Australian Government
Department of Health

phn
An Australian Government Initiative

Primary Health Networks Core Funding

Primary Health Networks After Hours Funding

Activity Work Plan 2016-2018

- Annual Plan 2016-2018
- Annual Operational and Flexible Funding Streams Budget 2016-2017
- After Hours Budget 2016-2017

Murray PHN

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

The Activity Work Plan must be lodged to your Grant Officer via email to VicTasPHN@health.gov.au on or before 6 May 2016.

Introduction

Overview

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

- Increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- Improving coordination of care to ensure patients receive the right care in the right place at the right time.

Each PHN must make informed choices about how best to use its resources to achieve these objectives.

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

This document, the Activity Work Plan template, captures those activities.

This Activity Work Plan covers the period from 1 July 2016 to 30 June 2018. To assist with PHN planning, each activity nominated in this work plan can be proposed for a period of 12 months or 24 months. Regardless of the proposed duration for each activity, the Department of Health will still require the submission of a new or updated Activity Work Plan for 2017-18.

The Activity Work Plan template has the following parts:

1. The Core Funding Annual Plan 2016-2018 which will provide:
    a) The strategic vision of each PHN.
    b) A description of planned activities funded by the flexible funding stream under the Schedule – Primary Health Networks Core Funding.
    c) A description of planned general practice support activities funded by the operational funding stream under the Schedule – Primary Health Networks Core Funding.

2. The indicative Core Operational and Flexible Funding Streams Budget for 2016-2017.

3. The After Hours Primary Care Funding Annual Plan 2016-2017 which will provide:
    a) The strategic vision of each PHN for achieving the After Hours key objectives.
    b) A description of planned activities funded under the Schedule – Primary Health Networks After Hours Primary Care Funding.

4. The indicative Budget for After Hours Primary Care funding stream for 2016-2017.

Annual Plan 2016-2018

Annual plans for 2016-2018 must:

- provide a coherent guide for PHNs to demonstrate to their communities, general practices, health service organisations, state and territory health services and the Commonwealth Government, what the PHN is going to achieve (through performance indicator targets) and how the PHN plans to achieve these targets;

- be developed in consultation with local communities, Clinical Councils, Community Advisory Committees, state/territory governments and Local Hospital Networks as appropriate; and
- articulate a set of activities that each PHN will undertake, using the PHN Needs Assessment as evidence, as well as identifying clear and measurable performance indicators and targets to demonstrate improvements.

Activity Planning

The PHN Needs Assessment will identify local priorities which in turn will inform and guide the activities nominated for action in the 2016-2018 Annual Plan. PHNs need to ensure the activities identified in the annual plan also correspond with the PHN Objectives; the actions identified in Section 1.2 of the PHN Programme Guidelines (p. 7); the PHN key priorities; and/or the national headline performance indicators.

PHNs are encouraged to consider opportunities for new models of care within the primary care system, such as the patient-centred care models and acute care collaborations. Consideration should be given to how the PHN plans to work together and potentially combine resources, with other private and public organisations to implement innovative service delivery and models of care. Development of care pathways will be paramount to streamlining patient care and improving the quality of care and health outcomes.

Primary Health Networks After Hours Funding

From 2016-17, PHNs will have greater flexibility to commission programme specific services, having completed needs assessments for their regions and associated population health planning. PHNs are funded to address gaps in after hours service provision and improve service integration within their PHN region. Item B.3 of the After Hours Funding Schedule may assist in the preparation of the After Hours components of your Activity Work Plan (pages 12-15 of this document).

Measuring Improvements to the Health System

National headline performance indicators, as outlined in the PHN Performance Framework, represent the Australian Government's national health priorities.

PHNs will identify local performance indicators to demonstrate improvements resulting from the activities they undertake. These will be reported through the six and twelve month reports and published as outlined in the PHN Performance Framework.

Activity Work Plan Reporting Period and Public Accessibility

The Activity Work Plan will cover the period 1 July 2016 to 30 June 2018. A review of the Activity Work Plan will be undertaken in 2017 and resubmitted as required under Item F.22 of the PHN Core Funding Agreement between the Commonwealth and all Primary Health Networks.

Once approved, the Annual Plan component must be made available by the PHN on their website as soon as practicable. The Annual Plan component will also be made available on the Department of Health's website (under the PHN webpage). Sensitive content identified by the PHN will be excluded, subject to the agreement of the Department.

It is important to note that while planning may continue following submission of the Activity Work Plan, PHNs can plan but must not execute contracts for any part of the funding related to this Activity Work Plan until it is approved by the Department.

Further information

The following may assist in the preparation of your Activity Work Plan:

- Clause 3, Financial Provisions of the Standard Funding Agreement;
- Item B.3 of Schedule: Primary Health Networks After Hours Funding;
- Item B.4 of Schedule: Primary Health Networks Core Funding;
- PHN Needs Assessment Guide;
- PHN Performance Framework; and
- Primary Health Networks Grant Programme Guidelines.

Please contact your Grants Officer if you are having any difficulties completing this document.

1. (a) Strategic Vision

PHN's may attach an existing strategic vision statement. If the PHN does not have a strategic vision statement please outline, in no more than 300 words, an overview of the PHN's strategic vision for the 24 month period covering this Activity Work Plan that demonstrates how the PHN will achieve the key objectives of:

- *Increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and*
- *Improving coordination of care to ensure patients receive the right care in the right place at the right time.*

Murray PHN's Vision is:
"Better health and wellbeing for our community through better care and better systems".

Our role is to:
Understand and address the health needs of our communities by engaging key partners to deliver targeted actions that:

- Increase the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes, and
- Improve the coordination of care to ensure patients receive the right care in the right place at the right time.

Our strategic goals are:

1. Ensure that the coordination of care is targeted and tailored to our communities and that innovation and engagement are core to our efforts in improving our healthcare systems and service delivery.
2. Address national priority areas as well as explore emerging health and healthcare issues with our communities, and work with service providers pursuing opportunities based on evidence and expertise, and being clear about how we will measure shared success.
3. Strengthen our organisational capability so that we are responsive, accountable and productive.

1. (b) Planned activities funded by the flexible funding stream under the Schedule – Primary Health Networks Core Funding

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2016-18. These activities will be funded under the Flexible Funding stream under the Schedule – Primary Health Networks Core Funding.

Summary of planned activities

NP1 Cancer screening, early detection and coordination
NP2 Murray Health Pathways
NP3 Supporting health workforce capacity
NP4 Increase access to primary health care services for Aboriginal and Torres Strait Islander people with chronic disease
NP5 Health promotion, prevention and health education for people at risk of poorer health outcomes
NP6 Autism Assessment and diagnosis service
NP7 Healthy lifestyle programs and service coordination for targeted rural communities
NP8 Improve coordination of care through access to a range of specialist allied health services for rural patients
NP9 Improve access to health services for older Victorians living in smaller communities
NP10 Regional collaboration
NP11 Potential avoidable hospitalizations

OP1 Quality improvement in General Practice
OP2 Population health planning and evaluation

Proposed Activities	
Priority Area (e.g. 1, 2, 3)	Bowel Cancer
Activity Title / Reference (e.g. NP 1.1)	NP1 Cancer Screening, early detection and coordination
Description of Activity	Victorians living in regional and remote locations commonly have a lower 5 year cancer survival rate than urban areas. While the Murray Needs Assessment identified the significance of bowel cancer, this activity incorporates initiatives that address continuity and quality of cancer care at the health systems, services, teams and individual level. This activity includes: **1. Needs Assessment** This will build upon and integrate evidence. Its focus is to understand and respect the complexities and challenges of cancer screening, care pathways and survivorship care so that there is clarity, confidence and appropriate resource allocation across all stakeholders. **2. Capacity Building (resourced separately as part of Core Funding : GP support)** • Use of GP patient evidence to identify current and target screening rates. Decision support and risk stratification tools will be deployed to support efficient and efficient workflows. • Professional development General Practitioners to assess patients, offer support and advice, refer back to secondary care or signpost to other services as appropriate (e.g. counselling and financial and social support), and be aware of the possibility of a second cancer. • Utilisation of the Chronic Disease Management Plans and MBS items to design region appropriate screening workflows and survivorship care plans. **3. Information Technology** • Incorporate optimal care pathways (from the National Work Plan to improve cancer care) within the implementation of health pathways. Localised health pathways will include colorectal and lung cancer pathways will be completed. • Implementation of telehealth technology to enable cancer survivors in rural and remote areas to access specialist services using a stepped care approach. **4. Redesign of Services**

	Re-designing existing services focus upon early detection workflows, care coordination and to facilitate the transition of patients off active cancer treatment, support for rehabilitation, return to work, psychosocial and community based support. Initiatives will include: • Embedding routine and systematic screening tools within General Practice workflows and within localised health pathways • Developing models of shared care between acute sector, GP's, nurses, allied health and community organisations. For example, shared care and discharge to GP follow-up has the potential to increase specialist clinic capacity. • Working with community nursing services and Royal Flying Doctors Service (RFDS) in order to provide improved access to supported care **5. Community Led Initiatives** • Investigate the need for establishing volunteer-led support groups and networks for cancer survivors, with a focus upon encouraging self management • Provide seed funding for small-community-led initiatives which show potential in a sustainable and replicable way. • Work with Aboriginal and Torres Strait Islander communities to redesign existing services to better address local needs.
Collaboration	• Acute hospital services, including oncology specialists • Loddon Mallee and Hume Region Integrated Cancer Support • Department of Health and Human Services (Victoria) • Loddon Mallee and Hume Regional Health Alliance • ACCHOs • Community and Clinical Advisory Councils • General Practice
Indigenous Specific	Engagement with Aboriginal and Torres Strait Islander Communities is an explicit area of focus for this project, but not exclusive.
Duration	2 years

Coverage	Network wide. The activity will begin within the Local Government areas of Campaspe, Gannawarra, Loddon and Buloke and then scale across the catchment area.
Commissioning approach	Direct delivery: Flexible funding will be directed– integrated within GP support and engagement with acute services and workforce development
Data source	• De-identified patient records from General Practice • Clinical and Patient feedback mechanisms • Victorian Cancer Registry, Cancer Council Victoria 2015 • Practice activity data, describing MBS activity, Shared Health Summaries and GP Management Plans

Proposed Activities	
Priority Area (e.g. 1, 2, 3)	Integrated Care Pathways
Activity Title / Reference (e.g. NP 1.1)	NP2 Murray Health Pathways
Description of Activity	**Overview of Health Pathways** Murray HealthPathways is a collaborative and structured approach to improving health care quality, integration and efficiency across primary health, the acute sector and community health. It brings together general practitioners (GPs), specialists, community based health providers and allied health professionals to discuss optimal assessment and management of common medical conditions, including when and where to refer patients. The result is a single, web-based portal for localised and evidence-based information that is designed to be accessed by GPs and primary care health professionals at the point of care. Murray PHN is implementing HealthPathways across the whole region partnering with the five major regional hospitals (Mildura Base Hospital, Bendigo Health, Goulburn Valley Health, North East Health Wangaratta, and Albury Wodonga Health) to provide specialist expertise. Murray PHN will complete a minimum of 40 pathways in the first year and each pathway being developed will tap into a minimum of 10 external specialists, health professionals or community services. Murray PHN has employed general practice clinical editors to work with each hospital and services within each hospital's catchment to develop pathways concurrently. This provides significant efficiency, reducing duplication of effort whilst supporting a localised approach. **What the activity will allow for:** • A web-based platform to support the management, coordination and referral of patient care available to all APRA registered practitioners across the catchment area. • Systemic and integrated decision support tools and localised health pathway access for General Practitioners to minimise the variation of care coordination, and improve quality of referrals. • Employment of 4 GP Clinical Editors to localise HealthPathways for Murray PHN population

	• Structured and recurrent methodology for Murray PHN to collaborate and co-design improvements to local health pathways with acute and primary health sectors across a diverse catchment area. • Platform to systematically address the management of care relative to health priorities at scale, across the catchment area. **Why is this important?** - Addresses the national health priorities and local health needs identified in Murray PHN needs assessment - Ensures that the coordination of care is targeted and tailored to the local health system context - A scaled and systematic investment to drive improvement in health care coordination, effectiveness and efficiency - Embeds innovation and engagement as core to our efforts in improving our healthcare systems and service delivery - There is an investment logic with a focus on outcomes - Focus on optimising quality care within the primary health setting - Provides a systematic and accessible platform to support consistent management, coordination and referral of patient care, particularly for patients with or at risk of chronic disease. **Murray HealthPathways will support the primary health sector through:** - Integrate referral options and decision support tools for clinicians within General practice and health service operating systems. This will support more efficient use of health specialists and resources, potentially beyond historical referral avenues. - Providing a tangible and systematic way to address the fragmentation of our health systems, and enables health organisations and disciplines catchment to work collaboratively to improve coordination of care with particular focus on chronic, complex and at risk population groups.

	- Increased standardisation of primary health care, as there are now 5 of the 6 PHNs in Victoria all in the process of developing Health Pathways collaboratively. - Providing a forum for primary health clinicians to drive patient management processes in collaboration with their secondary care clinician colleagues. - Promotion of timely care of patients in primary care settings as well as more effective referral of patients to the acute sector, with potential to reduce avoidable hospital admissions. Murray HealthPathways applies a catchment wide approach to implementation and a regional approach to general practice and hospital engagement. This approach maximises activity efficiencies and economies of scale to deliver the program across a significant geographic area, as well as ensure the structures are in place to allow for nuance and variation at a local level.
Collaboration	Murray HealthPathways is partnering with five regional health services within our catchment area: • Mildura Base Hospital • Bendigo Health • Goulburn Valley Health • North East Health Wangaratta, and • Albury Wodonga Health. Each of these health services is in the process of signing a memorandum of understanding committing their staff, including specialists, to contribute to HealthPathway development and review. The Loddon Mallee and Hume regions of the Victorian Department of Health and Human Services is also actively involved, with early work on vulnerable children and cancer pathways, identified as high need areas in these regions. Smaller, rural health services, community health, community services and non-government organisations across the Murray PHN region have been consulted and will contribute as HealthPathways are localised.
Indigenous Specific	The project specifically incorporates indigenous specific pathways, but it is not exclusive. Decision support tools and resources and referral options embedded within Health Pathways will:

	• Linking of culturally accessible referral options and culturally appropriate patient information within local health pathways • Decision support tools to support systematic and consistent approaches to appropriately identify Aboriginal and Torres Strait Islander people
Duration	Two year: January 2016 – June 30 2018
Coverage	Murray HealthPathways covers the entire PHN region.
Commissioning approach	The implementation of Health Pathways, incorporating the support and development of clinical editorial groups to localise pathways, is coordinated and managed by Murray PHN. Clinical Editors are employed directly by Murray PHN and are based relative to hospital catchment areas to ensure effective engagement
Data source	Quarterly reports will be prepared that draws from financial reporting systems and the administration software of HealthPathways. The scope of which will include: • Health pathways Activity • Clinical feedback • Patient Feedback, incorporated within organisation-wide consumer participation strategy.

Proposed Activities	
Priority Area (e.g. 1, 2, 3)	Workforce Development
Activity Title / Reference (e.g. NP 1.1)	NP3 Supporting Health Workforce capacity
Description of Activity	This activity will see the Murray PHN continue to work in collaboration with expert agencies to provide support to rural and regional health professionals through a tailored, targeted and accessible professional development program. The program is RACGP accredited. The scope of the professional development includes: • Accessible education and training delivered face to face and remotely via webinars • Support cultural competency skills development • Facilitation of forums that encourage peer support, networks which are place-based and or speciality based. • Information and guidance on building practice sustainability and viability • Delivered locally to reinforce local context (health evidence, service system characteristics and specialists). • Development of learning platforms and central information hubs to support self-directed learning and networking. • Development of targeted strategies to foster the Indigenous Health Workforce participation and engagement in professional development and networking with mainstream health professionals. • Evaluation of the region wide professional development activities to assess quality, delivery modes and ongoing impact to clinical activity and capacity relative to regional and population health needs and priorities. Professional development is coordinated by the PHN across the region. This resource provides for ongoing coordination and development of CPD in line with National Performance Indicators. PD content is delivered by third parties relative to specific subject matter.

Collaboration	Collaborations will be sought with expert agencies to deliver this activity. Expert agencies may include the Rural Workforce Agencies, GP Training providers, RACGP, ACRRM, Accreditation Bodies, peak bodies such as APNA, AAPM.
Indigenous Specific	The project specifically incorporates which are working with indigenous issues, but it is not exclusive. Professional development content and participation will activity target specific issues associated with Indigenous health and wellbeing, and reinforce culturally accessible regional pathways. Specific strategies to support the capacity of the Indigenous health workforce is also incorporated within the scope of this activity.
Duration	1 July 2016 – 30 June 2018
Coverage	This activity will cover the PHN catchment.
Commissioning approach	This activity is coordinated by PHN regional teams delivered within Mildura, Shepparton, Bendigo and Albury/Wodonga. Implicit to effective coordination is the integration of professional development topic areas with localised referral paths and recognised clinical leaders. The outcome of professional development coordinated by the PHN allows for: • Integration of population health evidence with the ongoing learning and development of primary health clinicians to support contemporary understanding of issues and needs within local areas • Regional tailoring of professional development to addressed localised system and population health issues • Reiteration of preferred clinical care, coordination and management of patient care relative to local context, or the identification of opportunities to improve clinical pathways and standards of care based upon system characteristics and population health evidence.
Data source	• Feedback from clinicians • Professional development participation relative to geographic area, disciple and modality of delivery.

Proposed Activities	
Priority Area (e.g. 1, 2, 3)	Prevention and early intervention
Activity Title / Reference (e.g. NP 1.1)	NP4 Increase access to primary health care services for Aboriginal and Torres Strait Islander People with chronic disease
Description of Activity	The aim of this activity is in line with the priority area identified in the Murray PHN annual plan for Aboriginal & Torres Strait Islander communities and key focus on impact of chronic disease. The service will support Aboriginal and Torres Strait Islander people who have chronic disease to access health checks and improve management through care planning and coordination of their health care needs. Support is provided by a registered nurse/ Aboriginal Health Worker. This activity is funded through the Flexible Fund (formerly RPHS), not funded through CCSS activity. The service is delivered in partnership with an Aboriginal Community Controlled Health Organisation (ACCHO) to promote access and cultural safety. The service provides access to Aboriginal Health Checks for the broader Aboriginal community, unlike CCSS which is targeted at people with a diagnosed chronic condition. It links closely with the General Practitioners located within the service and allied health and other mainstream services available in the community. Murray PHN will continue to work with the service provider to assess need and context for this service to inform future commissioning decisions.
Collaboration	Murray PHN will work closely with the ACCHO in delivery and review of the service. Local General Practitioners are also able to refer clients to the service and Murray PHN encourages feedback from these stakeholders to ensure the service is supporting improved health management and longer term outcomes. Murray PHN has a consumer participation strategy which will help to inform consumer engagement.
Indigenous Specific	Yes. This activity is specifically targeted towards supporting Aboriginal and Torres Strait Islander people.

Duration	The duration of this activity is 1/7/16 to 30/6/17. We will continue to monitor and review over the course of the service.
Coverage	Echuca, Victoria in the Shire of Campaspe.
Commissioning approach	The commissioning approach for this service is to directly recommission services with the current service provider for continuity of care. The services are currently provided by Njernda, the local ACCHO, which has strong connections with the local Aboriginal and Torres Strait Islander community. The contracted services will be monitored and evaluated through regular review of qualitative and quantitative performance metrics.
Data source	The data will be collected and reported as output data from the contractor. Data collection will cover the period of service from 1/7/16 to 30/6/17.
Proposed Activities	
Priority Area (e.g. 1, 2, 3)	Prevention and early intervention
Activity Title / Reference (e.g. NP 1.1)	NP5 Health promotion, prevention and health education for people at risk of poorer health outcomes
Description of Activity	The Murray PHN needs assessment has identified a high prevalence of chronic disease and poor access to allied health services, particularly in rural communities. This can contribute to poorer health outcomes and increased burden of disease. Murray PHN is planning to utilise the existing experienced workforce and resources available for health promotion, prevention and health education as an adjunct to allied health access to support rural communities with improved health literacy and support. The aim of these activities is to provide health education and health promotion for people at risk of poor health outcomes. The target population will be people with chronic disease or people at risk of developing chronic disease, who live in these rural communities. The focus of these activities will align with regional health priority areas. Murray PHN will continue to work with service providers, the community and other stakeholders to explore future direction of these activities and alignment with regional PHN and Commonwealth priority areas through continued

	development of regional health profiles and engagement with clinical and community advisory councils.
Collaboration	We are engaging with service providers, local government and Victorian Government funded Primary Care Partnerships to identify local health promotion and prevention priorities to support collaborative effort across the continuum of health promotion intervention. We will work with service providers and General Practice in the continued review of service delivery arrangements and accessibility.
Indigenous Specific	No
Duration	The duration of these activities is 1/7/16 to 30/6/17. We will continue to monitor and review over the course of the service in line with emerging health needs and priority areas.
Coverage	These activities will be purchased across the Murray PHN catchment, with a focus in rural communities including the Shire of Loddon, Gannawarra Shire, the Rural City of Swan Hill and the Alpine Shire.
Commissioning approach	The commissioning method is to recommission services with the service providers who have existing health promotion experience and capability in our rural and regional communities, this enables leverage of existing efforts and capacity. The contracted services will be monitored and evaluated through regular review of qualitative and quantitative performance metrics.
Data source	This will be captured through Murray PHN data reporting contractual requirements and the data system. Data will be collected from the date of commencement of commissioned services.

Proposed Activities	
Priority Area (e.g. 1, 2, 3)	Prevention and early intervention
Activity Title / Reference (e.g. NP 1.1)	NP6 Autism Assessment and Diagnosis Service
Description of Activity	This service was commissioned in line with the requirement for PHNs to ensure continuity of Medicare Locals services in 2014/15. The service was identified in the Lower Murray Medicare Local needs assessment and has strong community support. Murray PHN has worked with the commissioned service provider to strengthen the service delivery protocols and linkages with mainstream services and supports for people and carers of people with autism. The Autism assessment and diagnosis service facilitates early assessment and diagnosis through access to specialists. The target population is people aged 0-25 years of age, living in the Sunraysia and Northern Mallee District, who have been referred by a GP, Paediatrician or Psychiatrist for assessment of Autism Spectrum Disorder. This service has facilitated the enhancement of local service provider networks and skills in assessment and management of Autism. Murray PHN will continue to work with the local community, service providers, advisory councils and other stakeholders to support the transition of this service to broader mainstream service providers.
Collaboration	This project includes collaboration with the local hospital network, a network of autism health service providers and community allied health providers. The service has connections with consumers and carers through a local autism support group. The Murray PHN consumer participation strategy will help to inform consumer engagement.
Indigenous Specific	No.
Duration	The duration of this activity is 1/7/16 to 30/6/17.
Coverage	These services will be available in the Rural City of Mildura, and surrounding district.
Commissioning approach	This service was commissioned through an open tender in June 2015. The existing service provider will be directly re-engaged. Murray PHN will work with the current service providers and

	stakeholders to explore future options for the service in the context of PHN and Commonwealth priority areas.
Data source	The data will be reported as output data from the contractor. Data collection will cover the period of service from 1/7/16 to 30/6/17.

Proposed Activities	
Priority Area (e.g. 1, 2, 3)	Access to allied health
Activity Title / Reference (e.g. NP 1.1)	NP7 Healthy lifestyle programs and service coordination for targeted rural communities
Description of Activity	The Murray PHN needs assessment has identified a high prevalence of chronic disease and poor access to allied health services, particularly in rural communities. This is contributing to poorer health outcomes and increased burden of disease. Murray PHN is planning to utilise the existing experienced workforce and resources available to provide access to primary health services and support including service coordination, and health education and health promotion activities for people at risk of poor health outcomes who live in isolated, rural communities. In many cases these communities do not have any other service provision arrangements located within the community. The target population will be people who live in isolated, rural areas with limited access to health services and at risk of poorer health outcomes. The services will focus on locally based health education and promotion, risk factor screening, service coordination support, and community capacity building activities. The focus of these activities support regional health needs. Murray PHN will continue to work with service providers, the community and other stakeholders to explore future direction of these activities and alignment with regional PHN and Commonwealth priority areas through continued development of regional health profiles and engagement with clinical and community advisory councils.
Collaboration	We will engage service providers, local government and Victorian Government funded Primary Care Partnerships, and advisory council's to build shared understanding of the local health needs and context including other services in the district that could have a role in these communities to support needs. Through collaboration we will seek to determine the most efficient and effective service arrangements to meet the health needs of these communities in a regional context.
Indigenous Specific	No.
Duration	The duration of this activity is 1/7/16 to 30/6/17.
Coverage	The services are located in Violet Town, Walwa and Corryong.
Commissioning approach	The existing service providers will be directly engaged to support continuity of care and participation in the review and possible re-design of future service models and access arrangements.

	The contracted services will be monitored and evaluated through regular review of qualitative and quantitative performance metrics.
Data source	This will be captured through Murray PHN data reporting contractual requirements and the data system. Data will be collected from the date of commencement of commissioned services.

Proposed Activities	
Priority Area (e.g. 1, 2, 3)	Prevention and early intervention
Activity Title / Reference (e.g. NP 1.1)	NP8 Improve coordination of care through access to a range of specialist allied health services for rural patients
Description of Activity	The Murray PHN needs assessment has identified a high prevalence of chronic disease and poor access to allied health services, particularly in rural communities. This can contribute to poorer health outcomes and increased burden of disease. Murray PHN will utilise the existing experienced workforce and resources available in these rural communities to facilitate access to a range of allied health services and to improve coordination and integration of care. Services are targeted at PHN priority areas of chronic disease through access to allied health professionals and services in rural communities including: Podiatry; Diabetes Education; Dietetics; Physiotherapy; Exercise Physiology; Social Work; Occupational Therapy. The target population is people living in rural communities with a particular focus on people with chronic disease or people at risk of developing chronic disease, who live in these rural communities. Murray PHN will continue to work with service providers, the community and other stakeholders to explore future direction of these activities and development of models of care that strengthen efforts for outcomes in line with regional PHN and Commonwealth priority areas through continued development of regional health profiles and engagement with clinical and community advisory councils. Service providers will be supported to develop more integrated approaches to delivery of services. Uptake of innovative solutions to support service access and appropriate sharing of client information, for instance through utilisation of My Health Record, will be supported.
Collaboration	We are engaging with service providers, local government and Victorian Government funded Primary Care Partnerships to build a shared understanding of local health priorities and context. We will work with service providers and General Practice in the continued review of service arrangements and service coordination and integration arrangements.
Indigenous Specific	No.

Duration	The duration of these activities is 1/7/16 to 30/6/17. We will continue to monitor and review over the course of the service in line with emerging health needs and priority areas.
Coverage	These activities will be commissioned in communities including : • Mildura, Robinvale, Ouyen, Manangatang, Sea Lake and surrounding districts, • Swan Hill, Nyah, Kerang, Boort, Cohuna and surrounding districts, • Charlton, Birchip, Inglewood, Wedderburn and surrounding districts, • Castlemaine, Elmore, Heathcote and surrounding districts, • Shepparton, Benalla, Cobram, Euroa, Alexandra, Kilmore, Eildon, Yea and surrounding districts, • Yarrawonga, Wangaratta, Beechworth, Chiltern, Rutherglen and surrounding districts, • Mansfield, Mt Beauty, Bright, Ovens, Myrtleford, Yackandandah and surrounding districts.
Commissioning approach	The commissioning approach is to recommission services with current service providers with existing skills and capabilities to support continuity of care. This enables leverage of existing efforts and community capacity. The contracted services will be monitored and evaluated through regular review of qualitative and quantitative performance metrics. Where new service arrangements are commissioned, procurement approaches commensurate with the services and complexity will be undertaken.
Data source	This will be captured through Murray PHN data reporting contractual requirements and the data system. Data will be collected from the date of commencement of commissioned services.

Proposed Activities	
Priority Area (e.g. 1, 2, 3)	Access Issues for Aged Population
Activity Title / Reference (e.g. NP 1.1)	NP9 Improve access to health services for older Victorians living in smaller communities.
Description of Activity	The Murray PHN needs assessment has identified a significant ageing population and variable access to services for the elderly. This activity will facilitate access to a range of specialist allied health services for aged people. The target population will be older people with chronic disease or complex health needs who live in smaller rural communities. Service delivery models will support improved access, coordination of care and integration. Murray PHN will work with service providers and the community to explore future focus and context for of these activities, and alignment with PHN and Commonwealth priority areas.
Collaboration	We are engaging with service providers, local government and Victorian Government funded Primary Care Partnerships to identify local health priorities. We will work with aged care service providers and General Practice in the continued review of service arrangements.
Indigenous Specific	No
Duration	The duration of these activities is 1/7/16 to 30/6/17. We will continue to monitor and review over the course of the service in line with emerging health needs and priority areas.
Coverage	These activities will be commissioned in communities across the Murray PHN catchment including : • Mildura, Robinvale, Ouyen, Manangatang, Sea Lake and surrounding districts, • Swan Hill, Kerang, Boort, Cohuna and surrounding districts, • Castlemaine, Heathcote and surrounding districts
Commissioning approach	The approach to commissioning is to recommission services with the current service providers for continuity of care. The contracted services will be monitored and evaluated through regular review of qualitative and quantitative performance metrics. Appropriate procurement arrangements will be undertaken for new services commensurate with the complexity and scale of proposed services.
Data source	This will be captured through Murray PHN data reporting contractual requirements and the data system. Data will be collected from the date of commencement of commissioned services.

Proposed Activities	
Priority Area (e.g. 1, 2, 3)	Health System Fragmentation
Activity Title / Reference (e.g. NP 1.1)	NP10 Regional Collaboration
Description of Activity	Health system fragmentation has been reported by health services, clinicians and consumers as a major challenge for our catchment. Its impact to the efficiency of health service systems and access to health services will have a direct and significant impact of health outcomes for patients across the Murray PHN catchment. The complexity of health service systems, diversity of these arrangements and the community context in which they operate across the Murray PHN catchment area is significant. Some examples of defining and arguably unique features to the Murray PHN catchment include: • The significance of health system coordination across State jurisdictions, particularly in twin-city populations such as Albury/Wodonga and Echuca / Moama; • The diversity of population settings, ranging from very few, large Regional population centres of over 100,000 people to very many, smaller rural settlements of less than 3000 people • The variability in health care arrangements across health services and its impact to accessing primary, secondary and tertiary services; • The characteristics of health workforce populations, particularly as it relates to areas of workforce shortage across different geographies and specialties. The responsive design and development of models of care and commissioning value is underpinned by: • Ongoing and collaborative arrangements that exist locally. For Murray PHN that applies to the establishment of four regional hubs across the Murray PHN area, located within Mildura, Shepparton, Bendigo and Albury / Wodonga. • Embed locally respected and influential General Practitioners and clinical leaders within the engagement work of the regional hubs to support effective and transparent collaboration and influence across health and community services and systems. Medical Advisors and the interface with local advisory structures are important elements of regional engagement.

	• Ensure strategic focus and efficiency by supporting regional efforts through a catchment wide commissioning, performance and strategic planning frameworks.
Collaboration	• Acute and sub-acute health facilities across the catchment • Aged care facilities • Health workforce training organisations, universities and regional associations (eg. Rural Workforce Agency). • Local Government • Human Services • General Practice and practitioners • ACCHOs • Pharmacy • Allied Health
Indigenous Specific	The needs of indigenous people are incorporated within this activity but is not exclusive.
Duration	1 July 2016 – 30 June 2018
Coverage	This activity will cover the PHN catchment.
Commissioning approach	This activity is coordinated by PHN regional teams delivered within Mildura, Shepparton, Bendigo and Albury/Wodonga. Implicit to effective regional coordination is the integration of population and commissioning evidence with valued and accessible engagement.
Data source	• Business intelligence systems to be developed

Proposed Activities	
Priority Area (e.g. 1, 2, 3)	Potential avoidable hospitalizations
Activity Title / Reference (e.g. NP 1.1)	NP11 Potential avoidable hospitalizations
Description of Activity	Increasing rates of avoidable presentations and preventable admissions and readmissions to acute health services add significant burden to the Victorian health system. Effective management of patients enduring chronic disease by improving access and connections to community based and primary care services can improve health outcomes and reduce increasing costs attributable to these growing issues. Primary Health Networks will focus on system change and service improvement through greater co-ordination and integration underpinned through the utilization of collaboration and evidence based information. Murray PHN will undertake a specific project with relevant partners to utilize hospital data, identify and track patient's journey through the acute and community based health systems, identify system and service change that improve access and provision of care and prospectively monitor and assess intervention effectiveness. The project is based as a qualitative and quantitative prospective study to identify contributing process issues and care/support improvements in acute and community settings It will provide comparative analysis and significant benchmarking opportunities It will include comprehensive analysis of general practice data and care arrangements relative to cohort eligibility and location It will rely upon analysis of relevant acute and primary care system and acute processes in 4 distinct communities triggered by the identification of acute and primary care system and care improvements in 4 distinct communities The project will identify avoidable presentations to • Emergency Department • Acute facility admissions with length of stay = or < 2 days of patients with defined chronic disease Illnesses

	• Candidates that eligible for cohort 2 that are readmitted to hospital within 28 days of prior admission
Collaboration	The following 4x Acute hospital services will be involved in • Mildura Base Hospital • Bendigo Health • Goulburn Valley Health • Albury Wodonga Health General Practice, Allied Health Pharmacy and other primary care health providers in the 4 respective locations will be involved designing enhanced care provision to identified patients through this project.
Indigenous Specific	Engagement with Aboriginal and Torres Strait Islander communities is an explicit area of focus for this project, but not exclusive.
Duration	1 July 2016 – 30 June 2017
Coverage	This activity will be implemented across our catchment area through the large regional health services in each of our four regions that span our catchment area.
Commissioning approach	Direct delivery: Flexible funding will be directed– integrated within GP support and engagement with acute services and workforce development
Data source	• Hospital Emergency Department and Admission data • De-identified patient records from General Practice • Clinical and Patient feedback mechanisms • Practice activity data, describing MBS activity, Shared Health Summaries and GP Management Plans

1. Planned core activities funded by the operational funding stream under the Schedule – Primary Health Networks Core Funding

PHNs must use the table below to outline core activities (excluding administrative and governance related activities) funded under the Operational Funding stream as described in section 1.5.1 of the PHN Grant Programme Guidelines.

Note 2: Indicate within the duration section of the table if the activity relates to a two year period (2016-2018) or a one year period (2016-2017).

Proposed general practice support activities	
Activity Title / Reference (e.g. OP 1)	OP1 Quality Improvement in General Practice
Description of Activity	Central to the Murray PHN General Practice support program is the medical home model of care. With this comes the focus to provide patients with continuous, accessible, high-quality and patient-centred care via the agency of General Practice. Care coordination by the GP that is supported by information technology, delivered by a multidisciplinary team and adherent to evidence-based practice guidelines. There are 185 General Practices across the almost 100,000 sqkms of the Murray PHN catchment area; each of which are diverse in scale, complexity and business structure. A relationship-management approach with General Practice is cornerstone to our approach to support tailored and effective influence to the workflows, systems and quality of care within General Practice. General Practice support staff are located in each of the four regional centres across the catchment in Bendigo, Mildura, Shepparton and Albury / Wodonga. There are four dimensions of the General Practice support as described below **a. Quality Data Program** Accurate and real-time data is pivotal to the performance and impact of general practice to health outcomes. Data is an important tool and can drive process changes across many levels in general practice settings. The Quality Data Program will utilize the Pen CS CAT Plus technology to assist general practices perform regular clinical audits and data cleansing of their patient population and ultimately improve the quality of care delivered to patients. At an aggregated de-identified patient data level, the PHN will be able to monitor trends in clinical activity and health indicators and report performance at a practice, local area, regional and catchment level. This activity is a primary data source that informs population health understanding and commissioning activities of the PHN. **b. Quality Improvement Program** The CAT Plus functionalities (CAT4 – clinical audit tool and Topbar – clinical decision support) will be integrated across PHN quality improvement initiatives that will systematically target preventable hospital admissions through four specific target areas:

	• *Increasing cancer screening activity* including bowel, breast and cervical and other cancer prevention activities identified in the needs assessment. • *Increasing childhood immunisation* coverage rates and other groups included in the National Immunisation Program Schedule identified as priorities in the needs assessment. • Systematic and catchment wide implementation of *integrated risk assessment*, embedding risk stratification and assessment tools, specifically targeting patients with and at risk of chronic disease. • Provision of case management and *tailored performance reports to general practices* across the PHN catchment that focus on capacity building and opportunities to improve patient experiences and health outcomes. **c. Case Management Support for General Practice** Provision of tailored and case management support to assist general practices to develop well performing teams that focus on quality care and risk management; that is achieving and maintaining Accreditation. **d. Embed Digital Health technology within General Practice** This activity focuses on promoting and supporting general practices to participate in the Practice Incentives Payment (PIP) eHealth program. A range of supports will be provided including: • Training to general practice teams on the My Health Record (MyHR) system • Quality improvement activities in general practice to improve the quality of their patient health summaries • Provide information and guidance to general practices to be able to make informed decisions on technologies (telehealth, MyHR, Secure Messaging, e-referrals) that will improve care delivery and coordination.
Collaboration	This activity will be delivered in partnership with participating general practices, local health providers and potentially with other stakeholder groups with shared mutual benefits (eg. DHHS) relevant to the initiative.
Duration	1 July 2016 – 30 June 2018.

Coverage	The activities will cover the entire PHN region.

Proposed general practice support activities	
Activity Title / Reference (e.g. OP 1)	OP2 Population Health Planning & Evaluation
Description of Activity	Aim: To develop and implement an integrated, systemised population health information management strategy that responds to identified health and service priorities and systemises the collection of population health based data and knowledge, integrates clinical and community advisory structures into strategic decision making in commissioning, engagement and coordination functions for the identified priority areas across the catchment. **Action area 1: Building population health knowledge management** 1a) Catchment profile: • Catchment overview – demographics, summaries of health and service needs, strategic directions and related priority actions and projects underway or planned • Sections 2 and 3 from needs assessment • Case studies and/or exemplars to showcase key partner agencies, service providers, co-funders • Hyperlinks to key documents about the catchment that impact on primary health care 1b) Regional profiles (x4): • Regional overview from health needs and services system perspective • set of case studies (2-4) linked to priorities • set of exemplars (2-4) showcasing collaborative models of care, local innovation in bespoke service design, evidence of success from formal, active partnering strategies • set of identified priority actions and projects underway or planned 1c) Health Issue profiles based on identified priorities, including but not limited to: • AOD • Mental health • Aged care • Aboriginal & Torres Strait Islander health • CDM (diabetes, cardiac related, possibly respiratory) These are short form style reports with more regional level evidence about need, service issues and challenges and planned improvement; and produced across multi-media platforms. **Action Area 2: Implementation of advisory council structure**

	2a) Consultation and establishment of 3 types of advisory council: population health planning, clinical and community across the catchment. Design of induction and development program for members of the Population Health Planning, Community and Clinical Advisory Councils to optimise their contribution and strategic alignment. 2b) Council members' induction and development program, including planning and evaluation frameworks established and implemented for advisory council structure. 2c) Advisory council activities and input integrated into governance and management decision making structures and documented for broader publication, ie: periodic reports to community, web based 'collaborative dialogues', etc. **Action Area 3: System development in population health planning & evaluation** 3a) Development and implementation of a population health planning framework that embeds new business processes across all teams, levels and projects that will achieve a more integrated, accurate and iterative knowledge management system. 3b) Consultation and potential establishment of a high level population health network in the catchment to strengthen the primary health care sector's access and uptake of evidence based interventions and appropriate models of care. 3c) Development of an enterprise wide system to drive service effectiveness and system efficiencies through: • Service mapping: work will be incorporated, initially to support the Health Pathways implementation, and then be scaled across other activity and for other priority areas as required, particularly for primary care service providers, to address equity and access needs as well as identify effective models of care and service system efficiencies. • Research, evaluation & analytics: methodologies and tools for measuring outputs and outcomes, including investigation and adaptation of an outcomes based evaluation framework commencing with a trial of an outcomes based investment model to test alternative financing and business logic models. • Service gap and market analyses for specific populations as identified through ongoing needs assessment work, specifically identifying increased care coordination and pathways for vulnerable populations or under resourced communities, ie: clients of AOD, mental health, aged care services and GP patient populations from low socio economic communities. **Action Area 4: Innovation Development**

	4a) Establish an innovation strategy that fosters new or modified interventions, emerging collaborations and partnerships to produce improved patient outcomes that are linked to population health indicators.
Collaboration	The overall activity will be delivered through a range of collaborations to be developed as placed based forums; system based networks; institutional and sector based alliances. Where possible, this work will draw on existing structures and networks to inform and progress the broader population health planning and evaluation work. Given the advisory council structure, key stakeholders have indicated their commitment to participate including: universities (Melbourne, Monash and Latrobe); state government regional offices; and a range of health services from acute, large hospitals through to small rural health and community health services; key place based community and social services; and local government. In addition to this, a number of key business or corporate stakeholders are considering engaging in this work with three emerging drivers: their perceived corporate social responsibility, as employers concerned about workplace health; and as prospective suppliers in the future primary health care market (such as telehealth providers). It is expected that some initiatives will result in co-investment and/or financial sponsorship as an outcome.
Duration	July 2016 – June 2018
Coverage	Murray PHN catchment and discrete projects across each of the four regions within the catchment as determined

2. Indicative Operational and Flexible Fund Budget 2016-2017

Please attach the PHN's 2016-17 indicative operational and flexible fund budget in an excel file and in the format provided below.

Note: Total Income less Total Expenditure should equal zero

3. (a) Strategic Vision for After Hours Funding

Please outline, in no more than 500 words, an overview of the PHN's strategic vision for the 24 month period covering this Activity Work Plan that demonstrates how the PHN will achieve the After Hours key objectives of:

- increasing the efficiency and effectiveness of After Hours Primary Health Care for patients, particularly those with limited access to Health Services; and
- improving access to After Hours Primary Health Care through effective planning, coordination and support for population based After Hours Primary Health Care.

In 2016-17 and onwards, your organisation is required to:

- Implement innovative and locally-tailored solutions for after hours services, based on community need; and
- Work to address gaps in after hours service provision.

Please note, although PHNs can plan for activities in the 2017-18 financial year, at this stage, current funding for PHNs After Hours is confirmed until 30 June 2017 only. PHNs must not commit to spend any part of the funding beyond 30 June 2017.

The Murray PHN strategic vision for Murray PHN for After Hours Services has four key elements.

We envisage an After Hours Primary Health Care system that

1. Encourages coordination and appropriate market led responses where possible and ensures access in areas where there is market failure.
2. Is sustainable innovative and responsive utilising appropriate technology and collaborative approaches to reduce the burden on isolated GPs
3. Continues to increase consumer awareness of the best way to determine which level of clinical support is needed after hours through more localised marketing strategies that build on the 2015/16 Network wide approach through a multifaceted marketing campaign.
4. Has reduced demand for After Hours services per capita through the effective implementation of better in hours support for key cohorts such as RACS residents, Chronic Disease sufferers, palliative patients and particular demographic groups.

These four elements will guide investments we plan to make over the next two years

3(b) Planned activities funded by the Primary Health Network Schedule for After Hours Funding

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2016-18. These activities will be funded under the Primary Health Networks After Hours Funding.

Note 1: Please copy and complete the table as many times as necessary to report on each activity.

Note 2: Indicate within the duration section of the table if the activity relates to a two year period (2016-2018) or a one year period (2016-2017). Please note, although PHNs can plan for activities in the 2017-18 financial year, at this stage, current funding for PHNs After Hours is confirmed until 30 June 2017 only. PHNs must not commit to any part of the funding beyond 30 June 2017.

Summary of planned activities

AH1 2016/17 Grants round
AH2 After hours primary health care engagement and diversion at Mildura Base hospital emergency department (MBH ED)
AH3 Regional after-hours workshops
AH4 Improve consumer and provider awareness of After Hours options
AH5 Ongoing support for access to After Hours
AH6 Continuation of the 2015/16 Grants round

Proposed Activities	
After Hours Priority Area (e.g. 1, 2, 3)	Fostering sustainable local innovations to achieve improved coordination and access.
After Hours Activity Title / Reference (e.g. AH 1.1)	AH1 2016/17 Grants Round
Description of After Hours Activity	Implement an After Hours one-off grants round for reviews and/or innovative solutions that seek to achieve one or more of the following • improve appropriate after hours access in targeted communities • reduce demand through improved patient support • reduce the burden on rural and remote GPs • address after hours challenges associated with particular cohorts or locations such as RACS, ATSI, Palliative patients, rural and remote • other applicant identified needs or gaps subject to MPHN consideration The round would be scheduled to allow commencement of projects as early as possible in 2016/17. The Need Analysis identifies a range of complexities in relation to After Hours service's including service gaps, duplication, pressure on isolated GPS, demand for non-urgent services, seasonal peaks and support for specific populations such as palliative and mental health patients. The Grants would allow organisations to undertake work to better understand their local issues and/or implement new approaches.
Collaboration	Murray PHN will work with key stakeholders in particular communities and clinical areas, the clinical council and advisory committees to ensure the grants are targeted appropriately.
Duration	The project will run throughout 2016/17and It is anticipated all funded activities will conclude on or before 30 June 2017.
Coverage	Murray PHN will seek submissions from across the Network Catchment Area.
Commissioning approach	Murray PHN will invite competitive tender submissions from an open market
Data source	The data source will be dependent of the nature of the submissions.

Proposed Activities	
After Hours Priority Area (e.g. 1, 2, 3)	Aboriginal and Torres Strait Islander Communities
After Hours Activity Title / Reference (e.g. AH 1.1)	AH2 After Hours Primary Health Care engagement and diversion at Mildura Base Hospital, Emergency Department (MBH ED)
Description of After Hours Activity	This activity will provide enhanced support to Aboriginal and Torres Strait Islanders non-admitted presentations at MBH ED to ensure • Improved referral flow back to community based services such as GPs and Aboriginal health Services. • Improved information provision back to referred agencies and primary GP. • Culturally safe and appropriate support • Identification of the drivers for presentation at ED and support awareness of primary care services in community to promote use of more appropriate and timely services. The Need Analysis states that Aboriginal and Torres Strait Islanders are over represented in UCC and ED presentations and are more likely to have a chronic disease. It also identifies the need for culturally appropriate service and support models. The Analysis also found that indigenous presentation rates to ED were higher in Murray PHN than the Victorian average. The Project was identified through engagement with regional stakeholders in relation to After Hours issues, this was also an emerging issue through innovation funding engagement in 2015/16.
Collaboration	Murray PHN will work with Mildura Base Hospital and the Mildura Aboriginal Health Forum as a steering group for the project. The forum includes key regional Indigenous and mainstream stakeholders. We will also work with relevant allied health service providers and General Practice
Duration	This project will be funded in 2016/17 and conclude by June 30 2017.
Coverage	The focus will be on all Aboriginal and Torres Strait Islanders presentations to Mildura Base Hospital ED which predominantly come from Mildura, Robinvale and Dareton.
Commissioning approach	Murray PHN will undertake a direct approach to the service provider.
Data source	The data will predominantly be sourced from MBH as the commissioned service provider.

Proposed Activities	
After Hours Priority Area (e.g. 1, 2, 3)	Regional engagement and planning.
After Hours Activity Title / Reference (e.g. AH 1.1)	AH3 Regional After Hours Workshops
Description of After Hours Activity	Implement a series of After Hours Workshops in various locations across the Murray PHN catchment area in order to • Encourage a mutual understanding of the after-hours issues and opportunities in a particular location • Encourage collaborative approaches between health service providers in a particular location • Share innovations and learnings from across the network The Need Analysis identifies a range of complexities in relation to After Hours service's including service gaps, duplication, pressure on isolated GPS, demand for non-urgent services, seasonal peaks and support for specific populations such as rural and remote, RACS residents and palliative and mental health patients. The workshops would be focused around three key areas • Residential Aged Care Services • Rural and remote GPs and Urgent Care Centres • Regional issues - which may consider larger centres and/or specific population groups or morbidities Funding will be available to address emerging issues and support initiatives and innovations arising from the workshops.
Collaboration	Murray PHN will work with key stakeholders in particular communities and clinical areas, the clinical council and advisory committees to identify suitable foci for the workshops.
Duration	The workshops will be held during 2016/17 to inform planning and after hours support during this period but also learnings for future investment and service design.
Coverage	The workshops will occur in various locations across the Network Catchment Area.

Commissioning approach	Murray PHN will undertake appropriate procurement commensurate with the planned activity. Murray PHN will ensure that transparency and probity is maintained.
Data source	The data will collected as the workshops are held and in follow up with participants. Reporting for funded activities and projects will be designed and established in the agreement.

Proposed Activities	
After Hours Priority Area (e.g. 1, 2, 3)	Improved Consumer literacy and Awareness
After Hours Activity Title / Reference (e.g. AH 1.1)	AH4 Improve consumer and provider awareness of After Hours Options
Description of After Hours Activity	It is recognised that community members are often not aware of the options available to them in the after hours period and how best to inform their decision making with respect to making choices to access services, or wait. Anecdotal evidence suggests this as a driver for avoidable or unnecessary Emergency Department (and Urgent Care Centre) attendance. The Needs Analysis states there is increasing community expectations of care on demand for non-urgent conditions. This activity aims to inform consumer awareness of appropriate after hours choices and build on the 2015/16 general marketing through undertaking targeted marketing and education to improve the understanding for After Hours Options for both consumers and providers in particular cohorts or locations. Review impact of 2015/16 generic/network wide marketing • Identify specific cohorts/locations that would benefit from targeted marketing • Develop and implement appropriate strategies in consultation with relevant stakeholders
Collaboration	The Murray PHN will work with a range of stakeholders to identify the level of awareness of the after options and to develop strategies to improve awareness where needed. This will include • ACCHO's and indigenous communities, • Local Hospital Networks • mental health providers and advocate groups, • carers • Service providers and General Practice. • Ambulance Victoria • Primary care service providers • We will also liaise with the Healthdirect Australia marketing team about the proposed marketing activity

Duration	The project will run throughout 2016/17and it is anticipated all funded activities will conclude on or before 30 June 2017.
Coverage	The marketing campaigns will be targeted to focus on discrete communities and/or locations, however they will spread across the entire PHN region.
Commissioning approach	Murray PHN will take a lead role in some elements of this work but may engage specific expertise to assist in developing appropriate strategies or marketing artwork, (e.g. An indigenous design artist). Murray PHN will determine and undertake the most appropriate approach to commissioning of services commensurate with the service being commissioned and to ensure contestability, transparency and value for money. The bulk of the anticipated expenditure is for advertising costs and production of promotional material.
Data source	The data will be sourced from Health Direct, after hour primary care services and EDs or UCCs.

Proposed Activities	
After Hours Priority Area (e.g. 1, 2, 3)	Continuing support for access to After Hours
After Hours Activity Title / Reference (e.g. AH 1.1)	AH5 Ongoing support for access to after hours
Description of After Hours Activity	Murray PHN has worked closely with service providers to support continuing access, especially in rural and regional communities and for particular cohorts such as Aboriginal and Torres Strait Islanders. This has included support for improving coordination, collaboration and improved access to afterhours support and services. The needs analysis identified key challenges in relation to the high use of UCC and ED across the network. This is particularly the case for the Aboriginal and Torres Strait Islander communities. It also identified the access challenges for patients in small remote communities. We will continue to support these communities while we review these arrangements during 2016/17 to determine viability and suitability and develop long term sustainable approaches. This approach is complimented by the After Hours Workshops and the 2016/17 Grants will be utilised to provide guidance to all stakeholders of improved systems arrangements and the targeted marketing strategies which will increase consumer awareness of the options and appropriate after hours health services.
Collaboration	Murray PHN will work with the existing providers and a range of other stakeholders to develop long term sustainable approaches.
Duration	The contracted arrangements will commence on 1 July 2016 and conclude on or before 30 June 2017.
Coverage	The contracted arrangements are in discrete locations, however they are spread across the Murray PHN catchment area.
Commissioning approach	Murray PHN will undertake a direct approach with the relevant service providers.
Data source	The data will be sourced from the contracted agencies

Proposed Activities	
After Hours Priority Area (e.g. 1, 2, 3)	Fostering sustainable local innovations to achieve improved coordination and access. (2015/16)
After Hours Activity Title / Reference (e.g. AH 1.1)	AH6 Continuation of the 2015/16 Grants Round
Description of After Hours Activity	The Murray PHN invited Applications for the 2016 After Hours Funding Grants which closed on Monday 15 March 2016. The Guidelines stipulated that the projects were to be completed by 30 December 2016. Duse to the time frame of the grant some milestones and associated payments will occur in the 2016/17 financial year.
Collaboration	Murray PHN will work with the preferred providers to finalise the approaches and the contractual arrangements.
Duration	The contract arrangements will commence shortly and conclude on or before 30 December 2016.
Coverage	The contract arrangements are in discrete locations, however they are spread across the Murray PHN catchment area.
Commissioning approach	Murray PHN undertook an approach to market in early 2015. This approach attracted very strong interest from across the PHN region from a wide range of service providers – which is evidence of strong sector engagement in regards to after-hours services.
Data source	The data source will be varied, dependent of the nature of the submissions.

4. Indicative Budget 2016-2017 for After Hours Funding

This budget should reflect funding as provided under Schedule *Primary Health Networks After Hours*.