WSLHD DRUG HEALTH · BLACKTOWN LGA · CNC1 GP LIAISON

GP Liaison Playbook

KPI delivery and the permanency strategy for the Drug Health GP Liaison CNC role — built from the SLHD GLAD Model of Care (the exemplar) and the draft WSLHD Model of Care (the scoreboard).

Prepared September 2026 · Personal working document

> Working document. Adapt all templates to WSLHD-approved formats and get manager sign-off before anything goes out to GPs — the WSLHD Model of Care is still a draft.

01 · ORIENTATION

The two documents, decoded

You have been handed a proven playbook and a scoreboard. The job is to run the playbook, hit the scoreboard, and document it well enough that the Drug Health Executive funds the role permanently.

THE EXEMPLAR

SLHD GLAD Model of Care

Sydney LHD's established GP Liaison for Alcohol and other Drugs service: 0.8 FTE CNC Grade 1 + 0.1 FTE Medical Officer, PHN-funded, based at Croydon. Phone advice, practice visits, short-term shared care (caseload capped at 15), GP education, and transfer of low-risk Opioid Treatment Program (OTP) clients to GP prescribing. Governance: weekly Clinical Review Meetings, ISBAR handover, safety huddles, DNA risk rating on SPOM criteria, eMR documentation plus a non-clinical shared-care database.

HER ROLE

WSLHD draft Model of Care

CNC1 Drug Health GP Liaison — equity-funded, Blacktown LGA focus, implementation 2026–2028, quarterly reporting to the Drug Health Executive, WentWest PHN named in the implementation strategy. Contains the KPI table, which is tougher than the mature SLHD service's targets. Equity funding is time-limited: that is why the role is a contract, and why the evidence file starts on day one.

02 · THE SCOREBOARD

KPIs and the run-rate they demand

Assume roughly 46 working weeks (~11 effective months) after leave and public holidays. These numbers do not happen passively — they require generating demand, and counting everything.

KPI	TARGET/YR	RUN-RATE
GP consultations Every advice call counts — log same day	**100**	**~2 / wk**
Referrals supported Needs active marketing to practices	**150**	**~3 / wk**
Case conferences CRMs + GP case discussions	**100**	**~2 / wk**
Shared care clients Clarify cumulative vs concurrent — SLHD caps concurrent at 15	**50**	**~4–5 / mo**
Direct treatment occasions Flows from shared care volume	**75**	**~7 / mo**
OTP clients transitioned to GP care HARDEST Needs prescriber + willing GP + pharmacy per client — start the pipeline week one	**50**	**~1 / wk**

GP education sessions Easy to plan, easy to fail by starting late	**12**	**1 / mo**
GP satisfaction Of survey completers — manage the denominator	**>85%**	**ongoing**
Aboriginal client engagement Unprovable without a recorded baseline	**Increase**	**baseline now**
CALD client engagement Same — record the baseline in month one	**Increase**	**baseline now**

Context: the established SLHD service targets only 80 consults, 80 treatment occasions, 80 referrals and 50% GP satisfaction. These targets exceed a mature service's — worth raising diplomatically when the data dictionary is agreed, and a reason to track from day one.

03 · THE REAL GAME

What actually converts a contract

The Executive funds permanency on evidence, assembled continuously — not on effort, and not on a year-end surprise. Six things win it:

1. **KPI attainment with trajectory.** Monthly run-rate vs target, shown as a trend. A service at 70% of target but climbing steeply is fundable; a silent year is not.
2. **A cost-offset story.** Each stable OTP client moved to GP care frees a public dosing place — waitlist relief and specialist capacity. Community management reduces avoidable ED presentations and admissions. Dollars and capacity are the language of a business case.
3. **Demand exceeding capacity.** Referral volumes, practices engaged vs total practices in the LGA, waiting-time creep. "The service is full and GPs want more" is the strongest argument the role cannot lapse.
4. **Equity outcomes.** Aboriginal and CALD engagement growth against baseline — this is why the equity funding exists; it headlines every report.

5. **Stakeholder voice.** GP testimonials and satisfaction data, WentWest PHN endorsement, AMS and Aboriginal Health Worker partnership, OTP clinic support.
6. **Governance cleanliness.** CRM attendance, ISBAR handovers, documentation compliance, no scope breaches. Permanency reviews look at risk as well as output.

Timing: start drafting the business case at month 6–9 so it lands before the LHD budget planning cycle — typically February–April for the July financial year — not after the decision is already made.

04 · LAUNCH

The 90-day action plan

WEEKS 1–4 · INFRASTRUCTURE

- **Data dictionary agreed in writing** — what counts as a consultation, a referral supported, a case conference; whether one contact can count toward multiple KPIs; whether 50 shared-care clients is cumulative or concurrent. Counting rules decide the year as much as the work.
- Build the KPI tracker mirroring SLHD's non-clinical database: GP contact log, engagement attempts, OTP transfer list, education register.
- Set up the GP satisfaction micro-survey (REDCap or approved equivalent).
- Map every GP practice in Blacktown LGA (WentWest supplies the list). Flag high-OTP prescribers, AMS pathways (Mount Druitt / Blacktown), CALD-heavy practices.
- Record Aboriginal and CALD engagement baselines.
- Book the first three education sessions. Confirm referral inbox, advice line, eMR conventions.

WEEKS 4–8 · DEMAND GENERATION

- Introduction email to mapped practices, then visit offers — flagged practices first.
- Same-week response on advice and referrals; acknowledge every referral with the acceptance / non-acceptance letters — each one a documented KPI unit.
- OTP transfer candidates become a **standing agenda item** at OTP clinic reviews; build the pipeline of stable, low-risk clients and match to willing GPs and pharmacies.
- Engage WentWest formally — co-promotion through GP newsletters and their CPD calendar. Free reach now, endorsement later.

WEEKS 8–12 · VISIBILITY

- First monthly one-page KPI report to the manager. Never skip a month.
- CRMs and safety huddles attended; ISBAR and D&A clinical-note conventions followed.
- Evidence folder opened: GP quotes, de-identified vignettes, thank-you emails, survey results.
- First quarterly report to the Drug Health Executive.

05 · DAILY DISCIPLINE

Operating directives

1. **Log every contact the same day.** An unlogged call is a KPI unit lost forever. If it isn't counted, it didn't happen.
2. **Friday data hour** — a protected 60 minutes to reconcile the tracker weekly.
3. **One education session per month, locked a quarter ahead.** Falling two behind by June is unrecoverable.
4. **Survey systematically** — after every closed shared-care episode and every education session. >85% is achievable when the denominator is people actually helped.
5. **Report monthly without being asked.** Managers champion what they can see — and the manager needs ammunition upward too.

6. **Stay in scope.** No case management, NDIS, housing applications or self-referrals — both MOCs exclude them, and scope creep kills KPI hours. Redirect politely; log the redirect as demand evidence.
7. **Escalate by the book.** High-risk clients to the medical officer / senior clinician per pathway; ISBAR for every handover; DNA risk rating on every accepted referral.
8. **Collect the story, not just the count.** One de-identified vignette per month: patient stabilised in community, ED presentation avoided, GP upskilled.
9. **Month six: open the business case file** and start populating it.
10. **Protect the equity narrative.** Aboriginal and CALD engagement figures lead every report — they justify the funding source.

06 · THE PACK

Templates

Square-bracketed **[fields]** are yours to fill; everything goes into WSLHD-approved formats before external use.

6.1 GP practice introduction email

Subject: New Drug Health GP Liaison Service — specialist AOD support for your practice

Dear Dr **[name]**,

I am the Clinical Nurse Consultant for the new WSLHD Drug Health GP Liaison Service, supporting GPs across Blacktown LGA in the care of patients experiencing alcohol and other drug (AOD) concerns.

The service offers, at no cost to your practice:

- **Same-week phone/email advice** on AOD management — alcohol, opioid dependence (including long-acting injectable buprenorphine), methamphetamine, benzodiazepines, and withdrawal management
- **Short-term shared care** for suitable patients, with comprehensive assessment and treatment planning
- **Support transferring stable Opioid Treatment Program clients** to GP prescribing, including pharmacy coordination
- **Free CPD-aligned education** delivered at your practice or online

Referrals and advice: **[phone]** / **[email]**. Patients must be adults residing in the WSLHD catchment who consent to referral.

I would welcome 15 minutes to introduce the service to you or your practice team — would **[date/time]** suit?

Kind regards,
[Name], Clinical Nurse Consultant — Drug Health GP Liaison, WSLHD Drug Health Services

6.2 Referral acceptance letter

Dear Dr _____,

Thank you for your referral for **[patient name and DOB]**. Your referral has been **accepted** by the Drug Health GP Liaison Service.

The service provides advisory and short-term shared care to assist GPs in managing AOD concerns at the primary care level. A key component of shared care is open and continuous communication between clinicians.

I will contact the client shortly and collaborate with you regarding the treatment plan. **[Insert recommended pathway if applicable.]**

Kind regards, [Name], CNC — Drug Health GP Liaison

Adapted from SLHD GLAD Appendix C.

6.3 Referral not-accepted letter

Dear Dr _____,

Thank you for your referral for **[patient name and DOB]**. On this occasion the referral has not been accepted by the Drug Health GP Liaison Service **[insert reason — e.g. outside catchment, acute needs requiring inpatient management, intensive case management required]**.

We recommend the following pathway/service: **[insert]**.

Please contact the service on **[phone/email]** Monday–**[day]**, **[hours]**, or the WSLHD Drug Health intake line on **[number]** if you have questions.

Kind regards, [Name], CNC — Drug Health GP Liaison

Every non-acceptance is still logged — it is documented demand.

6.4 Phone advice log entry (ISBAR)

Date/time · GP name & practice · Duration

I — Caller and role; patient identified? (Y/N — if N, log as non-clinical advice)

S — Presenting AOD issue and immediate question

B — Relevant history provided

A — Assessment/advice given (guideline referenced, e.g. NSW Opioid Dependence 2018, LAIB 2024)

R — Recommendation and agreed next step (advice only / referral invited / escalated to MO)

KPI tags: ☐ GP consultation ☐ Referral supported ☐ Case conference ☐ Education

Follow-up required: Y/N — date

6.5 GP satisfaction micro-survey

1. The advice/support I received was timely. **(Strongly disagree → Strongly agree)**

2. The advice was clinically useful and practical. **(5-point)**

3. My confidence managing AOD presentations has improved. **(5-point)**

4. I would use the service again and recommend it to colleagues. **(5-point)**

5. What could we improve? **(free text)**

Satisfied = agree/strongly agree on Q2 or Q4. Send after every closed episode, every education session, and quarterly to active GP contacts. Two minutes, five items — response rate is the KPI's hidden variable.

6.6 Education session invitation

Subject: Free AOD education for [practice name] — [topic]

Dear **[practice manager / Dr name]**,

The WSLHD Drug Health GP Liaison Service offers free education for GPs and practice staff. Coming sessions: **[topic — e.g. "Long-acting injectable buprenorphine: what GPs need to know", "Alcohol withdrawal in primary care", "Naloxone and harm reduction"]**. Delivered at your practice or online, **[30/45]** minutes, lunchtime slots available. **[CPD alignment statement if applicable.]**

Reply to book a date for your team.

6.7 Monthly KPI report to manager (one page)

GP Liaison Service — Monthly Report, [Month 20XX]

KPI	TARGET	MONTH	YTD	TREND
GP consultations	**100**			↑ ↓ →
Referrals supported	**150**			
Case conferences	**100**			
Shared care clients	**50**			
Direct treatment occasions	**75**			
OTP → GP transitions	**50**			
Education sessions	**12**			
GP satisfaction	**>85%**			
Aboriginal clients engaged	**↑**			
CALD clients engaged	**↑**			

Practices engaged: [n] of **[total]** in Blacktown LGA · **New this month: [names]**
Highlight: [one vignette or GP quote]
Risks/barriers: [one line + what's needed]
Next month focus: [two lines]

6.8 Quarterly executive report structure

1. Service snapshot (2 lines)
2. KPI dashboard — the monthly table, quarterly view
3. Equity outcomes — Aboriginal / CALD engagement vs baseline
4. System impact — OTP places freed, ED-avoidance examples, GP capability built
5. Stakeholder feedback — satisfaction %, quotes, WentWest activity
6. Governance — CRM participation, escalations, incidents (nil or detail)
7. Risks and asks
8. Next quarter priorities

6.9 Business case for permanency — skeleton

1. **Purpose** — convert the CNC1 GP Liaison position to recurrent funding from **[date]**
2. **Strategic alignment** — WSLHD Strategic Plan, equity funding priorities for Blacktown LGA, NSW Health AOD Clinical Care Standards, NSW Aboriginal Health Plan
3. **Demonstrated performance** — KPI table, actuals vs targets, trajectory charts
4. **Demand** — referrals received, practices engaged / waiting, growth curve
5. **System benefit** — OTP capacity released (n places × value), avoidable ED presentations and admissions, GP capability (education reach, satisfaction, confidence)
6. **Equity impact** — Aboriginal and CALD engagement growth; alignment with funding intent
7. **Stakeholder endorsement** — GP testimonials, WentWest PHN letter of support, OTP clinic and AMS partnerships
8. **Consequence of discontinuation** — loss of referral pathways, GP disengagement, reversal of OTP transitions, equity outcomes unsustained
9. **Cost** — 1.0 FTE CNC1 + on-costs vs quantified offsets
10. **Recommendation and decision sought**

Open this file at month six; land it before the February–April budget cycle.

6.10 Thirty-second elevator pitch

"I'm the bridge between Blacktown GPs and Drug Health. GPs get same-week specialist AOD advice, shared care for complex patients, and I move stable opioid treatment clients out of public clinics into GP care — which frees specialist places and keeps people in treatment close to home. **[X]** practices engaged, **[n]** transitions so far, **[%]** GP satisfaction."

Risks, met early

RISK	PRE-EMPTION
Slow referral uptake in months 1–3 drags annual totals	Front-load promotion; count and report engagement *attempts* (SLHD logs these too)
Ambiguous KPI definitions counted against you	Data dictionary agreed in writing, month one
OTP transition target (50) stalls on GP willingness	Pipeline list + standing OTP agenda item + target GPs already prescribing; report barriers early so the target is contextualised, not silently missed
Satisfaction survey response too thin	Survey at every warm touchpoint; short instrument; quarterly sweep
Scope creep — case management, housing, NDIS	Polite redirect scripts; log redirects as demand evidence
Single-officer service = invisible workload	Monthly one-pager, quarterly executive report, evidence folder
Leave or absence gaps in KPI months	Bank surplus early in the year; note coverage arrangements in reports

08 · THE SHORT VERSION

Explain it like I'm five

The hospital's drug and alcohol team lives on one side of a river, and all the local GP doctors live on the other side. Your new job is to **be the bridge**. Doctors call you

when they're not sure how to help a patient with alcohol or drug problems, you give expert advice, help look after tricky patients together, teach the doctors new skills, and help stable patients move from the busy hospital clinic to their own friendly GP.

The bosses gave you a **scoreboard** — the KPIs: how many calls answered, how many patients helped, how many classes taught. Right now the job is a **trial period**; the money runs out in 2028. To make it permanent, you have to show the bosses that lots of people use the bridge, that it saves the hospital money and space, and that the doctors love it.

The trick is simple: **write down every single thing you do, the same day you do it** — because to the bosses, anything not written down never happened. Then, once a month, show them a one-page scorecard so they watch you winning all year long. By the time you ask "can this job be permanent?", the bosses should already know the answer is yes — because they've been watching the score the whole time.

Sources: SLHD Drug Health Services Guideline — GP Liaison for Alcohol and other Drugs (GLAD) Model of Care, DHS_SLHD_PCP2024_016 (Sept 2024) · Draft WSLHD Drug Health GP Liaison Service Model of Care (July 2026). Personal working playbook — not an official NSW Health or WSLHD document.