CNC GP LIAISON ROLE AND PRIMARY CARE ENGAGEMENT PLAN

WSLHD Drug Health | WentWest / Western Sydney PHN | General Practice and Primary Health Care

WORKING ASSUMPTION

This document interprets “Westend” as WentWest, the Western Sydney Primary Health Network, and “PHC” as primary health care. Confirm those terms with your manager if a specific service called Westend or PHC was intended.

ROLE IN ONE SENTENCE

Your role is to make it easier and safer for GPs and primary-care teams to care for people receiving OTP by providing fast specialist access, improving communication, coordinating general healthcare, reducing stigma and building a sustainable shared-care pathway without assuming that GPs will take over prescribing.

1. Breakdown of your role

Role area	What you do	What you produce	How success may be measured
Specialist access	Respond to GP questions, triage urgency, obtain specialist input and close the communication loop.	Advice pathway, call log, response standard and escalation process.	Response time, resolved queries, GP confidence and safety escalations.
Care coordination	Reconnect OTP patients with general practice and support management of general health needs.	Verified-GP process, care-plan prompts, annual summary and referral follow-up.	Verified GP rate, care plans, preventive care and completed referrals.
Practice engagement	Build relationships with practices, GPs, nurses, managers and reception teams.	Practice map, contact register, engagement plan and visit schedule.	Practices contacted, meetings held, active champions and repeat engagement.
Education	Deliver targeted education on OTP, methadone, buprenorphine, stigma and trauma-informed care.	Brief presentations, front-desk module, GP resources and patient information.	Attendance, feedback, confidence change and requests for further support.
Shared-care design	Help define responsibilities, communication triggers, review points and re-entry arrangements.	Tiered shared-care model, minimum dataset, ISBAR and role matrix.	Shared-care plans used, fewer incomplete handovers and safer transitions.
Quality improvement	Identify service gaps, test solutions, collect data and report outcomes.	Baseline audit, PDSA cycles, dashboard and project reports.	Referral quality, access, continuity, incidents and patient experience.
Stigma reduction	Promote respectful language, privacy, safe-space signalling and inclusive practice.	Practice checklist, staff education and patient feedback process.	Training completion and patient-reported respect and access.
Sustainability	Build team-based processes that continue beyond the grant and do not depend on one person.	Coverage model, SOP, governance owner and succession plan.	Coverage reliability, documented workflow and ongoing resourcing.

2. What to start looking for immediately

Inside Drug Health

☐ Current OTP patient numbers by clinic, suburb, medicine and treatment stability.
☐ Percentage of patients with a recorded GP, and how often the GP is wrong or unverified.
☐ Current consent process for sharing information with GPs and pharmacies.
☐ Existing annual review letters, discharge summaries, referral forms and GP correspondence.
☐ Common GP calls, complaints, safety incidents and communication failures.

☐ Who can provide clinical backup when you are unavailable.
☐ Current eMR documentation location for GP advice and shared-care activity.
☐ Available administrative, IT, data, education and research support.

Across primary care

☐ Which practices already care well for OTP patients.
☐ Which practices have GPs interested in AOD, mental health, pain, hepatitis, homelessness or justice health.
☐ Which practices have practice nurses, pharmacists or care coordinators who can support chronic disease care.
☐ Which practices are accessible by public transport and accept new patients.
☐ Billing arrangements and whether cost may block attendance.
☐ Languages, interpreter use and cultural capability.
☐ Current attitudes, fears and knowledge gaps about OTP.
☐ Preferred education format: practice visit, webinar, case discussion, written guide or HealthPathways.

Patient and community perspective

☐ What makes patients feel unwelcome or stigmatised in general practice.
☐ What helps patients disclose OTP treatment safely.
☐ Whether patients have a regular GP and what prevents attendance.
☐ Which resources patients want sent to GPs.
☐ Needs of Aboriginal, CALD, LGBTQ+, homeless, justice-involved and older patients.
☐ Preferences for consent, communication and shared decision-making.

3. Which GPs and practices to look for

DO NOT START WITH A RANDOM PUBLIC LIST

A public website can identify practices, but it cannot reliably identify GP willingness, OTP confidence, capacity or prescribing interest. Build the target list with WentWest, Drug Health clinicians, verified patient GPs, HealthPathways contacts and local practice-development teams. Contact practices through approved organisational channels.

Priority group 1: Existing patient GPs

- Ask patients to verify their current regular GP and practice.
- Start with GPs already providing general healthcare to multiple OTP patients.
- Check consent before contact or correspondence.
- Offer support for primary healthcare and communication, not an immediate prescribing request.

Priority group 2: Known AOD-friendly or high-relevance practices

- GPs with previous OTP, AOD, addiction medicine or harm-reduction experience.
- Practices caring for people with mental illness, chronic pain, hepatitis C, homelessness or justice-system contact.
- Practices involved in Aboriginal health, refugee health, LGBTQ+ care or youth health.
- Practices with strong chronic-disease and team-care systems.
- Practices near Blacktown, Mount Druitt, Parramatta, Westmead and existing OTP dosing locations.

Priority group 3: WentWest and PHN-supported practices

- Ask WentWest for the appropriate primary-care engagement lead, AOD program contact and practice-development officer.
- Request a de-identified or approved practice segmentation approach rather than personal GP data.
- Use WentWest education events, newsletters, practice visits and quality-improvement networks.
- Explore Western Sydney HealthPathways and local referral-pathway promotion.
- Identify practice champions willing to test communication and annual-summary processes.

WESTERN SYDNEY CONTEXT

WentWest is the Western Sydney PHN and reports 336 GP clinics in its region. WentWest's functions include coordinating care, building primary-care capability, commissioning services and supporting quality improvement. Its AOD activity identifies priority groups including Aboriginal and Torres Strait Islander people, people with mental health comorbidity, CALD communities, older people, people released from prison, LGBTQIA+ people, people experiencing homelessness and young people.

4. Practice selection criteria

Domain	Questions	Rating	Evidence / notes
Existing relationship	Does the practice already care for OTP patients or receive Drug Health correspondence?	Low / Medium / High	_____
Patient access	Accepting patients? Affordable? Public transport? Suitable appointment availability?	Low / Medium / High	_____
Clinical capacity	Chronic disease, mental health, BBV, pain and care-plan capability?	Low / Medium / High	_____
Team capacity	Practice nurse, pharmacist, manager or care coordinator available?	Low / Medium / High	_____
Attitude and safety	Willing to undertake stigma/trauma-informed training and protect confidentiality?	Low / Medium / High	_____
Communication	Secure messaging, eReferral, reliable phone response and named contact?	Low / Medium / High	_____

Population fit	Relevant location, languages, cultural safety and priority populations?	Low / Medium / High	_____
Readiness	Interested in communication-supported care, active shared care or eventual prescribing?	Low / Medium / High	_____
Sustainability	Can more than one GP or staff member participate?	Low / Medium / High	_____

5. First 90-day action plan

Time	Priority actions	Deliverables	People to involve
Weeks 1-2	Clarify project scope, role boundaries, response standard, clinical backup, documentation and data requirements.	Role statement; escalation map; stakeholder list.	Manager, Tracy, Addiction Medicine, OTP clinic leads, research team.
Weeks 2-4	Audit current GP data and correspondence; identify existing patient GPs and communication gaps.	Baseline audit; verified-GP workflow; minimum dataset.	Data/eMR staff, clinic nurses, consumers, administration.
Weeks 3-6	Meet WentWest and PHN engagement leads; map practice networks and education channels.	WentWest engagement plan; practice selection criteria; contact pathway.	WentWest AOD lead, practice-development staff, HealthPathways.
Weeks 5-8	Recruit a small pilot group of practices and complete a needs assessment.	5-10 pilot practices; baseline GP/practice survey; agreed support offer.	GP champions, practice managers, nurses, reception staff.
Weeks 6-10	Deliver front-desk stigma training and GP OTP education; test rapid advice and annual-summary process.	Education pack; advice log; annual-summary template; patient resources.	Drug Health educators, GPs, consumers, Aboriginal Health.
Weeks 9-12	Review data, incidents and feedback; refine workflow and plan scale-up.	Pilot report; PDSA actions; revised Model of Care; sustainability proposal.	Governance, project investigators, WentWest, participating practices.

6. Questions to ask WentWest / PHN

☐ Who is the primary contact for AOD, integrated care and general-practice engagement?
☐ Can WentWest help identify practices with relevant patient populations and existing AOD interest?
☐ What privacy and approval process applies before sharing practice or GP contact data?
☐ Which current practice-development officers cover Blacktown, Mount Druitt, Parramatta and Westmead?
☐ Can the project use WentWest newsletters, webinars, education calendars and practice visits?
☐ Is there an existing Western Sydney AOD GP education program or GP champion network?
☐ How can HealthPathways be updated to include the rapid advice and shared-care pathway?
☐ What practice-level quality-improvement data or support is available?
☐ Can WentWest help evaluate GP confidence, referral quality and patient access?
☐ What existing commissioned AOD, mental health, homelessness, Aboriginal health and justice-transition services should be connected?

7. Questions to ask each GP practice

☐ Do you currently care for patients receiving methadone, buprenorphine or LAIB?
☐ What are the biggest barriers for the GP, nurses and reception team?
☐ What advice would make the practice more confident?
☐ How should urgent and routine Drug Health communication reach the practice?
☐ Who should be the named clinical and administrative contacts?
☐ Would the practice receive annual OTP summaries with patient consent?
☐ Would staff attend short stigma and trauma-informed care training?
☐ Which patient information or clinical resources are needed?
☐ What follow-up can the practice provide, and what must remain with Drug Health?
☐ What would make participation sustainable?

8. GP and practice engagement tracker

Practice	Suburb	Key contact	Existing OTP patients	Interest level	Needs	Next action	Date

9. Measures to track from the start

- Number of patients with a verified GP and documented consent.
- Practices contacted, engaged and actively participating.
- GP, nurse and reception training completion.
- Type and volume of GP advice requests.
- Median response/callback time and percentage within target.
- Referral completeness and annual-summary delivery success.
- Primary-care appointments, care plans and preventive-health activity.
- Patient-reported stigma, access and continuity.
- Clinical incidents or treatment gaps linked to communication.
- Rapid re-entry requests and outcomes.
- GP prescribing interest or transfers as a secondary longer-term outcome.

10. Your first conversations

WITH WENTWEST

“I am the WSLHD Drug Health CNC GP Liaison working on improving specialist access, care coordination and stigma for people receiving OTP. The immediate goal is not to ask GPs to prescribe. I would like to identify suitable pilot practices, understand their needs, use existing PHN engagement channels and jointly develop a sustainable communication pathway.”

WITH A GP PRACTICE

“Drug Health will retain OTP specialist treatment. We want to make it easier for your practice to provide the patient’s usual primary healthcare. We are offering rapid specialist advice, clearer summaries, education and a defined escalation pathway. We would like to understand what your practice needs to participate safely.”

11. Immediate next steps

☐ Confirm that “Westend” means WentWest and clarify what “PHC” refers to locally.

☐ Ask Tracy and the manager for the approved project protocol, role description and practice-engagement boundaries.

☐ Request a meeting with the WentWest AOD or integrated-care lead.
☐ Audit verified GP details for a small OTP patient sample.
☐ Identify five practices already caring for multiple OTP patients.
☐ Prepare a short GP needs-assessment survey.
☐ Define the rapid-advice coverage and escalation model before advertising the phone number.
☐ Prepare the annual-summary minimum dataset and patient-consent process.
☐ Select a small pilot rather than approaching all practices at once.

Names and contacts to follow up:

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Potential pilot practices:

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Questions for Tracy / manager:

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My actions and due dates:

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Source notes

Current public sources checked 24 September 2026: WentWest identifies itself as the Western Sydney PHN and describes its coordination, capability-building, commissioning and quality-improvement roles. WentWest reports 336 GP clinics across its region. The NSW Government WSLHD Drug Health page lists OTP and other AOD services and central intake. Public directories do not confirm individual GP willingness or capacity to participate, so the final GP target list should be developed through approved WentWest, WSLHD and patient-verification processes.

OTP REFERRAL AND SHARED-CARE PATHWAY

Draft workflow for discussion, testing and approval

PATHWAY PRINCIPLE

The immediate aim is communication-supported primary care, not automatic transfer of OTP prescribing. Drug Health retains specialist OTP care unless a separate formal prescribing transfer is agreed. Every step requires patient consent, verified information, named responsibility and closed-loop communication.

1 IDENTIFY	Drug Health clinician identifies a patient who may benefit from stronger GP involvement.	**CLOSED LOOP** **Patient preference discussed; current GP verified.**
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2 ASSESS	Complete focused AOD, risk, health and psychosocial review. Confirm OAT medicine, dose, last dose, missed doses, pharmacy and current risks.	**CLOSED LOOP** **Eligibility, risks and level of shared care documented.**
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3 CONSENT	Explain the proposed information sharing and GP role. Record consent and any limits.	**CLOSED LOOP** **Consent and verified practice details recorded in eMR.**
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4 REFER	CNC GP Liaison sends the minimum dataset through the approved secure route. Complex or urgent cases receive verbal ISBAR handover.	**CLOSED LOOP** **Referral receipt acknowledged by named practice contact.**
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5 GP REVIEW	GP/practice reviews capability, access, patient needs, costs and support required. GP accepts, declines or requests more information.	**CLOSED LOOP** **Decision communicated to Drug Health and patient.**
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6 AGREE PLAN	Drug Health, GP, patient and pharmacy clarify clinical roles, monitoring, annual summary, advice access and escalation.	**CLOSED LOOP** **Shared-care plan names owner, timeframe and next appointment.**
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7 ACTIVATE	Patient attends GP. Drug Health continues OTP prescribing unless a separate formal transfer is approved.	**CLOSED LOOP** **First review completed and outcome returned to CNC liaison.**
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8 MONITOR	CNC follows communication, access, health-care actions, incidents and GP/patient feedback.	**CLOSED LOOP** **Review date and outcome measures remain current.**
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9 ESCALATE / RE-ENTER	For intoxication, missed doses, overdose, severe withdrawal, medical or mental-health deterioration, use the agreed urgent advice, ED/000 or rapid Drug Health re-entry pathway.	**CLOSED LOOP** **Receiving clinician accepts handover and documents responsibility.**

URGENT SAFETY OVERRIDE

Do not wait for the routine pathway when there is reduced consciousness, breathing concern, overdose, severe intoxication, seizure, delirium, acute psychosis, imminent self-harm or violence, or serious medical instability. Activate emergency and local escalation procedures immediately.

GP AND PRACTICE CONTACT TRACKER

Use only approved organisational and patient-consented information

PRIVACY AND GOVERNANCE

Do not use the tracker as a clinical record. Store it only in an approved WSLHD location. Do not record unnecessary patient-identifying information. Verification of a patient's current GP and consent remains documented in the clinical record.

Practice / GP	Suburb	Contact person / role	Phone / secure channel	Existing OTP patients*	Interest / readiness	Support needed	Next action / owner	Review date

**Use aggregate or de-identified information only unless patient consent and approved clinical processes permit otherwise.*

Practice readiness rating

Rating	Meaning	Suggested next step
High	Existing relationship with OTP patients; willing contact; suitable systems and team capacity.	Invite to pilot; complete needs assessment and agreed communication plan.
Medium	Interested but needs education, workflow clarification or internal practice discussion.	Offer education and follow-up; identify named champion.
Low / not ready	Limited capacity, access barriers or not currently interested.	Respect decision; record barriers; offer resources and revisit only if appropriate.

Contact log

Date	Practice / contact	Method	Purpose / summary	Agreed action	Follow-up due

FIRST 30-DAY ACTION PLAN

Build the foundation before promoting the service to practices

30-DAY OUTCOME

By day 30, aim to have a confirmed role scope, safe rapid-advice coverage model, baseline GP-data picture, approved minimum dataset, WentWest engagement route, selected pilot-practice criteria and a small list of practices ready for needs assessment.

Timeframe	Priority actions	Deliverable / evidence	Key people	Status	Notes / risk
Days 1-5	Confirm role boundaries, project protocol, ethics constraints, target population, business hours, 15-30 minute response expectation, clinical backup and leave coverage.	Written role/scope statement; escalation and coverage map.	Manager, Tracy, project investigators, Addiction Medicine, OTP leads.		
Days 1-7	Collect current forms, annual summaries, referral routes, eMR documentation location and existing GP/PHN contacts.	Document inventory and communication-gap list.	Clinic NUMs/CNCs, administration, eMR/data staff.		
Days 5-10	Define the minimum communication dataset and patient-verification/consent process.	Draft referral dataset, verified-GP prompt and consent wording.	Privacy/governance, clinicians, consumers.		
Days 5-12	Complete a small baseline audit of OTP records to estimate recorded GP accuracy, consent documentation and current correspondence.	Baseline audit with de-identified results and limitations.	Data/eMR staff, clinic leads, research team.		
Days 8-14	Meet WentWest/Western Sydney PHN contacts to clarify practice-engagement routes, education channels, HealthPathways and data/privacy boundaries.	Named PHN contacts; agreed engagement route; list of available channels.	WentWest AOD/integrated-care lead, practice-development staff.		
Days 10-18	Finalise practice selection criteria and identify a shortlist through approved sources: verified patient GPs, Drug Health knowledge and WentWest support.	Shortlist of 5-10 possible pilot practices; no unapproved personal data.	WentWest, Drug Health clinicians, patients/consumers.		
Days 12-20	Prepare a brief GP/practice needs-assessment survey and introductory script.	One-page survey; phone/email script; contact-log template.	Research team, GP adviser, practice manager representative.		
Days 15-23	Prepare the support offer: rapid advice pathway, annual summary, GP OTP information, receptionist stigma/trauma training and patient resources.	Draft practice pack and education outline.	Educator, Tracy, consumers, Aboriginal Health, LGBTQ+ inclusion contacts.		
Days 20-26	Approach 3-5 practices for exploratory discussion, not prescribing recruitment. Record barriers, preferred communication and education needs.	Completed needs assessments and engagement notes.	CNC liaison, WentWest contact, practice champions.		
Days 25-30	Review findings, revise pathway, confirm pilot practices and agree measures, governance and next 60-day plan.	30-day report; revised pathway; pilot proposal; KPI baseline and next steps.	Manager, Tracy, investigators, governance, WentWest.		

Weekly checklist

Week 1: Clarify and collect

☐ Role and project scope confirmed
☐ Clinical backup and escalation confirmed
☐ Current documents and systems collected
☐ Stakeholder map started

Week 2: Audit and connect

☐ Baseline audit commenced
☐ Verified-GP and consent process drafted
☐ WentWest meeting completed or booked
☐ Practice criteria drafted

Week 3: Build the offer

☐ Needs survey prepared
☐ GP/practice script prepared
☐ Education and resource pack outlined
☐ Potential pilot practices shortlisted

Week 4: Test and decide

☐ Initial practice discussions completed
☐ Barriers and requirements analysed
☐ Referral pathway revised
☐ Pilot and next 60-day actions agreed

Day-30 review

What has been completed?

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What is blocked and why?

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What requires governance or ethics approval?

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Which practices are suitable for the pilot?

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What support have GPs requested?

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What are the priorities for days 31-90?

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