Western Sydney CAREcollective

phn WESTERN SYDNEY

NSW GOVERNMENT | Health Western Sydney Local Health District

WESTERN SYDNEY CARE COLLECTIVE VALUE BASED URGENT CARE

URGENT CARE SERVICE CENTRE PROSPECTUS

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WentWest acknowledges the Darug people as the First Nations peoples and the traditional custodians of the land on which we work. We pay our respects to Elders, past, present and future and extend that respect to all Aboriginal and Torres Strait Islander people within Western Sydney.

01 OUR PURPOSE

Since 2002 WentWest has been part of the Western Sydney community, delivering support and education to primary care and working with our partners to progress Western Sydney's health system and ultimately deliver better health outcomes for the region.

Primary Health Networks (PHNs) were established by the Commonwealth Government with 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.

WentWest as the Western Sydney Primary Health Network (WSPHN) is one of 31 PHNs across Australia and functions as a commissioner of services. As a regional commissioner, we are responsible for planning and funding primary health care services, and we action this through our commissioning framework. We also play an integral role in supporting primary care transformation across the region.

Transforming health care requires sustained effort at all levels of the health system, but what is clear is that there is significant international evidence that the way in which primary care development takes place really does matter. WentWest positions itself as a leader, an interpreter, an influencer and a coach to bridge the gap between policy, strategy and practical implementation of health care change in the community. We support practices on their transformation journey to Patient Centred Medical Homes (PCMH).

To empower individuals and support our regional workforce, we need to understand and know our region. Undertaking a Health Needs Assessment is just one way in which we do this and is a key function of the PHN. We work closely with health service providers and consumers to identify the priority health needs of Western Sydney. This enables us to commission services that support health service delivery, access, and equity, and ensures health care is delivered efficiently and effectively across the region.

02 PRIMARY CARE

A NEW HORIZON

The primary care landscape is evolving with "game-changer" initiatives coming out of both the Commonwealth Department of Health and the NSW Ministry of Health. As a Primary Health Network, it is our role to ensure not only general practice, but the community of Western Sydney, are at the forefront and beneficiaries of such opportunities.

COMMONWEALTH INITIATIVES

Primary Health Care 10-Year Plan -

The Australian Government recognises the immense value of primary health care in providing high-quality outcomes and experiences for all Australians. In August 2019, the Government announced the development of a Primary Health Care 10-Year Plan as part of Australia's Long Term National Health Plan. The focus of the 10-Year Plan is on Australia's primary health care services provided through general practices, Aboriginal Community Controlled Health Services (ACCHS), community pharmacies, allied health services, mental health services, community health and community nursing services and dental and oral health services. The plan also focuses on, but is not limited to, the following:

- The integration of primary health care with hospitals and other parts of the health system, aged care, disability care and social care systems with the vision of creating one integrated system
- Primary health care workforce development and innovation
- Innovation and Technology
- Research, data and continuous improvement

The draft plan is now open for consultation and will drive innovation and change across the health sector leading to significant reform and improved outcomes.

STATE INITIATIVES

Collaborative Commissioning

Collaborative Commissioning aims to incentivise locally-developed integration of care across the entire care continuum, and embed local accountability for delivering value-driven, outcome-focused and patient-centred health care.

WentWest, the Western Sydney Primary Health Network (WSPHN), and Western Sydney Local Health District (WSLHD) were successful in their joint proposal to the NSW Ministry of Health for two new pathways of care: Cardiology in Community and Value Based Urgent Care. The pathways have been co-designed by GPs, hospital physicians and consumers. They are being supported by the Patient Centred Collaborative Commissioning (PCCG) Executive, co-chaired by the Chief Executive Officer of WSPHN and the Chief Executive of WSLHD.

The opportunity to invest in primary care transformation in Western Sydney has never been greater. Largely due to the strength of Collaborative Commissioning (now known as Western Sydney Care Collective) and its shared vision of one Western Sydney health system.

> “We are committed to transforming primary care with our partners to achieve our vision of healthier communities, empowered individuals and a sustainable primary health care workforce and system.”

LOCAL INITIATIVES

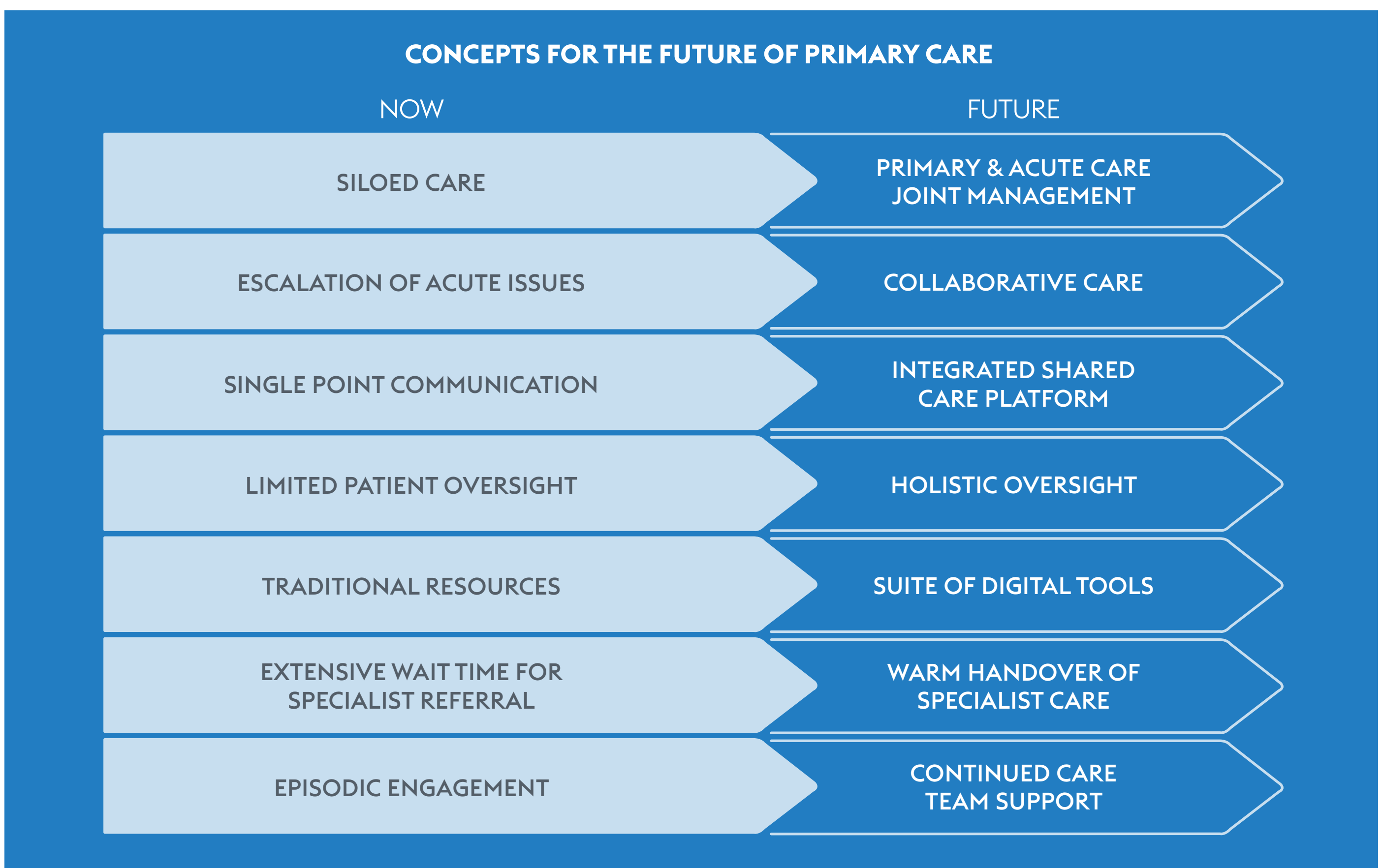
Patient Centred Medical Homes

The case for high performing primary care has never been stronger – as repeatedly articulated in international literature and practice. Supporting and guiding practices on the transformation journey are the 10 Building Blocks of High Performing Primary Care – a conceptual model, that identifies and describes the essential elements of primary care to facilitate high performance. In Western Sydney, our Patient Centred Medical Home (PCMH) practices are embarking on this journey, supported by a comprehensive education curriculum, a suite of digital health tools and the guidance of a WSPHN practice facilitator. Together, we collectively embrace the concepts for the future of primary care, and enhance the patient-centred journey in Western Sydney.

03 WESTERN SYDNEY CARE COLLECTIVE

Western Sydney Care Collective is a whole-of-system approach designed to enable and support delivery of value-based health care in the community. Resources are pooled to deliver the vision of 'one Western Sydney Health Care System'. Service gaps are collaboratively commissioned through our strategic commissioning function and Western Sydney Local Health District (WSLHD) resources are realigned to support the care pathway design. Through integrated governance, delegations, shared culture, information sharing, community engagement and communications, WSLHD and WSPHN can work together to overcome previous organisational barriers and focus on the patient, family and carers who need that care.

In order to achieve the vision of Western Sydney Care Collective it is imperative that there is significant investment in primary care to design, enable and support the delivery of value-based health care across the broader health system to deliver the right care, in the right place at the right time.



04 RATIONALE

In Western Sydney, there was approximately a 14.17% increase in overall emergency department (ED) admissions over a two-year period (2015/16 – 2018/19).[1] There is considerable evidence that links this increase of ED presentations to overcrowding, over-utilised workforce and poorer patient experience and outcomes.

In Australia and across the world, it has been recognised that EDs deal with a significant number of presentations that could have been treated within the primary care setting. This is especially the case for category 4 and 5 presentations to ED. The Royal Australian College of General Practitioners (RACGP) conservatively estimates that well-coordinated general practices could manage nearly one-third of all emergency department presentations, saving $1.5 billion a year.[2]

Literature reviews have shown that the primary reason for non-emergency presentations to EDs was the lack of timely alternative treatment options in the community, despite continued efforts to strengthen primary care.

The reasons behind the ongoing rise in non-emergency ED presentations can be linked to:

- The lack of GP availability (particularly after hours)[3]
- Lack of awareness around alternative treatment options[4]
- Convenience of attending ED[5]
- Increasing age of population and therefore prevalence of age-related disease and co-morbidities
- Increased prevalence of chronic disease
- Shifts in community attitude that EDs are a 'one-stop-shop'
- Perceived affordability of ED compared to GP visitations.[6]

WSLHD data shows that 58% of category 4 and 5 presentations can be grouped into 5 main categories (musculoskeletal, ongoing care processes/patient review, abdominal pain, wound, and unwell) raising the question of alternative care options and the capacity of primary care to treat such conditions. While it is understood that not all patients triaged as category 4 or 5 could necessarily have had their presenting issue dealt with in a primary care setting, it has been acknowledged that improved access to primary care services and extended hours of services can significantly reduce the burden of less urgent presentations to the ED.

[1] WSPHN/WSLHD, Western Sydney Proposal for Collaborative Commissioning (2019) Internal Document

[2] RACGP, Vision for General Practice and a sustainable healthcare system (2019) available online: https://www.racgp.org.au/getattachment/e8ad4284-34d3-48ca-825e-45d58b2d49da/The-Vision-for-general-practice.aspx

[3] NSW Health, Value based healthcare (2019) available online: https://www.health.nsw.gov.au/Value/Pages/default.aspx

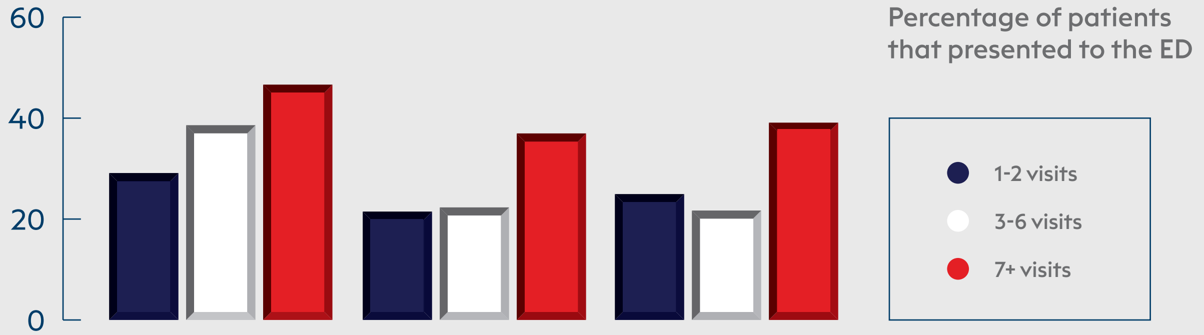
[4] WSPHN/WSLHD, Collaborative Commissioning Proposal (2019) Internal Document

[5] WSLHD/WSPHN, Western Sydney Collaborative Commissioning Proposal (2019) Internal Document

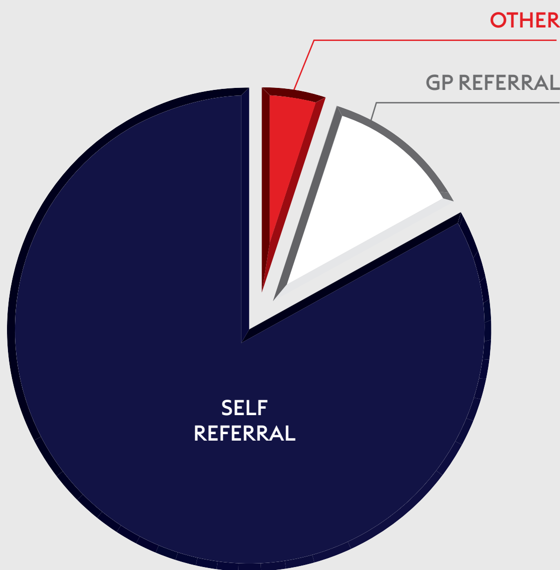
[6] Adie J and Philips J, The case for Urgent Care in Australian integrated Primary Care Centres, RACGP Webinar (2019) available online: https://www.racgp.org.au/FSDEDEV/media/documents/Education/Professional%20development/Online%20learning/Webinars/The-case-for-urgent-care.pdf

WESTERN SYDNEY SNAPSHOT: 2019 - 2020

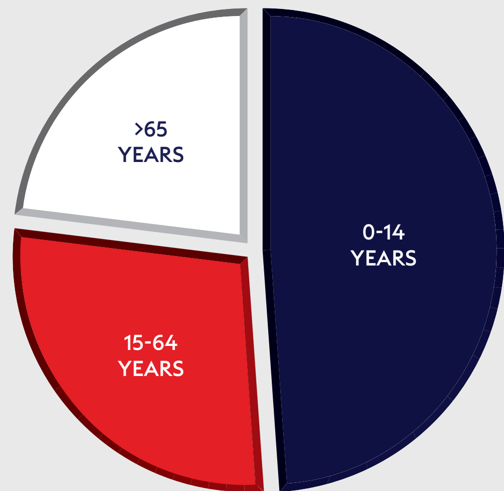
Percentage of patients that presented to the ED



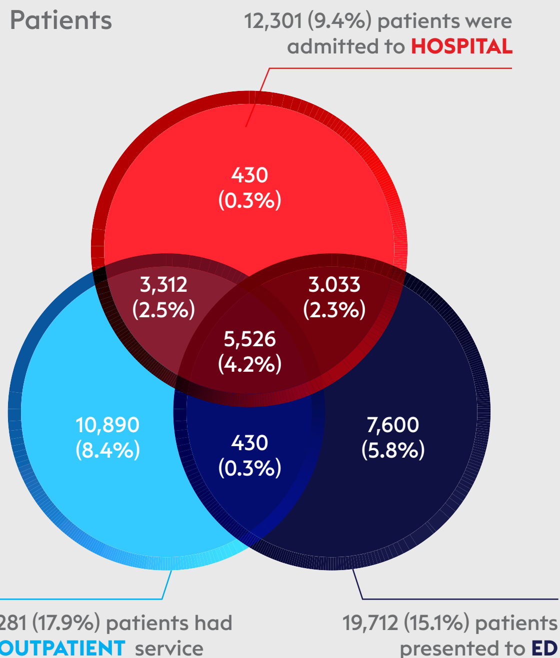
ED presentation by referral type



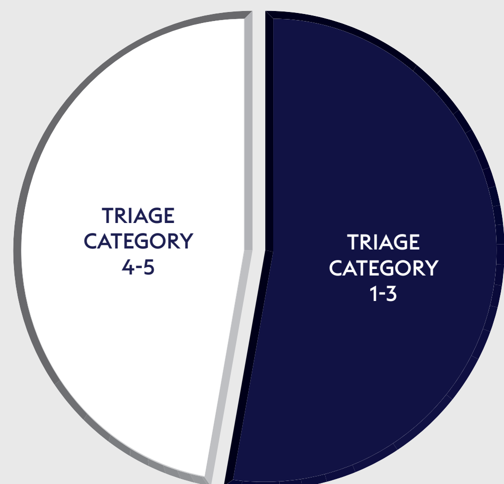
Percentage of patients who presented to ED with Triage Category 4-5 by age group



Patients



Percent of patients who presented to ED



Data source: Lumos

05 VALUE BASED URGENT CARE

Many people who have a non-life-threatening urgent condition (NLTUC) choose to go to the emergency department when they cannot be seen or treated by a General Practitioner (GP). Urgent Care Service (UCS) centres will provide an alternative treatment option for patients who have a minor illness or injury. The UCS centre will allow people who live in Western Sydney local government areas (LGAs) to book a same-day appointment with a UCS centre to be seen and treated by a GP who is close to where the person resides without the long wait times that are associated with ED. This will in turn support the continuity of patient care within the primary care setting.

The objective of Value Based Urgent Care (VBUC) is to reduce the number of patients requiring treatment for a NLTUC presenting to Western Sydney EDs, by providing access to sustainable local patient-centred urgent care services. Patients who would usually present to EDs with a non-urgent or semi-urgent triage category 4 or 5 condition can receive the same level of patient-centred and cost-effective care at the right time and in the right place by attending a UCS centre, instead of an ED.

AIM OF THE PATHWAY

To reduce the number of low acuity conditions requiring 'urgent' treatment presenting to Western Sydney EDs, through provision of sustainable alternative, local patient-centred urgent care services.

TARGET COHORT

Patients with low acuity conditions (minor injuries and illnesses) who would have otherwise gone to a Western Sydney ED.

OBJECTIVES OF THE PATHWAY

Reduction of low acuity (minor injuries and illnesses) hospital admissions and enhanced relationship and directive to general practice

A reduction in general practice-type low acuity ED presentations

Facilitate a reduction of re-presentations to the ED

Facilitate a reduction in ambulance arrivals to the ED

PATHWAY OVERVIEW

The key stages of the pathways are:

Awareness

Intake and Access

Treatment and Referral

Discharge and Ongoing Care

1. Awareness

- Changing patient and consumer behaviour will be critical to driving the success of VBUC. A key component of this will be a wide-reaching public awareness campaign. This campaign will be multi-faceted and target potential patients through a variety of channels and mediums. This will include direct to patient and direct to provider engagement as well as large-scale public engagement.
- The purpose of the awareness stage is to:
  - Raise community and patient awareness so that patients recognise UCS centres as a safe and accessible care provider, and a preferred option over EDs for semi-urgent and non-urgent conditions.
  - Raise provider awareness to encourage appropriate referral to non-urgent treatment options as an alternative to ED.
- Broad public engagement campaigns and targeted engagement campaigns with care providers will be key to raising awareness so that there is a sufficient uptake of VBUC.

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2. Intake and Access

- There are two overarching ways in which patients will be referred to and can access a UCS centre:
  1. Intake and access made through the Central Intake Line (CIL):
     - The CIL is a central provider and gatekeeper for access to UCS centres and is responsible for taking calls from providers and the public for urgent care conditions, classifying and directing patients accordingly.
     - Access via the CIL is the primary referral pathway into the UCS centre. Patients call into the CIL to be triaged and are then referred to the UCS centre if they meet the UCS criteria. Provider-initiated referrals will also be triaged through the CIL.
  2. Accessing services directly via 'walk-ins'
     - Walk-in patients are all patients that would be considered the UCS centre practices' usual patients and who refer directly to the UCS centre without having accessed the CIL directly (via self-referral) or indirectly (via provider-referral).
- The CIL will have a key role in supporting and directing patients to a range of care providers in Western Sydney including UCS providers, ED, hospital-based services, community-based services, and usual care general practices.

3. Treatment and Referral

CIL Referral

- Based off the information gathered, the CIL staff member will determine the most appropriate referral pathway and book an appointment on behalf of the patient.
- The CIL can refer to the following care providers:
  - UCS centre
  - Emergency Department
  - Rapid Access and Stabilisation Services (RASS)
  - Hospital in the Home (HITH)
  - Community-based response teams (CBRT)
  - Other hospital-based services (e.g., fracture clinics, WSLHD Geriatric Rapid Evaluation, Assessment & Treatment (GREAT) service and Chronic-wound Service)
  - Other community-based services within the health care neighbourhood (HCN).

Referral pathways to each of the abovementioned care providers will be available on HealthPathways.

Walk-in Referral

- Where a patient walks into a UCS centre, the practice will triage them and provide the most appropriate care to treat the patient depending on the condition for which they are presenting. Where a UCS centre is unable to treat the patient, a referral to a Level 2 UCS or ED will be made.

Treatment

- Treatment at the UCS centre is acute and episodic in nature and focused on conditions that present to an ED but could be treated in primary care (e.g., minor illnesses and injuries).
- The nature of treatment within the UCS centre will be dependent on the patient's presenting problem.
- UCS centres uniquely distinguish their services from usual care general practices as they focus on a range of higher acuity services, have extended hours of operation, walk-in availability, appropriately trained doctors and nurses, have access to a pooled network of resources and can streamline referrals into HCN providers. These resources will provide specialist advice and may also be directly involved in treatment.
- The focus of the UCS centres is to provide episodic treatment, not ongoing treatment. This means that immediate treatment will be provided for NLTUC, however streamlined referrals will exist with the patient's usual care general practitioner (GP) and other supporting service providers to ensure follow-up and ongoing care is provided.

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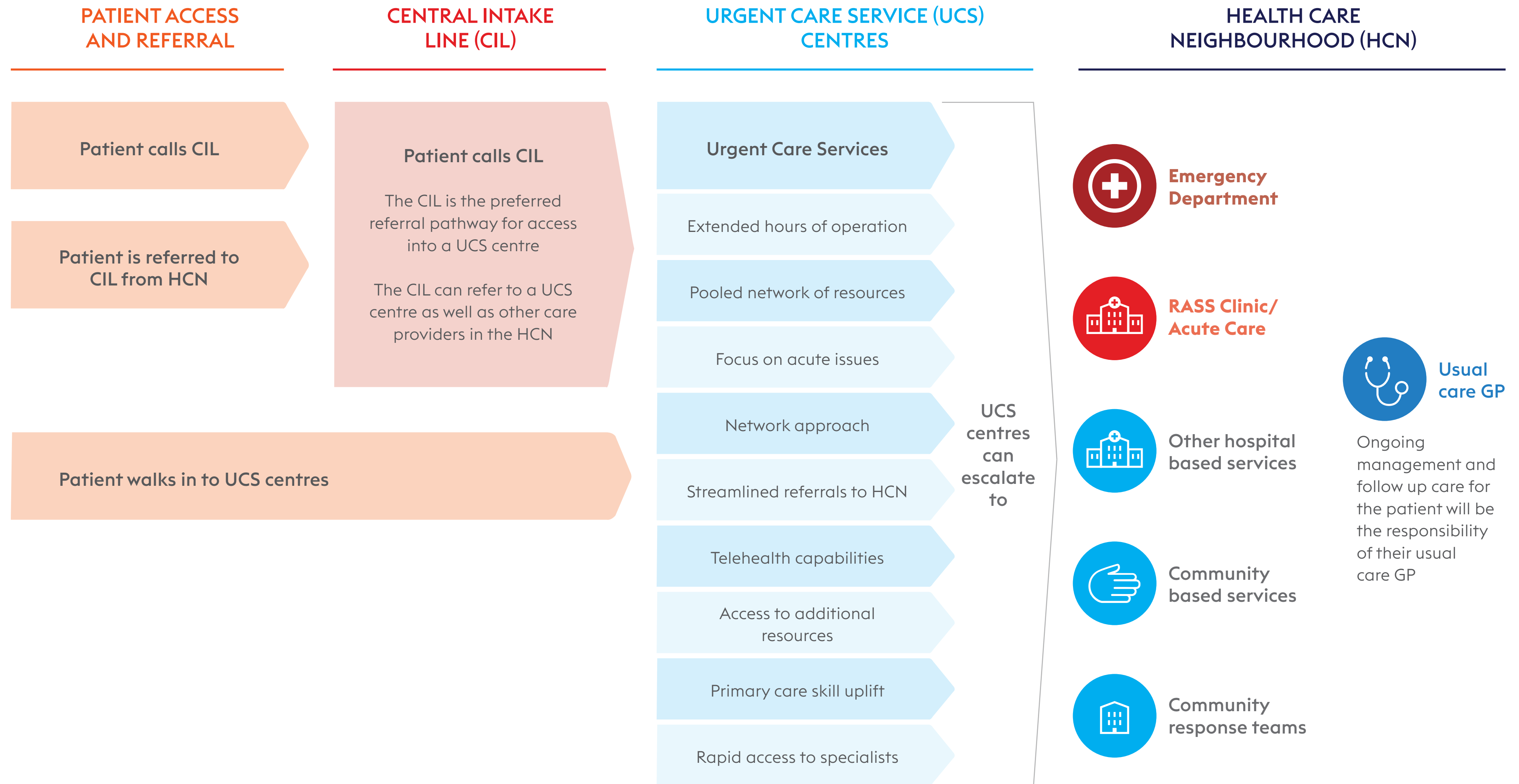
4. Discharge and Ongoing Care

- A key component of the model is ensuring there is a warm handover from the UCS centre to the patient's usual care GP so that patients can be referred back to their usual care GP for ongoing management and follow-up.
- UCS centres are designed to be episodic, so it is important that the patient's usual care GP is fully informed and has oversight over the patient's episodic treatment to avoid patients 'falling through the gaps'.
- The UCS GP will be required to prepare a discharge summary outlining the patient's presentation and treatment at the UCS centre.
- Patients must be handed back to their 'regular' GP. In the case where a patient does not wish to nominate a regular GP or does not have a GP, the patient should be encouraged to maintain a relationship with the GP providing the episodic GP urgent care appointment.

HIGH-LEVEL PATHWAY

A high-level care pathway for Value Based Urgent Care is depicted below.

The visualisation outlines how the patient may interact with key providers across the different stages of the pathway.



06 URGENT CARE SERVICES AND CONDITIONS

UCSs are available for semi-urgent and NLTUC. Urgent care is when a patient requires medical attention for an acute illness or injury. The ailment or injury requires attention but isn't quite severe enough for an ED presentation. If presenting to the ED, these patients would likely be triaged as a category 4 or 5.

Participating practices treat patients with urgent non-life-threatening injuries and illnesses that are typically in the usual scope of general practice.

UCSs are not available for children under three months of age, people over 65 years who require an infusion, people undergoing chemotherapy or those with a primary mental health diagnosis.

UCS centres will need a variety of elements to function optimally, these include (but are not limited to):

- Consumables and resources
- Staffing, including ED nurse on rotation to help build relationships and trust
- Extended operating hours (Monday to Friday, 8am to 8pm)
- Access to imaging and pathology service

Urgent care services relate to not just the infrastructure used to deliver this model (i.e., general practices) but also the related and connected services that are provided to urgent care patients through the HCN. Urgent care services provide regular primary care as well as urgent care, they are therefore enhanced general practices. To be an urgent care service, a general practice must meet the service requirements as detailed below.

To allow a wider range of practices to be able to participate as UCS centres, services will be aligned based on a tiered structure:

URGENT CARE SERVICES (UCSs)

Reduce patient demand for the ED by treating injuries/ailments not quite severe enough for a visit to the ED

Quick and effective and can have knowledge about alternative treatment sites

Can improve patient experience in those close to/co-located with emergency services due to faster intervention and reduced duplication

Urgent Care Service - Level 1

Wound management (suture, stitching, wound incision and drainage, bandaging)

Basic fracture management (backslab, slings, and aid/ equipment prescribing)

Urgent Care Service - Level 2

Ability to insert intravenous lines and catheters to allow for IV antibiotics, infusions and catheter changes

Level 1 UCS Conditions

Most of the infrastructure and resources required to treat conditions within a Level 1 UCS centre already exist as part of delivering standard GP care.
As such, only requirements that may not be typical within primary care have been detailed below.

Condition	Infrastructure and Resources
MINOR INJURY	

• Basic fracture management (backslab, sling) (Note: Suspected fractures should be referred to ED if there is an obvious deformity, mobility issues as a result of the fracture, severe pain or the fracture is compound)
• Lacerations and abrasions
• Wound incision
• Stitching
• Suture
• Drainage
• Bandaging
• Minor burns
• Leg ulcers
• Skin tears
• Pressure injuries
• Tetanus prone wound
• Insect and animal bites (not requiring antivenom)
• Minor dental (i.e., pain-related)
	• Timely access to radiology (same day or next), this includes X-ray and ultrasound
	• Backslab
	• Shoulder immobilisers, wrist splints, range of motion braces,
	• Zimmer splints for knees
	• Stax splints for fingers and toes
	• Plastering with Plaster of Paris
	• Bennet's and Scaphoid
	• Streamlined referral pathways for timely follow up and management i.e., to a fracture clinic or Orthopaedic specialist, streamlined referral to have casting undertaken within 24 to 72 hours and access to physio support
	• Bandaging, antiseptic, suture, staples,
	• Suitable burns dressings, i.e,
	    ◦ hypafix
	    ◦ acticoat
	    ◦ mepitel
	• Steristrips, glue
	• Tetanus vaccine

MINOR ILLNESS	
• Bronchitis • Upper respiratory tract infections • Ear, nose and throat infection: tonsillitis, pharyngitis, laryngitis, otitis media, otitis externa, rhinitis, sinusitis, cellulitis • Rashes • Gastroenteritis/Gastritis: when oral hydration is appropriate (other conditions where oral rehydration is the primary treatment are also in scope) • Urinary tract infections • Sexually transmitted infections • Cellulitis/abscesses (non-septic and treatable by oral or intramuscular only) • Deep Vein Thrombosis (DVT): Requiring oral treatment, bloods and next day ultrasound) • Conjunctivitis • Management of first-trimester pregnancy bleeding (need USS and anti-D)	• Masks, tubing, nebuliser machine (if O2 saturation < 94%) (not recommended during COVID-19 outbreak due to aerosols enabling the spread of disease) • Spacers • Oral rehydration solution • Oral or intramuscular antibiotics • A range of catheter sizes and bags • Xylocaine gel • Anti D administration within 72 hours (i.e., via UCS centre or through streamlined referral)

Level 2 UCS Conditions

Level 2 UCSs provide an extension to the services provided at Level 1 UCS centres. This includes the ability to insert intravenous lines and catheters to allow for IV antibiotics, infusions and catheter changes.

Condition	Infrastructure and Resources
MINOR INJURY	
• ENT: foreign body in ear, nose or throat, minor epistaxis, minor trauma • Eye injury (foreign body) • Acute wounds requiring IV • Insert IV lines and catheters to allow for IV antibiotics, infusions and catheter changes	• Microscope for ENT related injuries • Slit lamp to examine eye injuries • IV drugs: Ceftriaxone, Cefazolin, Flucloxacillin, Flagyl (all IV)
MINOR ILLNESS	
• Abscess (requiring immediate treatment with IV) • Simple catheter insertion or change (condition agnostic) • Gastritis, gastroenteritis, hyperemesis and other conditions requiring IV rehydration • Mild head injury – with GCS 15/15 and no history of unconsciousness • Treatment of suspected fractures requiring casting • Eye foreign body removal (limited treatment intervention with treatment linked to integrated optometrist)	• Drips in various sizes • Normal Saline • Tubing • IV antibiotics such as: Cefazolin, Ceftriaxone, Metronidazole, Flucloxacillin • A range of catheter sizes and bags • On-site sluice room • Slit lamp to examine eye illnesses or timely referral • Point of care testing capabilities and equipment (e.g., D-dimer, Creatinine and Beta-HCG tests) • Immediate treatment for DVT, cellulitis and infusions

07 OUTCOMES AND REPORTING

PATHWAY OUTCOMES

People, Families and Carers

- People can access care in an out-of-hospital setting to manage their health and wellbeing
- Reduces wait-times to access care and treatment for semi-urgent and non-urgent conditions
- Improved patient experience

Service Providers and Clinicians

- Reduction in representations to ED and/or urgent care due to more coordinated patient management and follow-up care
- Establishment of dynamic and collaborative relationships between ED, UCS providers and other care providers in the HCN
- Improved provider experience

Population Health

- Reducing the need for urgent/emergency care
- Reduction in patients who do not wait for care in the ED and later present and are admitted

The Health System

- Reducing the need for urgent/emergency care
- Reduction in patients who do not wait for care in the ED and later present and are admitted

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Collaborative Commissioning incentivises locally-developed integration of care across the entire continuum of care, and embeds local accountability for delivering value-driven, outcome-focused and patient-centred health care through leveraging the principles of the Quadruple Aim.

THE QUADRUPLE AIM OF EFFECTIVE PRIMARY CARE

PATIENT EXPERIENCE OF CARE
- Reduced waiting times
- Timely and equitable access
- Patient and family needs met

SUSTAINABLE COST
- Cost reduction in service delivery
- Reduce avoidable or unnecessary hospital admissions
- Return on innovation costs invested
- Ration of funding for primary acute care

QUALITY AND POPULATION HEALTH
- Improved health outcomes
- Equity of access
- Reduced disease burden

IMPROVED PROVIDER SATISFACTION
- Sustainability and meaning of work
- Increased clinician and staff satisfation
- Teamwork
- Leadership
- Quality improvement culture

08 BENEFITS FOR YOUR PRACTICE

We have learnt that practices with a focus on whole of practice transformation, i.e., improved delivery of patient-centric and integrated health services through a coordinated set of care interventions, develop a greater capacity to adopt the many business and clinical programs that are available.

By becoming a UCS centre, your general practice will have the opportunity to:

- Fill vacant appointments throughout the day
- Support continuity of care for patients in the primary care setting
- Help reduce the need for emergency department presentations
- Contribute to stronger integration between public hospitals and primary care
- Increase exposure through the National Health Service Directory (NHSD)

WORKFORCE DEVELOPMENT

- Focused training and competency development in delivering urgent episodic care for health care staff.
- Medical Practice Assistant Qualification for upskilling administrative team members
- PCCG Implementation Lead supporting staff engagement

QUALITY IMPROVEMENT SUPPORT

- Provision, support, and training on a range of Digital Health Solutions supporting quality improvement including:
  - PenCAT for Data Driven Improvement
  - QLIK Data Visualisation Tool
  - Patient Reported Experience Measures
  - Patient activation and self-management tools: GoShare
  - Shared care platform: CareMonitor
  - Range of assessment tools
- Participation in Lumos - generating information and insights on your patient's journey across health care services, providing GPs with meaningful information about their patients that can help to improve care
- PCCG Implementation Lead supporting and activating QI methodology and activities such as Practice Quality Improvement Plans underpinned by comprehensive review of general practice data dashboards

ACCESS TO ENHANCED SUPPORT

- The PCCG Implementation Lead will:
  - Support access to newly updated and developed HealthPathways
  - Assist in the development of UCS processes and standards
  - Assist in the development of an education curriculum to support UCS centre staff

SUPPORT INTEGRATING PROGRAMS INTO PRACTICE MODELS OF CARE

- Support Healthcare Neighbourhood Mapping
- Support through WSLHD realigned services, community-based response teams (CBRT) and outpatient clinic access
- Your WSPHN Practice Nurse Facilitator will support you and your team with clinical re-design, considering current workflows, patient journeys and current team capacity/knowledge to enhance team-based care

09 SUITE OF TOOLS

There is a suite of tools that are available to support patients through Value Based Urgent Care.

The types of tools available can be modified to suit the needs of the patient.

CareMonitor – Shared Care Platform

- Shared care platform that enables discharge summaries and notes from the patient's treating specialist, primary care clinicians and ED staff to be uploaded and shared across the patient's shared care team.
- Links health care teams with patients to monitor and manage care plans and outcomes along the patient's care journey.

GoShare

- GoShare allows health professionals to customise and send health resources to patients. Patient education information can be sent on a single occasion or scheduled overtime as part of a digital program.
- Enables easy, appropriate and timely educational resources to be shared with patients
- GoShare can provide practitioner-driven support for the continuation of care at home, minimise unnecessary returns for consultation and ensure the recipient has access to the latest version of patient education information.
- Allows GPs to share tailored health resources to increase health literacy and enhance patient awareness and engagement.
- There are VBUC-specific GoShare bundles that can be provided to patients.

1300 972 915

GP Support Line

The support line gives direct access to specialty advice from RASS in Westmead hospital.

It also allows patients to be linked with RASS and other WSLHD services (when and if escalation is required) so that they can get direct access to specialty assessment in RASS.

Support line hours are Monday to Friday, 9:00am to 7:00pm.

HealthPathways

HealthPathways is an online portal/website that functions as an information portal for GPs that focuses on clinical topics at the interface of primary and second care.

The website hosts clinical protocols (called "pathways") which are co-created by local GPs and specialists to meet the needs of the local population.

Allows GPs to understand local resources, including public clinics, private specialists, and options for investigation.

Referral information from VBUC will be incorporated into existing localised clinical pathways on HealthPathways which will allow GPs to access, manage and refer patients to facilitate the best possible use of primary care resources, hospital-based clinics and private care pathways.

Western Sydney CAREcollective

phn WESTERN SYDNEY

NSW GOVERNMENT Health Western Sydney Local Health District

ONE WESTERN SYDNEY HEALTH CARE SYSTEM

FOR MORE INFORMATION:

Email: wscarecollective@wentwest.com.au

www.westernsydneycarecollective.com.au