North Coast - After Hours Primary Health Care
2025/26 - 2028/29
Activity Summary View

AH-HAP - 1 - Homelessness Access Program

Activity Metadata

Applicable Schedule *

After Hours Primary Health Care

Activity Prefix *

AH-HAP

Activity Number *

1

Activity Title *

Homelessness Access Program

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 *

The Homelessness access program aims to deliver frontline medical and clinical services (assertive outreach model) to support people sleeping rough in the North Coast PHN region with a focus on the Byron, Ballina, Tweed and Coffs Harbour LGAs

Description of Activity *

Homelessness and rough sleeping is a significant program across the NSW North Coast region. 2475 people were identified as homeless across the North Coast on Census night in 2021. Nearly 3 in every 10 people aged over 55 years who identified as homeless were in Tweed.

Nearly half of all people counted as sleeping rough in the 2023 Street Count in NSW are on the North Coast (HNC, Homelessness in

the North Coast, October 2023). The 2023 NSW Statewide Street Count identified 779 people as homeless on the North Coast. Byron Shire had the largest number of rough sleepers in the state, with 300 individuals identified as sleeping rough.

360 First Nations peoples identified as homeless on Census night, with Tweed LGA having the highest number in NSW. Coffs Harbour has shown a 22.3% growth in primary homelessness during 2016-21People who are homeless have multiple risk factors and health problems as well as higher premature mortality compared with the general population. Health problems may be the cause or result of being homeless. A large proportion of those who are homeless have mental illness and misuse of alcohol and/or drugs. These problems result in greater difficulty in accessing health care and social services and retaining accommodation. This extends across several social determinants of health, including housing, income, employment, education, safety, security and health care access.

Linking people sleeping rough to health services is a critical aspect of an Assertive Outreach (AO) model. AO is an approach used with people who do not present to, and/or have difficulties engaging with, housing, homelessness or health services, such as people who are sleeping rough, or living in rooming houses, squats or caravan parks. AO addresses homelessness by delivering services in an integrated response in partnership with a range of services.
A program to deliver three AO initiatives (clinical services - nurse/GP) in the LGAs of Byron, Tweed and Coffs Harbour for people who are homeless or are at risk of homelessness. Insights from the Tweed AO model report that a GP and nurse combined is much more effective than a nurse or GP operating alone.

Providing point of care (fixed and mobile) medical and nursing services for people who are experiencing homelessness or at risk of homelessness will be the key program service delivery component.

There will be three different approaches developed, co-designed with stakeholders in each of the LGAs. These initiatives will include an ongoing sustainability model where clients will be integrated and connected with local GPs to establish trusted relationships moving forward.

Stage 1 implementation and delivery will include the LGAs of Tweed and Byron and Stage 2 will focus on Coffs LGA.

Dedicated workshops will be conducted with the participating GPs and other stakeholders in each of the 3 LGAs to evaluate the model/approach.

Commission services to support primary health care access for people experiencing homeless and those at risk of homelessness where there are physical, geographic or other barriers to accessing primary care services at Tweed Heads LGA at Freds place, Byron Bay LGA at Fletcher Street Cottage and Mullumbimby Neighbourhood Centre at Mullumbimby, Coffs Harbour LGA at Pete's place, and Mary's Place at Ballina. Services will focus on outreach engagement, integration into ongoing, community-based primary care. Client and clinician experience survey to be developed as part of quality improvement, monitoring and evaluation.

Participation in regional alliances with key stakeholders to enact systems-change through transforming practice, policy, and resourcing - foundational membership with Northern Rivers Zero initiative

Support development of Homelessness Access program Framework in collaboration with other PHNs and key stakeholders.

Develop qualitative insights from local stakeholders and evidence sources to better understand pathways into homelessness and identify opportunities for prevention, early intervention and cross-sector collaboration.
Build relationships with regional health and social sector leaders, coordinate collective action and maintain momentum across initiatives that improve housing, health and homelessness outcomes.

Additional activity development will broaden the program beyond the original assertive outreach sites to include the Clarence Valley Primary Care Access Initiative, fortnightly nursing outreach, and a qualitative insights project to better understand local pathways into homelessness and opportunities for earlier intervention. Together, these components strengthen the program's regional reach and evidence base by combining direct clinical outreach, localised service design, lived experience and stakeholder insights, and targeted service expansion in locations where people experiencing homelessness continue to face significant barriers to timely, continuous primary health care.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 20206/27

Priorities

Priority	Page reference
Explore opportunities to support rough sleepers in the North Coast, particularly in Byron and Tweed LGAs	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 GP services, particularly after-hours, to facilitate management of non-urgent care needs	145
Improve prevention and management of chronic disease, including management of risk factors, multimorbidity and polypharmacy	145
Improve clinician understanding of health needs for specific population groups, such as LGBTQ+ health, neurodiversity, women and children	142



Activity Demographics

Target Population Cohort

People experiencing homelessness or at risk of homelessness across the NSW North Coast, with a focus on Byron, Ballina, Tweed and Coffs Harbour LGAs.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The Primary Health Network has been an active participant of the District Homelessness Implementation Group committee and has developed the program initiative in close consultation with multiple subject matter experts and specialised homelessness service providers.

Collaboration

In order to optimise the impact and effectiveness of frontline clinical service provision for the targeted population, NCPHN will work closely with a collaborative of specialised homelessness and social service and providers. This joint response recognises homelessness to be viewed more holistically as a broader public health issue, both in cause and effect. Key alliance and collaboration partners include Tweed Assertive Outreach
District Homelessness Implementation Group
Department of Communities and Justice
Tweed and Byron Shire Local Councils
Momentum Collective, Social Futures and Mission Australia
Ending Rough Sleeping Collaborative – Byron Shire
Northern NSW and NSW Mid North Coast LHD
Homes NSW
Northern Rivers Housing
Aboriginal Community Controlled Health Organisations
Homelessness Access Program Governance Group

Activity Milestone Details/Duration

Activity Start Date

01/07/2024

Activity End Date

31/03/2027

Service Delivery Start Date

1/08/2024

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): Yes
Other Approach (please provide details): No

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



AH-MAP - 1 - Multicultural Access Program



Activity Metadata

Applicable Schedule *

After Hours Primary Health Care

Activity Prefix *

AH-MAP

Activity Number *

1

Activity Title *

Multicultural Access Program

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 *

An initiative to educate mainstream general practice about the needs of refugee patients and support General Practices to accept and retain refugee patients transitioning from the Refugee Health Service in the Coffs area.

The program will establish primary care referral pathways to and from refugee health services to ensure a seamless and efficient process for clients.

There will also be a focus on coordinating community outreach and education sessions with refugee and multicultural communities to raise awareness of healthcare services and how to access them.

Description of Activity *

Coffs Harbour is a major regional settlement location for newly arrived refugees to Australia. The Coffs Harbour Refugee Health Service (RHS) is a multi-disciplinary clinic for these newly arrived humanitarian entrants.

Most refugees who receive care at the RHS are unable to transition to mainstream general practice. A range of factors are contributing to this issue, including limited availability of GPs in the area, cultural barriers, inconsistent use of support services, difficulties in navigating the health system and financial barriers. The inability to transition clients to mainstream general practice is not sustainable and if it is not addressed, it will result in even greater burden as patients continually return to the RHS or present at emergency departments.

Educating mainstream general practice about the needs of refugee patients will support GPs to take on and retain refugee patients. The key to successful transition of patients will be in a new social worker position. Trials in other health districts across NSW and the ACT are demonstrating the advantage of using social workers in general practice to effectively link patients with other services to support coordinated multidisciplinary care (Zuchowski et al. 2023; Northern Sydney PHN; Capital Health Network). This model, if used at the RHS, could help transition refugees to mainstream general practice.

The role of the Social Worker will be to collaborate with community GPs to improve access to care for refugees and assist in addressing any barriers they may face when delivering care to refugee patients. Other aspects of the initiative will include capability upskilling in general practices will also be required with a package of resources developed.

There is currently a Social Worker employed two days per week at the RHS. Our proposal is to provide initial funding for 18 months for the Social Worker position to be 1 FTE, which is an additional three days per week (two days per week are already funded by the LHD).

The initiative will be piloted within large general practices in the Coffs Harbour area, providing support to these general practices for costs associated with training and development to support refugee health service provision. Additional resourcing is required to facilitate transition to mainstream general practice for primary health care needs including appointment scheduling, initial patient assessment and registration, additional time taken to set up management and care plans, as well as the evaluation and write up of the quality improvement initiatives and journey involved with practices increasing multicultural health service capability.

A social worker has been engaged to support the delivery of the following:
• establishing referral pathways to and from RHS to ensure a seamless and efficient process for clients

• coordinating community outreach and education sessions with refugee communities to raise awareness of health care services and how to access them
• connecting refugee patients and their families to necessary healthcare services
• assisting refugees to navigate the health system
• advocating for the needs of refugee patients
• providing culturally sensitive support and generally bridging communication gaps between refugee and providers.
• working with HNC in the collection of data to evaluate the program and make improvements where identified.

HNC has engaged 3 general practices to support the refugee transition, which are:
• Woopi Medical Centre
• Coffs Harbour GP Super Clinic
• Coffs Doctors

Codesign underway to enhance social work transition support of refugees in Coffs Harbour through multidisciplinary teams by expanding access to culturally appropriate health services for multicultural and refugee communities in regional areas.

Commissioned STARTTS to deliver trauma-informed, culturally safe allied health services for refugee and culturally and linguistically diverse (CALD) communities in the Coffs Harbour region. The program will increase access to physiotherapy, occupational therapy and related supports through flexible, person-centred delivery (including clinical, community and outreach settings), and will use validated pre- and post-intervention measures to track functional outcomes and participation. A structured transition model will support clients to build confidence navigating services and successfully link into ongoing mainstream care.

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 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
Explore opportunities to improve access to health services, including screening services, because people do not feel comfortable with the clinician/staff gender	149

Activity Demographics

Target Population Cohort

Refugee and multicultural health populations around the Coffs Harbour region

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

No

SA3 Name	SA3 Code
Coffs Harbour	10402



Activity Consultation and Collaboration

Consultation

The Primary Health network has worked closely with the Coffs Harbour Refugee Health Service and the general practices in the Coffs region currently providing services to refugee health populations. In consultation with the North Coast Population and Public Health Unit a multicultural access program, proposal has been developed to support transition of care for appropriate patients into mainstream general practice, reducing their reliance on hospital-based care through the Emergency Department and the refugee health service.

Collaboration

The North Coast Population and Public Health Unit have supported the key positional description and role requirements for the Primary Care transitional social worker role.

The refugee health service has assisted in quantifying the cohort of appropriate patients for supported transition, and the Coffs Harbour GP network have identified the practices with capacity and capability to support transition to primary care GP services for refugee health clients.



Activity Milestone Details/Duration

Activity Start Date

01/07/2023

Activity End Date

29/06/2026

Service Delivery Start Date

01/07/2024

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): Yes
Other Approach (please provide details): No

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

AH - 3 - After-Hours Primary Care

Activity Metadata

Applicable Schedule *

After Hours Primary Health Care

Activity Prefix *

AH

Activity Number *

3

Activity Title *

After-Hours Primary Care

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 *

The After Hours Primary care program has aims to address gaps in After Hours primary health services across our region and aims to improve service integration, co-ordination, access and availability.

Promoting coordination and connection between services and frontline clinical care providers at a local level will optimise the use of appropriate care pathways for lower acuity and unplanned presentations, with an aim to reduce non-urgent attendances at hospital emergency departments in the after hours period.

A key aim of the program is to foster collaboration and develop shared models of care and protocolised referral pathways between primary, secondary and tertiary care providers. This will be achieved through co-design with health care professionals working to top of their scope of practice and utilising triage, navigation and digital front door pathways to access care.

Description of Activity *

The key activities that will be undertaken to address challenges, gaps and inefficiencies in After Hours Primary Care Access include

1. Streamlining of Services
The key activities include transition of a current After Hours GP Telehealth Support lines toward the single digital front door to local service connection via National HealthDirect Service.
This will also involve a plan to Transition the triage and appointment booking component of the North Coast PHN North Coast Health Connect Program towards HealthDirect

2. Expanding Access to Unplanned Primary Care Appointments
This activity includes capacity creation to increase the number of available Primary Care Access appointments in pharmacy and general practice settings provided following centralised triage and booking processes. These appointments will expand to provide access for patients across a 7-day care spectrum for low acuity presentations. These appointments will be available across more suburbs and sites, complementing the existing urgent care centre network.
Phase 2 of this program, the Local GP Access model is being trialled across the North Coast to improve access to same day, unplanned care, particularly in communities without an Urgent Care Clinic. Authorised referrers (including community pharmacists, virtual care services and paramedics) can book patients directly into quarantined GP appointments using approved booking platforms. Participating practices and pharmacies are supported through a blended funding and incentive model to recognise the extra work involved in delivering urgent, low acuity care. In 2026/27, we will onboard NSW Ambulance including the Virtual Care Service and Healthdirect as authorised referrers to have a local, state and national digital front door.

3. Increasing access to After Hours care during periods of natural disaster and emergency. The “We Are Open” access program

supports general practice, AMSs and pharmacies to open for additional hours at short notice, during an emergency or natural disaster and in the immediate recovery. The program supports providers and acknowledges the coordination work required to prepare for additional service delivery and outlays, should patient volume be extremely high (or low) at such short notice.

An expansion of this program to work with HealthDirect to set up a process whereby local updates to the National Health Service Directory (NHSD) can be made using local intelligence gathered by HNC during periods of emergency and natural disaster. Having a single source of truth of local primary care service openings and closures for listed services providers on the NHSD will greatly assist co-ordination and access to critical health services and reduce demand for local Emergency Departments in after-hours periods.

4. Managing change in primary care during transition period a Primary Health Coordination Team will have a key focus of optimising after hours integration, coordination and service delivery, supporting primary care providers and the community to transition towards new care pathways, new models of assessment and triage, alternate ways to access GP, pharmacy and allied health services for unplanned and same day care for lower acuity injuries and conditions.

A focus on change management, promotion and awareness, education and learning across the primary care landscape will be important to adopt the wave of new changes and enhancements, embed and reinforce the behaviours for both the community and the providers responsible for their care.

5. Updated Rural Urgent Care program positioning
The Rural Urgent Care program has now moved from concept development into active network implementation. The current model is supporting a network of approximately 30 participating general practices to provide same-day, unplanned care appointments for people with urgent but non-life-threatening needs. Each participating practice will make around 10 appointments available per week, using a funding approach informed by the Medicare Urgent Care Clinic model and adapted for rural general practice settings.
The program is being positioned as a potential national demonstrator for rural and regional urgent care access. It tests a scalable alternative for communities that are unlikely to ever have a standalone Medicare Urgent Care Clinic, but still need a visible, reliable and coordinated urgent care pathway close to home. Rather than relying on a bricks-and-mortar clinic model, this approach builds urgent care capacity through a network of existing general practices, supported by consistent funding, Healthdirect-enabled bookings, and clear referral pathways.
The program is designed to improve timely access to primary care, reduce avoidable emergency department presentations, and strengthen local pathways for patients who need urgent clinical assessment but do not require hospital-level emergency care. The model builds on the existing capacity of general practice, rather than establishing standalone clinics, and supports participating practices to offer a more structured and visible urgent care option within their usual service environment.
A key implementation milestone is the integration with Healthdirect, with online and phone-assisted bookings scheduled to go live from 30 September 2026. This will create a more consistent pathway for community members to identify and book into available same-day urgent care appointments across the participating rural general practice network.
In parallel, NSW Ambulance will pilot a referral pathway from 30 September 2026 in Kempsey, Nambucca and Port Macquarie. This pilot will test how paramedics and ambulance services can safely refer suitable patients to participating general practices where their care needs can be managed in primary care rather than through an emergency department presentation.
The next phase of program development will also include an Expression of Interest for after-hours weekend clinics in three priority SA3s: Port Macquarie, Kempsey–Nambucca and Clarence Valley. This will extend the program's focus beyond weekday same-day access and test additional weekend capacity in areas where access pressures, emergency department demand and rural workforce constraints are most significant.
Overall, the program is now best described as a networked rural urgent care model and national demonstrator that combines commissioned general practice capacity, Healthdirect-enabled bookings, ambulance referral pathway development, and targeted after-hours expansion in priority locations. It provides a practical and scalable model for rural and regional communities where a standalone urgent care centre is not feasible, but where timely access to urgent, non-life-threatening care remains a clear priority.

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 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 access to GP services, particularly after-hours, to facilitate management of non-urgent care needs	145



Activity Demographics

Target Population Cohort

•Place-Based Approaches will target whole populations at town or LGA level, with a particular focus on vulnerable population groups including older people, Aboriginal and Torres Strait Islander people and people experiencing socio-economic disadvantage.
•After-Hours Service Awareness Campaigns will target the whole population. Targeted campaigns may address particular groups (e.g. parents, people living in remote areas, older people, and people with chronic disease).
•Health Education will target vulnerable communities and population groups.
•Innovative digital solutions will target patients experiencing barriers to accessing appropriate primary care. Digital solutions will target consumers under the age of 35 with options for 24/7 digital triage platforms in addition to telephone services.
•Alternative to ED models recognise the Northern NSW regional problem of after-hours mental health presentations. Many of these presentations leave ED without basic support, this model promotes support for patients with non-emergency conditions to engage in recovery and resilience building mental health supports outside of hours in line with the stepped care approach.
Primary care providers, including GPs, Allied Health, Nurses and Aboriginal Health Workers

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

A Primary Care Access Reference group has been formed to assist in removing barriers that may impede the design and delivery of the project, as well as optimise and refine operational models and key activities being delivered to improve access to primary care in the after hours period. The group facilitates access to stakeholders and is a key advisory and consultation avenue for the PHN with industry partners, frontline clinicians, peak organisations, consumer representatives, IT and digital health experts. Consultation through this and other mechanisms allow the stakeholders to work collaboratively and
- Provide advice on project direction, codesign strategies, stakeholder engagement and procurement approaches.
- Play a leadership role in Primary Care Access project forums and workshops.
- Provide advice to the HNC Executive and Project Team to guide decision making.
- Champion policy and system-level changes that enhance access to after-hours primary care for regional communities.

Collaboration

Activity Milestone Details/Duration

Activity Start Date

01/07/2024

Activity End Date

30/06/2025

Service Delivery Start Date

01/07/2024

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): 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

Yes

Decommissioning details?

Decommissioning of a 24/7 GP Telehealth Service line. Negligible impact is forecast as a transition plan to substitute service line with like offerings through HealthDirect and NCHC line (until streamlined) is in place.
Decommissioning of North Coast Health Connect and transition to single digital front door – Healthdirect.
Community awareness and provider awareness of alternate options to the GP telehealth line will be rolled out prior to decommissioning

Co-design or co-commissioning comments

n/a