North Coast - Aged Care
2023-24 – 2027-28
Activity Summary View

AC-OSP - 1 - On-Site Pharmacist - Operational

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-OSP

Activity Number *

1

Activity Title *

On-Site Pharmacist - Operational

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Aim of Activity *

Increase uptake and improve access to aged care on-site pharmacists by RACHs in the footprint with the aim of:
• Improved medication management and safety in RACHs, and
• Integration of aged care on-site pharmacists with the health care team in the RACH.

Description of Activity *

• Conduct an initial review of those homes that would be interested in participating in the program and identify those that would require support
• Use HNC channels and relationships to promote the program and provide education on the benefits of On site Pharmacists to RACH's. This includes promotional flyer, newsletters, webinar, face to face RACH visits and at RACH Communities of practice.
• Use HNC's networks to promote the ACoP measure to eligible pharmacists through newsletters, individual engagement and via peak bodies.

• Offer proactive support to those RACHs interested in participating, providing support by way of information about the measure and how to participate and supported connections to community Pharmacy and potential pharmacists.
• Support the engagement and relationships between the RACH's, participating pharmacies and pharmacists, GP's, residents and families
• Create opportunities to share good news stories, case studies and use cases
• Implement activities which activities that promote ACOP opportunities, the role of ACP as a career option and introduce interested pharmacists to RACH's in their geographic reach
• Establish a CoP for participating On site pharmacists
• Collaborate with other PHN's in joint promotional and awareness campaigns

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Support older people to access aged care services, reducing the impact of the complexities of referral and funding pathways	151
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 integration of services, continuity of care and consumer/provider experience	145

Activity Demographics

Target Population Cohort

Residential Aged Care Facilities residents

Indigenous Specific *

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consultation with:
- RACH's to understand appetite and support required
- Pharmaceutical Society of Australia to understand training requirements, barriers and opportunities and supply of potential Pharmacists
- Community pharmacy to understand opportunities and any barriers to participate

Collaboration

Collaboration with:
- Pharmaceutical Society of Australia to understand training requirements, barriers and opportunities and supply of potential Pharmacists
- Community pharmacy to understand opportunities and any barriers to participate
- Other PHN's to explore opportunities for joint promotion campaigns, CoP's and the potential for other common strategies

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Activity Milestone Details/Duration

Activity Start Date

01/01/2025

Activity End Date

31/12/2027

Service Delivery Start Date

01/03/2025

Service Delivery End Date

31/12/2027

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): 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

AC-CF - 2 - Care Finder Program - Operational

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-CF

Activity Number *

2

Activity Title *

Care Finder Program - Operational

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Aim of Activity *

Operational activity

Description of Activity *

Operational activity

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Support older people to access aged care services, reducing the impact of the complexities of referral and funding pathways	151
Support coordination of health and social care services that contribute to improving social determinants of health, including social	147

isolation/loneliness, cost of living and housing availability	
Improve integration of services, continuity of care and consumer/provider experience	145

Activity Demographics

Indigenous Specific *

No

Coverage

Whole Region

Activity Milestone Details/Duration

Activity Start Date

01/07/2023

Activity End Date

30/06/2029

Service Delivery Start Date

01/07/2025

Service Delivery End Date

30/06/2029

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): No

AC-CF - 5 - Care Finder ACH Contract Providers

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-CF

Activity Number *

5

Activity Title *

Care Finder ACH Contract Providers

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Aim of Activity *

To transition the ACH providers into the Care Finder program for the region.

Description of Activity *

Key milestones:
Transition of ACH providers
Two of the three ACH providers have transitioned across to care finders – both services are now active in the provision of Homeless care finders services. The third provider did not transition across due to conflicts with contractual arrangements. This providers area has been picked up by Footprints. Key stakeholders have been informed of the care finder services for homeless.

The new Care finder services provide coverage across the footprint and provide services to homeless clients in areas the transitioned ACH providers do not cover as part of their care finder service, to ensure no clients are missed.

Under the new Care finder program, the requirement to appoint former ACH providers has been removed and this discrete activity will no longer be applicable from July1 2025.
Former ACH providers, (now Care Finder providers) have been given the opportunity to apply for funding for the new Care Finder program 2025 -2029 and applications have been evaluated in line with all other submissions.
Along with all current Care finder providers, transition out plans have been received in preparation for the end of the current contract.

Needs Assessment Priorities *

Needs Assessment

NCPHN HNA 2021 - 2024

Priorities

Priority	Page reference
Improve access to aged care services, care packages and RACFs in a region with a large proportion of older people	126
Enhancing care navigation to improve delivery of health and social care services	120

Activity Demographics

Target Population Cohort

People who are eligible for aged care services and have one or more reasons for requiring intensive support to:
- interact with My Aged Care and access aged care services and/or
- access other relevant supports in the community.

Indigenous Specific *

No

Coverage

Whole Region

No

SA3 Name	SA3 Code
Port Macquarie	10804
Kempsey - Nambucca	10802
Richmond Valley - Coastal	11201
Tweed Valley	11203
Coffs Harbour	10402
Richmond Valley - Hinterland	11202

Activity Consultation and Collaboration

Consultation

Meetings and stakeholder engagement have been held with Assisted with Care and Housing organisations servicing the North Coast region. Data collected and added to the broader key stake holder engagement included an understanding of their client base, client outputs and the challenges and barriers the clients and care finders face. The average client base for an ACH worker

was approximately 100 clients and barriers commonly faced included secure housing for those with mental health issues such as hoarding or drug and alcohol complexities. Supporting Aboriginal clients with secure housing is particularly challenging with younger generations often causing the older family members issues with their lease security.

The lack of housing stock is causing significant issues in the region pre floods. The floods have now resulted in many people having to move right out of area or are living in unsafe situations. Many Aboriginal people are struggling being off country or are choosing to live in very unsafe situations.

Three focus groups were held in with a mix of local health district staff, community service providers (a mix of aged care and general community programs), other agencies; ambulance, police, Advocacy groups, local government and Aboriginal workers. Specific settlement services and members from the LGTBQI+ community were also included. Consumers were living in a range of accommodation such as caravan parks, retirement villages and in temporary housing. Vulnerable groups were identified and synthesised into the following groups: those with complex mental health conditions; people that are isolate; older carers (i.e. are one or have one); and living in volatile and unsafe situations.

Collaboration

The care finder organisations have been provided with listings of key stakeholders in the region to collaborate with as they promote the new services and provide inreach

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Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

30/09/2025

Service Delivery Start Date

01/01/2023

Service Delivery End Date

30/06/2025

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

Yes

Decommissioning details?

These contracts expire on 30th June 2025. All Care Finder providers, including former ACH providers, have been required to submit transition plans in case they are not successful in securing funding for the 2025–2029 contract period. This is to ensure a smooth handover to any new provider and the continued, uninterrupted delivery of services to Care Finder clients. HNC is working with each provider to facilitate the de-commissioning/transition.

AC-EI - 1 - Early Intervention - Operational

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-EI

Activity Number *

1

Activity Title *

Early Intervention - Operational

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Aim of Activity *

To support senior Australians to maintain their functionality and live at home for as long as possible by commissioning early intervention initiatives

Description of Activity *

Operational and Administration costs:
3.6 FTE

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 2026/27

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
Enhance capacity of the health and social care services, including workforce capability, to manage increase of older person population	144
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
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 and Aboriginal and Torres Strait Islander people aged 50 years and over

Indigenous Specific *

No

Coverage

Whole Region

Yes

Activity Milestone Details/Duration

Activity Start Date

01/06/2022

Activity End Date

30/06/2025

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: Yes
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?

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

AC-EI - 3 - Early Intervention

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-EI

Activity Number *

3

Activity Title *

Early Intervention

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Aim of Activity *

To support senior Australians to maintain their functionality and live at home for as long as possible by commissioning early intervention initiatives

Description of Activity *

*Analyse HNC's Healthy Ageing systems dynamic model developed in 2021-2022 by the SAX Institute to model and test the impact of a range of different healthy ageing initiatives. Shortlisted interventions include: healthy housing options for Aboriginal and older people; chronic disease wrap around models, healthy ageing health promotion campaign; rural telehealth hubs; healthy communities inclusive of healthy lifestyles, social prescribing and rural living.
*Analyse HNC's Health Ageing Social Research developed in 2021-2022 by ARTD to better understand how older people want to age and what services they need to age well.
Conduct community consultation across the footprint to understand perceptions of healthy living and ageing and levels of health self efficacy , what communities need to live and age well, the barriers they face and the things that are working well and should be amplified.

Early interventions through primary care
1, Commission an expert practice nurse capacity building provider to enhance the capability of practice nurses to deliver new, nurse-led healthy ageing appointments. Through these appointments, nurses will support relevant patients to understand and manage their chronic conditions, improve lifestyle behaviours and engage in healthy aging activities. The provider will also support general practices to align business systems and billing options to support financial sustainability. 5 new Early Intervention Health Pathways have been developed, tailored specifically to support practice nurses in this intervention.

2. Primary Care Nurse Capacity Building program provided by Australian Practice Nurse Association (APNA). Supports nurse led care for early management of chronic and complex conditions in general practice settings through early intervention clinics which aim to improve community health outcomes in chronic disease and other aged related risk factors eg cardiovascular health, diabetes and mental health.

Early interventions in community
• Promote the importance of social determinants of health for healthy ageing – to workforce and community through events, newsletters, social media and contributions to conferences and articles.
• Educate the clinical workforce across the footprint on social prescribing as an evidence based early intervention approach to prevent/reduce chronic disease, with tools and resources to support its adoption
• Commission accredited social prescribing/loneliness training to be offered to all community pharmacy teams as the shop front to primary care
• Taking an evidence based all- of -community approach to early interventions, in two selected locations with high prevalence/risk factors of chronic disease. HNC will fund
o Primary care provider(s) to embed a 'social prescribing link-worker' into the practice team; supporting identified patients to reduce risk factors of chronic disease through a 'social prescription' of connections to community, activities and mainstream supports
o A Community development partner(s) to work with community (local residents, community organisations, Council, health providers and main stream supports) to promote the importance of social determinants for health and wellbeing, map and promote community activities and services that are known to reduce risk factors for chronic disease (e.g. walking and other exercise groups, opportunities for education, arts, craft and culture, green prescribing, volunteering opportunities and centralised access hubs). This activity will highlight opportunities to scale activities and services that are working, as well as identify gaps in community assets and barriers to access
o The distribution of needs-based grants as identified through community development and local consultation (above) to scale successful activities, address gaps in services or overcome barriers (eg transport). and in
Digital Solution to Early Interventions
Studies show that that technology offers an opportunity to assist high numbers of people to self-manage improved health outcomes and reduce risk factors for chronic disease, outside of the consultation room, empowering them to live at home for longer, with less need for primary and other health and care services
o HNC is commissioning the co-design, development and integration of a digital solution
o that enables North Coast residents to build self-efficacy to understand and address their individual Social Determinants of Health with low intensity resourcing. Activities include

o 1. Commission co-design and consultation activities to explore what healthy ageing means to people across the North Coast, the enablers, barriers and if and how technology could support. Findings assimilated into a comprehensive report to inform commissioning and the design and characteristics of solution, as well as promotion strategies.
o 2. Commission a provider to design, protype, develop, improve, monitor and maintain the tech solution,
o 3. Establish an academic partnership to develop an evaluation framework and recommended strategies for impact measurement. This will include how the intervention supports the target cohort to live at home for as long as possible, with less need for health services, in turn reducing demand on the primary care system and improving access for those who need it.
o 4. Roll out solution across HNC footprint in tranches

The interventions will include a mix of all the determinants of health ensuring diversity in approaches influencing better health outcomes. Awareness campaigns and education programs will be used to promote the program of commissioned activities.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 2026/27

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

Activity Demographics

Target Population Cohort

People aged 65 years and over and Aboriginal and Torres Strait Islander people aged 50 years and over

Indigenous Specific *

No

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 HNC Aboriginal Partnerships and Aboriginal Health), HNC's Healthy Living and Ageing Strategy Reference Group

and academics.
Co-design activities commissioned and conducted as follows
o GENERAL COMMUNITY: Surveys; 1 x codesign sessions (c45px) in each of 3 locations, 1x feedback session in each of same 3 locations,
o CLINICIANS: consultation in 5 Social Prescribing clinical societies; virtual co-design sessions; individual consultations.

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 HNC Aboriginal Partnerships), HNC's Healthy Living and Ageing Strategy Reference Group and academics.

Activity Milestone Details/Duration

Activity Start Date

01/06/2022

Activity End Date

30/06/2025

Service Delivery Start Date

1/04/2023

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Literature review for early interventions in community completed May 2024
Primary Care Nurse Capacity Building solution: commissioned July 2024
Mid point of Nurse led early interventions clinic program reached- all clinics operating March 2025
New Nurse Led healthy aging HealthPathways and capacity building activities live in 5 pilot sites: April 2025
Social Prescribing Clinical Societies and Social Prescribing Showcase Event Complete April 2025
Loneliness Training for Pharmacists commissioned May 2025
Co-design and consultation activities for Digital Early Intervention Solution and final report completed June 2025

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: 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

AC-VARACF - 1 - Virtual Access in RACFs

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-VARACF

Activity Number *

1

Activity Title *

Virtual Access in RACFs

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Aim of Activity *

Increase RACHs residents' access to clinically appropriate virtual care health services

Description of Activity *

- Environmental scan undertaken to determine all RACFs digital health capacity as a baseline
- Procure equipment for RACFs based on their digital maturity
- HNC HLA team to develop activities to help RACFs embed telehealth into routine practice
- Coordinate consultations between RACFs, GPs and LHD services to co-design solutions to create enhanced virtual care services for RACF residents.
- Provide training to RACF staff to support them to have the capabilities to assist their residents in accessing virtu al consultation services.
- Promote the use of enablers of digital health (such as My Health Record);
- Consult with LHDs to ensure the initiative complements, but does not duplicate, efforts underway by state and territory governments to improve technological interoperability between the aged care and health systems.

Co-commission the development of Tele-health training modules with 15 other PHN's – subsequently open for all PHN's to use. Uploaded to ALIS and to HNC's LMS provider.
Commissioning a Nurse Education provider to undertake a RACH nurse training Needs Assessment in order to develop and education framework which includes Tele-health training

- Intensive support to RACHs (equipment, training and change management) so that they can better engage with LHDs virtual aged

care and Aged Care outreach services
- Expanding number of aged care homes using Visionflex carts, to allow a more comprehensive virtual care consultation with LHD, GPs and other healthcare service providers
- Partner with local university to deliver a targeted face to face training program for residential aged care staff, including the use of telehealth and Visionflex carts to manage deteriorating residents.
- Continue to promote National Telehealth Training modules and embed them as part of targeted training as pre-learning prior to attending simulation-based workshop with the university.
- Supporting to embed other virtual care models in aged care, particularly where thin markets are identified
- Piloting of Virtual Wound Care in RACHs in partnership with University of Sydney
- Continue to promote use of other enablers of digital health (such as My Health Record- Commission an independent Insights Analysis to assess the status and adoption of Tele-health in every RACH in the footprint- to inform the change management activities planned for the next contract period
Development of promotional assets and use cases to support uptake of digital health and telehealth in residential aged care homes
- Undertake evaluation of the program to June 30 2025

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Explore opportunities to prepare the healthcare system to manage the expected growth in the older adult population	150
Promote early help seeking for medical concerns from primary care services to reduce burden on EDs	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 integration of services, continuity of care and consumer/provider experience	145
Enhance the understanding of telehealth services for people in the North Coast	142

Activity Demographics

Target Population Cohort

Residents in residential aged care facilities

Indigenous Specific *

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Residents and families, primary health care services and clinicians, Residential Aged Care Homes (RACHs), 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), HNC's Healthy Living and Ageing Strategy Reference Group, universities and academics.

Collaboration

Residents and families, primary health care services and clinicians, Residential Aged Care Homes (RACHs), 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), HNC's Healthy Living and Ageing Strategy Reference Group, universities and academics.
Existing collaborative meetings and relationships will be utilised in expanding and embedding virtual care in aged care models. RACH, GPs and the LHD will participate in all aspects.

Activity Milestone Details/Duration

Activity Start Date

18/04/2022

Activity End Date

30/06/2025

Service Delivery Start Date

1/07/2022

Service Delivery End Date

30/06/2025

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: 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?

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

Co-design or co-commissioning comments

Virtual care was incorporated in healthy living and ageing codesign workshops in 2022. Lessons and assumptions drawn from the RACHs digital health needs assessment and advanced technology solutions were tested and validated as part of the workshops. Further consultation occurred as the technology offering was refined, as well as LHD and RACH representation on the panel to select the advanced technology provider.
Provisioning of equipment and design of training – co-designed with RACH's, education specialists and other PHN's
Development of tele-health training modules co-commissioned with other PHN's

AC-VARACF - 1 - Virtual Access in RACFs - Operational

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-VARACF

Activity Number *

1

Activity Title *

Virtual Access in RACFs - Operational

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Aim of Activity *

Increase RACFs residents' access to clinically appropriate virtual care health services

Description of Activity *

Operational and Administrative Costs
3.6 FTE

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
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
Enhance the understanding of telehealth services for people in the North Coast	142

Activity Demographics

Indigenous Specific *

No

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), HNC's Healthy Living and Ageing Strategy Reference Group and academics.

Collaboration

Existing collaborative meetings and relationships were utilised in scanning the environment and determining solutions. RACH, GPs and the LHD participated in all aspects. Resulting from the relationships will be a place based integrated model of wrap around support for RACHs will be one outcome from this project

Activity Milestone Details/Duration

Activity Start Date

18/04/2022

Activity End Date

29/06/2025

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

AC-AHARACF - 2 - After Hours Access in RACFs

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-AHARACF

Activity Number *

2

Activity Title *

After Hours Access in RACFs

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Aim of Activity *

Help reduce unnecessary hospital presentations among RACH residents by addressing awareness or utilisation issues of available local out of hours services among RACFs located on the North Coast.

Description of Activity *

*Undertake an assessment of current after-hours strategies available to, and used by, RACHs. Analyse data for gaps, common trends and current solutions that are working well.
*Coordinate consultations between RACHs, GPs and LHD services to codesign solutions to create enhanced after-hours care for RACH residents.
*Provide guidance to RACHs to develop and implement after-hours action plans which will support their residents to access the most appropriate medical services out-of-hours.
*Educate RACH staff on out-of-hours health care options and processes for residents inclusive of digital and telehealth options, older persons HealthPathways and clinical communication tools.
*Encourage RACHs to implement procedures for keeping residents' digital medical records up to date, particularly following an episode where after-hours care was required
*Support engagement between RACHs and their residents' GPs (and other relevant health professionals), as part of after-hours action plan development.
* Develop clinical tools to support practice development for RACF RNs – resulting in the Deteriorating Resident's Triage Tool (DRTT)

New activities

• Commission the co-design of an integrated model of RACF support, joining up services of ambulance, RACH's, ED, pharmacy and GP's for right care, right place, right time.Commission the Co-design, and implementation of a nurse education framework with tools and resources to build capability of RACH staff, to better care for residents in place. In addition to After Hours Plans, this training builds the confidence and capacity of RACH clinicians to provide quality care for residents at home, during afterhours periods and to better anticipate and address deterioration in hours when GP support is available. Includes triaging and management of resident deterioration, communication protocols, use of tele-health to enable access to other services from home, wound care, the use of HealthPathways for clinical management, use and access of Advance Care Directives through MyHealthRecord and anticipatory practices for palliative care.
Commission the evaluation of the effectiveness of the RACH Nurse Capacity Building program to support residents in place. (Scyne Advisory).

• Promote and support RACH's to access recently developed local services to avoid preventable hospitalisation of residents including Aged Care Outreach Services, Urgent Care Services, Virtual GP's and RACH Fast track GP Access afterhours telehealth service
• Implement the recommendations for Integrated Model of Support
• Undertake a review of each RACH's after-hours services to understand what's working well and what's not since last review, so that PHN support can be tailored and prioritised
• Promote the utilisation of the HNC Deteriorating Resident Triage Tool to support clinical decision making in the after hours period, including a comprehensive education program (above), community of practice, use case stories and an external advisory committee to support enhancement and integration with NSW Ambulance, and Mid North Coast and Far North Coast LHD's.
• Tailored support to improve the uptake of Advance Care Directives in RACHs, including processes and resources to support residents and families
• Work with HealthDirect to trial new virtual care options to fast track all hours access to telehealth for RACH residents

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
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 access to GP services, particularly after-hours, to facilitate management of non-urgent care needs	145
Improve integration of services, continuity of care and consumer/provider experience	145
Enhance the understanding of telehealth services for people in the North Coast	142

Activity Demographics

Target Population Cohort

Older people

Indigenous Specific *

No

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), HNC's Healthy Living and Ageing Strategy Reference Group, Geriatricians, Nurse Practitioners, Pharmacists, NSW Ambulance and university facilitators.

Collaboration

Existing collaborative meetings and relationships will be utilised in scanning the environment and determining solutions. RACH, GPs, NSWAS and the LHD will participate in all aspects. An outcome of this activity will be a place-based integrated model of wrap around support for RACHs.
Codesign sessions to support the design of HNC's Regional Integrated Model of Support for RACHs were attended by over 50 representatives from Residential Aged Care Homes, The Local Health Districts, General Practitioners, Nurse Practitioners, Pharmacists, NSW Ambulance and university facilitators. HNC is collaborating with MNC and NNSWLHD in the implementation of the Aged Care Outreach Service, playing a pivotal role in supporting RACH's with tele-health, ACD's, use of MHR management of resident deterioration and anticipatory practices.
Regular collaboration and engagement with HealthDirect
The commissioning process includes a member of community, a clinician and a local council representative on the evaluation panel for the Digital Solution provider.

Activity Milestone Details/Duration

Activity Start Date

18/04/2022

Activity End Date

30/06/2025

Service Delivery Start Date

1/07/2022

Service Delivery End Date

30/06/2025

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: 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?

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

Co-design or co-commissioning comments

Since the last AWP:
- Scyne Advisory were commissioned to undertake co-design of the Integrated Model of Support.
-Primary Care Innovation (including Aria Health) has been commissioned to deliver tailored, localised nurse capacity activities in RACHs to enhance out of hours care. This work has been co-designed with RACHs and other stakeholders following a comprehensive needs assessment.

AC-CF - 4 - Care Finders

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-CF

Activity Number *

4

Activity Title *

Care Finders

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Aim of Activity *

The Care Finder program is to establish and maintain a network of care finders that will provide specialist and intensive assistance to help people within the target population to understand and access aged care services and connect with other relevant supports in the community.

The program targets vulnerable groups that would be unlikely to receive assistance without this intensive program to navigate and access services.

Vulnerable groups may include those who are socially isolated, have minimal English language skills and/or literacy, have difficulty processing information, have resistance to engage with government agencies in any capacity, and/or those who are in insecure housing or sleeping rough.

The program will result in a network of care finders across the regional footprint, who will provide intensive support to the vulnerable population identified. Care finders within the HNC footprint will have local knowledge of aged care supports, other agencies required to support set up the older person to receive services and an understanding of the local needs of clients on the NSW North Coast.

Care finder services are delivered by organisations that have experience in supporting vulnerable older people's needs i.e. mental health, capacity, distrust in the system etc and have local knowledge of services and the relevant agencies available.

Care finders actively engage with vulnerable communities through an outreach model. Clients will be supported to access My Aged

Care and other related services. Care finders will stay involved with the client until the client does not require or want any further support from the care finder.

Description of Activity *

2023 - 2025 Activity
Undertake a comprehensive needs assessment which complements HNC's regional Health Needs Assessment. The needs assessment summarises local needs through an analysis of data and literature and consultation with local stakeholders.
- Undertake a procurement process to contract Care Finder providers.
- Transition the existing Assistance with Care and Housing program over to the Care Finder program (excluding hoarding and squalor services).
- Care finder model of care:
o Assertive outreach: Tailored to regional and rural environments, connections with health practitioners, agencies, and rural community groups. Flexibility as to how and where they meet with community members promoting awareness. Building new networks and sources of trusted third parties to be referred to/connected with most vulnerable.
o Integration between aged care, LHDs, primary care and other agencies such as police, ambulance, housing etc has begun in other activities in the region and the care finders assertive outreach program will continue to imbed these relationships.
o Registration, screening, and assessment: the organisation will have an efficient person-centred informed intake process, preferably using local people that know regional living and the community. Intake will ensure the person being referred is within the care finder target population and where it is not a warm referral process will be in place to other agencies. The assessment phase with the care finder will begin with contact with the referring agency, in a meeting with the consumer in a place that is safe for them. The assessment process will be undertaken over a period of contacts using the most suitable approach for the consumer e.g., storytelling focused on what is most important to the person, first balanced with introducing supports that will ensure security, e.g., housing, finance, nutrition.
o Support post assessment: support to access services, any further or changed needs are addressed and the person is empowered to manage life. Warm referrals are made with the consumer to differing agencies and eventually the aged care provider.
o High level check-ins: will be conducted by the care finder until the consumer has settled into a trusted relationship with the new provider and their current needs are being supported.
o Follow up support is made available to the consumer as needs change or if initial services are short term.
o Each care finder will continue to build networks of local agencies that have been established through HNC's own networks and key stakeholder engagements.

HNC will review and monitor the outcomes of the Care Finder Program locally using the combined NSW PHN performance measures currently under development which aligns with the Australian Govt., Evaluation of the care finder program, Summary evaluation plan (2022). HNC will also review the performance of each provider, via HNC's commissioning processes, to ensure consumers are receiving a high quality service and the providers are meeting all key deliverables under their contracts.

New activity 2025-2029
Following announcement of the extension of the Care finder program, Healthy North Coast conducted an open competitive tender process to commission a network of Care finders for 2025 – 2029.
Planning data has been used to cluster LGA's into 4 Zones across the footprint based on forecasted older populations, dementia, SEIFA, living alone and geographic spread/population density.
Weighting was given to these criteria to ensure funding was appropriate to the service requirements of each Zone. Organisations were able to apply for one or more Zones. 12 organisations submitted applications and following a rigorous selection process, by zone, two existing providers have been successful and collectively, will cover all zones under new contracts.

Zone 1: Tweed and Byron: Footprints
Zone 2 a) Ballina, Kyogle: Footprints
Zone 2b) Clarence valley, Richmond, Lismore: Each
Zone 3: Coffs harbour, Nambucca, Bellingen : Each
Zone 4: Port Macquarie Hastings, Kempsey: Each

Provider selection and subsequent contracts pays particular attention to
• Assertive out reach strategies – including temporary accommodation hubs and services for rough sleepers
• Service intensification during disasters including support for Care finder clients at evacuation centres
• Culturally appropriate services and any identified positions to further enhance quality and safety of care and support provided to First Nations peoples.

• Community development activities to identify wrap around supports for people whilst waiting for assessments and or packages
• Service integration

Note:
a) based on the evaluation outcomes, Zone 2 was divided into two parts a and b.
b) The two providers from 2023-2025 program that were unsuccessful are Care Excell and Lifetime Connect and they will transition clients and services to Each by 30th June in a planned transition process.

PHN Activities for the new contract include
• Conduct updated Care finder Needs Assessment (completed March 2025)
• Transition out of existing providers
• Communication of new service providers to sector stakeholders
• Review of provider implementation plans and service delivery plans
• Support successful providers to establish services
• Establishment of new KPI's, reporting requirements, outcomes and contract meeting cadence
• Develop and implement a joint promotional and awareness campaign
• Introduction of Elder care program
• Establish Communities of Practice schedule

PHN Integration activities include
• Lead the design and delivery of a joint Integration plan with care finder organisations
• Integrate Care finders into Health Pathways (complete) and Medical objects
• Community of Practice with Care Finders in other PHN regions – having data informed discussions to progress integration through collaboration.
• System level relationship development with key stakeholders including Local Government, Police, Local Health Districts.
• Using data to inform policy at regional, jurisdiction and national levels. Sharing data in forums to drive strategic decision making.
• Program promotion and messaging including Interagency/networks, Councils, Expos and Symposiums, Primary Healthcare and clinical networks.
• Identify opportunities to work collectively to leverage local level social capital to support wrap around services
• Set KPIs and outcome measures for providers to initiate and report on integration activities and outcomes

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
Support older people to access aged care services, reducing the impact of the complexities of referral and funding pathways	151
Enhance capacity of the health and social care services, including workforce capability, to manage increase of older person population	144
Improve integration of services, continuity of care and consumer/provider experience	145

Activity Demographics

Target Population Cohort

People who are eligible for aged care services and have one or more reasons for requiring intensive support to:
• interact with My Aged Care and access aged care services and/or
• access other relevant supports in the community.
Includes people who are
o Financially and socially disadvantaged
o Experiencing homelessness or at risk of homelessness
o Lives in a rural or remote area
o Aboriginal and Torres Strait Islander
o From a culturally and / or linguistically diverse background
o Has been affected by forced adoption or removal
o Care leaver
o Veteran
o LGBTQ+

Indigenous Specific *

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Meetings and stakeholder engagement will be held with Assisted with Care and Housing organisations servicing the North Coast region. Data collected and added to the broader key stake holder engagement included an understanding of their client base, client outputs and the challenges and barriers the clients and care finders face. The average client base for an ACH worker was approximately 100 clients and barriers commonly faced included secure housing for those with mental health issues such as hoarding or drug and alcohol complexities.

Supporting Aboriginal clients with secure housing is particularly challenging with younger generations often causing the older family members issues with their lease security. The lack of housing stock is causing significant issues in the region pre floods. The floods have now resulted in many people having to move right out of area or are living in unsafe situations. Many Aboriginal people are struggling being off country or are choosing to live in very unsafe situations.

Three focus groups were held with a mix of local health district staff, community service providers (a mix of aged care and general community programs), other agencies; ambulance, police, Advocacy groups, local government and Aboriginal workers. Specific settlement services and members from the LGTBQI+ community were also included. Consumers were living in a range of accommodation such as caravan parks, retirement villages and in temporary housing.

Vulnerable groups were identified and synthesised into the following groups: those with complex mental health conditions; people that are isolate;, older carers (i.e. are one or have one); and living in volatile and unsafe situations.
New activities
Consultation with Care finder providers, as well as other stakeholders including LHD and Single Assessment Service Providers in January 2025 has informed the commissioning of the program for the period 2025-2029.

In preparation for the new contract, HNC used feedback from community consultations and most recent HNA data/insights to update the Care finder needs assessment produced in 2023.

Collaboration

On commencement
Key members from the stakeholder engagement plan have been included in the design and implementation of the program. In particular, the local ACH providers. LHD staff that interface with the program include Emergency Department, social workers and discharge planners as well as aged care managers. Councils can provide access to remote community halls. Aboriginal workers have been employed to ensure services are culturally appropriate for those Aboriginal people who do not wish to use the Elder Care Support Program. Care finders have also established links with, migrant groups, CALD community representatives and LGTBQI+ organisations.

Ongoing collaboration includes
• Provider collaboration with health, aged care and community sector stakeholders
• Provider collaboration through an HNC facilitated Care finder CoP, which meets quarterly to share learnings and best practice, supplemented with an annual 2 day conference
• HNC collaboration with other PHNS supported through regular PHN network meetings and Care finder Communities of Practice.
• Elements of the 2025–2029 program have been, and will continue to be, developed in collaboration with other PHNs — particularly in relation to integration activities, performance metrics and outcome measures for commissioned providers, service enhancements, and quality improvement initiatives.

Activity Milestone Details/Duration

Activity Start Date

01/07/2022

Activity End Date

30/06/2029

Service Delivery Start Date

01/01/2023

Service Delivery End Date

30/06/2029

Other Relevant Milestones

Completion of an updated Care finders Needs Assessment to inform new service planning: March 30th 2025
Commissioning of a network of Care finders for the 2025-2029 period: By May 30th 2025
Transitioning of existing unsuccessful providers where applicable: By June 30th 2025
Services under new contracts operating from 1 July

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: 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?

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?

Unsuccessful providers from 2023-2025 contract to be decommissioned with transition out activities commencing from March 2025

Co-design or co-commissioning comments

The program has been developed based on person centred principles, working with the complexity of vulnerable groups following the guidance documents, utilising and or adapting COTA developed resources to localise approaches.