-use interfaces for collecting data from, and providing data to, health service providers to improve efficiency and effectiveness across PHN's.
- Improve the financial viability and sustainability of digital services by leveraging existing investments in the Primary Health Insights (PHI) platform, and by developing or adopting appropriate and re-usable standards, processes and frameworks.
- Improve the quality and timeliness of information provided through digital services offerings by implementing new technologies such as Artificial Intelligence to enhance and target the provision of clinically relevant options to clinical practitioners at the point of care, particularly in the use of clinical health pathways.
- Improve the cyber security and privacy of digital service offerings by enhancing cyber-security controls, processes and standards across all systems.
- Improve the flexibility and agility of digital service offerings by designing and implementing architectures that facilitate, simplify and speed up the addition of new functionality in response to emerging needs across the health system.
- Improve the stability and performance of digital service offerings by enhancing the integration, automation, reliability and scalability of application and platform technology capabilities.
- Improve health system integration by implementing improved data linkage, clinical health pathways and digital connectivity with national and state health agencies.
- Improve clinical acceptance and defensibility by undertaking or commissioning reviews, assessments or validation of enhanced tools, methods and outcomes that assist in improving primary care productivity.
- Improve the frequency and quality of performance reporting via PHOCUS across all PHN's.
- Improve adoption and support by providing additional documentation, training, user support and change management services to staff from of PHN's, general practices and commissioned service providers.

Managed within WAPHA and working closely with the PHI National Services Team and other participating PHN's across Australia, a detailed work plan will be developed that

will identify, prioritise and schedule a range of new and enhanced digital service offerings. These will include existing capabilities such as online portals for commissioned service providers and general practices, data collection from and reporting to general practices, and clinical health pathways information for health practitioners.

Where feasible, and where doing so will not adversely affect the delivery of outcomes for WAPHA or any other PHN, WAPHA may seek to work collaboratively with one or more PHNs in the design, development, testing or piloting of digital services offerings as a way of improving their re-usability and decreasing the total cost and effort required from other PHNs to adopt or adapt them, if they so desire.

The following outputs are expected to be delivered as an outcome of this Activity:

Health Pathways Project
Development of a new "in house" clinical pathway system and support model, within the PHI Platform, that has been built using Artificial Intelligence and integrated with existing or future clinical support tools that provide contextual real time clinical pathway options to general practitioners or other clinicians during a consult. It is expected that this will significantly improve quality of care and reduce wasted search time by clinicians while with a patient who may have complicated symptoms. It is expected that this option will provide more quality consult time with the patient improving primary health care for the community. In addition, it is expected that there will be significant cost reduction in the application of nationally consistent pathways compared with State based or PHN based clinical pathway development.

Status: Feasibility for Clinical Referral Pathways program was completed in January 2024, and the Department of Health and Aged Care has been provided with a copy of the report, which has also been presented to all PHNs. A key part of the feasibility study was the delivery of high-level solution architecture (i.e. what could a service like this, developed and managed by PHNs, look like both technically and operationally) which was completed in December 2023. The Steering Committee approved moving to the next stage of Design in February 2024, which is currently underway. While no PHNs will be asked to 'sign up' until the Design stage has ended and approval to develop has been given, 13 PHNs have currently indicated an intention to commit. Governance and advisory groups to provide oversight and input from and by PHNs to every stage of the project have been established and are working well.

GP / Commissioned Services Reporting Portal Scale-up
Extending New Portals created by WAPHA as a national offering allowing commission service providers to submit performance and qualitative information in real time providing PHNs with timely information and delivering performance information across providers.

Communicating with general practitioners via email and facsimile machines is outdated and subject to security breaches. A GP Portal offers PHNs a direct, safe and secure method of distributing timely clinical and performance reports, educational material, grant offerings and digital seminars that is stored within PHI to ensure reliable security frameworks. It is expected PHNs will be more efficient in the delivery of information and support to GP's and commissioned service providers, reducing labour effort and responding in shorter time frames.

Status: WAPHA's Primary Care Portals are now operational. A pilot program is currently being planned to provide Gippsland PHN with their own versions of the portals (suitable since they use almost the same reporting framework as WAPHA) as a pilot before the end of December 2024. Another pilot project is also under discussion with Northern Territory PHN to pilot use of a localised version of PHOCUS as a data collection tool in a 'Portal-lite' version for commissioned service providers, also by December 2024.

GP Data Linkage Project (WA)

The Australian health environment is scattered with various systems and technologies driven by various policies, commercial advantages and poor procurement practices. The opportunity to develop methods, technologies and agreements with various interested health entities including State Health organisations, will allow for a more joined up health system. This approach should be led by PHNs to integrate with commercial and government owned systems that will assist and deliver linked data to inform government and the community of a patient journeys across various health agencies. Automating data linkage will assist in close to real time understanding of the health system allowing government to plan for future cost based on scientific and current evidence.

Status: WAPHA have initiated a pilot project with WA Health and Curtin University to establish a data linkage capability between general practice data (extracted using Primary Sense, which can provide LinXmart privacy-preserving linkage keys) and acute care data. The initial evaluation data set will be used to evaluate a Chronic Heart Failure (CHF) commissioned program. The project is currently underway and expects to output a linked data set in PHI by March 2025.

PHI/PHN Cyber Security Improvement

New or enhanced software tools and systems built within the security and framework of the PHI platform or dependent on PHI that enable more, easier and quicker data-driven collaboration and integration among PHNs, GP Practices and Commissioned Service Providers. Improved cyber security monitoring, integration and standardisation of data collection, analysis and reporting tools will be used by PHNs that leverage PHI.
Status: work in this space is still being planned and is awaiting some inputs from WAPHA's ISO 27001 compliance work.

PHOCUS Stage 2
Full implementation of PHOCUS technology within the PHI Platform including change management and support for the adoption of newly developed national performance indicators that has dynamic report (one demand) capability at a PHN level, collaborative level (state by state) or nationally. PHOCUS will reduce the burden placed on PHNs in reporting to the Commonwealth while offering real time access to data at a PHN level or at a national level.

Status: The development of PHOCUS was funded by AWP (CF 5050). Work undertaken in FY24 under this AWP has been limited to planning and scoping for the future of PHOCUS in relation to PPERS. A meeting held with the Department of Health and Aged Care in late March has helped clarify this, and a proposal for the expansion of PHOCUS capabilities to extend across the entire PHN performance range, including commissioned service activity reporting, is in development. If approved, funding under this AWP will contribute to that scope of work.

GP Data Systems Integration
WAPHA as Lead PHN supports other PHNs with data extraction tool integration and operation, including ensuring that general practice data can be managed and processed effectively within the Primary Health Insights (PHI) platform, that practice data in transit and at rest is secure, and that PHNs have access to adequate technical support to respond to issues reported by a practice.

Status: Additional help desk support services were engaged for PHNs, initially through the PHI Managed Services Provider early in 2023 and then through dedicated staff within WAPHA once the service was designed and established. Storage and movement of extracted practice data within PHI was enhanced with improved database segregation, and improved management of authentication for network traffic coming from practices with data. Additionally, investigation and analysis work is underway to determine how PHNs can best leverage and support both commercial and internally developed FHIR-compliant APIs to improve the consistency and security of data extraction from general practices.

When this funding was originally requested, it was also identified that several technical and support streams would operate across all projects to incorporate new technologies and ensure effective adoption and transition. The following two activities are undertaken in support of all of the previous six projects:

1. Artificial Intelligence (AI)
   New software that provides greater access to the use of artificial intelligence tools that also provides real time data and insights to WAPHA, clinicians and commissioned services in relevant clinical settings. AI will also be integrated across various platforms to assist in better decision making by clinicians and PHN's.

Status: Leveraging self-funded work by WAPHA, limited investigation into the viability of using Microsoft's OpenAI-backed services within PHI is currently being undertaken. This includes Co-pilot for Power BI (to support natural language queries) and Azure Co-pilot (to assist in writing queries in Synapse and SQL). Consultation with Microsoft indicates that many of these services should only be deployed after an update of PHI architecture to the new Fabric standard, which would be within the scope of other funding proposals.

2. Change Management
   Adoption of new technologies, methods, agreements, policies and procedures in a risk adverse environment requires significant focus on the change program to educate, train, test and improve the views and attitudes of various participants in the primary care health system including PHN's, GP's, allied health providers, commission service providers and the community. Moving to a more digital and virtual world is a difficult process and it's usually faced with initial resistance before even testing the options. People work in different ways and the community has high expectations when dealing with their digital data. Building confidence takes time and investment to ensure that what is implemented (namely those items listed above) is undertaken robustly building confidence in the health system. A detailed and comprehensive change management and support plan will be developed for each of the initiatives listed above.

   Status: A comprehensive Change Support Framework has been established, supported by regular communication with PHNs through a variety of channels (dedicated PHI intranet, regular newsletters, targeted emails, surveys, and explanatory videos). Change support staff are engaging directly with PHNs adopting or exploring new services to identify and adjust to barriers. Training materials have been developed and hosted within the PHI LMS.

Addressing the Issues in the Health System

The following are provided as an example of the type of current health system issues this Activity will target through the enhancement of relevant digital service offerings:

- Outdated and cumbersome software platform – Health Pathways that is not meeting clinician expectations which is also a costly service offered by private industry.
- Manual processing by PHN's of Excel files and/or the need for paper forms in the collection of performance and contract information from commissioned service providers and GP's.
- The number of different systems that a GP needs to interact with in order to receive or retrieve clinical information, grants, education and training from PHN, state or national sources.

- Removal of the dependence of the use of facsimile transmission between health providers.
- The time and effort required to develop and make available specific reports or data collections relevant to population health issues such as disease outbreaks, national immunisations, and targeted interventions for chronic health conditions
- Inability to link data between primary and acute care or develop full patient journeys.
- Reluctance by general practice and other health service owners to fully adopt digital services due to fears around cybersecurity, privacy, and their legal liabilities.
- Difficulties experienced by general practitioners in adopting new services due to the limited time available during patient visits and limited time available for training.
- Improving transparency of PHN's performance via new reporting platform PHOCUS.
- Difficulties with quickly updating the clinical evidence base for information or advice provided to health practitioners to keep pace with the latest research.

Perth North PHN Needs Assessment

Priorities	**Page reference**
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.	13
Support Primary Health Care providers to implement effective health interventions for those living with overweight and obesity.	13
Improve coordinated and integrated care for people experiencing complex and severe mental health who can be managed in within primary care settings.	21
Promote integration and coordinated care pathways for clients with mental health condition and harmful alcohol and other drug use.	30
Support Aboriginal people to navigate the primary care system and access appropriate services.	37

Collaboration

WAPHA intends to deliver the outputs and outcomes of this Activity in collaboration with the providers of other systems being integrated with (such as State Health Agencies) as well as with other PHNs (where appropriate).

Consultation

WAPHA and other PHN's will consult with the following in developing and delivering the work plans under this Activity:

- General practices, through GP Champions, the GP Advisory Panel, and GP users of existing and new digital services
- Commissioned Service Providers
- Professional bodies such as the RACGP
- State Health agencies
- Commonwealth health agencies, including Department of Health and Aged Care, Australian Institute of Health and Welfare and Australian Digital Health Agency
- Other PHNs across Australia.

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Work Plan as amended and agreed by the Department, as appropriate.	100%

Activity Milestones	**Due Date**
Activity Work Plans and Budgets	30 April 2024, 30 April 2025
Annual Activity Needs Assessment	15 November 202
Twelve Month Performance Report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025
Clinical Health Pathways feasibility assessment	June 2024
Clinical Health Pathways feasibility assessment prototype implemented for at least one PHN	June 2025
Primary Care Portals piloted with at least one PHN (outside of WAPHA)	June 2025
Data Linkage pilot project commenced by December 2023	March 2025
PHOCUS full adoption and implementation	June 2024

Coverage

Australia-wide in collaboration with participating PHNs.

Activity Start Date	Activity End Date
7 December 2023	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
PHN Shared Data Warehouse Primary Health Insights	$4,470,000.00	$0.00	$0.00

CF 6010 – GP Urgent Care Network Public Awareness and Education Campaign

Activity Title

GP Urgent Care Network Public Awareness and Education Campaign

Activity Number

6000

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

To reduce primary care type presentations at emergency departments by building knowledge and raising awareness among consumers about their options as part of a larger project to provide alternative and optimal urgent care options in a general practice setting.

Description of Activity

WA Primary Health Alliance partnered with the WA Department of Health (WADoH) to pilot a service to address behavioural change encouraging people to choose primary care over hospital options. The optimal urgent care model was identified as a General Practice Urgent Care Network (GPUCN), with membership for existing general practices demonstrating direct action towards integrated urgent care, supported by development and implementation of a public awareness campaign to improve urgent care awareness and knowledge, and demonstrated use of the GPUC Network.

The pilot ended in September 2021. The final report from the pilot indicated that before additional investment is made in the GPUC Network model for the purposes of reducing ED demand, further research is needed to understand:

- GP capacity and whether it is possible to provide enough urgent care appointments to scale the program to a size where it can make a significant reduction in ED attendances.
- Reasons for the low conversion rate between landing page visits and GPUC appointments booked.
- How to improve the referral of calls from the 1800 Healthdirect helpline to GPUC practices.

In 2022 the Australian Government committed to the establishment of 58 Urgent Care Clinics (UCCs) across all states and territories, to deliver a new model of care to reduce pressure on hospital emergency departments. With varying levels of specificity (generally at the electorate level) announcements were also made about clinic locations.

In WA, the commitment for 7 UCC was for one in each of the following electorates: Perth, Hasluck, Forrest, Tangney, Moore, Brand, Durack. Consultation with the GPUCN is required to determine how both Urgent Care Services can co-exist and complement one another for optimal impact on emergency departments demand.

As of 31 May 2023, 26 practices were participating in the GPUCN in the Perth North PHN. No new applications will be accepted while work is ongoing to establish the Medicare UCCs and gain an understanding of how both urgent care programs can co-exist and complement one another.

In collaboration with WA Health, updates are underway to streamline urgent care services within the National Health Service Directory (NHSD). The NHSD is implementing a consistent approach for listing all urgent care services. The shared goal between WA Health and the NHSD is to ensure all services are listed as accurately as possible to guide people to the right level of care.

The success of the GPUCN is dependent on people's awareness and acceptance of such services. The intention is that the GPUCN will assist people's knowledge of primary care urgent care, options for management of urgent care needs, and specific locations for where urgent care can be managed.

WA Health's 'Is ED where you need to be' campaign directs patients to the GPUCN as an alternative care pathway, the PHN will continue to develop and adapt public awareness campaigns to complement and clearly define the differences between the GPUCN and Medicare UCCs.

Training for general practice staff to up-skill in urgent care is a key component of the project. This includes general practitioners, practice nurses and other administration staff who manage the reception desk.

The Primary Health Network (PHN) will continue to work with the existing GPUCN to understand the current capacity within the network and establish services to assist with reducing ED demand. The PHN will explore opportunities to strengthen relationships with local hospitals and general practices to promote the GPUCN and where required, the commissioned services may be modified, and additional services commissioned to help the PHN to continue to meet the aims of the activity and the needs of the priority target groups.

Perth North PHN Needs Assessment

Priorities	Page reference
Reduce non-urgent emergency department attendances and improve access to alternative services. (Metro)	12

Target Population Cohort

General practitioners, practice nurses and other administration staff who manage the reception desk. Health care consumers in general.

Consultation

The PHN consulted with and continues to consult with a variety of stakeholders including:

- Hospital emergency department teams
- WA Health management
- GP Urgent Care network
- National Health Service Directory
- Health Direct

Consultation occurred with the GPUCN to understand the current capacity within the network and where the PHN can support practices to deliver Urgent Care services. The PHN are working in collaboration with WA Health to explore opportunities to link the GPUCN with ED Diversion activities and initiatives such as the Virtual Emergency Medicine service, strengthen relationships with local hospitals and General Practices to promote the GPUCN and where required, the commissioned services may be modified, and additional services commissioned to help the PHN to continue to meet the aims of the activity and the needs of the priority target groups.

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Work Plan as amended and agreed by the Department, as appropriate.	100%

Activity Milestones	Due Dates
Activity Work Plan and Budgets	30 April 2024, 30 April 2025
Annual Activity Needs Assessment	15 November 2024

Twelve Month Performance Report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025
Initial workshop with GPUCN to discuss the current challenges and better understand how the services might complement the Medicare UCC's.	April 2023
Update to National Health Services Directory to ensure practice details are correct and appear correctly in the urgent care filter.	July 2023
Once UCC's are established in WA, the PHN will continue to work with both Medicare UCC's and GPUCN to better understand how the services can complement one another.	April – December 2023
Media Campaigns developed in collaboration with WA Health and DHAC to ensure consistency in messaging and streamlined. Consider practice level social media tools for promotion of the clinic's services to their local community.	January 2024
Clinical skills training regularly over the year. Training includes wound management, IV cannulation, ear syringing and suturing.	Ongoing

Coverage

Perth North PHN

Activity Start Date	Activity End Date
1 January 2023	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
Core Flexible	$150,000.00	$125,000.00	$0.00

CF 8000 – COVID-19 Vaccination for Vulnerable Populations

Activity Title

COVID-19 Vaccination for Vulnerable Populations

Activity Number

8000

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

The activity aims to support and coordinate local solutions that enable the delivery of COVID-19 vaccinations to vulnerable populations including older members of the multicultural community, residential aged care home residents, people with a disability, those without access to Medicare and individuals who cannot access or have difficulty accessing the vaccine through existing mechanisms.

Description of Activity

The PHN will continue to consult and collaborate with key stakeholders to ensure COVID-19 vaccination activities are responsive and dynamic in response to community need. The analysis of WAPHA needs assessment and other data indicates that the focus locations to target vulnerable populations are SA3s (Swan, Wanneroo, Stirling). Swan is also likely to be a priority location to work with Aboriginal communities and services to increase COVID-19 vaccination rates. Residential aged care facilities (RACF) in Perth North PHN with COVID-19 vaccination rates of 0-30% full coverage will also be a priority population.

The PHN will:

1. Collaborate with COVID-19 vaccination providers including general practice, pharmacy, PHN contracted providers, state health services and nurse practitioners to enable access of the COVID-19 vaccination to vulnerable people in identified priority locations.
2. Facilitate partnerships and work with local government, community organisations and Aboriginal Community Controlled Health Services on tailored solutions to suit local context.
3. Communicate existing relevant COVID-19 assessment and vaccination funding

mechanisms for vaccination services to GPs and health professionals.

4. Explore innovative strategies to enhance vaccination rates among target cohorts, leveraging the expertise of pharmacists and registered vaccination providers. This will include initiatives such as outreach services and educational events tailored to address prevalent barriers hindering COVID-19 vaccine uptake.
5. Build the capacity of key providers (e.g., RACFs, general practice, pharmacies, nurses, and Aboriginal Community Controlled Health Services) to provide sustainable vaccination services to vulnerable community members.

The activity will be guided by the WAPHA Stakeholder Engagement Framework which has been developed by the organisation to set clear standards and expectations for staff and external stakeholders.

Perth North PHN Needs Assessment

Priorities	**Page reference**
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11
People living at home or in RACFs need support to manage conditions to prevent escalating acuity. (Metro)	41
Improve the management of chronic conditions for ageing populations and promote healthy ageing at home. (Metro)	41

Target Population Cohort

Populations identified as having difficulty accessing COVID-19 vaccines include (but is not limited to):

- Those who are experiencing homelessness, including those living on the streets, in emergency accommodation, boarding houses or between temporary shelters.
- People with a disability or who are frail and cannot leave home.
- People in rural and remote areas with limited healthcare options, including those who cannot travel to a regional centre.
- Culturally, ethnically and linguistically diverse people, especially asylum seekers and refugees and those in older age groups who may find it difficult to use other vaccination services.
- Those who do not have a Medicare card or are not eligible for Medicare.
- Aged care and disability workers, with consideration to all auxiliary staff working on-site.
- Aboriginal and Torres Strait Islander people.
- Any other vulnerable groups identified as requiring dedicated support to access vaccinations.

With lower COVID-19 vaccination rates than that of the general population, this sector will continue to be the focus of the Vulnerable Populations Vaccination Program. To support this, engagement with General practice, Aboriginal Community Controlled Health Organisations (ACCHOs), community and non-government organisations and state health will continue.

Consultation

The PHN consulted with and continues to engage with a range of stakeholders in the planning and delivery of the Vulnerable Populations Vaccination Program, including but not limited to:

- General practice
- WA Department of Health
- Aboriginal Community Controlled Health Organisations
- Residential Aged Care Facilities
- Community organisations
- Commissioned services
- Local government
- Education institutions
- Peak bodies

Collaboration

The PHN is working with the WA Department of Health, general practitioners, community organisations, Aboriginal Community Controlled Health Organisations, Residential Aged Care Facilities and education institutions to identify vulnerable people within their area that have limited access to COVID-19 vaccination and information. These stakeholders will be directly involved in facilitating access to and administering COVID-19 vaccinations and information.

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Work Plan as amended and agreed by the Department, as appropriate.	100%

Activity Milestones	**Due Date**
Activity Work Plan and Budget	30 April 2024, 30 April 2025
Annual Activity Needs Assessment	15 November 2024

Twelve Month Performance Report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025

Coverage

Perth North PHN

Activity Start Date	Activity End Date
9 September 2021	31 December 2024

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
Core Flexible	$925,841.31	$637,533.32	$0.00

HSI 1000 – Health Systems Improvement

Activity Title

Health Systems Improvement

Activity Number

1000

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

Health Systems Improvement funding is provided to enable PHN's to enhance the integration and coordination of primary health care services by undertaking data analysis and working strategically with local communities, clinicians, service providers, government agencies and other stakeholders to:

- Identify and prioritise health care needs through population health planning.
- Commission and monitor safe, high quality and culturally appropriate service.
- Determine health priorities and vulnerable cohorts, with the aim of improving access to primary care for those most at risk of adverse health outcomes.
- Assess and realise opportunities for joint commissioning arrangements with strategic partners.
- Progressively improve system performance, health outcomes and the quality and safety of primary care services.
- Ensure primary health care gains and potential are understood and utilised at regional, state and national levels.
- Underpin PHN and Government reform related decisions and activities with advanced digital health and data analytics capability which can facilitate partnership approaches.
- Direct resources to where they are most needed and where they will have the greatest impact.

Description of Activity

WA Primary Health Alliance (WAPHA) is the operator of three Primary Health Network (PHN) regions - Perth North, Perth North and Country WA. As a statewide agency, WAPHA is well positioned to systemically improve the quality, standard and connection of primary health care services across WA.

Strategic planning activities include:

- Leveraging WAPHA's statewide remit to consider and address system-wide issues of equity and access and progress actions to address local, regional, state, and national priorities.
- Understanding and interpreting Australian Government Guidance and health policy reform and translating it for application within the local primary health care context.
- Progressing the strategic objectives of the National Health Reform Agreement and 10-year primary health care plan by working with the State-funded health system to continuously improve health outcomes and address inequity in WA.
- Continued leadership of the national PHN Cooperative and collaboration with other PHNs to ensure collective value and impact is optimised and PHN effectiveness is enhanced through sharing models of care, learnings, and resources.
- Progression of PHN priorities for action in response to Strengthening Medicare Taskforce recommendations and ongoing strategic leadership as a member of the Taskforce. Demonstrating commitment to joint planning, shared accountability, and co-commissioning through formalised relationships with partners/system managers including the WA Mental Health Commission and Health Service Providers.
- Working with other state-wide agencies, such as the Aboriginal Health Council of WA, Mental Health Commission, and the Departments of Health and Communities to ensure that primary health care is appropriately represented to shape the direction of the WA health system and deliver better connected, patient-centred, high quality, innovative and sustainable care.
- Collaboration with training organisations, professional colleges, and health workforce agencies to plan for the future primary health care workforce and improve workforce capability.
- Cultivating local relationships and engaging with relevant stakeholders to coordinate care and develop pathways appropriate to local needs. This includes developing, trialing and evaluating integrated care precincts to attend to unmet need and reduce duplication, gaps and fragmentation in services.
- Planning, developing, and maintaining agile, comprehensive, primary health care pandemic and disaster response and management capabilities and coordinating a strong primary health care response to deliver care where and when it is needed.
- Joint advocacy on behalf of primary health care stakeholders to influence primary health care reform and decision making.
- Leading the development of evidence based, innovative, best practice models of primary health care and evaluating initiatives against the Quintuple Aim.
- Developing the cultural competence and capability of WAPHA and commissioned

primary health care services to better meet the needs of priority communities through the development and implementation of the Multicultural Competence and Capability Framework, an Aboriginal Cultural Competence and Capability Framework, and the LGBTIQA+ Equity and Inclusion Framework.
- Managing and monitoring the performance of WAPHA staff to encourage ongoing improvement and continuous professional development, contributing to the maturity and functionality of the organisation.

Data Analytics activity includes:
- Increasing data and analytics capacity and capability for WAPHA.
- Assigning appropriate data governance roles and responsibilities.
- Reducing exposure to information risk that would negatively impact WAPHA's ability to meet program objectives, as well as impose appropriate confidentiality restrictions to effectively manage disclosure risks and appropriately safeguard personal and private information.
- Improving data quality to ensure the provision of accurate and reliable information.
- Developing WAPHA's data and analytics capacity with appropriate training and infrastructure.
- Taking a systemic approach to the use of evidence; drawing critical insights to drive continual improvement in primary health care.
- Maturing WAPHA's approach to data sharing and linkage through formal governance arrangements with key stakeholders.

Digital Health activities include:
- Working across the primary health care system to enhance readiness for digital health adoption, and to improve workforce participation and confidence in digital health.
- Implementing programs leveraging Digital Health technology that support the objectives of the Quintuple Aim and health priorities.
- Encouraging and influencing the use of specific digital health applications, such as MyHealthRecord and HealthPathways WA.
- Assisting health care providers to understand and make meaningful use of digital health technology and collaborate with partners to pilot and innovate in the delivery of quality health care services.
- Prioritising good data governance, security, privacy and consent principles that facilitate positive digital health outcomes.
- Supporting primary health care providers to improve data quality and undertake data driven decision making and quality improvement.
- Taking a future focused approach to understanding opportunities for primary health care in virtual care, point of care testing and e-prescribing, for example

Population Health Planning activity includes:

- Identifying primary care needs and priorities by triangulating multiple supply and demand data sets at a geographically granular level, integrating this with contextual local intelligence.
- Providing insights for activity planning based on health, demographic and workforce data, identifying potential geographical locations where limited resources can be most effective in collaboration with our external partner.
- Identifying priority populations to target for WAPHA's activities, including those experiencing economic disadvantage, Aboriginal people, CALD people, LGBTQI+ people, older people and other groups at risk of poor health outcomes or access barriers

Commissioning activity includes:

- Identifying opportunities for state-wide and place-based joint planning and coordinated commissioning.
- Developing and utilising frameworks to apply a consistent state-wide and locally tailored approach to the design, commissioning, monitoring and evaluation of outcome-based interventions to address prioritised health and service needs.
- Ensuring that commissioned primary health care services in WA are evidence based, meet local identified population health needs effectively and efficiently and are sustainable.
- Working with commissioned primary health care services to improve cultural competence, capability, equity and inclusion of priority population groups including Aboriginal people, LGBTQIA+ and multicultural communities.
- Continuing to monitor and respond to emerging trends in health and service needs.
- Managing performance of contracted providers through a relationship-based approach and monitoring and evaluating the impact of commissioned programs.
- Designing and commissioning services that remove duplication, foster connection, and strive for seamless patient care.

The WA Primary Health Alliance Commissioning cycle for both state-wide and place-based services involves:

- Planning - to identify local needs and service gaps based on data and service analysis and consultation with key stakeholders.
- Designing - using best practice models and with local and state-wide service providers and stakeholders to develop appropriate service responses.
- Procurement -using a range of approaches based on an analysis of the marketplace including EOIs, Requests for Proposal and Requests for Tenders.
- Monitoring and Review - outcome-based contracts and reporting are developed

and implemented across WA Primary Health Alliance. The implementation of the Performance Management Framework will occur with clinical mental health services the first to get standardised mental health indicators followed by other programs such as drug and alcohol, Aboriginal health and chronic conditions.

- Evaluating - the performance of services is evaluated, and it is determined whether, and to what extent, a reshaping of the structure of supply is required.

The Perth North PHN continues to focus on managing performance (applying sound principles of relationship management) of contracted providers including reviewing/monitoring and evaluating services to determine: how well targeted and efficient services are - using a diverse range of data collection methods (i.e. provider reports, referral agency feedback, patient opinion) that, for each of the commissioned services, will provide the PHN with the information to assess improvements to health outcomes, help shape future service provision and/or seek alternative commissioning activity.

This activity will assist the PHN to:

- Understand how effective services and systems are in relation to patient experience and patient health outcomes with focus on the efficacy of treatment to deliver a positive patient outcome.
- Improve service/system integration, service sustainability including provider experience/governance and findings of formal evaluation (if conducted externally).

Perth North PHN Needs Assessment

Priorities	**Page reference**
Promote integration and coordinated care pathways for clients with mental health condition and harmful alcohol and other drug use. (Metro)	27
Reduce non-urgent emergency department attendances and improve access to alternative services. (Metro)	12
Support Primary Health Care providers to implement effective health interventions for those living with overweight and obesity. (Metro)	11
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11
Ensure integrated and stepped care services are available for people experiencing mental health issues, including younger people. (Metro)	18

Improve coordinated and integrated care for people experiencing complex and severe mental health who can be managed within primary care settings. (Metro)	18

Target Population Cohort

- People with, or at risk of, developing chronic and complex health issues. This includes mental disorders, problematic and harmful alcohol and drug use, chronic conditions and complex co-morbidities – for example, obesity and chronic heart failure.
- Communities experiencing enduring disadvantage This includes some older people, Aboriginal and Torres Strait Islanders, Culturally and Linguistically Diverse communities, LGBTQIA+ communities, people in poverty or deprivation, and socially and culturally marginalised groups.
- People at risk of developing significant health issues This includes earlier intervention and management for people with co-existing chronic conditions and complex care needs in general practice, with emphasis on data driven quality improvement and research to identify innovative solutions to support prevention activities.
- Communities facing gaps in the health system This includes integrating primary health care, and our commissioned services, into the local health environment through effective partnerships. Utilising data informed assessments about health priorities to better address the needs of Western Australians.

Consultation

The PHN utilises strategic partners, special interest panels, reference groups and targeted community consultation to inform the planning, design, delivery and monitoring of activities. Key stakeholders include commissioned service providers, peak bodies, primary care practitioners, state and local government, health service providers, health professionals, consumers and people with lived experience.

Collaboration

PHN's member organisations provide the Board with direct insight into the local primary care landscape and current operating environment, sharing priorities, strategies and progress in the delivery of health outcomes. They also share information on topics of mutual interest and work collaboratively to develop joint proposals and advocacy statements supporting our vision. Member organisations include the Royal Australian College of General Practitioners (WA), Rural Health West, WA Department of Health, Mental Health Commission WA, Western Australian Council of Social Service, Health Consumers' Council, Western Australian Local Government Association, Community Employers WA and the Australian College of Rural and Remote Medicine.

The PHN also has formal partnership arrangements in place to support coordination, collaboration and joint action on shared priorities.
with the:

- WA Mental Health Commission
- Australian Digital Health Agency
- Aboriginal Health Council of WA
- Health Service Providers

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Work Plan as amended and agreed by the Department, as appropriate.	100%

Activity Milestones	Due Date
Activity Work Plan and Budget	30 April 2024, 30 April 2025
Annual Activity Needs Assessment	15 November 2024
Twelve Month Performance Report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025
Final Report	30 September 2025

Coverage

Perth North PHN

Activity Start Date	Activity End Date
1 July 2019	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
Health Systems Improvement	$2,738,671.70	$2,964,809.42	$0.00

HSI 1010 – Health System Improvement: General Practice Support

Activity Title

General Practice Support

Activity Number

1010

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

To build capacity and capability of WA general practice to work in an integrated manner within the health system and respond to Commonwealth Department of Health and Ageing policy direction and reforms.

The activity includes two initiatives:

- Support general practice staff and clinicians, and other providers of primary health care to provide high quality and evidence-based care for their patients, including preventive and proactive activities with a focus on those at risk of poor health outcomes, to improve population health and equity of access.
- Enabling general practice to provide holistic care to their patient population through data driven quality improvement initiatives and by leveraging technology. Consistent with the Quintuple Aim of the Patient Centred Medical Home model the activity will be underpinned by Bodenheimer's ten building blocks of high performing primary care.

Description of Activity

General Practice Support will be provided to all staff working in general practice and where appropriate in primary care. This encompasses multidisciplinary staff including general practitioners, practice managers, practice nurses, allied health practitioners and support staff.

Support to general practice staff and primary care

Support will be provided via several channels:

- The Practice Assist website (www.practiceassist.com.au) allows general practice staff to search through a comprehensive library of information, resources,

templates, and factsheets on a variety of topics. They will be able to search for upcoming education events and webinars, find information on research studies and surveys, and links to the Practice Connect newsletter. Ongoing work includes reviewing and maintaining the website, keeping content up to date. It also includes generating or curating new content in line with identified needs, feedback and new policy or program.

- The Practice Assist helpdesk provides non-clinical support by phone and email to all general practice staff with an aim to respond to simple queries within one business day and more complicated queries within 3 business days, this may include liaising with subject matter experts within the PHN.
- Practice Support Staff regularly provide more in-depth support and coaching, centred around quality improvement and practice needs. They also provide and navigate information and support on a range of topics including accreditation, cancer screening and immunisation. This in-depth support can occur virtually or face to face.
- Inform, educate, and utilise quality improvement tools to increase practice uptake of bowel, breast and cervical cancer screening programs, and interventions and to improve childhood, Aboriginal, adolescent, and adult immunisation coverage.
- Contributing to service directories containing information that practices require when making referrals to specialist and community-based services. These include HealthPathways request pages, National Health Service Directory and My Community Directory.
- Networking and education events are facilitated to allow practice managers and practice nurses to share lessons both of what works well and the challenges they experience. Updates regarding primary health reform measures and new information are also provided through these forums.
- Webinars and Community of Practice forums for General Practitioners and other general practice staff around reforms and priority subjects identified by the PHN and GPs.
- Informing and updating practices on Commonwealth health policy initiatives such as Strengthening Medicare reforms (including MyMedicare), Practice Incentives Program (PIP) Quality Improvement (QI) incentive and Workforce Incentive Program (WIP) to support understanding and access.
- Connecting general practices with quality, evidence-based services to support their patient needs in their catchment areas, including WA Primary Health Alliance's commissioned services.
- Data analysis regarding the practices' screening targets and service delivery to enable their continuous improvement.
- Education on the use of HealthPathways to support clinical decision making by clinicians to increase positive patient outcomes.
- Inform, educate and support the use of digital health platforms, such as

telehealth and ePrescribing, within practice to address access and equity challenges for vulnerable patient cohorts.

Data driven quality improvement

Enabling practice transformation will have a whole of general practice approach to support data driven quality improvement (QI) activities to improve the health outcomes of the practice population. This will be achieved by:

- Providing access to a highly advanced business intelligence toolset (including data extraction) license software at no cost to practices who have a data sharing agreement with the Primary Health Network (PHN).
- The business intelligence tool set will support general practices to make timely decisions regarding better health care for their respective populations. This data supports service and business planning, reporting and population health needs
- Providing ongoing training and support to leverage the business intelligence suite of tools.
- Providing data reports to practices and assisting in their interpretation and application providing support and coaching to set up a QI team to undertake regular QI activities, assisting general practices to register and actively participate in digital health platforms including My Health Record (MYHR) and secure messaging.
- Providing support and training to embed recall and reminder processes in practice.
- Providing support and training for the QI practice incentive program
- Assisting practices to embed the ten (10) building blocks of high performing primary care in line with the Quintuple health aims.

Data governance enhancements

Invest in improvements to WAPHA's data management capacity to protect the confidentiality, integrity and accessibility of information, guided by the ISO/IEC 27001 Standard. This will be achieved by:

- Funding a dedicated position within the PHN to lead the development of an ISO 27001-compliant Information Security Management System (ISMS). This includes enhanced definition of information management roles and responsibilities, information security risk assessment and treatment.
- Procurement of certification services and, as required, consultant support in the development of a compliant ISMS.
- Dedicated project management support to ensure best practice information management is embedded in organisational culture through appropriate governance, change management strategies, staff training and communications as part of the preparation for ISO 27001 certification and ongoing ISMS maintenance and improvement.
- Purchase of standards and of technology supports e.g., risk management

software) and other tools as determined necessary by the ISO 27001 Steering Committee to enable best practice Information Security Management practices.

Perth North PHN Needs Assessment

Priorities	Page reference
Reduce non-urgent emergency department attendances and improve access to alternative services. (Metro)	12
Improve the rates of cancer screening and reduce avoidable deaths from cancer. (Metro)	11
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11
Increase Aboriginal childhood immunisation rates for regions not meeting national immunisation targets. (Metro)	34

Consultation

The PHN consulted with the following:

- Primary Care workforce
- Regional and local primary care services including general practice
- Rural Health West
- Consultation with WAPHA GP Advisory Group

Collaboration

The PHN sought collaboration from the following:

- Private general practices,
- Aboriginal Medical Services
- Practice Managers
- Practice Nurses
- Allied Health providers
- Pharmacists
- Data Officers – administrators
- Regional Integration Managers

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Work Plan as amended and agreed by the Department, as appropriate.	100%

Activity Milestones	Due Date
Activity Work Plan and Budget	30 April 2024, 30 April 2025
Annual Activity Needs Assessment	15 November 2024
Twelve Month Performance Report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025

Coverage

Perth North PHN

Activity Start Date	Activity End Date
1 July 2019	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
Health Systems Improvement	$435,128.38	$435,128.38	$0.00

HSI 1020 – Health System Improvement: HealthPathways

Activity Title

HealthPathways

Activity Number

1020

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

- To develop (localise), enhance, maintain and promote comprehensive suite of WA specific HealthPathways. Pathways will provide GPs (and other health professionals) best practice clinical guidance and local patient referral information. The result is patient care that is well coordinated, efficient and effective.
- To develop and deliver targeted educational events and activities, supporting the awareness of engagement with and utilisation of HealthPathways and how to maximise user experience.
- Maintain the license of the HealthPathways software and technical writing services provided by Streamliners.
- WA HealthPathways support a multidisciplinary approach to patient care, providing information to GPs (as the primary target audience) and other healthcare professionals (including primary care clinicians and allied health professionals).

The WA HealthPathways team works collaboratively with Health Service Providers, the WA Department of Health, Subject Matter Experts (SMEs), peak bodies and consumers (limited), in addition to general practice, to inform the resulting HealthPathways. This collaboration also contributes towards population health planning through the identification and escalation of care and service gaps.

Description of Activity

WA HealthPathways provides high quality, evidence based, clinical and referral pathways for clinicians working in general practice to reference during patient consultations.

The HealthPathways team consists of general practitioner clinical editors who are supported by coordinators and a leadership team. The team develops, reviews and maintains content, and develops and delivers educational events and materials related to HealthPathways.

The main activities of the team include:

- Identifying, prioritising and developing new clinical (and non-clinical) HealthPathways and Request (referral) pages.
- Reviewing and maintaining existing HealthPathways.
- Facilitating multi-disciplinary working groups which inform HealthPathways and identify care and service gaps for escalation.
- Mapping services and incorporating them into new and existing pathways.
- Administering and maintaining the HealthPathways website.
- Facilitating pathway consultation in conjunction with WA Department of Health – Health Networks.
- Preparation and delivery of reports related to HealthPathways engagement and usage.
- Demonstrating the use of and providing targeted education about how to maximise the HealthPathways user experience.
- Facilitating HealthPathways promotional activities.

The PHN will continue to monitor and assess the impact of COVID-19 on this activity. COVID-19 related HealthPathways work will be further incorporated into this activity with a business-as-usual approach to support sustainability. If required, this strategy may be modified, and/or additional strategies commenced to help the PHN to continue to meet the aims of the activity.

Perth North PHN Needs Assessment

Priorities	**Page reference**
Promote integration and coordinated care pathways for clients with mental health condition and harmful alcohol and other drug use. (Metro)	27
Support Primary Health Care providers to implement effective health interventions for those living with overweight and obesity. (Metro)	11
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management. (Metro)	11
Support primary health care providers to provide culturally appropriate chronic disease management for Aboriginal	34

populations and build capacity for patient self-management. (Metro)	
Improve the management of chronic conditions for ageing populations and promote healthy ageing at home. (Metro)	41
Support the mental health of older people and assist primary care providers to identify older people who may need additional support or referrals to services. (Metro)	18
Improve coordinated and integrated care for people experiencing complex and severe mental health who can be managed within primary care settings. (Metro)	18

Target Population Cohort

General practitioners are the primary audience of this activity, in addition to clinicians working in/supporting the provision of primary healthcare (e.g. Practice Nurses, Allied Health professionals).

Consultation

The PHN engages numerous stakeholders to support progression of the WA HealthPathways program including:

- WA Department of Health
- Health Service Providers
- WA HealthPathways Users
- General practitioners and other primary health professionals
- Other PHNs across Australia

The PHN promotes WA HealthPathways to specific audiences at conferences (e.g., Rural Health West Conference), through internally and externally produced written communications and articles (e.g. WAPHA publications GP Connect and Practice Connect; Medical Journal of Australia; Medical Forum).

The PHN delivers education and training to those working in general practice (and other clinicians) and primary care services.

Collaboration

The PHN collaborates with the following stakeholders to support progression of the WA HealthPathways Program:

- WA Department of Health
- Royal Australian College of General Practitioners
- Subject Matter Experts

- Including hospital clinicians, non-GP medical specialists, allied health practitioners, nurses etc.),
- Consumer representatives, GPs, Health Service Providers, Peak Bodies (e.g. Diabetes WA, Australasian Society of Clinical Immunology and Allergy (ASCIA)) to:
    - Inform clinical and referral pathways
    - Provide representation and specialist expertise in working groups related to HealthPathways development and/or review
- Streamliners NZ - The PHN administers the WA HealthPathways platform, which is owned by Streamliners NZ. The PHN develops and authors new clinical (and non-clinical) HealthPathways and Request (referral) pages and maintains and updates existing HealthPathways in line with the style guide provided by Streamliners. Streamliners provide technical writing services to standardise, draft and publish the provided content to the WA HealthPathways platform
- Other stakeholders as they are identified.

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Work Plan as amended and agreed by the Department, as appropriate.	100%
Total number of consultation periods facilitated with WA Department of Health – Health Networks	3 per year
Total and type of education events or activities related to HealthPathways delivered to local health professionals	3 per year
Total pathway views and top five most viewed pathways (clinical and referral)	3 per year

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Activity Milestones	**Due Date**
Activity Work Plan and Budget	30 April 2024, 30 April 2025
Annual Activity Needs Assessment	15 November 2024
Twelve Month Performance Report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025

Coverage

Perth North PHN

Activity Start Date	Activity End Date
1 July 2019	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
Health Systems Improvement Populations	$138,986.19	$138,986.19	$0.00

HSI 2000 – Health System Improvement: Stakeholder Engagement and Communication

Activity Title

Stakeholder Engagement and Communication

Activity Number

2000

Activity Status

Modified

PHN Program Key Priority Area

Population Health

Aim of Activity

Communications and stakeholder engagement activities aim to establish and nurture strong and purposeful relationships with the diversity of stakeholders in primary care.

Establishing and maintaining trusting and purposeful relationships is essential to achieving our vision of better health, together.

The strength of our relationships with stakeholders enables us to work collaboratively with others and to engage a diversity of knowledge, skills, and experience through all aspects of commissioning and practice improvement.

The strength of our stakeholder relationships enables us to represent our stakeholders needs in our policy responses and our advocacy for a strong and response primary care sector in WA.

Demonstrating and maintaining a positive reputation is essential as an approach to managing risks for WA Primary Health Alliance as a local commissioner, and for risks to the Primary Health Network (PHN) Program.

Description of Activity

The PHN will continue to communicate WAPHA's purpose and work by delivering high quality written and digital communications both internally and externally, to demonstrate impact, innovation and achievement.

This work is underpinned by:

- Strategic marketing and communications: develop the right message for the

right channel.

- Brand management: build and maintain a consistent corporate image
- Media relations: facilitate favourable and timely media coverage.
- Government relations: support with visits and information requests.
- Issues Management: handle contentious issues/protect WAPHA's reputation
- Internal communications: facilitate the delivery of interesting and important news and updates.

Priorities to 2025 include:

- Developing strategic key messages to align with the WA Primary Health Alliance Strategic Plan 2023 – 2026 targeting specific high interest/ high influence groups and used to educate our staff, Board and stakeholder networks to ensure we speak to our stakeholders consistently.
- Continuing to build our audiences and engage with them in a targeted manner, consistently and appropriately; refining our communication approach and channels, ensuring cultural appropriateness, and building on those channels and methods which are most effective; and maintaining our online/ digital presence to ensure our voice is heard and that we are part of strategically important online conversations.
- Embedding culturally inclusive language and images across our platforms to demonstrate WAPHA's leadership in culturally safe and inclusive practice.

Stakeholder Engagement

The PHN will continue to:

- Lead and coordinate strategies, projects and activities that maintain the integrity of stakeholder engagement approaches across WAPHA.
- Build engagement capacity of staff and empower them to engage effectively with our stakeholders, including in use of digital platforms and enablers such as our stakeholder database and digital engagement platforms.
- Support projects and activities that uphold the cultural security of our stakeholder engagement approaches, ensure stakeholders are well informed and engaged in the development and implementation of our Reconciliation Action Plan and direct the work.
- Identify, facilitate and mature WAPHA's state-wide partnerships and support a strategic approach to the planning and delivery of local stakeholder engagement.

Priorities to 2025 include:

- Strengthening and embedding commissioning approaches and practices that work towards increasing the opportunities for a collaborative design approach to be applied.

- Increasing the ways in which community, consumers, family, and carers are engaged across the commissioning cycle.
- Implementing the activities as outlined in the Stakeholder Engagement Framework Roadmap, with an emphasis on our digital enablers to engagement and evaluation of engagement practice and stakeholder sentiment to WAPHA.
- Further developing the WA GP Advisory Panel, in partnership with Rural Health West and RACGP (WA), to provide a trusted platform through which to engage the expertise and interest of general practitioners in operational and strategic directions setting and policy implementation.
- Establishing allied health and Consumer Leader Panels to formalise engagement channels with key stakeholders.
- Maturing partnerships with strategic stakeholders.

The PHN recognises the impact COVID-19 had on the community, primary health care and commissioned service activity. With services having returned, monitoring and service impact assessment will continue, to ensure the PHN continues to meet the aims of the activity and the needs of the priority target groups.

Perth North PHN Needs Assessment

Priorities	**Page reference**
Reduce non-urgent emergency department attendances and improve access to alternative services.	12
Promote integration and coordinated care pathways for clients with mental health conditions and harmful alcohol and other drug use.	27
Support primary health care providers to manage chronic disease populations and build capacity for patient self-management.	11

Consultation

WAPHA has drawn on the expertise of specialist reference groups of external stakeholders (Multicultural, LGBTIQA+ and Aboriginal) to inform communications and engagement planning and priorities.

Feedback from stakeholders on communications and engagement activities is used to inform continuous quality improvement to ensure content, channels and activities are meeting the needs of stakeholders.

Collaboration

The WA GP Advisory Panel has been established as a partnership with RACGP WA and

Rural Health West. RACGP make a kind contribution by administering payment to GPs, and all partners play an equal role in setting agendas and actioning comments raised by members.

Activity Key Performance Indicators

Performance Indicator Description	Target
Activities have been undertaken in accordance with the approved Activity Work Plan as amended and agreed by the Department, as appropriate.	100%

Activity Milestones	Due Date
Activity Work Plan and Budget	30 April 2024, 30 April 2025
Annual Activity Needs Assessment	15 November 2024
Twelve Month Performance Report	30 September 2024, 30 September 2025
Financial Acquittal Report	30 September 2024, 30 September 2025

Coverage

Perth North PHN

Activity Start Date	Activity End Date
1 July 2019	30 June 2025

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26
Health Systems Improvement	$246,802.31	$246,802.31	$0.00

END