

North Coast - Core Funding 2023-24 – 2027-28 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

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 will be 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 will commence in December 2024 when a deep dive will be 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 provides 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 will identify 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 will conclude in May 2025 with an expected minimum 75% of RACH's being included in the final report. 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.

Consultation and in-depth face to face interviewing and insights development occurred between March – May 2025.

Alongside the RACH stakeholder consultation, community and RACH resident forums will provide 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 are intended 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 will focus on finding and supporting general practices to accept new residents entering aged care setting and to finding alternatives, 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 publish any out of region general practitioners with capacity and/or appropriate telehealth and specialised care support services to optimise direct access to general practice care. It is anticipated that standby support and a surge medical workforce will be stood up for those locations where a mismatch in clinical supply (from either RACH, primary care or both) and resident/RACH need has been identified (or is anticipated)
- Identify barriers and risk factors to GP supply in specific locations and provide individualised solutions to "at risk" GP's to address barriers and risk factors

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) Grants for allied health, nursing and supportive care interventions including grants for GP's to supervise Nurse practitioners
- ii) Co-design and promotion of solutions which build practice capacity and efficient models for RACH coverage
- iii) Evaluate and procure alternative virtual or mixed models of care where no local services exist.

These solutions will reduce demands on frontline medical care service requirements for GPs in RACHs, provide residents with timely care and reduce unnecessary use of ED as an alternative to local primary care.

It is anticipated that the focus of the two primary elements of care delivery under this activity will be determined by several key indicators. 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
- Places where a single GP is responsible for a significantly high number (absolute or relative) of RACH residents.

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, including incentives for supervising nurse practitioners, 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.

Outcome reporting will be finalised after the co-design and prioritised key implementation strategies have been agreed upon, Evaluation improvements at regular intervals expected to be completed against a selection of the following baseline data

- 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
- # of people awaiting RACH admission for sole reason of being unable to source a GP for admission
- RACH GP access risk score improvement

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.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 2026/27

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
Improve prevention and management of chronic disease, including management of risk factors, multimorbidity and polypharmacy	145
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 health workforce stability in the North Coast, particularly GPs and specialist workforce	142



Target Population Cohort

Permanent residents in residential aged care homes.

Indigenous Specific *

No

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, residents and families 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



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 GP's. 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.

FY25/26 activities will include the

1. Commissioning of allied health, nursing and supportive care services to reduce demand on frontline medical care service requirements for general practitioners in RACH's.

2. Establishment of a Primary Care consortia – supporting GP's to formalise arrangements for shared RACH coverage

FY26/27 activities will be determined following review of solutions proposed in 2024-2026 and 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): 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

Co- design will continue throughout the program as needs emerge- each thin market solution will be developed relative to the characteristics of that market and the stakeholders involved. Initial co-design activities have involved RACH staff at all levels;
-GPs and practice managers nurse practitioners and practice nurses using surveys, interviews, forums, open space technology, and virtual collaboration sessions.
-Further co-design will include ACCHSs, LHDs, allied health providers, geriatricians and peak bodies



CF-COVID-VVP - 1 - Vaccination of Vulnerable Populations



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF-COVID-VVP

Activity Number *

1

Activity Title *

Vaccination of Vulnerable Populations

Existing, Modified or New Activity *

Modified



Activity Priorities and Description

Program Key Priority Area *

Population Health

Aim of Activity *

This activity seeks to enhance primary health care and vaccine accessibility for vulnerable people across Australia, through the implementation of targeted and local vaccination solutions.

The vulnerable populations program has greater focus on non-Medicare eligible vaccinations and aims to provide a more consistent approach to homebound vaccinations. Including delivery of booster doses to this cohort, while continuing the primary course vaccination work. Support and coordination of local solutions and facilitation of urgent vaccination of vulnerable populations in collaboration with COVID-19 vaccination are key aims of the program.

Description of Activity *

Providers including general practices, pharmacies, contracted providers and state health services providing targeted vaccination services to priority and vulnerable populations across the NSW North Coast.

Specific vaccination program activities for these populations include:

Refugee Health Services -

Dedicated demand-based vaccination services in primary care with trusted local general practices for refugee health patients

Rural, Remote and isolated Vaccine Access Services-

Regular dedicated vaccine access sessions and programs for Booster or primary courses where isolated and remote residents are unable to get to vaccine access points. Focus on supporting existing care providers to dedicate resources to hub based COVID-19

vaccination activities. Remote and rural communities: 10 key identified areas in 6 LGAs including Coraki/Casino (Richmond Valley LGA), Ulong/Lowanna (Coffs LGA) Iluka/Woombah (Clarence LGA), Long Flat/Laurieton (Port Macquarie LGA and Kyogle/Urbenville (Kyogle/Tenterfield LGA)

Migrant workers, seasonal workers, Meat Workers and Dairy industries-

Partnership between meat and dairy co-operatives to provide vaccination services for remote and rural employees in high risk industries

Homeless and Rough Sleepers -

Mobile vaccination services to residents experiencing homelessness, those in temp accommodation and rough sleepers

Booster programs for residential Aged Care Facilities

Vaccinations for Non-Medicare eligible people -

Additional support to GP in reach and fixed clinics for dedicated vaccination services for seasonal and hospitality workers a cross North Coast, high rate of Medicare ineligible workers in regional areas for seasonal fruit picking, agriculture, meatworks and coastal hospitality workers. Newly migrated population being sent to regional and remote regions who require short notice on site vaccinations. Workers have very limited transport options and no understanding of alternate options for health care. They work shifts and often require out of hours vaccination appointments, or sessions onsite at specific changeover times.

Nurse led services to support vaccination for chronic disease and at-risk populations. A focus on higher complexity cohorts, homebound residents, people with disabilities and those receiving community nursing and home support services. The promotion of COVID 19 vaccination services through trusted existing in-home care providers will assist in increasing the uptake of COVID -19 vaccination for vulnerable populations.

A focus on providing regular dedicated vaccine access sessions and programs for Booster or primary courses where isolated and remote residents are unable to get to vaccine access points. Focus on supporting existing care providers to dedicate resources to hub based COVID-19 vaccination activities in remote and rural communities. 10 key identified areas in 6 LGAs include:

Coraki/Casino (Richmond Valley LGA),

Ulong/Lowanna (Coffs LGA)

Iluka/Woombah (Clarence LGA)

Long Flat/Laurieton (Port Macquarie LGA)

Kyogle/Urbenville (Kyogle and Tenterfield LGA)

An aim of providing fortnightly frequency for rural and remote community to access satellite and hub based services is planned.

Optimisation of joint messaging and cross promotional activities supporting vaccination campaigns, management of older persons health, homelessness and refugee health program activities and COVID safe / winter preparedness behaviours for at risk populations.

Formation of joint steering committee with North Coast Population and Public Health Unit to prioritise key partnered activities and areas of focus to improve vaccination rates in areas with lower immunisation coverage, less access to services and populations at higher risk.

Promotion of MyMedicare, GPACI, strengthening medicare reforms, pharmacy support initiatives to primary care providers to improve awareness of government schemes supporting practices to provide vaccination coverage for vulnerable people, including RACH residents and homebound residents

Work with nursing peaks and state-based health protection unit to maximise scope of practice and sustainability for nurse led independent vaccination services for vulnerable people.

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
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



Activity Demographics

Target Population Cohort

Vulnerable and priority populations who are eligible for or who have been recommended to receive COVID-19 vaccinations

Indigenous Specific *

No

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

Co-ordination of COVID19 External Partners Forum Meetings – regular updates with Local Health Districts, Aboriginal Medical Services, Private Hospitals, Primary Acre Providers to share key updates and areas of focus for targeted vaccination strategies

Local Business and industry – regular meetings with Regional Development Australia, Public Health Unit, chamber of commerce representatives and Local Councils to identify priority industries, regions and workforces

Expression of Interest circulated to Primary Care providers to identify lead sites with capability and capacity to support mobile and onsite vaccination service provision.

Collaboration

Collaboration with AMS partners, LHD's, Public Health Unit, Primary care providers, local councils and NGO's to sequence and prioritise areas of focus, provide joint efforts and co-ordinated marketing and awareness campaigns for community, pool resources and co-ordinate place based activities to implement vaccination rollouts.

Collaboration with GP vaccine service providers through fortnightly vaccine service providers forums also assisted to identify key areas of focus and critical design elements to ensure efficiency of operation and client/community centred approaches

Working with Interpreter services for bulk vaccination clinics of refugee and overseas seasonal worker vaccination clinics

Partnership with Local Councils, NGO's and crisis/temporary accommodation service centre providers to co-ordinate suitable and safe locations and service design for vaccination services for homeless and rough sleeping populations

Working with AMS services to support culturally safe mobile and community based vaccinations for Aboriginal Communities

Working with disability service providers to support Department of Health identified priority providers to access in reach vaccination services from local providers.

Promotion and support of nurse immunisation programs and capability development of nurse immunisers to have critical conversations with vaccine hesitant communities

Increased collaboration with nurse led services and pharmacy services to support vaccination uptake for identified vulnerable populations receiving current care at high frequency with existing services capable of administering COVID19 vaccinations.



Activity Milestone Details/Duration

Activity Start Date

06/09/2021

Activity End Date

31/12/2025

Service Delivery Start Date

06/09/2021

Service Delivery End Date

31/12/2025



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): 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



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

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 practices and RACHs with onboarding to MyMedicare and registering residents for 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.
 - Participate in the development and dissemination of the GP ACI Toolkit including face to face presentations
4. Communications and Promotion
- Develop and disseminate 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.
 - Engage GP ACI ambassadors (e.g., GPs, NPs, RACH clinicians) to share lived experience and practical insights via events and testimonials.
5. Monitoring, Data Collection and Reporting
- Implement 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
 - Number and percentage of practices supported to implement Best Practice Guidelines
 - Education and promotional activities delivered

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
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



Activity Demographics

Target Population Cohort

Permanent residents in residential aged care homes.

Indigenous Specific *

No

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



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



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

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 - 2026/27

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.

Indigenous Specific *

No

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



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



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

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

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 2026/27

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.

Indigenous Specific *

No

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



Activity Milestone Details/Duration

Activity Start Date

01/06/2024

Activity End Date

30/06/2025

Service Delivery Start Date

01/07/2024

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): 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



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

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).
- o 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.

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
Enhance capacity of the health and social care services, including workforce capability, to manage increase of older person population	144
Improve access to palliative and end-of-life care services	152
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
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



Activity Demographics

Target Population Cohort

Residents aged over 50 years

Indigenous Specific *

No

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

30/06/2026

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2026



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



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

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.
 - Update and develop population health resources for the community, including via HNC's website.

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
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

Indigenous Specific *

No

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

30/06/2026

Service Delivery Start Date

July 2019

Service Delivery End Date

June 2026



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



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 *

Modified



Activity Priorities and Description

Program Key Priority Area *

Population Health

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 - 2026/27

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

Indigenous Specific *

No

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, CHES Employment, Allied Health Association and other affiliated bodies



Activity Milestone Details/Duration

Activity Start Date

01/07/2019

Activity End Date

30/06/2025

Service Delivery Start Date

July 2019

Service Delivery End Date

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: 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



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 *

Modified



Activity Priorities and Description

Program Key Priority Area *

Population Health

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 - 2026/27

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

Indigenous Specific *

No

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

Consumers, first nations elders, Aboriginal community-controlled organisations (AMs, 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 e.g. 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 (e.g. 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

30/06/2026

Service Delivery Start Date

July 2019

Service Delivery End Date

30/06/2026



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



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 *

Modified



Activity Priorities and Description

Program Key Priority Area *

Aged Care

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 - 2026/27

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
Improve prevention and management of chronic disease, including management of risk factors, multimorbidity and polypharmacy	145
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 older

Indigenous Specific *

No

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

30/06/2025

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?

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

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.





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 *

Modified



Activity Priorities and Description

Program Key Priority Area *

Population Health

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 through 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 - 2026/27

Priorities

Priority	Page reference
Reduce alcohol consumption to reduce alcohol-related risks and hospitalisations	149
Facilitate opportunities for individuals and communities to participate in preventative health activities	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
Strengthen primary health care services, community health education and health literacy to reduce hospitalisations, particularly in the Mid North Coast area	152
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

Indigenous Specific *

No

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

30/06/2026

Service Delivery Start Date

July 2019

Service Delivery End Date

30/06/2026



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



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

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.

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 2026/27

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

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 NSW LHDs.

Collaboration

To be guided by the consultation process



Activity Milestone Details/Duration

Activity Start Date

01/07/2020

Activity End Date

30/06/2026

Service Delivery Start Date

01/07/2020

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?

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.



HSI - 1220 - System Integration and Stakeholder Engagement



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

1220

Activity Title *

System Integration and Stakeholder Engagement

Existing, Modified or New Activity *

Modified



Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

HSI, Population Health, System Integration, Support to General Practice

Aim of Activity *

Work with our consumers and clinical community to set the strategy for HNC to ensure decisions are patient centred and locally relevant.

Drive system improvements to deliver improved health outcomes for targeted populations

Description of Activity *

- Maintain community advisory structures.
 - Involve Clinical advisors and Clinical Councils in strategy direction.
 - Utilise community and clinician members in planning for commissioned activities.
 - Work with the Mid North Coast and Northern NSW LHD's.
- Collaborate with partners to implement system enablers including
- Improving communication between the health care home, hospitals, Aboriginal Health Services and the wider health care neighbourhood.
 - Addressing barriers to safe transfer of care, including for Aboriginal people
 - Increasing the uptake of shared care planning
 - Improving care pathways and referral processes, to make navigation easier
 - Empowering patients to engage with the health care team (including advanced care planning)
 - Engage with GPs, practice nurses, Aboriginal health workers, home based care providers, RACFs, NGOs and other stakeholders to

identify and address barriers to coordinated care.

- Hosting primary Health care reform forums and interactive discussions with local stakeholders to hear perspectives on primary care access, multidisciplinary care in general practice and aged care, chronic disease management and hospital avoidance programs.

Connected with LHD's to deliver education and referral pathways support to primary care workforce, particularly socialising new services operated from the recently expanded Tweed Valley Hospital.

Drive collaborative work to establish shared model of care for stable paediatric patients with ADHD. Inclusive of co-design and model of care development with GP's, specialist paediatric staff from the private and public sector, Aboriginal medical services and the Local Health Districts, development of a person and family centred service to significantly improve local access to care. Key activities include enabling GPs to safely manage ADHD prescriptions with support from paediatric specialists with a view to reduce long wait times for paediatric appointments, improve access to timely medication reviews and script renewals, and free up specialist capacity to focus on new and complex cases

Facilitated opportunities for all parts of the health workforce to connect at region-wide education forum event.

Support opportunities for local health workforce to increase proficiency working with priority populations, including Cultural Safety training, and education on delivery of gender affirming care.

Collaboration with peak advisory bodies, peak advocacy organisations, alliances and industry partners to align contributions and efforts to address local health workforce and community needs. This includes participation at national health workforce summits and alliances, representation at regional development forums, hosting primary care reform forums with national leaders and experts

Needs Assessment Priorities *

Needs Assessment

Needs Assessment 2024/25 - 2026/27

Priorities

Priority	Page reference
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

Indigenous Specific *

No

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

Regular Clinical Council, Community Advisory and Joint LHD Board and executive meetings

Collaboration

- Establishment of Combined and Whole of Region Advisory Councils,
 - Clinical Advisory Council (GP led)
 - Consumer Advisory Council

These amalgamated advisory councils have replaced the previous:

Community Advisory Groups:

- Community Engagement Advisory Council (with NNSW LHD)
- Community Reference Group (with MNC LHD – Coffs Clinical Network)
- Community Reference Group (with MNC LHD – Hastings Macleay Network)
- Ngayundi Aboriginal Health Council (with NNSW LHD) - Peak Aboriginal Advisory Group
- Mid North Coast Aboriginal Health Accord

Clinical Councils:

- Northern NSW
- Mid North Coast
- Hastings Macleay

The whole of region advisory councils are inclusive of a diverse group of representatives from LGBTQ+ communities, Aboriginal people, people from CALD backgrounds from across the entire region. The Clinical council has a multidisciplinary membership including representation from professions and disciplines including dentistry, psychology, physiotherapy, specialist medical services, children’s health, Aboriginal Health, general practice, nursing, mental health and pharmacy services.

- Establishment of Partnership agreement with Aboriginal Medical Services

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.

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

30/06/2026

Service Delivery Start Date

July 2019

Service Delivery End Date



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
