Australian Government
Department of Health

phn
An Australian Government Initiative

Activity Work Plan 2018-2019:

Core Funding

General Practice Support Funding

After Hours Funding

ACT PHN

1. (a) Strategic Vision for PHN

Please provide a link to your organisation's strategic vision published on your website.

https://www.chnact.org.au/sites/default/files/CHN-Strategic-Plan-2016-2019.pdf

1. (b) Planned PHN activities

– Core Flexible Funding Stream 2018-19

Proposed Activities	
Activity Title / Reference (e.g. CF 1)	**CF 1 Geriatric Rapid Acute Care Evaluation model implementation**
Program Key Priority Area	Aged Care
Needs Assessment Priority Area (e.g. 1, 2, 3)	• Residential Aged Care Facilities and elderly housebound patients – lack of rapid access to GPs in After Hours period (refer page 17) • Improving hospital/community care integration: (refer page 42) • Prevention of avoidable ED attendances. Possible Option: Commission and evaluate a Geriatric Rapid Acute Care Evaluation (GRACE) type model integrating RACFs, GPs and ED – jointly with Calvary Health. (refer page 43).
Description of Activity	This activity localises and commissions a Geriatric Rapid Acute Care Evaluation (GRACE) model of care, integrating RACFs, GPs and hospital outreach resources, jointly with Calvary Health Care ACT. Central to the model is the GRACE Clinical Nurse Consultant (CNC) who, along with the resident's GP and hospital staff, coordinates a single entry, 7 days per week, rapid response service for aged care facility residents and their general practitioner. This program includes services provided in the after hours period as it operates 8am-8pm Monday to Friday and 8am-4pm Saturday and Sunday. GRACE staff work in collaboration with GPs and RACF staff to provide enhanced care 'at home' for residents. Older residents who are acutely unwell and at risk of rapid deterioration are given access to rapid treatment and support in the community. Access to clinical care as close to the point of residence as possible acts to decrease transfers to ED or in situations where transfers are required, ensures an improved transition of care between the acute care and residential aged care settings. The model provides a decision support system, utilising 'outreach' hospital resources to assist with assessment and care provision and provides short-term coordinated management plans.
Target population cohort	RACF residents in the catchment area of Calvary Public Hospital Bruce in the northern suburbs of the ACT.
Consultation	Consultation with ACT Health and Calvary Health Care framed the proposal. Broad aged care sector consultation was undertaken including key groups such as ACT COTA and Health Care Consumers Association.

Collaboration	Collaboration with Calvary Health Care ACT in co-design and planning to localise and implement the GRACE model in the ACT. This is an activity that is under the umbrella of the ACT Coordinating Committee for Primary Health Care and Chronic Conditions, a cross-sectoral committee developed as a joint initiative between the PHN, ACT Health, Calvary Health Care and HCCA.
Indigenous Specific	No
Duration	July 2018 – June 2019 (January 2017 – June 2019).
Coverage	The program is delivered from Calvary Public Hospital Bruce to residential aged care facilities located in the Calvary Public Hospital Bruce catchment area in the north of the ACT.
Commissioning method	ACT PHN undertook a co-design, localisation and direct delivery approach with Calvary Health Care ACT. Monitoring of the services is via custom-built activity data analysis and project status reporting. External (third party) evaluation has been built into the implementation and project plan.

Proposed Activities	
Activity Title / Reference (e.g. CF 1)	**CF 2 Primary Care In-Reach Clinic at Canberra Hospital (Building 7)**
Program Key Priority Area	Vulnerable people
Needs Assessment Priority Area (e.g. 1, 2, 3)	• Access to primary health services and ongoing need for outreach services for people who are homeless or at risk of being homeless. Possible option: Continuation of the primary health care service at the Early Morning Centre (EMC) and assessment of the potential for this type of 'in-reach' model to be expanded to other locations that have concentrations of homeless people (refer page 46). • Access to high quality, well-coordinated health care (for vulnerable people including people released from prison). Possible option: Establish an out-reach primary health care service, preferably on the north and south side of Canberra (similar to the model operating for homeless people at the Early Morning Centre). In terms of a south side clinic, negotiations are underway in relation to an outreach clinic at The Canberra Hospital Alcohol and Drug Services – ACT PHN will commission Directions Health Services to provide the primary health care service. Directions also receive ACT Health funding via the PHN for a once a week drop-in service (nurse only clinic) at the Needle and Syringe Program (Civic) with once a fortnight in reach to Ainslie Village for opportunistic drop-ins (refer page 49).

Description of Activity	In/out reach services are those that are delivered directly to the targeted community and may be effective in linking vulnerable groups to mainstream health care. This model of care has been used effectively in reaching vulnerable populations in the ACT with the delivery of The Early Morning Centre and the Nurse Outreach Clinics at the Civic Needle and Syringe Program and Ainslie Village. A crucial element of the success of these programs has been location of the service where the targeted population congregate. The core elements of an 'in-reach' service are: • 'in-reach' to a place that is already frequented by the target group on a regular basis and that is considered trustworthy, safe and non-threatening by the client group • filling a void i.e. adding value and not duplicating similar services • acting as a first access point for vulnerable people who do not have access to a trusted primary care home in the ACT • facilitation of client transition back into mainstream general practice, in the local area. The Alcohol and Drug Service at Canberra Hospital has been identified via a scoping study as a site where those with complex needs, including people recently released from prison seek specialist care but do not link with primary health care. In response to this ongoing need, a Primary Care In-Reach Clinic at the methadone treatment clinic at Canberra Hospital was established in December 2017. The clinic operates weekly for 4 hours and is staffed by a General Practitioner. In addition to reaching people exiting the ACT prison system, the activity aims to link other vulnerable sectors of the community, including people with chronic alcohol and other drug conditions and people with chronic mental health conditions, with primary healthcare. The expected outcomes of the Primary Care In Reach Clinic at Canberra Hospital are the provision of tailored high quality access to primary health care services for vulnerable populations and fewer barriers to accessing primary health care services and include: • increased provision of Bulk-Billed, accessible health care in a safe and trusted setting, familiar to the client group • improved ongoing monitoring of chronic health conditions, such as diabetes and hypertension • earlier attendance for health care, potentially avoiding acute care episodes • a facilitated pathway from primary health care to other health services and other social support systems/services in the ACT • linkage back to mainstream primary health care services for a significant number of vulnerable clients In addition to the above service ACT PHN also commissions, on behalf of ACT Health, two other in reach services for vulnerable groups in the community. These services operate from the Needle Exchange Service in Civic, and Ainslie Village a public housing estate. These services have been externally evaluated and have demonstrated

	success in improving access to health services for vulnerable people with complex health needs. Through the evaluation the need was identified to provide in reach services to another very vulnerable group living at the Oaks Estate a public housing estate on the outskirts of Canberra. ACT PHN proposes to direct additional funding to co-commission with ACT Health additional services into Ainslie Village and to commission services into Oaks Estate.
Target population cohort	Vulnerable people (those exiting prison; those with mental illness; those affected by the harms caused by alcohol and other drugs; people who are homeless; those with a disability etc.)
Consultation	A scoping study was undertaken to outline the possible options for expansion of the successful in/out reach model of primary health care service provision to further locations and for other vulnerable population groups in the ACT. Key informant interviews (including Smith Family, Uniting Care Kippax, St Vincent de Paul, Headspace, ATODA, ACT Health, ACT Community Services (Housing) were undertaken face to face or by telephone to identify any possible locations that would be suitable for engagement with vulnerable groups of people in the ACT.
Collaboration	This activity is a joint initiative with ACT Health and builds on the existing in/out reach services for vulnerable people in the ACT funded by ACT Health. ACT Health provide in-kind support through provision of clinic consultation rooms, referral and promotion of the primary health care service to users of the Alcohol and Drug Service at Canberra Hospital. Clinical services are provided through partnership with Directions Health Services. This is an activity that is under the umbrella of the ACT Coordinating Committee for Primary Health Care and Chronic Conditions, a cross-sectoral committee developed as a joint initiative between the PHN, ACT Health, Calvary Health Care and HCCA.
Indigenous Specific	No
Duration	July 2018 – June 2019
Coverage	ACT PHN region
Commissioning method	A direct source approach to market with an EOI was undertaken. An external evaluation has been commissioned to address the outcomes listed in the activity description and will be undertaken in 2018. This will include key informant interviews conducted with practitioners and other stakeholders in the relevant sectors and the staff at the clinic location and a voluntary, self-administered client satisfaction feedback survey. Key deliverables and performance measures have been established in associated service agreements and monitored in line with ACTPHN Contract Management Policy and Framework.

Proposed Activities	
Activity Title / Reference (e.g. CF 1)	**CF 3 Innovative Primary Care Workforce Models**
Program Key Priority Area	Workforce
Needs Assessment Priority Area	Increase the capacity and capability of the health system to deliver coordinated care (including shared care) to patients with complex chronic conditions who would most benefit (refer page 59).
Description of Activity	ACTPHN funded, through our 2015-2017 flexible funds, a two year pilot program to support the employment of a pharmacist in three general practices. The pilot program was externally evaluated by the University of Canberra and has demonstrated successful outcomes in improving medication safety and compliance, and improved health outcomes for patients. The pilot has also been effective in demonstrating to the GPs/practices involved the benefit of embedding and sustaining the pharmacist role as part of the health care team. Building on the key findings and success of the Pharmacist in General Practice Program, ACT PHN plans to extend the pharmacist model to other general practices and also look to pilot in a small number of general practices the employment of a social worker to assist patients with complex conditions to be linked in with community support services required for improving their health outcomes. ACT PHN is seeking further information from Sydney North PHN on their trial of commissioning a service that allows general practice to refer patients to social workers to assist patients by facilitating and coordinating additional assistance. The results of the SNPHN trial will assist ACT PHN to develop the model for access to social workers to be piloted in the ACT. This activity aligns with the PHN objective to increase the efficiency and effectiveness of health services to deliver care to patients, particularly those with chronic and complex health conditions. Having explored the option to pilot a social worker service in a small number of general practices, ACT PHN has determined that the need for this service is uncertain at this stage and further planning needs to be undertaken before proceeding. Therefore ACTPHN will not proceed with this service in this funding period. ACT PHN will direct the total expenditure to the Pharmacists in General Practice Program, extending the program to an additional general practice i.e. four general practices in 2018 – 2019.
Target population cohort	Patients of participating ACT General practices with chronic and complex conditions
Consultation	Community engagement and consolation with key stakeholders occurred in the development and delivery of the Pharmacist in general practice pilot. Further engagement and consultation will occur with this initiative through input from the ACT PHN Community Advisory Council members and via a stakeholder group of GPs,

	pharmacists and social workers to guide the program. ACT PHN is also consulting with other PHNs who have implemented primary care workforce models.
Collaboration	ACT Health and Calvary Hospital – GP Liaison Officers: planning and design ACTPHN General Practice Advisory Council Members: planning and monitoring Participating general practice staff members: implementation and monitoring ACTPHN Practice Development Team members: support to practices with implementation and management.
Indigenous Specific	No
Duration	July 2018-June 2020
Coverage	Participating general practices in the ACT
Commissioning method	Open tender to all ACT general practices – at this stage it is anticipated the program with be wholly commissioned

1. (c) Planned PHN activities

– Core Operational Funding Stream: Health Systems Improvement 2018-19

– General Practice Support Funding 2018-19

Proposed Activities	
Activity Title / Reference (e.g. HSI or GPS)	**HSI 1 HealthPathways**
Description of Activity	The ACT PHN has implemented a HealthPathways program in partnership with the SouthEastern NSW PHN, ACT Health and SNSW Local Health District (SNSWLHD). The project initially 'went live' in April 2015. This activity involves the development and promotion of integrated patient care pathways through HealthPathways. The activity is supported by a high-level governance committee made up of major stakeholders and has a team composed of a cross border program manager, project coordinators, administrative supports, GP clinical editors and two GP clinical leads. The program team also includes a project coordinator employed by SNSWLHD to exclusively work with HealthPathways. The HealthPathways activity produces an online tool for primary health care teams, to help guide patient assessment and management and appropriate referral to local specialist and allied health and community services.
Supporting the primary health care sector	The HealthPathways project produces local clinical and referral pathways which are developed and agreed by local general practitioners, hospital and community health clinicians, and other professionals involved in local patient care and support services. Thus the HealthPathways methodology is also a useful engagement strategy through which to promote communication and teamwork amongst local primary care and specialist providers. The HealthPathways activity will support primary care by; • increasing GP knowledge about the most appropriate patient care in their local community • increasing consistency of care provision by using agreed and local pathways • reducing inappropriate referrals and improve pre-referral work-up • promoting better integration between and across health and community services, • facilitating post-specialist care feedback to, and integrated shared care with, GPs, and • identifying opportunities for system redesign to better facilitate patient flow between primary and acute care settings.

Collaboration	HealthPathways is a joint initiative that is funded by four major stakeholders – ACT PHN, SE NSW PHN; ACT Health and SNSWLHD. Each of these organisations has a senior executive on the HealthPathways Governance Committee in addition to Health Care Consumers Association. This is an activity that is under the umbrella of the ACT Coordinating Committee for Primary Health Care and Chronic Conditions, a cross-sectoral committee developed as a joint initiative between the PHN, ACT Health, Calvary Health Care and HCCA.
Duration	July 2018 – June 2019 (2015 – 2021)
Coverage	The activity covers the ACT PHN and the southern areas of SE NSW PHN (as covered by the previous SENSWML).

Proposed Activities	
Activity Title / Reference (e.g. HSI or GPS)	**HSI 2 Comprehensive and Systematic Chronic Heart Failure Care**
HSI/GPS Priority Area	Care Co-ordination
Description of Activity	The pilot program will involve the implementation of priority key interventions aimed to enhance patient health outcomes, improve the patient experience and reduce avoidable demand on local health services. These interventions include: • A referral form and protocol to fast track access to Echocardiograms from General Practitioners to Canberra Hospital. The protocol will support staff internally and will include focussed study parameters to increase access to timely and accurate diagnosis. • A Heart Failure Cycle of Care checklist and supporting roles and responsibilities guideline to provide a more structured approach to heart failure care management, clarifying roles and responsibilities of the care team. • A comprehensive, patient-led Heart failure management/care plan to enhance transitions of care and improve patient self-management. • A suite of end-stage heart failure management protocols/guidelines to provide coordinated, best practice palliative care for heart failure patients. • Delivery of professional development (targeted education sessions) for practice nurses and general practitioners to increase their skills, knowledge and confidence in heart failure care diagnosis and management.

	Developmental activity to progress the above interventions is led by consumer-focused and clinician-led working groups. Interventions will be piloted across a small number of general practices and Canberra Hospital Cardiology services from July 2018 - March 2019. Adaptive learning processes (e.g. PDSA approaches) will be established to monitor change effectiveness and inform continuous improvement. The ACT PHN's 2016 Baseline Needs Assessment identified the initiative as a potential program that could assist in increasing the capacity and capability of the health care system to deliver coordinated care (including shared care) to patients with complex chronic conditions. Further support from our strategic partners was provided as it aligned with the service level reform program that ACT Health is undertaking with the development of a Territory-Wide Health Services Framework 2017-2027.
Supporting the primary health care sector	The interventions proposed in the pilot program aim to improve management of patients with heart failure in general practice through the delivery of improved coordinated care, improved access to timely and accurate diagnosis, enhanced clinical capabilities of General Practitioners and Practice Nurses in heart failure management and improved clinical data quality.
Collaboration	The initiative is delivered in partnership with the following strategic partners: • ACT Health • Health Care Consumers' Association ACT • Heart Foundation ACT The Project Steering Group, responsible for oversighting the initiative, comprises representation of each partner. The initiative is delivered in collaboration with clinicians and consumers spanning the spectrum of care. • The Heart Failure Care Clinical Leadership Forum (25 members) encompasses representation across heart failure care (e.g. General Practitioners, Nurses, Pharmacists, Allied Health, Sonographers, Specialists (Public and Private)) and all settings (e.g. general practice, community, Emergency Department, outpatient, inpatient and palliative care). • A small number of general practices (3-4) will initially be engaged to participate in the pilot program, leading the implementation of the interventions detailed above, in collaboration with the Heart Function Clinic (Cardiology, Canberra Hospital). Consumers are proactively engaged in the development of the patient-led Heart Failure management/care plan through the adoption of experience-based design and supported by the Health Care Consumers' Association ACT.

Duration	July 2018 – June 2019 (2016 – 2019)
Coverage	ACT PHN region

Proposed Activities	
Activity Title / Reference (e.g. HSI or GPS)	**HSI 3 Cross Sector Chronic Disease Care Coordination – Transition of Care Implementation**
HSI/GPS Priority Area	Care Co-ordination
Description of Activity	The Transitions of Care program is a primary care-led service model for community-based care coordination for targeted (risk stratified) patients with chronic condition/s recently discharged from an acute care setting. The program aims to successfully transition their care to a primary health care setting and build sustained and effective team care arrangements. This proof of concept model was co-designed with key partners during the planning and procurement stage. Key components of the service model and delivery modes include: • one Manager and two Transition Coordinators employed by the PHN to support and facilitate successful continuity of care following discharge from the acute setting • targeted participants and enrolment: development and utilisation of a local risk stratification tool to identify Tier 2 level needs encompassing patients with chronic conditions and complex needs and incorporating social determinants of health • close working relationships with the staff at the Canberra Hospital to identify and enrol patients into the program prior to discharge • the Transition Coordinators working with the patient to link them back with their GP; to ensure follow up appointments are made; to assist the patient to access community and social supports as required; and to support the patient to understand their condition and be confident to self-manage. A Plan, Do, Study, Act (PDSA) approach was adopted to measure and monitor implementation, change and adoption, service effectiveness and integration. A formative evaluation is currently being conducted to monitor results and inform implementation. This activity aligns directly with the second PHN objective of improving the coordination of care of patients, particularly those with chronic conditions. The implementation of the program has been undertaken in conjunction with ACT Health. A business case will be prepared in readiness for the 2019-20 ACT Health budget process (commences September

	2018), to influence and inform how the program can be embedded in the local health system into the future. ACT PHN will then transition the program and clients into the new externally provided service.
Supporting the primary health care sector	The improvement of communication and service integration between hospital and primary care provides an opportunity to improve patient outcomes across these health settings and the Transitions of Care program also encourages the primary care sector to remain at the centre of the patients care coordination.
Collaboration	This system improvement and integration initiative is supported by and requires a high degree of collaboration with ACT Health extending to co-design in association with GPs and the Health Care Consumers' Association, as well as other community-based organisations and health care providers. This is an activity that is under the umbrella of the ACT Coordinating Committee for Primary Health Care and Chronic Conditions, a cross-sectoral committee developed as a joint initiative between the PHN, ACT Health, Calvary Health Care and HCCA.
Duration	June 2018 to July 2019 (2016 – 2019)
Coverage	ACT PHN region

Proposed Activities	
Activity Title / Reference (e.g. HSI or GPS)	**HSI 4 High performing primary care**
HSI/GPS Priority Area	General Practice Support
Description of Activity	ACTPHN is implementing a targeted collaborative approach to facilitating and supporting the continued development of general practice capacity to provide evidence-based patient centred care. Recent evidence about high performing practices supports a framework for practice development strategy and priorities. These have been defined as the Bodenheimer's 10 Building Blocks of High Performing Primary Care. This activity will include a range of general practice support activities including: • quality improvement initiatives, including individual practice planning and goal setting, as well as CHN led initiatives working with target practices • support for practices to achieve and maintain practice accreditation • facilitation of networking and professional development workshops for practice managers and practice nurses.

	• provision of a service for general practice and other primary care providers in ACT to post notices of vacant positions on the ACT PHN website. This service provides the primary care sector with the facility to reach a broader audience in order to recruit suitable staff to work in the ACT.
	• orientation of new health professionals into primary care.
	• practice nursing support, including immunisation support and information, particularly targeted on maintaining childhood immunisation targets.
	• a focus on data quality improvement and improved use of data in general practice through the QI Data program, including support to:
	  ▪ code patient data accurately in the electronic record
	  ▪ submit de-identified practice population data to the PHN
	  ▪ examine practice data to identify areas for quality improvement, particularly in the provision of best practice care for people with chronic conditions
	  ▪ benchmark across practices based on quality outcomes, and
	  ▪ implement quality improvement initiatives including relating to recalls and reminders, improved screening etc.
	• Provision of business leadership training to clinicians.
	• Identifying their practice population particularly patients requiring planned and coordinated care for chronic and complex conditions and encouraging 'voluntary enrolment'.
	• Building business viability to deliver team-based care; reviewing how care is prioritised, coordinated and delivered.
	• Facilitating change in practices to utilise population data to plan and maximise care and to build patient-team partnerships.
	Continuing professional development programs will continue with a focus on multidisciplinary care for chronic health conditions. Practice support is provided by the practice development team to support the use of GP Management Plans (GPMP) and treatment plans, particularly for patients with chronic and complex care needs.

Supporting the primary health care sector	This activity provides support to build and sustain the primary health workforce. It supports general practices to collect, analyse and understand their population data and to undertake quality improvement activities to deliver high quality care with a particular focus on improved team based chronic disease care. The activity will provide continuing professional development, tools and resources and practice-based advice and support to the primary health care workforce.

	This activity continues the ongoing work of practice development and support, which will allow the *high performing general practice program* to be built upon well-established principles within general practices.
Collaboration	Local universities, General Practice champions, local hospitals, specialists and other subject-matter experts are key stakeholders working collaboratively with the PHN to identify and support opportunities for primary care practitioners to be provided with an opportunity to further develop existing knowledge and skill-sets, as well as provide opportunities for development of new and innovative service delivery models better suited to complex and chronic conditions.
Duration	July 2018– June 2019 (2016 – 2021)
Coverage	ACT PHN region

1. (a) Strategic Vision for After Hours Funding

4. (b) Planned PHN Activities – After Hours Primary Health Care Funding 2018-19

Proposed Activities	
Activity Title / Reference (e.g. AH 1)	**AH 2 After Hours Palliative Care Medications**
Needs Assessment Priority Area (e.g. 1, 2, 3)	More cost-effective deployment of after-hours primary care resources for urgent care (refer page 54.)
Description of Activity	An increasing number of palliative care patients are choosing home base care, with up to 20% of Canberrans receiving palliative care choosing to die at home. The availability of home-based supports extends the time that people can spend at home. The service includes: • Engagement of two pharmacies, one in the north and one in the south of Canberra to provide a home-based delivery service for palliative care patients • Both pharmacies to stock terminal phase medications identified in consultation with prescribers • Provide home deliveries for patients in the after-hours period with a tiered pricing structure based on distance from pharmacy.
Target population cohort	Patients receiving palliative care and their carers who experience difficulty accessing services during the final weeks of life.
Collaboration	• ACT Palliative Care Network – promotion and monitoring of the service • ACT Palliative Care Services – promotion of the service • GPs – advice to patients/carers regarding the service availability • ACT community pharmacies – advice to their customers requiring the service in the after-hours period for urgent needs.
Indigenous Specific	No
Duration	July 2018 – June 2019
Coverage	Whole PHN region

Proposed Activities	
Activity Title / Reference (e.g. AH 1)	**AH 3 Ambulance extended care paramedic**
Needs Assessment Priority Area (e.g. 1, 2, 3)	Ambulance extended scope (refer page 55).
Description of Activity	As a result of recommendations from the Ambulance Scoping Study undertaken by ACT PHN in 2017-2018, ACTAS will introduce Extended Care Paramedics (ECPs). The ECPs will receive additional training to enable them to safely treat many primary care type illnesses or injuries without the need to transport the patient to a hospital. The range of cases that ECPs in Australia can attend includes wound care, pain management, minor burns, back pain, gastroenteritis and diarrhoea, urinary tract infections and catheter changes, allergies, bites and minor lacerations. ACT PHN will support this activity by ensuring that the introduction by ACTAS is well integrated with general practice and other primary care providers across the ACT.
Target population cohort	Whole of population with non-urgent minor illness or injury
Collaboration	• ACTAS – implementation, monitoring and evaluation • ACTPHN – promotion of the service to consumers, general practice and other primary care providers. Monitoring of the service. Supporting ACTAS to integrate the service with general practice. • ACT Health –support to ACTAS to integrate the service with Walk in Centres and other services as required. Service monitoring.
Indigenous Specific	No
Duration	ACTAS anticipate the service will commence from 1 July 2018 however actual start date is yet to be confirmed.
Coverage	*Whole of PHN region*

(c) Decommissioned PHN Activities – After Hours Primary Health Care Funding 2018-19

Decommissioned Activity	
Activity Title / Reference (e.g. AH 1)	**AH 1 After Hours Radiology**
Decommissioning	ACT PHN notified the Department on 2 August 2018 of the decision to cease the trial of AH Radiology Services effective 19 August 2018. Our Needs Assessment and consultation with general practice and Canberra radiology services indicated there was a need for such a service. However, despite extensive promotion to general practice there was very low uptake since commencement in January 2018 and the decision was made that the service was not viable.