North Coast - Core Funding
2025/26 - 2028/29
Activity Summary View

GPACI-TM - 1 - General Practice In Aged Care Incentive Thin Markets

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

GPACI-TM

Activity Number *

1

Activity Title *

General Practice In Aged Care Incentive Thin Markets

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

The activity aims to support innovative and local solutions to address lack of primary care services for permanent residents in residential aged care homes (RACH).

Description of Activity *

NSW North Coast PHN will design and deliver a needs based, co-designed program to address two core elements of service response and care delivery for RACH residents across our region.

A comprehensive approach to market via RFP was undertaken in November 2024 to commission a specialised needs analysis and a stakeholder consultation program targeted at understanding and improving access to primary care services for RACH residents. The program commenced in December 2024 where a deep dive was undertaken with each RACH, providing insights into place-based characteristics including current and forecast GP coverage, RACH clinical capability, telehealth capability, and other primary care barriers and enablers. This needs analysis was completed and reported in May 2025 by Enkindle Consulting.

The report provided HNC with real time updates after each RACH consultation as well as a thematic analysis in local RACH clusters and across the region, forming a foundation for HNC's specialist 'Co-ordinator for Aged Care access to primary care' to prioritise and deliver prioritised effective interventions to ensure aged care residents receive regular quality care in areas where GP services are thin, at risk or non-existent. This work identified any current and forecast service gaps faced by RACHs, and any tailored support they might need and help them prepare for future initiatives and improvements. The project concluded in May 2025 providing insights on 75% of RACHs in the region.
Concurrently, across the footprint, HNC's specialist co-ordinator tracks and monitors the supply of GP's providing care to Aged Care residents, including intention to continue supply, to anticipate and respond to future gaps.

Alongside the RACH stakeholder consultation, community and primary care provider forums provided input and assistance from stakeholders to identify key areas of focus and critical design elements to ensure efficient and consumer centred approaches.

Two streams of service activity were implemented to address Thin markets

1. Immediate access to General Practice Services in areas of need – acute and immediate response services to support patient flow, new resident placements and unmet acute care needs in RACH settings.

A significant component of the request for primary care service support in RACH settings arise when patients and community members are awaiting admission into residential aged care but unable to do so though lack of admitting GP. For various reasons, many GPs in regional areas within our footprint have transitioned away from providing frontline RACH services or taking on new RACH residents for care, whilst others have closed books.

The activities designed and delivered under this program area focus on finding and supporting general practices to accept new residents entering aged care setting and to finding alternatives for RACH providers, such as virtual GP's where this is not possible.

Healthy North Coast will
• identify and co-ordinate GP services with capacity to take on care new aged care residents to improve the efficiency and logistics of care delivery. Includes promoting team based models of care for example Nurse Practitioners.
• identify and promote details of out of region general practitioners with capacity and/or appropriate telehealth and specialised care support services to optimise direct access to general practice care.
• Identify barriers and risk factors to GP supply in specific locations and promote alternative options and facilitate introductions with emerging GPs with interest in aged care. Combining this workforce supply strategy with a demand reduction strategy as tabled below will minimise the frequency of short notice requests for GP assistance where extended delays to access care have occurred.

2. Increasing the comprehensiveness of care for existing RACH residents to reduce demand on primary care and hospital services – supportive and assistive interventions

Providing an optimal frequency, intensity and range of primary care services and resident support activities will support the management of demand for medical and hospital care for RACH residents. This service care stream will support primary care services to improve health and wellbeing in RACH settings through
i) Commissioning an 'Enhancing Primary Care' grants program for allied health, nursing and supportive care interventions and other alternative approaches, as co-designed by providers
ii) Co-design and promotion of solutions which build practice capacity and efficient models for RACH coverage
These solutions will reduce demands on frontline medical care service requirements for GPs in RACHs, adding capacity to the system, This means residents receive timely care and unnecessary use of ED as an alternative to local primary care is reduced.

The program activities will focus on localities where the unmet demand for RACH primary care services is high, where the current care supply is low, or where the risk of the continuity of workforce supply is high. This may be evidenced by:
- Localities where higher numbers of general practices have indicated they have 'closed books' and are no longer accepting any

new patients into their practice
- Local Health District escalations and patient flow information identifying inpatients medically cleared for discharge to a RACH setting who do not have an identified GP to support admission, thus leading to delayed discharge
- Places where a single GP is responsible for a significantly high number (absolute or relative) of RACH residents.

Outcomes for these grants are tailored to the unique circumstances of each location/provider/RACH

HNC will supplement these activities with a comprehensive campaign to build the capacity of the primary care workforce in current or expected thin markets. This campaign targets GP's potentially withdrawing from aged care and new GP's considering aged care or looking to specialise in aged care and presents alternative models of care delivery to make Aged Care more appealing/ sustainable. Examples in this campaign include Dinner events with GP- led discussion on solutions to sustainable primary care for RACH's, promotional videos and collateral, webinars and clinical societies on sustainable aged care practices, individual support for GP's on business models and innovative models of care, nurse led care planning and case conferencing, business support for practices to continue in aged care and recruitment messaging for nurses and nurse practitioners to specialise in aged care.

reporting will be finalised after the co-design and prioritised key implementation strategies have been agreed upon, Evaluation of the program of activities will be conducted against a selection of the following baseline data that might include:
- Occasions of primary care services delivered in RACH settings as a direct result of PHN program for GPACI thin markets
- # residents receiving services under the PHN delivered programs
- Volume of HNC access enquiries requesting support for GP services
- Volume of presentations to ED for low urgency presentations suitable for primary care and management in alternate settings – reported by RACHS
- Satisfaction scores- staff, residents' families, GP's and allied health/nursing professionals participating in program activities.
These metrics are included in the project status reports required of grant recipients, and the data collated and reported will contribute to overall program outcome reporting.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Improve attraction and retention of general practitioners in the North Coast, particularly in Clarence Valley, Nambucca Valley and Kyogle LGAs	151
Encourage GPs to continue to build strong relationships with patients and families	146
Enhance capacity of the health and social care services, including workforce capability, to manage increase of older person population	144
Explore opportunities to prepare the healthcare system to manage expected growth in the older adult population with a specific focus on dementia care and improving healthy ageing	141
Improve prevention and management of chronic disease, including management of risk factors, multimorbidity and polypharmacy	145
Improve health workforce stability in the North Coast, particularly GPs and specialist workforce	142

Activity Demographics

Target Population Cohort

Permanent residents in residential aged care homes.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consumers, general practitioners, practice nurses, allied health professionals, Aboriginal health workers, general practices, Aboriginal Medical Services, RACFs, community aged care providers, aged care peak bodies, MNC and NNSW LHDs, Booroogen Djugun, local government, Clinical Advisory Council.

Collaboration

Collaboration with AMS partners, LHD's, Primary care providers of allied health and team care services to sequence and prioritise areas of focus and support culturally safe, high quality MDT services being delivered in RACH settings

Plans to co-ordinate awareness and assistance from stakeholders to identify key areas of focus and critical design elements to ensure efficiency of operation and client/community centred approaches

Working with RACHs, community representatives, primary care providers and allied health to identify key service needs and access pathways to GP care, preventative care and appropriate clinical services.

Working with other PHN's in the Thin Markets and GP Aged Care Incentive Communities of Practice facilitated by the DoH and Brisbane North PHN respectively

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Activity Milestone Details/Duration

Activity Start Date

01/06/2024

Activity End Date

30/06/2027

Service Delivery Start Date

01/10/2024

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Key milestones by FY are tabled below

FY24/25
1. Insights assessment and RACH stakeholder procurement and assessment completion May 2025
- Insights Assessment will be conducted with each RACH to capture critical information impacting the supply of GPs. Insights include:
• Current GP Access Profile:
• Mapping GPs currently visiting each RACH, frequency and type of visits (routine, acute, telehealth), and the stability of the relationship.
• Forecast GP Capacity Risk: Assessing the age, intention to withdraw, and volume of care responsibility per GP (e.g. GPs managing more than 50 residents). -
- Assessment of Telehealth Readiness: Infrastructure, digital literacy of staff, and current usage patterns.
- Clinical Capability in RACH: Availability of RNs, ENs, AINs, and allied health; confidence in escalating clinical concerns and to improve care for residents to reduce the need for GP's
- Recent Access Challenges: Documenting specific incidents where resident care was delayed or unmet due to GP access issues.

2. Community and clinical consultation – stakeholder insights First round complete May 2025 with ongoing consultation and updates. Stakeholder forums and primary care provider consultation will be held to support the development of solutions.

3. Explore integrated telehealth and virtual care services
partnerships with LHD and telehealth services providers to support RACH virtual care support. Change management assistance, promotion and awareness, implementation support of existing RACH care support services

High level outcomes commentary FY24/25
FY24/25 activities will result in increased understanding of the RACH and GP workforce capacity and capability to support RACH residents to connect to locally available GP services for residential care. Another key outcome will be to increase awareness and change readiness for support residents to access and appropriately use telehealth, virtual care and support services for planned and unplanned medical care. Stakeholder engagement and co-design to develop funded solution.

FY25/26 activities include
1. A grants program. commissioning of allied health, nursing and supportive care services to reduce demand on frontline medical care service requirements for general practitioners in RACH's.
A proactive program of targeted support to
a) homes with limited/no GP access
b) GP's wishing to commence or scale aged care services
c) Grant funded agreements were issued to 5 providers across the identified thin market regions, including Flynns Beach medical Centre, YFP PTY Ltd T/a Your Family Practice, Rose Avenue Medical, Woopi Medical and St Andrews Ballina (RACH)

FY26/27 activities will be determined following review of grant funding agreements awarded in 2025/2026 and associated activities as well as further developments in GP availability across the footprint

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): Yes
Other Approach (please provide details): No

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

Co- design will continue throughout the program as needs emerge
Initial co-design activities have involved RACH staff at all levels;
-GPs and practice managers, nurse practitioners and practice nurses using formal and informal conversations, interviews, forums, open space technology, and virtual collaboration sessions. Additional co-design included LHDs, allied health providers, geriatricians and peak bodies

GPIF - 2 - GP Incentive Fund Clarence Valley Region Phase 2 (NSW)

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

GPIF

Activity Number *

2

Activity Title *

GP Incentive Fund Clarence Valley Region Phase 2 (NSW)

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Workforce

Other Program Key Priority Area Description

Aim of Activity *

The activity aims to stabilise and strengthen access to primary care in the Clarence Valley, with delivery centred on Grafton and Maclean and reach to surrounding communities where access and transport barriers are significant. It responds to a documented thin-market failure driven by high and growing demand, constrained and unstable general practice and allied health capacity, limited same-day and after-hours options, low visibility of available services, affordability and transport barriers, and avoidable reliance on emergency departments for lower-acuity care.
The contributing factors are cumulative. Clarence Valley has an older population profile, projected growth in older age cohorts, and high levels of chronic and complex care need, which increase demand for coordinated, continuous primary care. This demand is intensified by socioeconomic disadvantage, housing insecurity, domestic and family violence, disability-related need, transport barriers and limited local access to diagnostics, specialist services and private hospital alternatives. At the same time, local primary care supply is fragile, with closed books, long routine waits, limited same-day capacity, constrained after-hours coverage, workforce instability, and low GP workforce supply relative to NSW and national benchmarks.
The activity will improve timely, affordable and appropriate access to primary health care by expanding workforce-ready access models, strengthening GP, ACCHO, pharmacy, allied health and LHD pathways, establishing trusted navigation support, and building sustainable practice-based prevention and chronic care capacity. It is designed to reduce fragmentation, support earlier intervention, improve community confidence in where to seek care, and create more sustainable access arrangements without relying solely on additional GP FTE in a constrained workforce market.

Description of Activity *

Healthy North Coast will commission and manage a four-stream implementation package aligned to the approved Clarence Valley Service System Recovery Plan. The activity will strengthen existing services and partnerships rather than create a stand-alone model, with delivery centred on Grafton and Maclean and linked to surrounding communities where access and transport barriers are significant.

Stream 1 – Reduce reliance on acute care through partnerships and strengthened whole-of-system pathways

- Develop shared referral, escalation and patient-flow pathways across general practice and ACCHO settings, Northern NSW Local Health District, community pharmacy and relevant community services
- Convene targeted partner working groups with workforce, council and correctional transition partners to formalise shared commitments and embed agreed pathway actions.

- Commission low-cost or bulk-billed low-acuity care options through community pharmacy, nurse-led and allied health services, including extended-hours access where feasible.

Stream 2 – Maximise use, awareness and promotion of existing services through a trusted front door

- Establish Primary Care Access and Liaison Officer functions embedded in, or formally linked to, participating general practice, ACCHO and community pharmacy services
- Support care navigation, referral coordination, warm handovers, escalation, follow-up and reduced administrative burden for clinical teams.
- Deploy a Community Connector in trusted, high-traffic non-clinical settings such as libraries, community hubs, neighbourhood centres and local events.
- Deliver place-based communications and outreach to improve health literacy, clarify when and how to use local services, and maintain visible community feedback loops.
- Leverage Healthy North Coast's AI-enabled service navigation and wayfinding platform to help community members identify appropriate local services, understand available care options, access up-to-date service information and support informed health system navigation, with promotion through Community Connectors, Primary Care Access and Liaison Officers and broader community awareness activities. Stream 3 – Expand proven, high-impact primary care models that can start quickly

- Commission general practices and ACCHO services to increase same-day, urgent and low-acuity appointment supply, including twilight and weekend access where feasible.
- Expand nurse-supported and team-based care models that are integrated with existing GP, ACCHO and LHD referral pathways.
- Support in-reach education and capability uplift for GPs, practice nurses and ACCHO teams to improve chronic, complex and preventive care capacity.
- Enable practice-based preventive, chronic disease and follow-up clinics through protected practice time, coordination support and minor enabling infrastructure- Improve diagnostic and specialist pathway coordination to reduce unnecessary travel, delays and avoidable escalation to hospital-based care.

Stream 4 – Monitoring, evaluation and sustainability

Establish baseline measures, minimum datasets and routine provider reporting to track access, equity, experience, service use and pathway performance. Maintain governance oversight through partner review, community feedback and Aboriginal stakeholder engagement mechanisms.
Develop sustainability and transition recommendations to identify which components should continue, adapt or be embedded into future PHN commissioning

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Facilitate opportunities for individuals and communities to participate in preventative health activities	146
Improve health literacy and wayfinding to facilitate access to the right services at the right time and engagement in preventative health behaviours	146
Improve access to GPs for people in the North Coast to reduce long wait times, reduce cost of healthcare, ensure quality of healthcare and reduce travel times	144
Increase access to after-hours GP services in the North Coast, particularly in Clarence Valley SA3	145
Improve integration of services, continuity of care and consumer/provider experience	145

Activity Demographics

Target Population Cohort

Clarence Valley LGA, with targeted access and equity actions for people most affected by primary care instability, including older people, carers, Aboriginal people, people with chronic and complex health needs, people experiencing housing insecurity or domestic and family violence, people with disability, people with transport barriers, and people transitioning from custody or otherwise disconnected from routine primary care.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

No

SA3 Name	SA3 Code
Clarence Valley	10401

Activity Consultation and Collaboration

Consultation

This activity has been informed by extensive local consultation and co-design undertaken during Phase 1, bringing together community, provider, Aboriginal, aged care, hospital, local government and health system perspectives. Consultation included targeted engagement with general practices and Aboriginal Community Controlled Health organisations across the Clarence Valley; engagement with residential aged care homes regarding GP access, admissions, discharges, after-hours escalation and continuity risks; open community consultation sessions in Maclean and Grafton; an Aboriginal Community Yarn in Grafton; and two peak/advisory group validation sessions with clinical, community, ACCHO, LHD, allied health, council and system representatives.

The consultation tested three priority areas for change: getting help earlier, finding the right service, and building on what works locally. Maclean participants highlighted after-hours gaps, diagnostic access, transport, Yamba and surrounding community access issues, and the need for both a local person and simple digital options to help people navigate care. Grafton participants emphasised workforce instability, specialist shortages, affordability pressures, the need for one trusted access point, and practical support to use telehealth where appropriate.

The Aboriginal Community Yarn strengthened the cultural safety and equity design of the activity. Aboriginal community members emphasised holistic wellbeing, trust, outreach, transport, clear current service information, culturally safe support workers, reserved same-day access for Elders and vulnerable people, and the importance of regular community yarns and ongoing feedback loops. Aged care engagement highlighted the fragility of GP access for approximately 850 residential aged care residents across Clarence Valley homes, with risks including avoidable hospital presentations, delayed discharge, palliative care delays and increasing reliance on external providers.

These findings directly shaped the solution streams by prioritising workforce-ready access uplift, embedded navigation and “front door” support, stronger GP/ACCHO/LHD referral and escalation pathways, bulk-billed or low-cost options and improved use of existing services.

The peak/advisory group validated the need to focus on practical, locally deliverable actions that can be implemented within the grant period while strengthening coordination and avoiding further fragmentation.

Collaboration

Participating general practices will deliver access uplift, practice-based care models, liaison functions and routine reporting.
Aboriginal Community Controlled Health Organisations (primarily Bulgarr Ngaru Medical Aboriginal Corporation) will support culturally safe design, engagement and implementation.
Northern NSW Local Health District will partner on ED, outpatient, community health, diagnostic and escalation pathways.
Community pharmacy, nurse-led and allied health providers will support low-acuity, extended-hours and integrated access models.
Clarence Valley Council and community organisations will support place-based access points, outreach, community communication and feedback.
The Clarence Valley Regional Training Hub, workforce partners and relevant NGOs will contribute to workforce pipeline, transition and pathway-strengthening activities.
A peak advisory governance structure will maintain partner alignment, manage risks and guide iterative implementation.

Activity Milestone Details/Duration

Activity Start Date

05/06/2026

Activity End Date

30/06/2027

Service Delivery Start Date

17/08/2026

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Key milestones include
- mobilisation and procurement from June to August 2026
- establishment of governance, provider agreements and minimum datasets by August 2026; commencement of service delivery from 17 August 2026
- recruitment and deployment of Primary Care Access and Liaison Officers and Community Connector roles by October 2026
- implementation of shared referral, escalation and patient-flow pathways by February 2027;
- implementation of same-day, extended-hours, preventive/chronic care and in-reach education models across the delivery period;
- baseline and rapid-cycle evaluation from commencement; interim evaluation and sustainability recommendations by June 2027

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: Yes
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): Yes
Other Approach (please provide details): No

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

The activity has been co-designed through Phase 1 community, provider and system engagement. Co-design findings have informed the four solution streams, commissioning approach, governance arrangements, access priorities and practical risk controls.
Implementation will continue to use co-design through provider briefings, peak advisory group oversight, community updates, Aboriginal engagement mechanisms, pathway workshops and routine feedback from commissioned providers and service users.

CMDT - 1 - Commissioning Multidisciplinary Teams - Commissioning

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CMDT

Activity Number *

1

Activity Title *

Commissioning Multidisciplinary Teams - Commissioning

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Workforce

Other Program Key Priority Area Description

Aim of Activity *

Design, commission and enhance support to multidisciplinary teams to provide care services in smaller general practices and Aboriginal Community Controlled Health Services.

Description of Activity *

Healthy North Coast will commission clinical workforces to provide MDT services in primary care settings. Smaller regional and rural general practices will be supported by nursing, allied health and other health professionals to deliver MDT care for chronic and complex health conditions in priority and at risk populations.
The most suitable MDT care teams and health professionals will support general practice management of complex and chronic conditions and diseases that place greater burdens of care on the health system.
Specific areas of focus that are nationally recognised and prominent within our region include the management of people with
• diabetes
• chronic obstructive pulmonary disease
• cardiovascular disease
• anxiety and depression.
Effective management of risk factors and co-morbidities associated with chronic and complex conditions are optimally suited to a team based care approach. Care interventions will be developed and co-designed with general practice staff, nursing, allied and other health professionals, ACCHOs and patients and may include:

- screening for at risk populations
- health literacy and patient education including pharmacy literacy
- patient empowerment and confidence to monitor and manage chronic health conditions
- improvements to diet, exercise and levels of physical activity
- wound care management
- increasing social connectedness.

Outcome measures will be finalised in line with the MDT clinical services and care models and will align with the Quintuple Aim of Health Care Improvement. Specific examples highlighting the impact of MDT care interventions resulting in care efficiency improvements which will be included in program evaluation (subject to the commissioned clinical workforce composition) may include:

- Nurse led MDT care for wound management in patients with diabetes and other chronic health conditions reducing overall cost of wound care, reducing ED presentations and reducing inpatient admissions though complications and infections
- Allied Health led balance and mobility programs in frail populations reducing rates of falls, fractures and the associated recovery care costs
- Social work services, social prescribing services and MDT mental health support services for conditions with higher frequency presentations to Emergency Departments – noted as highest for people with mood disorders and generalised anxiety disorders
- Complex mental health conditions in general practice requiring specialised MDT support – including psychotic disorders, noting higher rates of chronic disease and co-morbidity within these cohorts, as well as higher prevalence of mental illness in our region
- Pharmacy led health literacy and pharmacy literacy programs around safe use of medications improving consumer confidence, reducing adverse medicines events through incorrect dosage, polypharmacy or administration errors and reducing readmission rates to hospital
- Diabetic education programs improving glycaemic control and reducing hypoglycaemic events and associated care costs
- Timely access to MDT care in smaller general practices following hospitalisation for chronic and complex conditions with high readmission rates to keep people well, keep them managed in the primary care system and limiting their length of stay in hospitals.

In relation to extension of practice support to newly commissioned teams and to a broad range of other services providing nursing, allied health and Aboriginal Health services, the leveraging of partnerships and alliances will be critical. Connections and support through higher level partnership agreements will complement the current territory based HNC primary health and coordination support and engagement model that holds deep working relationships with primary care providers.

Regular engagement and practice support will be provided through face-to-face general practice visits, presentations at practice manager meetings and general practice team meetings, communication of key information through practitioner newsletter updates with focus on awareness of opportunities to deliver MDT services and commission clinical workforces in areas of need.

Commission small grants to enable tailored solutions that respond to specific community needs. This initiative will encourage the development of local partnerships between general practice and allied health providers, highlighting the importance of community-level, practice-informed evidence. Funding will be prioritised for areas and populations with the greatest unmet health needs and disparities. A dedicated grant round for Aboriginal Community Controlled Health Organisations (ACCHOs) will directly address specific health inequities. Community need and equity will be central to the evaluation criteria, and initiatives must demonstrate a clear plan for financial sustainability beyond the initial grant period.

The MDT evaluation plan will examine the processes, outcomes and impacts of the Primary Care Impact Grants program, with a focus on how a small-grant, locally driven commissioning model supports multidisciplinary team care in primary care. It will assess whether the program achieved its stated objectives (including chronic disease prevention and MDT-based care), whether implementation occurred as intended (including grant design, assessment and award processes, and key barriers and enablers across diverse settings), and the extent to which funded activities contributed to measurable health and system outcomes. The evaluation will also capture practical learnings about the effectiveness of flexible, locally commissioned grants compared with more centralised or condition- or geography-specific approaches, including lessons to inform future grant rounds and broader PHN commissioning.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Facilitate opportunities for individuals and communities to participate in preventative health activities	146
Promote early help seeking for medical concerns from primary care services to reduce burden on EDs	146
Improve prevention and management of chronic disease, including management of risk factors, multimorbidity and polypharmacy	145
Increase access to GP chronic disease management plans and GP health assessments (if required), particularly in Richmond Valley-Hinterland SA3	145

Activity Demographics

Target Population Cohort

All patients of smaller general practices and Aboriginal Community Controlled Health Services receiving or with potential to receive team-based care.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Broad consultation with allied health, nursing and general practice stakeholders to validate and stratify the current challenges and barriers to accessing timely MDT care will influence the target locations for clinical workforce placement.
Early design and development of a stakeholder engagement plan, a series of consultations, surveys, data collection and analysis, validation with relevant stakeholders and broad co-design activities are critical to ensure the activities planned will have the greatest impact.

Inclusion of subject matter expert in multidisciplinary team based care in Aboriginal communities to support assessment of models of service delivery and approaches to care that are culturally safe and appropriate.

Consultation with HNC Clinical Advisory Council to support the development of evaluation criteria and the design of the application process to optimise participation and uptake.

Collaboration

Aboriginal Community Controlled Health Services and General Practices with higher numbers of patients with chronic and complex disease and high numbers of at risk patients.

In addition to the above stakeholders, program activities will allow for multiple opportunities for supported collaboration to maximise outcomes.
• Collaboration and engagement with Allied health and Nursing groups eg North Coast Allied Health Association, Allied Health Professional Association, Australian Primary Health Nurses Association, peak professional Allied Health bodies such as APA, ESSA, PSA etc.
• Tertiary Partner education opportunities for students looking to undertake smaller local research and evaluation programs on impacts of multidisciplinary team care in general practice and Aboriginal Medical service settings.

Activity Milestone Details/Duration

Activity Start Date

01/06/2024

Activity End Date

30/06/2027

Service Delivery Start Date

01/07/2024

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): Yes
Other Approach (please provide details): No

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

WIP-PS - 1 - Workforce Incentive Program - Practice Stream

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

WIP-PS

Activity Number *

1

Activity Title *

Workforce Incentive Program - Practice Stream

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Workforce

Other Program Key Priority Area Description

Aim of Activity *

This activity will support working with practices receiving Workforce Incentive Program practice stream incentives to implement effective models of multidisciplinary team care that address key local primary health care needs.

Description of Activity *

Supporting the development and delivery of innovative team-based approaches to primary health care service delivery through multidisciplinary team-based models of care will be the focus of this activity.

A plan to undertake data collection and engagement activities to assist with understanding the issues, impact, and delivery of the current WIP - PS program offerings will be completed.

Collaboration, data sharing and workforce profiling with peak nursing and allied health organisations as well as professional associations will be undertaken. Information gathered will assist to focus prioritisation of efforts towards the primary care clinicians and geographical regions where WIP-PS optimisation will have the greatest impact on health outcomes and value in addressing community health needs.

Increasing WIP-PS participation with best practice models will help deliver effective and sustainable team care and will optimise scope of practice involvement from primary health care providers. Building on existing quality improvement programs and

mechanisms to support, evaluate and showcase exemplar models, publish stories and learnings through a Primary Care Impact Framework will ensure the impact of the WIP-PS program activities will be maximised and integrated.

The development and effectiveness assessment of WIP PS activities will also inform the development of new HealthPathways and associated resources to support primary care providers to establish and implement team-based models of care.

A territory-based approach to understanding the needs of practices participating in WIP-PS will be undertaken through PHN regional management team staff and this activity will not require a specific procurement process.

Building from engagement and identification of enablers to optimise multidisciplinary team care in WIP-PS and non WIP-PS practices, quality improvement activities focussed on improving multidisciplinary team care will commence. A focus on areas where MDT care improves health outcomes will include chronic disease management and prevention initiatives with inclusion of non-GP led care models. Provision of support for implementation of better multidisciplinary team-based care delivery in WIP-PS practices is anticipated to commence in February 2025.

Provide trusted, easy to understand information on the WIP-Practice stream incentive program and respond to any WIP-PS related queries from local general practice and primary care stakeholders

Transition key activities to operate as business as usual PHN practice support through embedding multidisciplinary, data informed workforce optimisation within core engagement, quality improvement and advisory functions.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Explore opportunities to increase bulk billing rates for allied health, obstetrics and GP attendances, particularly for people aged 16-64	150
Explore opportunities to increase allied health workforce in Kyogle, Richmond Valley, Kempsey and Nambucca to improve access	151
Improve access to GPs for people in the North Coast to reduce long wait times, reduce cost of healthcare, ensure quality of healthcare and reduce travel times	144
Improve access to health services for children and adolescents to better address their health needs	144
Improve prevention and management of chronic disease, including management of risk factors, multimorbidity and polypharmacy	145

Activity Demographics

Target Population Cohort

All patients of general practices receiving or with potential to receive team-based care.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

• Primary Care Workforce representatives inclusive of GP's, practice nurses, allied health and administrative support staff
• HNC Clinical and Consumer Advisory Councils, Aboriginal Medical Services
• Peak organisations with a focus on nursing and allied health associations

Collaboration

Aboriginal Community Controlled Health Services and general practices with higher numbers of patients with chronic and complex disease and high numbers of at risk patients.

In addition to the above stakeholders, program activities will allow for multiple opportunities for supported collaboration to maximise outcomes.
• Collaboration and engagement with Allied health and Nursing groups eg North Coast Allied Health Association, Allied Health Professional Association, Australian Primary Health Nurses Association and professional Allied Health bodies such as APA, ESSA, PSA etc.
• Engagement with National and State Disease Advocacy Organisations (Asthma Australia, Endometriosis Australia, Heart Foundation, Australian Menopause Society, Parkinson's NSW, Arthritis NSW, Diabetes NSW)
• Tertiary Partner education opportunities for students looking to undertake smaller local research and evaluation programs

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Activity Milestone Details/Duration

Activity Start Date

01/06/2024

Activity End Date

30/06/2026

Service Delivery Start Date

01/07/2024

Service Delivery End Date

30/06/2026

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): Yes
Other Approach (please provide details): No

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

GPACI-GPM - 1 - General Practice In Aged care Incentive – GP Capability Building

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

GPACI-GPM

Activity Number *

1

Activity Title *

General Practice In Aged care Incentive – GP Capability Building

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

To improve access to consistent, quality primary care for older Australians living in Residential Aged Care Homes (RACHs) by facilitating greater collaboration between RACH staff and General Practitioners (GPs), general practices and/or Aboriginal Community Controlled Health Services (ACCHSs) across the Healthy North Coast region. This activity will also enhance access to primary care for aged care residents through the promotion of the General Practice in Aged Care Incentive program and build capability in the primary care community through practical support and provision of program resources.

Description of Activity *

HNC will implement a comprehensive program of activities to facilitate enhanced collaboration between RACH staff, management and GPs, as well as supporting increased GP participation in the General Practice in Aged Care Incentive (GPACI). This activity will focus on workforce coordination, local engagement, communication, and education to increase the number and sustainability of GPs providing services in RACHs.
1. Stakeholder Engagement and Needs Assessment
• Conduct a detailed needs analysis of GP service gaps across RACHs in the region.
• Engage with GPs, general practices, RACHs, ACCHSs, and representative organisations (e.g., First Nations, CALD) to inform co-design and solution development.
• Recruit a dedicated HNC co-ordinator to serve as the central coordination point for matching GPs with RACHs, promotion, education and awareness and monitoring regional needs.

2. Workforce Coordination and Capacity Building
• Contact all general practices across the region to profile their current and potential interest and capacity for RACH work.
• Offer support or broker introductions and facilitate formalised agreements (e.g., MoUs) between practices and RACHs
• Provide direct support to practices to address administrative barriers and assistance to explore and implement nurse-supported and team care models, and promote billing optimisation.
• Assist and provide ongoing demand based support to general practices and RACHs with MyMedicare onboarding and registering aged care residents for incentive scheme participation.

3. Education and Best Practice Implementation
• Deliver proactive education sessions and practice support to implement best practice guidelines for aged care.
• Ensure participating GPs, nurses, and practices are aware of and trained in guideline content. This includes support in preparing for the strengthened Aged Care standards
• Support shared learning through regular communities of practice, webinars, and case study discussions.
• Participation in the development and dissemination of the GP ACI Toolkit including face to face presentations

4. Communications and Promotion activities to support implementation
• Development and dissemination of GPACI promotional materials tailored to GPs, practice managers, RACH staff, residents and families –
• Promote GP ACI via HNC communication channels including website, HNC produced video content, newsletters, cross-sector meetings, and digital platforms.

5. Monitoring, Data Collection and Reporting – Done, as per Reporting requirements
• Implementation of a GP-RACH tracker to monitor matches, demand, capacity, and ongoing workforce engagement.
• Collect data to report on:
-Number and percentage of RACHs, GPs, and ACCHS' contacted and engaged being captured in a communication statistics activity tracker
-Number and percentage of practices supported to implement Best Practice Guidelines being captured in a communication statistics activity tracker
-Ongoing delivery of education and promotional activities

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Explore opportunities to prepare the healthcare system to manage the expected growth in the older adult population	150
Improve attraction and retention of general practitioners in the North Coast, particularly in Clarence Valley, Nambucca Valley and Kyogle LGAs	151
Encourage GPs to continue to build strong relationships with patients and families	146
Explore opportunities to address expected health workforce shortages associated with workforce retention and retirement	152

Enhance capacity of the health and social care services, including workforce capability, to manage increase of older person population	144

Activity Demographics

Target Population Cohort

Permanent residents in residential aged care homes.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

General practices, frontline medical and nursing staff providing services to aged care residents, practice management and RACH facility management staff, GP telehealth providers, specialist geriatric service providers, aged care residents and families.

Collaboration

Collaboration with AMS services, general practices providing medical and nursing services to RACHs, GP telehealth service providers

Identifying key areas of focus and critical design elements to ensure efficiency of operation and client/community centred approaches will be possible with joint efforts working with RACHs, residents and families.

Identifying key service needs and access pathways to GP care, understanding challenges and enablers to providing GP services in RACH settings will also be a focus of collaborative discussion.

Collaboration with other PHN’s in developing resources and sharing best practice, data sharing and insights

Activity Milestone Details/Duration

Activity Start Date

01/06/2024

Activity End Date

30/06/2027

Service Delivery Start Date

01/07/2024

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: Yes
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

MyM - 1 - MyMedicare

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

MyM

Activity Number *

1

Activity Title *

MyMedicare

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Workforce

Other Program Key Priority Area Description

Aim of Activity *

The activity aims to develop resources to assist unaccredited practices across the PHN region to achieve and maintain accreditation, permitting their participation in MyMedicare and other Commonwealth incentives programs.

Description of Activity *

In order to achieve the aims of this activity, a program of identification, support and resource strengthening will be delivered by the PHN. Regionally based health co-ordinators will manage the identification and co-ordination of assistance for unaccredited practices in the regions to work towards accreditation, increasing the number of general practices participating in the Commonwealth funded programs as they meet national general practice accreditation standards. Through the specific allocation of PHN resourcing to engage, build relationships and identify barriers, challenges and enablers to accreditation for the unaccredited practices in our region, the objective to maximise the number of accredited practices able to participate in the Strengthening Medicare reform activities will be met. Developing individual lists by region will assist in:
- prioritising the PHN support to practices who have identified an intention to become accredited
- identifying practices who may need more education on the benefits of accreditation or a greater understanding of the resource and financial considerations in applying for accreditation
- identifying practices (eg skin clinics and satellite/outreach practice services) where planning for accreditation is not a consideration before the end activity date. As part of this activity, the creation, publishing and promotion of resources and support mechanisms to assist general practices in

achieving and maintaining accreditation throughout each accreditation cycle will be delivered.

A program to support the opening of new general practices in the region and expedite onboarding, registration and setup with the relevant schemes and incentives will support the efficiency of practice accreditation and will provide an excellent resource for new practices and new practice managers.

Development of Primary Care Impact pages around supporting accreditation will be reviewed and updated, providing clear, practical and succinct steps for general practice teams and staff to follow.

Through participation in the PHN MyMedicare Leads Group, senior leaders from all PHNs with responsibility for MyMedicare Activities within their PHN are able to collaborate and share strategies used to support the accreditation of general practices.

In addition, further support through the National Improvement Network Collaborative (NINCo) streams is leveraged for practical applications of activity readiness.

Providing a trusted, easy to understand, streamlined and efficient mechanism to respond to local general practice and primary care stakeholders about any key updates, material changes or matters of significance relating to the rollout of planned changes, incentives and programs.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Encourage GPs to continue to build strong relationships with patients and families	146
Enhance capacity of the health and social care services, including workforce capability, to manage increase of older person population	144
Increase access to GP chronic disease management plans and GP health assessments (if required), particularly in Richmond Valley-Hinterland SA3	145
Improve integration of services, continuity of care and consumer/provider experience	145
Improve provider and workforce understanding of the pathways for integrating, connecting and providing best practice care for the prevention and management of chronic and complex disease	142
Improve health workforce stability in the North Coast, particularly GPs and specialist workforce	142

Activity Demographics

Target Population Cohort

Unaccredited general practices, general practices working towards accreditation and general practices reporting barriers and challenges to maintain accreditation under the National General Practice Accreditation Scheme (NGPA Scheme) across the PHN region.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consultation with general practice owners and practice management staff frontline clinical and clinical support staff including GP and nursing teams will be important to identify challenges and opportunities, assess willingness, readiness and capability to progress towards practice accreditation.

Collaboration

Working with SMEs and local change champions and peers will be an important component of supporting practices. Through regular coordination of “Practice manager breakfast meetings” local groups of 15 -20 practice managers meet regularly and share insights, updates and strategies supporting effective practice management including the requirements and actions necessary to maintain accreditation.

Fostering a collaborative environment where practice managers from local communities can support each other will be an effective way to embed sustainable change.

Activity Milestone Details/Duration

Activity Start Date

01/06/2024

Activity End Date

30/06/2027

Service Delivery Start Date

01/07/2024

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: Yes
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

CF - 1 - Primary Health Care for Older People

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

1

Activity Title *

Primary Health Care for Older People

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

•Improve the functional capability and health outcomes for older people through evidence-based initiatives.
•Reduce the impact of age related frailty and chronic disease through targeted programs in primary care.
•Empower older people to participate in decisions about their health and end of life care.

Description of Activity *

•Commission general practices, to implement 'Exercise as Medicine' providing evidence based exercise interventions as part of comprehensive chronic disease management (2019-2022).
•Commission a Nurse Practitioner lead model – 'Safe and Well at home' to maintain wellness and provide support for older people with complex health care needs in the community to avoid unplanned hospitalisation (2019-2021).
•Support the development of an organisational capacity development roadmap for Aboriginal Community Controlled aged care provider Booroogen Djugun to ensure long term sustainability (2020-2022).
•Undertake initiatives to improve RACF residents' access to general practice and allied health (2021-2025).
•Develop and implement a Healthy Living and Ageing Strategy (2021-2025).
•Commission evidence-based initiatives that improve the functional capability of older people through the Healthy Ageing Strategy (2021-2024) including:
o Development, design and implementation of an integrated model of support for older people with expected outcomes of decreasing unnecessary hospital presentations for receiving end of life care/medications, and reducing unnecessary hospital

presentations and admissions for lower acuity unplanned medical care episodes. The activities related to an integrated model of support which strives to deliver joined up care between acute, primary care and aged care sectors.
o Delivery of digital and health technology into residential aged care homes to support integrated care and appropriate triage, assessment and management of residents, including appropriate management and care of clinically deteriorating residents. This activity is inclusive of education support to RACHs to support digital clinical practice.
o Education and primary care resource availability for Voluntary Assisted Dying and End of Life care programs.
o Complete comprehensive assessment of individual RACH's and supporting networks.
o Roll out of Nurse Education (Nurse Capacity Building) initiatives in Primary Care and Residential Aged Care to support healthy aging and living well.
o Initiation and development of a Community Facing Early Interventions Project incorporating low touch, high reach healthy ageing intervention and supports. These include localised wayfinding services to help people find and connect with activities and supports to meet their Social Determinants of Health and embedding Social Prescribing approaches in selected General Practices.
• Delivery of small one-off grants for chronic disease primary and/or secondary prevention of chronic disease prevalent the support healthy ageing and living and the care of older persons (2024-2025 to 2025-2026).
- The initiatives are designed to support new programs or expansion of existing chronic disease prevention and early management programs, use an evaluation rubric with weighted criteria for community need, equity, effectiveness and efficiency, sustainability and feasibility. The programs supporting primary health care for older people may include secondary and tertiary prevention activities with a strong focus on connecting teams and involving general practices in team-based care.

- Funding of a Physical Activities Grants program for older people to encourage local community organisations to establish or scale hyper local activities for older people that reduce improve lifestyle health, encourage health behaviours, reduce frailty and falls risk, improve social connections and sense of purpose. Conducted in Partnership with Northern NSW Local Health District
- Commissioning a range of activities to strengthen Emergency Management Plans in Residential Aged Care. This activity is of specific relevance to home in HNC's territory, considered one of Australia's most climate – risk regions. Supports residents to shelter in place, right care right time right place and assist homes in meeting strengthened standards (Organisation, Clinical Care).

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Explore opportunities to prepare the healthcare system to manage the expected growth in the older adult population	150
Facilitate opportunities for individuals and communities to participate in preventative health activities	146
Improve access to palliative and end-of-life care services	152
Enhance capacity of the health and social care services, including workforce capability, to manage increase of older person population	144
Explore opportunities to prepare the healthcare system to manage expected growth in the older adult population with a specific focus on dementia care and improving healthy ageing	141
Support early intervention and management of dementia in the North Coast	145
Improve prevention and management of chronic disease, including management of risk factors, multimorbidity and polypharmacy	145

Activity Demographics

Target Population Cohort

Residents aged over 50 years

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consumers, general practitioners, practice nurses, allied health professionals, Aboriginal health workers, general practices, Aboriginal Medical Services, RACFs, community aged care providers, aged care peak bodies, early childhood educators, MNC and NNSW LHDs, NSW Department of Communities and Justice, Booroogen Djugun, local government, Clinical Councils.

Collaboration

Consumers, general practitioners, practice nurses, allied health professionals, Aboriginal health workers, general practices, Aboriginal Medical Services, RACFs, community aged care providers, aged care peak bodies, early childhood educators, MNC and NNSW LHDs, NSW Department of Communities and Justice, Booroogen Djugun, local government, Clinical Councils.

Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2027

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2027

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: Yes
Continuing Service Provider / Contract Extension: Yes
Direct Engagement: Yes
Open Tender: Yes
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

Yes

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

Yes

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

N/a

CF - 3 - Population Health

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

3

Activity Title *

Population Health

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

To improve health outcomes for the population by supporting the adoption of protective behaviours by the population, particularly those at high risk of poor health outcomes.

Description of Activity *

Continuing Activities
•Commission a place based, whole of system approach to support the positive development of children in the first 2000 days of life who are socioeconomically disadvantaged (2019-2025)
•Collaborate with partners and invest in coordinated, evidence based, primary care strategies to improve access to, and empower consumer participation in immunisation programs, particularly in low immunising areas. Strategies will be prioritised in accordance with the Immunisation North Coast Action Plan (2019-2025).
•Use a service planning approach to scope, co-design, commission and evaluate the Primary Care Access program (2021-2025):
- Digital health initiatives to improve access to primary care services through the Primary Care Access program.
- Innovative minor accident and urgent primary health care services for young people and other targeted cohorts, as part of the Primary Care Access (PCA) initiative, with a specific focus in the local government areas of Port Macquarie, Kempsey, Grafton and Casino.
- Commission the North Coast Health Connect Service to increase primary care access to all communities across the HNC PHN footprint. Target populations include young people <35 years old accessing unplanned same day care needs.

- Provision of 24/7 access to triage services by phone call or web chat with registered nurse triaging presenting problem with possible outcomes including:
- direction to the nearest emergency department
- navigation to primary care via an integrated booking system for direct face to face local bookings in general practice or pharmacy, and/or advice to self-care.
- Coordination and integration of North Coast Health Connect with Commonwealth UCC planning in Lismore and Coffs Harbour regions and connection with HealthDirect (with transition to HealthDirect scheduled for June 2025)
- Undertake targeted mapping of primary health care services and work collaboratively with HealthDirect to update the National Health Services Directory
• Scope, co-design and implement a skin cancer prevention initiative in collaboration with local partner organisations and general practice (2022-2025)
Combined education and awareness campaigns for skin cancer prevention and early detection initiatives
• Commission clinical advice to ensure:
- population health initiatives are informed by specialist expertise; and
- specialist facilitation and health coaching is delivered to general practices (2019-2025).
•Build community resilience to improve health and wellbeing outcomes in the context of natural disasters and a changing climate (2024-2025). Focus on vulnerable and priority populations.
•Promotion and co-ordination of sexual adolescent health resources, knowledge, understanding and best practice to support the sexual health, sexuality & related issues for young people
•Education and support for health professionals through knowledge and skills training to competently deliver a high quality and safe immunisation service in areas of need.
•Commission support resources to improve workforce immunisation capability in identified populations or regions where rates are low.
•Support implementation planning for the National Lung Cancer Screening Program and other cancer screening initiatives.
•Establish a Population and Public Health Steering Committee to guide and oversee initiatives aimed at improving public health outcomes across the North Coast region. Operating under the governance framework outlined in the Memorandum of Understanding between Healthy North Coast and Mid North Coast Local Health District and Northern NSW Local Health District, fostering a collaborative approach to health system integration and service delivery.
•Adopt a multifaceted approach to improve childhood vaccination rates across North Coast by addressing access, hesitancy, education and community engagement. Design and develop a five year immunisation plan with both local health districts.
• Develop the implementation plan for the Better Health for North Coast Communities 5 Year Immunisation Plan 2026-31Update and develop population health resources for the community, including via HNC's website.
• Deliver and promote locally tailored skin cancer secondary prevention and early detection initiatives to build capacity in general practice for targeted outreach to high-risk groups, and strengthened referral pathways to support timely skin checks and follow-up care.
• Commission specialist providers to deliver clinical support, training and education to North Coast general practices to improve skin cancer screening, diagnostic accuracy and evidence-based management in primary care. Activities may include clinical mentoring and case discussion, dermoscopy training, implementation of digital diagnostic tools, and patient education initiatives. Activities will aim to increase the number of skin checks conducted in primary care, improve diagnostic accuracy, reduce unnecessary excisions and specialist referrals, and improve patient awareness of prevention and early detection.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Facilitate opportunities for individuals and communities to participate in preventative health activities	146
Increase childhood immunisation rates in the North Coast, particularly in Richmond Valley-Coastal and Tweed Valley SA3s	146
Improve access to health services for children and adolescents to better address their health needs	144
Improve access to GP services, particularly after-hours, to facilitate management of non-urgent care needs	145
Increase access to after-hours GP services in the North Coast, particularly in Clarence Valley SA3	145
Increase participation in skin cancer screening in the North Coast to reduce skin cancer incidence, particularly in Byron, Ballina and Lismore LGAs	145

Activity Demographics

Target Population Cohort

Whole of population, particularly those at high risk of poor health outcomes

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consumers, general practitioners, practice nurses, allied health professionals, Aboriginal health workers, general practices, Aboriginal Medical Services, pharmacists, early childhood educators, NSW Department of Communities and Justice, local government, community members, North Coast Cancer Institute, Southern Cross University, Public Health Unit, Clinical Councils, Cancer Institute of NSW, Cancer Council, 'Sharing Knowledge about Immunisation Project (SKAI), MNC and NNSW LHDs.

Collaboration

Consumers, general practitioners, practice nurses, allied health professionals, Aboriginal health workers, general practices, Aboriginal Medical Services, pharmacists, early childhood educators, NSW Department of Communities and Justice, local government, community members, North Coast Cancer Institute, Southern Cross University, Public Health Unit, Clinical Councils, Cancer Institute of NSW, Cancer Council, 'Sharing Knowledge about Immunisation Project (SKAI), MNC and NNSW LHDs.

Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2027

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2027

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: Yes
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

Yes

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

N/A

CF - 4 - Health Pathways Licences

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

4

Activity Title *

Health Pathways Licences

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

• Assist health professionals to navigate the health system at a local level
• Improve access to evidence-based resources, including for Aboriginal and Torres Strait Islander people and those from relevant CALD communities
• Conduct a process and outcomes-based evaluation of HealthPathways to identify opportunities for improvement (2021-2023).

Description of Activity *

HNC will commission Streamliners NZ to provide licenses and hosting for the Mid and North Coast HealthPathways portals. This will enable continued access to evidence based, locally relevant clinical and referral pathways to support delivery of the right care, at the right time in the right place.

The Health Pathways Program publishes and distributes a monthly dashboard and program update, summarising and displaying utlisation data, new pathways developed, new users, the top 10 clinical and referral pathways accessed and provides a commentary on key program achievements.

The publication of monthly utilisation data and new individual user logins will assist in the analysis of utilisation patterns, user characteristics and contribute to the effectiveness of program and pathway offerings. With the increase in data and information becoming available through individualised logins, targeted strategies will be used to increase awareness, registration and use of

the program amongst specific clinical workforces, within streams and geographical areas and within primary and acute care settings.

Health Pathways has submitted two papers regarding evaluation for publication, pending further feedback. Both of these papers were reviewed by NNSWLHD and MNCLHD and had significant input from the CEO of Healthy North Coast. Health Pathways actively contribute to the core educational activities delivered by the GP education team to primary health services. These include clinical societies, clinical forums and GP specialist evenings.

Health Pathways have also been instrumental in early career development for GPs and building awareness of Health Pathways, by attending RACGP and ACRRM Registrar events to discuss HealthPathways and sign up new users, and also speak with medical students at local universities.

Increase the use of HealthPathways as a centralised resource to support the implementation of shared models of care, with a focus on the management of chronic and complex disease.

Prioritisation of the development of new HealthPathways aligned with areas of current clinical service redesign, expansion, investment and identified need.

HealthPathways team facilitation of work groups of local clinicians and subject matter experts to develop new HealthPathways aimed at building capacity in practice nurses, residential aged care nurses and general practitioners when providing care to older people or those receiving palliative care. The pathways address early intervention for healthy ageing, living with dementia, multimorbidity, early intervention in palliative care, anticipatory prescribing and end-of-life care.

Development to support implementation of the National Lung Cancer Screening program in 2025.

Contribution to workgroup meetings with LHD stakeholders to provide GP and pathway of care perspectives into planning conversations about referral options for patients with high-risk screening results.

Change management support to increase the uptake of individualised logins to access Health Pathways. Access to HealthPathways has evolved from a single generic log-in to a new era of individualised log-ins. Benefits for users include an improved search function, CPD log, and the option to request access to other regions' HealthPathways sites. Benefits for the program include detailed reporting on site usage by different clinician types and location, which allows targeted clinician engagement activities, and data about the information needs of different clinician groups in the region.

Undertake program efficiency review to ensure limited resources available are used to optimise outcome and impact of high use and high importance pathways, reduce duplication of effort for editing lower variance and generic pathways and to archive or provide quick safety checks for lower use pathways on longer cycle low frequency reviews.

Commenced collaboration with Streamliners to pioneer in-platform linkage to referral pathway info in adjacent regions, noting the need to refer out of area due to specialist shortages in our regional area.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Improve health literacy and wayfinding to facilitate access to the right services at the right time and engagement in preventative health behaviours	146
Improve prevention and management of chronic disease, including management of risk factors, multimorbidity and polypharmacy	145

Improve provider and workforce understanding of the pathways for integrating, connecting and providing best practice care for the prevention and management of chronic and complex disease	142
Improve clinician understanding of health needs for specific population groups, such as LGBTQ+ health, neurodiversity, women and children	142

Activity Demographics

Target Population Cohort

Whole of population

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

General practitioners, public and private specialists, allied health professionals, nurses, peak bodies and social sector services

Collaboration

MNC and NNSW LHDs, the Science of Knowing, Streamliners, PHN Networks and WAPHA – PHN lead for feasibility review.

Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2027

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2027

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: Yes
Direct Engagement: Yes
Open Tender: Yes
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Is this activity being co-designed?

No

Is this activity the result of a previous co-design process?

Yes

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

Yes

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

HealthPathways is co-funded by HNC and MNC and NNSW LHDs

CF - 5 - Cross Sector Partnerships

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

5

Activity Title *

Cross Sector Partnerships

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

Improve health outcomes by
•Building integration of the health and social service sectors at a system level,
•Empowering and activating patients,
•Building regional capability for integrated responses to local needs and developing system enablers.

Description of Activity *

Initiatives supporting this activity are delivered collaboratively and may not be led by HNC. These initiatives include, but are not limited to Consortiums and partnerships with health and social care agencies.

Continuing activities include:
•The Centre for Health Care Knowledge and Innovation which delivers initiatives to build cross sector integration and understanding of the social determinants of health (continuing activity) (2019-2025).
•NNSW Joint Health Literacy Program which enables people, their families and carers to obtain, understand, interpret and have confidence to use health information (continuing activity) (2019-2025).
•Early parenting support services seeking to improve relationships between families and their children by promoting confidence and providing parenting education. Collaboration with nurse led services and care providers in partnership with families to develop plans to help them meet their parenting goals.

Inclusion of cross sector partners in delivery of primary care workforce education and clinical society offerings to raise awareness of services, educate health workforce on referral pathways and inclusion criteria and to share patient impact and benefit stories through partnered service delivery. Examples include
- Tresillian Care Services providing nursing service updates and key changes to group based program offerings during paediatrics clinical education services to primary health workforce.
- Routine inclusion of health literacy principles, key tips and links to resources at all training and education events

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Explore options to increase access to general practice services in the North Coast, particularly in Clarence Valley LGA	150
Improve health literacy and wayfinding to facilitate access to the right services at the right time and engagement in preventative health behaviours	146
Improve provider and workforce understanding of the pathways for integrating, connecting and providing best practice care for the prevention and management of chronic and complex disease	142

Activity Demographics

Target Population Cohort

Whole of population consumers and health professionals

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Clinical Councils, community advisory structures, MNC and NNSW LHDs, social service agencies, NGO's, universities, state wide agencies and Aboriginal community controlled organisations and NSW departments of education, communities, justice and police.

Collaboration

Northern NSW Local Health District, Mid North Coast Local Health District, NSW Ministry of Health, NSW Agency for Clinical Innovation, Southern Cross University, University Centre for Rural health, Social Futures, Bulgarr Ngaru Aboriginal Medical Service, CHESS Employment, Allied Health Association and other affiliated bodies

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Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2027

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2027

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: Yes
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

Yes

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

Yes

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

N/A

CF - 6 - High Risk Populations

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

6

Activity Title *

High Risk Populations

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

Reduce the impact and future burden of Chronic Disease on the population

Description of Activity *

Continuing activities
•Commission a Healthy Kidneys program, targeting early detection and proactive management of Kidney Disease in Aboriginal Patients (2019 – 2021 activity).
•Commission appropriate providers to deliver Healthy Self-Management initiatives, focussing on building protective behaviours and providing self-management skills and capabilities for people with, or at risk of, long term conditions (continuing activity).

New activities
•Incentive based quality improvement activities with primary health care providers to support evidence-based chronic disease prevention programs that improve the health of the north coast community. Activities will also develop capacity of the primary health care sector to support upcoming initiatives such as MyMedicare, the Strengthening Medicare Taskforce, the Scope of Practice review, Multidisciplinary Team Care grants and increasing PHN collaboration with allied health providers. Activities will address needs in the community across diseases and conditions in focus, geographical locations of highest need and priority population cohorts. Programs will use evidence-based interventions for the screening, prevention and early management of chronic disease with outcomes focused goals that are evaluated to measure impact and sustainability once established.

•Collaboration and engagement activities with peak organisations, specialist bodies with interest in the prevention of chronic and complex diseases, National and State Disease Advocacy Organisations, Tertiary and education partners will be engaged.

•Delivery of clinical subspecialty specialist medical education in general practice settings through an inreach program across general practices to:
- provide specific and detailed education and learning opportunities for managing chronic and complex conditions in primary care. Through in practice shared care appointments, individual case conferencing and case management consultations and structured learning presentations, general practice staff will gain new skills and methods of managing chronic and complex disease across identified high risk and at risk populations
- address the mismatch between supply and demand for specialist services across the region by focusing on reducing demand and improving GP workforce capability/scope in preference to increasing supply of specialist medical workforce.

• Delivery of clinical subspecialty education in general practice settings to improve the primary care management of complex and chronic disease. Through in-practice shared care appointments, individual case conferencing and case management consultations and structured learning presentations, general practice staff will gain new skills and methods of managing chronic and complex disease.
• Delivery of small one-off grants for chronic disease primary and/or secondary prevention of chronic disease prevalent in a community, priority or at-risk population. For new or expansion of existing chronic disease prevention programs. Evaluation rubric with weighted criteria for community need, equity, effectiveness and efficiency, sustainability and feasibility.

Additional expected benefits of delivering these activities include:
- improved GP confidence and primary care management of complex and chronic disease populations
- improved connections between GP and specialist staff
- increased collaboration, shared care and care co-ordination between acute and primary care services in the management of higher risk populations with complex and chronic disease.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Strengthen primary health care services, community health education and health literacy to reduce hospitalisations, particularly in the Mid North Coast area	152
Support communities living in areas of socio-economic disadvantage in the North Coast, particularly in Kempsey, Nambucca Valley, Richmond Valley, Clarence Valley and Kyogle LGAs	147
Improve prevention and management of chronic disease, including management of risk factors, multimorbidity and polypharmacy	145

Activity Demographics

Target Population Cohort

Patients with long term and health conditions
•The placed based ear, nose and throat Aboriginal children's initiative has been identified as a high priority due to the high occurrence of low urgency ED presentations (triage 4 and 5 without admission) for targeted cohorts – young people and Aboriginal people particularly in low socio economic areas such as Kempsey and Grafton.
•HNC has identified through consultation with community and providers that transport is not available for Aboriginal and Torres Strait Islander people in the Hastings Macleay region.
A data informed approach will support program delivery to targeted populations with conditions in focus in the geographical locations of highest need

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consumers, first nations elders, Aboriginal community controlled organisations (AMSs, land councils, children's services etc) general practitioners, practice nurses, MNC and NNSW LHDs, Clinical Councils, community advisory structures, peak bodies, Clinical Councils, NGOs

Collaboration

Aboriginal Health Services and General Practices with high Aboriginal populations, high numbers of people with chronic and complex disease, and high numbers of at risk people. Collaboration with Local Health District Specialist teams, Consumers, and Digital Health providers.
In addition to the above stakeholders, program activities will allow for multiple opportunities for supported collaboration to maximise outcomes.
• Collaboration and engagement with Allied health groups eg North Coast Allied Health Association, Allied Health Professional Association such as APA, ESSA, PSA etc.
• Potential shared funding opportunities with Private Health Insurers and Pharmaceutical Organisations
• Support from peak organisations and specialist bodies with interest in the prevention of chronic and complex diseases and cancer screening (eg Cancer Institute of NSW)
• Engagement with National and State Disease Advocacy Organisations (Asthma Australia, Endometriosis Australia, Heart Foundation, Australian Menopause Society, Parkinson's NSW, Arthritis NSW, Diabetes NSW)
• Tertiary Partner education opportunities for students looking to undertake smaller local research and evaluation programs as a core part of curriculum.

Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2027

Service Delivery Start Date

July 2019

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: Yes
Continuing Service Provider / Contract Extension: Yes
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

Yes

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

Yes

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

N/A

CF - 9 - Dementia Support Pathways

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

9

Activity Title *

Dementia Support Pathways

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

Ensure Mid and North Coast dementia HealthPathways are nationally consistent and reflective of individual services and supports available locally

Description of Activity *

*Engage with Dementia Australia.
*Consult with local primary care clinicians, other health, allied health, aged care providers and consumers about the current gaps and opportunities in the model of care for people living with dementia.
*Review and enhance the dementia HealthPathways to ensure they are comprehensive and reflect contemporary best practice dementia care.
*Develop, review, maintain and enhance localised consumer resources that support older people and their carers and families to understand and make informed choices about health and aged care services that may be of benefit to them.
*Promote awareness of primary care provider resources for local service navigation in the management of dementia
*Developing systems of care in general practice for people diagnosed with dementia and their families
*Optimise health literacy of PHN published primary care impact resources accessed by health care professionals and organisations providing primary care
*Develop, pilot and roll out an additional nurse led Dementia HealthPathway to build capability of Practice nurses to support patients and their carers on the dementia journey

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Facilitate opportunities for individuals and communities to participate in preventative health activities	146
Improve access to palliative and end-of-life care services	152
Explore opportunities to prepare the healthcare system to manage expected growth in the older adult population with a specific focus on dementia care and improving healthy ageing	141
Improve prevention and management of chronic disease, including management of risk factors, multimorbidity and polypharmacy	145
Improve provider and workforce understanding of the pathways for integrating, connecting and providing best practice care for the prevention and management of chronic and complex disease	142

Activity Demographics

Target Population Cohort

People aged 65 years and older

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Dementia Australia, Dementia Care Australia, local dementia experts, Consumers, primary health care services and clinicians, RACFs, community aged care providers, aged care peak bodies, MNC and NNSW LHDs, NSW Department of Communities and Justice, Booroogen Djugun, local government, HNC Councils (Clinical, Community and Aboriginal Health).

Collaboration

Consumers, primary health care services and clinicians, RACFs, community aged care providers, aged care peak bodies, MNC and NNSW LHDs, NSW Department of Communities and Justice, Booroogen Djugun, local government, HNC Councils (Clinical, Community and Aboriginal Health).

Activity Milestone Details/Duration

Activity Start Date

01/07/2022

Activity End Date

30/06/2027

Service Delivery Start Date

01/01/2023

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

HealthPathways co-designed with a working party of dementia experts and other stakeholders
Consumer resource developed after co-design with consumers, community organisations and health providers.

CF - 10 - Aged Care Clinical Referral Pathways

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

10

Activity Title *

Aged Care Clinical Referral Pathways

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

Ensure the currency, accuracy and consistency of aged care HealthPathways so that they are consistent with medical best practice and local services.

Description of Activity *

*Monitor, review, improve and update the aged care HealthPathways pathway to ensure currency, accuracy, and consistency with medical best practice and local services.
*Consult with local primary care clinicians, other health, allied health, aged care providers and consumers about the current gaps and opportunities in aged care clinical pathways.
*Optimise health literacy of PHN published primary care impact resources accessed by health care professionals and organisations providing primary care.
*Co design and develop high use HealthPathways for management of clinical deterioration in residential aged care settings

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Improve access to palliative and end-of-life care services	152
Support coordination of health and social care services that contribute to improving social determinants of health, including social isolation/loneliness, cost of living and housing availability	147
Explore opportunities to prepare the healthcare system to manage expected growth in the older adult population with a specific focus on dementia care and improving healthy ageing	141
Support early intervention and management of dementia in the North Coast	145
Improve provider and workforce understanding of the pathways for integrating, connecting and providing best practice care for the prevention and management of chronic and complex disease	142

Activity Demographics

Target Population Cohort

People aged 65 years and over

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consumers, primary health care services and clinicians, RACFs, community aged care providers, aged care peak bodies, MNC and NNSW LHDs, NSW Department of Communities and Justice, Booroogen Djugun, local government, HNC Councils (Clinical, Community and Aboriginal Health).

Collaboration

Consumers, primary health care services and clinicians, RACFs, community aged care providers, aged care peak bodies, MNC and NNSW LHDs, NSW Department of Communities and Justice, Booroogen Djugun, local government, HNC Councils (Clinical, Community and Aboriginal Health).

Activity Milestone Details/Duration

Activity Start Date

01/07/2022

Activity End Date

30/06/2027

Service Delivery Start Date

01/01/2023

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: Yes
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

CF - 11 - Dementia - Consumer pathway resource

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

11

Activity Title *

Dementia - Consumer pathway resource

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

Ensure consumer pathway resources for dementia are nationally consistent and available to consumers locally.

Description of Activity *

- Develop consumer-focused dementia support pathway resources detailing the support available for people living with dementia, their carers and families in that area, including local, state and federal government, private sector, and community-driven support
- Distribute resources to aged care and community organisations across the region.
- Conduct program consultation phase with engagement from Ballina and Port Macquarie Dementia Friendly Communities Alliances and Dementia Australia
-Engage directly with community through dementia specific community organisations to co-design resources and provide community education on preventative approaches and end of life planning
- Expand reach and target pathway cohort from people aged 65+ to include all people living with dementia, including their carers. This incorporates people and carers with younger onset dementia.
*Ongoing promotion and distribution of developed dementia resources through community events, clinical societies and distribution through primary care service providers, hospitals, community nursing teams, residential care homes and commissioned service partners. *Host and/or present at Dementia Forums and educational events to promote resources and information
Educate health providers to better identify and support improved health outcomes for carers of people living with dementia, using

the developed resources

Review of booklet May 2026
Re-print / re-distribute to all General Practices, RACHs and Community aged care providers, LHD staff and allied health – partial print and online

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Facilitate opportunities for individuals and communities to participate in preventative health activities	146
Improve health literacy and wayfinding to facilitate access to the right services at the right time and engagement in preventative health behaviours	146
Encourage GPs to continue to build strong relationships with patients and families	146
Explore opportunities to prepare the healthcare system to manage expected growth in the older adult population with a specific focus on dementia care and improving healthy ageing	141
Support early intervention and management of dementia in the North Coast	145
Improve prevention and management of chronic disease, including management of risk factors, multimorbidity and polypharmacy	145

Activity Demographics

Target Population Cohort

People aged 65 years and older

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consumers, primary health care services and clinicians, RACFs, community aged care providers, aged care peak bodies, MNC and NNSW LHDs, NSW Department of Communities and Justice, Booroogen Djugun, local government, HNC Councils (Clinical, Community and Aboriginal Health).

Collaboration

Consumers, primary health care services and clinicians, RACFs, community aged care providers, aged care peak bodies, MNC and NNSW LHDs, NSW Department of Communities and Justice, Booroogen Djugun, local government, HNC Councils (Clinical, Community and Aboriginal Health).

Activity Milestone Details/Duration

Activity Start Date

01/07/2021

Activity End Date

30/06/2027

Service Delivery Start Date

01/01/2023

Service Delivery End Date

30/06/2027

Other Relevant Milestones

*Engage with Dementia Australia on the development of new resources
*Consult consumers and clinicians on draft resource
*Promotion of developed dementia resources through HealthPathways, PHN newsletters, direct to primary care service providers including general practices through face to face visits,
*Promotion of resources via community events, clinical societies and distribution through residential care homes and commissioned service partners.
*Revision and distribution update May 2026

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: Yes
Continuing Service Provider / Contract Extension: No
Direct Engagement: No

Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

CF - 12 - PHN Clinical Referral Pathways

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

12

Activity Title *

PHN Clinical Referral Pathways

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Workforce

Other Program Key Priority Area Description

Aim of Activity *

Ensure Mid and North Coast HealthPathways are nationally consistent and reflective of individual service adaptations and locally available services
Improve access to evidence-based resources, including for Aboriginal and Torres Strait Islander people and those from relevant CALD communities

Description of Activity *

This activity will have a focus on increasing the awareness, engagement, and utilisation of Clinical referral pathways by local health care practitioners.

Consultation with local primary care clinicians, allied health, aged care providers, other health providers, and consumers about the current utilisation of available information to assist care navigation and access to services.

Clinical Advisory council input into operational effectiveness of clinical referral pathways and Consumer Advisory council input into patient experiences will be important to identify gaps and highlight opportunities in care co-ordination and access to care services.

This activity will also include optimising health literacy of PHN published primary care impact resources accessed by health care professionals and organisations seeking information on primary care referral pathways.

The Health Pathways Program publishes and distributes a monthly dashboard and program update, summarising and displaying utlisation data, new pathways developed, new users, the top 10 clinical and referral pathways accessed and provides a commentary on key program achievements.

Health Pathways have submitted two papers regarding evaluation for publication, pending further feedback. Both of these papers were reviewed by NNSWLHD and MNCLHD and had significant input from the CEO of Healthy North Coast. Health Pathways actively contribute to the core educational activities delivered by the GP education team to primary health services. These include clinical societies, clinical forums, and GP specialist evenings.

Health Pathways have also been instrumental in early career development for GPs and building awareness of Health Pathways, by attending RACGP and ACRRM Registrar events to discuss HealthPathways and sign up new users and also speak with medical students at local universities.

Increasing the breadth of clinical disciplines in the clinical editor roles for clinical pathway referral pathway to improve the content for all primary care providers. This has included use of a pharmacy clinical editor to review and develop clinical pathways with a pharmacy focus for urgent and unplanned care pathways.

Provision of fundamental support and communication tools to enable a partnership between the PHN and the NNSWLHD and local AMSs to develop a new co-management model of care for children and families living with ADHD. The co-management approach supports faster access for to see a paediatrician for ADHD diagnosis and assessment, with ongoing ADHD medication prescriptions managed by their general practitioner. HealthPathways provides assessment tools and information about ADHD medication and a central point to access latest referral care pathways, clinical checklists, e-referral information, local specialist contacts and nurse co-ordination and support resources.

HealthPathways developed updated, localised pathways in wound care, guided by workshops involving local CNS's and specialists. HealthPathways has comprehensive clinical and referral information about a range of wound types, including hard to heal wounds, skin tears, burns injuries and pressure injury in spinal cord injury, as well as a useful new resource page listing wound management products. Learnings from the workshops and HealthPathways resources were socialised with clinicians at the annual PHN conference in 2024.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Facilitate opportunities for individuals and communities to participate in preventative health activities	146
Improve health literacy and wayfinding to facilitate access to the right services at the right time and engagement in preventative health behaviours	146
Improve prevention and management of chronic disease, including management of risk factors, multimorbidity and polypharmacy	145
Improve provider and workforce understanding of the pathways for integrating, connecting and providing best practice care for the prevention and management of chronic and complex disease	142

Improve health workforce stability in the North Coast, particularly GPs and specialist workforce	142

Activity Demographics

Target Population Cohort

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

General practitioners, public and private specialists, allied health professionals, nurses, peak bodies and social sector services.

Collaboration

MNC and NNSW LHDs
Streamliners
National Health Services Directory and HealthDirect

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

30/06/2027

Service Delivery Start Date

01/01/2023

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

CF - 13 - Community and Health System Resilience (Disaster Management)

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

13

Activity Title *

Community and Health System Resilience (Disaster Management)

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Workforce

Other Program Key Priority Area Description

Aim of Activity *

Guide preparation, response and recovery activities relating to natural disasters with a focus on the building the resilience of community and primary health care providers.

Description of Activity *

In the context of increasing climate related hazards on the North Coast, strengthening the capacity of the health system to identify, understand, and respond to vulnerability is a priority health need for the region. Consistent with the National Health and Climate Strategy, this activity focuses on the systematic assessment of climate related health vulnerabilities to inform targeted, preventative, and adaptive action across communities, primary health care, and the broader health system.
Healthy North Coast (HNC) will lead place based and system level health vulnerability assessments and the development of a North Coast Climate and Health Strategy that integrates climate risk, population need, service capacity, and local context. These assessments will be used to guide commissioning, preparedness planning, and partnership activity, ensuring resources and interventions are directed to populations and locations most at risk of adverse health and wellbeing impacts from climate related events.

Key initiatives under this activity include:
Embedding community level health vulnerability assessments
Healthy North Coast will support the identification and monitoring of community level vulnerabilities to climate related hazards,

with a focus on access to care, and keeping services and supports open and accessible during events.
This includes:
• Undertaking and commissioning place-based health and wellbeing vulnerability assessments that consider exposure to climate related hazards, existing health inequities, psychosocial risk, local infrastructure and community protective factors
• Using vulnerability data and information to inform commissioning and investment decisions, including the prioritisation of communities and population groups with heightened risk
• Building local capability to understand and apply vulnerability information.

Strengthening primary health care workforce capability and preparedness
HNC will invest in education, training and quality improvement to strengthen the capability of the primary health care workforce to deliver safe, sustainable care in a changing climate.
This includes:
• Delivering education and training programs for primary health care providers on climate related health impacts, emergency preparedness, continuity planning and adaptive practice within scope of role.
• Supporting practice level planning and quality improvement activities to strengthen service sustainability, business continuity and preparedness.
• Where appropriate, supporting practices to undertake service level reviews or assessments to identify pressures, risks and opportunities for capability uplift.
• Developing and maintaining regionally consistent guidance and resources, including HealthPathways, to support clinical decision making and workforce capability.
• Supporting workforce wellbeing and resilience initiatives that contribute to retention, confidence and sustainability across the sector.

Coordinated whole of region approaches
HNC will contribute to coordinated regional approaches that strengthen learning, planning and adaptive capacity across the health system through the North Coast Climate Change and Health Strategy.
The Strategy will include:
• Working with Local Health Districts, NSW Government agencies and partners to support whole of system planning, education and preparedness activities, consistent with relevant policy frameworks and MoUs.
• Integrating local intelligence and lessons learned, including insights from assessments and place based initiatives, into regional planning and scenario development.
• Participating in joint training, scenario planning and preparedness exercises to strengthen shared understanding and readiness across the health system.
• Engaging with Aboriginal Community Controlled Health Organisations to support culturally informed approaches to workforce development and system learning.
• Aligning HNC's activities with state and national health, emergency management and climate policy directions, supporting consistent and sustainable system improvement
• Evaluating previous disaster response and recovery initiatives to build local learnings and evidence regarding the role of primary health care in disaster management. This will be a research study with the University Centre for Rural Health, University of Sydney in 2026-2027.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Explore opportunities to strengthen disaster resilience throughout the North Coast, particularly in low resilience areas	150
Collaborate with local agencies, communities and services to improve inclusive access to health and	152

wellbeing services and activities in the North Coast	
Support coordination of health and social care services that contribute to improving social determinants of health, including social isolation/loneliness, cost of living and housing availability	147

Activity Demographics

Target Population Cohort

Communities impacted by natural disasters. Primary care providers and practices in regions at elevated risk of natural disaster or emergency.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Collaboration

Development and implementation of this activity will be informed through learning from previous disasters, and ongoing collaboration and consultation with key partners across the regional health and wellbeing system. This included the Local Health Districts, Aboriginal Community Controlled Health Organisations, primary care providers, community organisations, local governments, and both state and national governments.
Consultation will focus on strengthening shared understanding of regional priorities, identifying opportunities for workforce development and capability building, and ensuring initiatives are relevant and aligned with the local context. Targeted consultation will inform the design of the vulnerability assessments, undertaken to support planning and investment decisions. This approach will be aligned with state, national health, emergency management and climate policy directionss

Activity Milestone Details/Duration

Activity Start Date

01/10/2024

Activity End Date

30/06/2027

Service Delivery Start Date

01/10/2024

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: Yes
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

HSI - 1 - Emergency Preparedness and Coordination

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

1

Activity Title *

Emergency Preparedness and coordination

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

This activity aims to
a. address the needs of people in the North Coast region, including an equity focus
b. provide support to general practices and other health care providers to improve quality of care for patients
c. improve access to primary health care by patients
d. improve coordination of care for patients and integration of health services in the North Coast
e. operate capable organisations which support the successful delivery of the PHN Program

Description of Activity *

Healthy North Coast will build capacity to manage emergency preparedness, planning and coordination functions across primary care in the North Coast region. To support this activity, Healthy North Coast will utilise activity funding towards the employment of a Senior Manager Readiness and Response role, with the requirements to deliver the following:
a. Preparing and maintaining emergency preparedness protocols
b. Updating protocols annually in line with Emergency Preparedness Policy Guidelines provided by the Department of Health, Ageing and Disability
c. Engaging regularly with local and district stakeholders relating to emergency

preparedness, planning, response, and recovery
d. Integration and coordination with Mid North Coast and Northern NSW Local Health Districts, Aboriginal Controlled Community Health Organisations and other health services across the North Coast region to prepare for disasters and other critical incidents
e. Scope the development of a Climate and Health Strategy, inclusive of vulnerability assessments for priority population groups and at risk geographical locations.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Collaborate with local agencies, communities and services to improve inclusive access to health and wellbeing services and activities in the North Coast	152
Support coordination of health and social care services that contribute to improving social determinants of health, including social isolation/loneliness, cost of living and housing availability	147

Activity Demographics

Target Population Cohort

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

This activity aims to enhance the health and primary care sector's readiness and response capacity for disasters and other critical events by aligning with national and state disaster risk management frameworks. HNC will continue to engage with local stakeholders to ensure preparedness and response activities are suited to the local landscape/needs.

Collaboration

The activity will be delivered in collaboration with Department of Health, Ageing and Disability, NSW Government, Mid North Coast and Northern NSW Local Health Districts, Aboriginal Controlled Community Health Organisations and primary care providers

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Activity Milestone Details/Duration

Activity Start Date

01/07/2026

Activity End Date

30/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Is this activity being co-designed?

No

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

HSI - 121 - Population Health Planning

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

121

Activity Title *

Population Health Planning

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

To identify through an expanding evidence-base, the health needs and service gaps experienced by residents across the North Coast NSW region with the aim of improving the quality of care, patient experience and health outcomes through the provision of a range of support activities.

HNC will implement a comprehensive commissioning program to ensure services, projects and programs meet the needs of the community, are high quality, efficient, effective and respond to identified population health needs

Description of Activity *

This will involve the following activities:
• quantitative and qualitative data analysis;
• population health monitoring;
• analysis of health needs and services gaps;
• service planning;
• establishing data visualisations of needs assessments that are available to the public and consumers;
• preparing and updating needs assessments.
Incorporation of value-based investment to support sequencing and prioritisation of commissioned activities.

Development of a chronic disease management database at a general practice level to assist in identification of at risk cohorts, people at risk of hospitalisation, people with co-morbidity and use data to support place-based initiatives delivering local and measurable impact.

Synchronisation of education and workforce support initiatives with population health and data insights to support targeted quality improvement activities in general practice.

Development of end-to-end follow-up and evaluation through a learning outcomes framework to demonstrate and measure the primary care impact of targeted education and general practice quality improvement offerings.

Implement the use of an economic prioritisation framework to support modelling decisions based on weightings or relative importance for each of the following dimensions: Health outcomes (focus on length of life), Time-to-impact (focus on long-term), Priority populations (focus on Aboriginal and Torres Strait Islander peoples), Age cohorts (from children to older population). Use of dimensions to focus scope of work against areas of need and relevant service models to ensure priority setting is value-based and economically sound.

Apply lessons learnt across a broad range of areas identified though needs analysis and stakeholder feedback to assist in sequencing and prioritisation of commissioning and delivery of key programs.

Apply economic prioritisation modelling principles to identify and preference areas for increased program investment and resource support.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Facilitate opportunities for individuals and communities to participate in preventative health activities	146
Strengthen primary health care services, community health education and health literacy to reduce hospitalisations, particularly in the Mid North Coast area	152
Improve access to GPs for people in the North Coast to reduce long wait times, reduce cost of healthcare, ensure quality of healthcare and reduce travel times	144
Reduce alcohol consumption to reduce alcohol-related risks and hospitalisations	149
Improve integration of services, continuity of care and consumer/provider experience	145
Enhance access to mental health services and reduce wait times, particularly for psychological therapies, to alleviate mental health issues	142

Activity Demographics

Target Population Cohort

N/A

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

General Practices, Aboriginal Medical Services, Local Health Districts, Clinical Council members, Community Advisory Committee members, NGOs, Health Professionals, Social sector organisations, Data custodians, Epidemiologists, NSW Ministry of Health and consumers

Collaboration

Providing data and information for the purpose of population health monitoring: General Practices, Aboriginal Medical Services, and Local Health Districts.

Establishment of a joint Memorandum of Understanding with Northern NSW LHD and Mid North Coast LHD to identify shared and co-owned population health improvement initiatives and areas of focus.

Providing advice and input when preparing and updating needs assessment: Clinical Council members, Community Advisory Committee members, NGOs, Health Professionals, Social sector organisations.
Providing statistical expertise, information and guidance when preparing and updating needs assessments:
Data custodians, Epidemiologists, NSW Ministry of Health, consumers, Clinical Council members, Community Advisory Committee members, Aboriginal Medical Services, and Local Health Districts.

Participation in communities of practice for quality improvement such as NiNCo.

Representation and contribution to partnered improvement collaboratives such as NSW Statewide Diabetes Management Steering and Advisory Groups, hospital partnered integrated care and patient flow improvement committees.

Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2027

Service Delivery Start Date

July 2019

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Is this activity being co-designed?

No

Is this activity the result of a previous co-design process?

No

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

N/A

HSI - 124 - Workforce Development

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

124

Activity Title *

Workforce development

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Workforce

Other Program Key Priority Area Description

Aim of Activity *

To improve the quality of care, patient experience and health outcomes through the provision of education and capacity building activities

Description of Activity *

HNC will deliver a range of initiatives to support the continued development of an accessible high-quality primary health care workforce through education, training and the development of high quality referral pathways.

Initiatives include:
•Developing an outcomes focussed education and workforce development framework; inclusive of community and consumer perspectives.
•Developing, implementing and evaluating innovative, high quality, inter-professional development activities for general practitioners, nurses and allied health professionals working in primary care.
•Supporting the establishment and maintenance of 8 clinical societies and 4 communities of practice that deliver high quality education, locally relevant content and foster integration between local services.
•Funding the development and regular medical review of over 500 high quality HealthPathways accessed by over 1,500 users monthly.
•Commissioning the provision of data driven, evidence-based recommendations to address identified local workforce and capability gaps, including strategies that improve the ability of clinicians to respond appropriately and confidently to local health

needs and promote the provision of integrated care across the local health system.
•Commission education to improve the cultural safety of primary health care services to Aboriginal and Torres Strait Islander people.
•Use a service planning approach to scope, co-design and commission care coordination and triage capacity building activities in primary care services as part of the Primary Care Access program.
The specialist in-reach pilot model has been developed in Port Macquarie around diabetes management in General Practice. This pilot will involve a 3-month trial of in-reach education supported by a Medical Educator from HNC and delivered by a local Endocrinologist. Outcomes and impact will be measured during this period.

The Workforce Planning and Prioritisation program as delivered by HNC aims to increase the profile of GP medicine as an attractive, viable and ongoing career within the HNC footprint. By working collaboratively with various workforce support partners during this period and beyond, this will also look at supporting areas of need within the geographical region, maximising partnership effort and enable less duplication of effort and resources. Partners already include but are not limited to RACGP, ACRRM, University Centre for Rural Health, UNSW, UNE, NNSWLHD and MNCLHD with collaboration around GP, registrar and medical student training and social supports.

Healthy North Coast continues to educate primary care clinicians in Cultural Safety Training in 2024, with two events planned for the first half of 2024 and others planned for the latter half of the year.

Promotion of health literacy awareness in primary health care settings, including improving organisational health literacy.

Development and socialization of a GP Registrars Handbook. The handbook has been developed for Registrars who have commenced GP Training.

Increase GP registrar awareness of the education & support available beyond their colleges. to make the transition into GP training and practice as smooth and enjoyable as possible.

Co-design and publication of a GP registrar handbook with availability in a digital format for quick and easy access via QRGs and URLs.

Broad distribution of workforce support materials and support resources at welcome and networking events, clinical societies, interdisciplinary learning forums and GP training events.

Supported education and networking for health workforce in the region, through in-person education events including clinical societies, cultural safety training, advanced life support, and a multidisciplinary education forum.

Local health workforce will be uplifted through an annual Primary Care Excellence awards program, which will highlight and acknowledge exceptional achievements in General Practice, Allied Health, Pharmacy and Aboriginal Medical Services.
Highly successful specialist in-reach program will be enhanced, supporting additional specialist education and case conferences delivered in General Practice.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Improve attraction and retention of workforce in health care services in the North Coast	151
Improve attraction and retention of general practitioners in the North Coast, particularly in Clarence Valley, Nambucca Valley and Kyogle LGAs	151

Strengthen primary health care services, community health education and health literacy to reduce hospitalisations, particularly in the Mid North Coast area	152
Improve health workforce stability in the North Coast, particularly GPs and specialist workforce	142

Activity Demographics

Target Population Cohort

Primary Health Care Professionals

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Community and clinician advisory structures, Divisions of General Practice, Aboriginal Community Controlled Health Services, Rural Doctors Network, GP Synergy, local rural training hubs, universities, and the MNC and NNSW LHDs.

Collaboration

To be guided by the consultation process

Activity Milestone Details/Duration

Activity Start Date

01/07/2020

Activity End Date

30/06/2027

Service Delivery Start Date

01/07/2020

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No
Continuing Service Provider / Contract Extension: No
Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): No
Other Approach (please provide details): Yes

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

Yes

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

Yes

Decommissioning details?

Commensurate with recent direction from the department of health regarding adherence to the PHN Grant Program Guidelines, North Coast PHN has de-commissioned the existing workforce education provider to appropriately manage issues with conflict of interest and related party transactions.

Co-design or co-commissioning comments

HNC's clinical and community advisory structures will be engaged in the development of the new workforce development framework, as well local clinicians, general practices, Aboriginal Community Controlled Health Organisations, Rural Doctors Network, GP Synergy, local rural training hubs, universities, and local health districts.

CF-COVID-PCS - 3 - COVID-19 Primary Care Support

Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF-COVID-PCS

Activity Number *

3

Activity Title *

COVID-19 Primary Care Support

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Workforce

Other Program Key Priority Area Description

Aim of Activity *

Provide support to North Coast primary, aged care and disability sectors to implement and support Australia's COVID-19 Vaccine and Treatment Strategy

Description of Activity *

COVID-19 response and treatment
• Provide guidance and expert advice to GPRCs, general practices, Aboriginal Community Controlled Health Services (ACCHSs), residential aged care facilities (RACF), disability accommodation facilities and governments on local needs and issues.
• Develop and implement frameworks to support a comprehensive and integrated response to COVID-19 outbreaks; with a particular focus on Aboriginal and Torres Strait Islander communities, residents living in RACFs and general practices managing mild cases of COVID-19.
• Work collaboratively with the Mid North Coast (MNC) and Northern NSW (NNSW) Local Health Districts (LHDs), the Public Health Unit (PHU), general practices, ACCHSs and NSW Ambulance to undertake scenario planning for COVID-19 outbreaks and implement plans if and when required.
• Develop and update health pathways, quality improvement activities and education to support the primary health care workforce in their COVID-19 planning inclusive of localised responses, such as increasing the capacity of frontline staff to manage anxious or demanding patients during the COVID-19 and influenza vaccine rollouts, and the adoption of national initiatives such as telehealth and e-prescribing.

COVID-19 vaccine roll out
• Coordinate the COVID-19 vaccine rollout with primary, aged care and disability sectors and vaccine providers.
• Conduct a needs assessment and expression of interest to identify suitable general practices and GPRCs to participate in the COVID-19 vaccine program.
• Support vaccine delivery sites in their establishment and operation of the vaccine program such as:
o Face to face support by HNC Primary Health Coordinators.
o Cold chain management capacity building.
o Ensuring vaccines and consumables supply chain between Commonwealth contractors and local providers is effective and smooth.
o Improving the recording and updating of immunisation data to the Australian Immunisation Register (AIR).
o Utilising the National Booking System.
o Support with understanding the process for reporting and following up on adverse events.
• Support vaccine delivery to be integrated within local health pathways.
• Support positive vaccine messaging in the community and undertake community consultation to inform effective, localised COVID-19 vaccine health messages.
Undertake other activities as required, dependant on COVID-19 outbreaks and updates to the vaccine program.
• Support vaccine delivery sites to respond to guideline changes for "in focus" populations as ATAGI recommendations and updates are released. Inclusive of changes in recommendation or booster vaccines in children, recommendations and encouragement for immunocompromised populations of differing ages and booster dose frequency changes and guidelines for older populations.
•Additional activities to support vaccine delivery sites to maximise opportunities for comprehensive immunisation service capability uplifts. Educating primary care services and frontline immunisers with training, upskilling to have difficult and critical conversations with vaccine hesitant populations will see increases in the understanding of COVID safe practices for vulnerable and at risk populations and access to specialised resources (including COVID-19 vaccinations),
• Supporting primary care providers to leverage opportunities to promote combined campaigns – eg Fluvax/COVID-19 primary care awareness, winter strategies and hygienic practices in the management of influenza like illnesses, combining COVID-19 vaccination and other immunisation messaging
• Combining home visiting and community service visits with COVID home care activities and COVID-19 vaccination education and administration for appropriate cohorts will directly support the implementation of COVID-19 vaccine and treatment strategies.
• Participation in weekly surveillance and monitoring meetings with Population and Public Health Unit to identify relevant primary health areas of focus. This includes review of weekly data trends, location-based changes in notification rates for influenza like illnesses including COVID-19 and providing qualitative feedback from GPs and primary care stakeholders on effectiveness of primary acre support activities in changing patient behaviours to managing COVID-19 and seasonal respiratory illnesses.

Broadened focus of activities to combine COVID-19 care support with immunisation strategy, prevention and preparedness, critical conversations to reduce vaccine hesitancy, improve primary care provider capacity and capability to support the prevention of communicable diseases (inclusive of influenza like illnesses, TB, shingles).

Support early management of communicable disease with a focus on vulnerable, at risk and priority populations

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Facilitate opportunities for individuals and communities to participate in preventative health activities	146
Improve health literacy and wayfinding to facilitate access to the right services at the right time and engagement in preventative health behaviours	146

Encourage GPs to continue to build strong relationships with patients and families	146

Activity Demographics

Target Population Cohort

North Coast population and primary health care workforce

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

- Public community consultation in 2021 with over 1,000 local residents.
- Scenario planning on COVID-19 responses.
- Involvement in targeted focus groups to road test new initiatives and resources.
- Participation in HNC's Immunisation Community of Practice.
- Discussion and consultation at HNC and ACCHSs CEOs forum, joint Board and Executive meetings between HNC and LHDs, sector network meetings.
- Vaccine providers forums and LHD / PHN vaccination work groups
- RACF and disability care facility support and information webinars
- COVID 19 external partners meetings with AMS, GPRC's LHD, Public Health unit, NSW Ambulance Service
- Combined NSW North Coast Clinical Council meetings and clinical reference groups

Collaboration

Commonwealth Department of Health
Coordination and partnership to support the implementation of the frontline response to the COVID-19 pandemic across all stages.
North Coast population
Public community consultation in 2021 with over 1,000 local residents. Media commentary and participation. Community newsletter.
General practice

Regular contact via HNC's Primary Health Coordinators. Input from Clinical Councils. Involvement in targeted focus groups to road test new initiatives and resources. Participation in HNC's Immunisation Community of Practice. Practitioner Newsletter.
ACCHSs
Regular contact via HNC's Aboriginal Health Coordinators. HNC and ACCHs CEOs forum. Participation in HNC's COVID-19 vaccine forum. Input from Clinical Councils. Involvement in targeted focus groups to road test new initiatives and resources. Participation in HNC's Immunisation Community of Practice. Practitioner Newsletter.
Local Health Districts
Joint Board and Executive meetings. HNC and ACCHs CEOs forum. Participation in HNC's COVID-19 vaccine forum. Involvement in targeted focus groups to road test new initiatives and resources. Participation in HNC's Immunisation Community of Practice. Practitioner Newsletter.
RACFs
Extensive contact via the Healthy Ageing Team. Participation in HNC's and LHD's RACF and community aged care sector fortnightly network meetings. Email bulletins and newsletters.
Residential Disability Services
Contact via HNC's Primary Health Coordinators. Participation in the LHD's residential disability sector fortnightly network meetings. Email bulletins and newsletters.
NSW Ambulance
Participation in HNC's COVID-19 vaccine forum. Participation in HNC's Immunisation Community of Practice. Practitioner Newsletter updates.
Pharmacy
Participation in HNC's COVID-19 vaccine forum. Involvement in targeted focus groups to road test new initiatives and resources. Participation in HNC's Immunisation Community of Practice. Practitioner Newsletter.
Develop and promote seasonal flu/COVID-19 awareness campaigns in partnership with state based Population & Public Health Units
Participation in weekly surveillance and monitoring meetings with Population and Public Health Unit to identify relevant primary health areas of focus.

Activity Milestone Details/Duration

Activity Start Date

01/07/2021

Activity End Date

30/06/2026

Service Delivery Start Date

1/07/2020

Service Delivery End Date

30/06/2026

Other Relevant Milestones

Activity Commissioning

Please identify your intended procurement approach for commissioning services under this activity:

Not Yet Known: No

Continuing Service Provider / Contract Extension: No
Direct Engagement: Yes
Open Tender: Yes
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Is this activity being co-designed?

Yes

Is this activity the result of a previous co-design process?

Yes

Do you plan to implement this Activity using co-commissioning or joint-commissioning arrangements?

No

Has this activity previously been co-commissioned or joint-commissioned?

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

Commissioned activities will be co-designed in collaboration with local service providers such as general practices, Aboriginal Community Controlled Health Services, Local Health Districts, the Public Health Unit and NSW Ambulance. Focus groups are held with target audiences to test assumptions and service models with providers to ensure alignment with service delivery realities and to support integrated service delivery.