Core Funding

Activity Work Plan - 2025/26 - 2028/29

phn
DARLING DOWNS AND WEST MORETON
An Australian Government Initiative

Local Integrated Primary Health Care

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1. Primary Health Networks - MyMedicare

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Population Health

AIM OF ACTIVITY

This activity aims to promote improved safety and quality of health care and increase GP access to Commonwealth funded programs such as MyMedicare and related incentives through awareness and support of General Practice accreditation and Strengthening Medicare initiatives. It also supports the creation of resources and support mechanisms to assist General Practices achieve and maintain practice accreditation throughout each accreditation cycle.

DESCRIPTION OF ACTIVITY

Our region currently holds an approximate 90% General Practice accreditation rate with most of the Darling Downs and West Moreton PHN (DDWM PHN) region's Accredited General Practices being registered for MyMedicare.

Through the PHN's research, unaccredited practices have reported common explanations for non-accreditation as primarily related to being solo practitioners, approaching retirement, and/or related to financial imposts associated with the accreditation process.

Our PHN will support unaccredited general practices in the Darling Downs and West Moreton region to meet the minimum standards of safety and quality and becoming accredited under the National General Practice Accreditation Scheme (NGPA Scheme).

A targeted approach will be undertaken regarding MyMedicare engagement with General Practices, ensuring all practices have been equipped with the relevant resources to adopt MyMedicare in practice. This will be achieved through i) assisting unaccredited practices to overcome barriers to accreditation. and ii) ensuring GPs and all other General Practice staff are informed about the benefits of MyMedicare.

Overcoming Barriers to Accreditation:

- DDWM PHN will assist unaccredited practices in the Darling Downs and West Moreton PHN region to overcome barriers to accreditation that may prevent them from receiving access to Commonwealth funded programs such as MyMedicare. This approach will involve:
- Implementation of a Practice Placement Program, that pairs high-performing clinics with those seeking accreditation support, facilitating tailored, peer-to-peer guidance to achieve and sustain industry standards.
- Continuation of linking unaccredited practices with relevant national support systems for obtaining accreditation including RACGP.
- Providing relevant links to resources on the PHN website regarding MyMedicare.

Providing information about the benefits and requirements of MyMedicare:

- Our PHN will work to ensure that all General Practices in our region are informed about the benefits of MyMedicare. This will include supporting practices with the guidelines of MyMedicare linked programs and initiatives, digital and practical registration of MyMedicare and ongoing support for incentives as they are introduced. This support will be provided through multiple methods to ensure a broad reach, and include:
- Implementation of repeated communication campaigns to General Practices informing practices of MyMedicare through our General Practice specific newsletter "In Practice", Health Professional Chapter Meeting Updates and via the DDWM PHN website which is updated with relevant information linked to Services Australia to ensure currency and validity.
- Quarterly Practice Manager education sessions facilitated by the PHN, with relevant subject matter experts providing information to general practices on MyMedicare and the various incentives as they are introduced.

- Utilisation of the PHNs digital health team to work with General Practices to support practices with the digital requirements of MyMedicare. Examples of specific practice visit activity dedicated to the implementation of the MyMedicare program will include:
    - Supporting practices with PRODA/HPOS/Organisation Register for MyMedicare registration.
    - Data cleansing initiatives including identification of inactive patients, clinical coding and ensuring all fields are completed in Practice Management Systems.
    - Providing de-identified data reports about practice populations, reviewing patient populations to identify eligible patients for MyMedicare.
    - Reinforcement of the digital and practice support available to practice for preparing for MyMedicare changes through our dedicated Primary Care Liaison Officer Team, providing one-on-one practice visits to promote the resources developed through the National MyMedicare Implementation Group, some of which have been adapted and localised to our region e.g. PDSA activities.
    - Utilisation of the PHN's two GP Liaison Officers to engage with GP's about MyMedicare, providing a GP perspective on the benefits and optimal ways of working with MyMedicare. This is achieved through podcasts, face to face practice visits and GPLO engagement at various networking events.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

PRIORITY
Enablers
Partnerships and integration

2. General Practice In Aged Care Incentive (GPACI) - Capability Building

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Aged Care

AIM OF ACTIVITY

This activity supports General Practitioners (GPs), practices and/or Aboriginal Community Controlled Health Services (ACCHS) to be matched with residents in residential aged care homes (RACHs), to allow for residents to receive regular visits and care planning services. It aims to improve access to quality, proactive General Practice care for older people who live in Residential Aged Care Homes (RACHs) by incentivising proactive visits, regular, planned reviews and coordinated care planning to deliver improved continuity of care and reduce avoidable hospitalisations.

DESCRIPTION OF ACTIVITY

The Darling Downs and West Moreton PHN will adopt a place-based approach using multiple projects targeted to the needs of our region, ensuring a holistic approach to address the challenges of connecting GP's to RACH's.

To achieve the aims of the GPACI activity, our PHN will:

- Offer training and guidance to support GPs, primary care practices and RACH's/ACCHS to meet the activities eligibility and servicing requirements under GPACI. This includes providing written resources, and in-person or virtual support to these stakeholders during the initial registration processes to MyMedicare and understanding the benefits and requirements of the program, including incentive payments and ongoing support to assist with the coordination of care.
- Support GP practices with Quality Improvement activities to enhance health outcomes for eligible GPACI patients.
- Respond to local access issues as required to ensure sufficient primary care access for residents in aged care. This includes working with practices to identify and assist RACH residents who do not have a preferred GP in MyMedicare to register, and link with their chosen primary care provider. Provide targeted engagement toward General Practices and RACHs who have identified interest in the GPACI program but have expressed concerns whether the initiative will be financially viable for them. This approach aims to share success stories from practices where GPACI has worked well, work with both GPs and RACHs to collaboratively explore sustainable approaches to link and strengthen relationships between General Practices and RACHs and streamline processes for effective implementation and shared understanding of the program's value.
- Leverage collaborative, reciprocal, and formal arrangements with local Aboriginal Medical Services to identify culturally safe and appropriate pathways for Aboriginal and Torres Strait Islander RACH residents who request healthcare from within the PHN region. This may involve connecting identified residents in RACH's in with the closest AMS to help provide care and support in a culturally safe way.
- Undertake a series of workshops with key stakeholders and system partners including practices, RACHs and ACCHs to:
    - Foster collaboration and connection between stakeholders and support access to primary care services in our region
    - Inform the design, implementation and monitoring of the GPACI activity, and
    - Ensure targeted supports are culturally safe and appropriate, and provided in regions with the most need.
- Provide communications about the GPACI program to all RACHs and practices identified in our region, including email correspondence, website updates, and direct contact via phone or in-person visits to all practices in our region, including:
    - Information provided to practices includes an overview of the benefits of the GPACI program, information on how to participate and the provision of ongoing guidance to uplift capability in relation to the GPACI.

- Updates about the progress of the program will be communicated to primary care practices through direct outreach and regular communications channels (e.g. PHN websites, PHN network forums, etc.)

Our PHN will also recruit a dedicated staff member to:

- Implement strategies to develop and enhance relationships between General Practice and RACH's, and to increase access to primary health care within residential aged care homes.
- Develop strategies of alternative models of care to ensure access to primary care with available workforce.
- Develop resources for General Practitioners and GP Practices to improve understanding and awareness of the activity.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

PRIORITY
Enablers
Partnerships and integration

3. PHN Commissioning of Multidisciplinary Teams

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Population Health

AIM OF ACTIVITY

The purpose of this activity is to commission multidisciplinary health care teams to improve the management of chronic conditions and reduce avoidable hospitalisations in our region.

DESCRIPTION OF ACTIVITY

The PHN will continue to commission multidisciplinary team services through a place-based approach that responds to community needs within our region. Our PHN efforts will focus on underserviced or financially disadvantaged communities with a high prevalence of chronic conditions, in order to coordinate care for priority patients and mobilise social supports for patients at risk of chronic conditions. Specifically, the PHN will:

- Continue to utilise health intelligence, including utilising de-identified GP data and local hospital data, to refine and adjust multidisciplinary team project sites, and ensure MDT projects are addressing areas of need.

By using this health intelligence data, three priority rural locations were identified that contained at-risk patient cohorts within our region in the Lockyer Valley, South Burnett and Western Downs SA3s. Each area identified has demonstrated a high prevalence of chronic disease and hospitalisation rates, as well as limited access to existing chronic disease programs. These sites were also identified as areas with limited access to chronic conditions services.

These GP-Led multidisciplinary project teams within the Darling Downs and West Moreton region are:

- An arthritis multidisciplinary clinic in the South Burnett LGA.
- GP led chronic pain multidisciplinary clinic in the Lockyer Valley LGA.
- GP led cardiac and lung multidisciplinary clinic including echocardiography services in the Western Downs LGA

In addition, our PHN will:

- Continue supporting small general practices to respond to the dynamic workforce in rural and remote communities, to formalise new relationships with allied health providers, improving access to integrated care for underserved communities with limited workforce.
- Monitoring implementation of the activity utilising relevant outcome measures through robust reporting activities, regular monitoring and engagement meetings, and supporting project teams to adjust scope accordingly in response to dynamic environments.
- Uplifting reporting processes supported by data collection and data management practices, including both activity and outcome measures.
- Supporting commissioned project teams with a variety of multidisciplinary team professional development opportunities, including interactive workshops facilitated by subject matter experts.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

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Enablers
Priority health conditions
Partnerships and integration

4. Aged Care Clinical Referral Pathways

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Aged Care

AIM OF ACTIVITY

The aim of the Aged Care Clinical Referral Pathways activity is to support and enable health professionals to provide advice, referrals and connections for Australians into local health, support and aged care services in the Darling Downs and West Moreton Region using the HealthPathways digital tool.

DESCRIPTION OF ACTIVITY

The PHN will:

- Update and review existing aged care pathways to reflect contemporary best practice in the Older Persons Care space. This includes consultation with local primary care clinicians, other health, allied health, aged care providers and consumers and will identify current gaps and opportunities in the current model of care.
- Continue to develop, enhance and maintain clinical referral pathways for Older Persons care that support General Practice and other local health professionals to provide advice and referral options that are relevant to the needs of our region.
- Engaged General Practitioners and other suitable primary care providers as Clinical Editors to develop, review and/or update existing Aged Care clinical pathways to ensure alignment with the most up-to-date clinical guidance.
- Ensure that referrers use the correct assessment, management and on-referral guidance relevant to our region.
- Support increased awareness, use and integration of the aged care clinical pathways by local health care practitioners through activities such as:
    - Web-based promotion of HealthPathways via the PHN website, social media and various digital marketing e-newsletters targeted to health professionals.
    - Promotion of HealthPathways at events such as PHN meet and greets, bi-annual GP Education Red Ant Roundup symposiums and various GP and health professional educational workshops aimed at specific cohorts.
    - Delivery of PHN monthly webinars that will include information regarding HealthPathways aimed at General Practitioners and Allied Health professionals in our region.
    - Development of a podcast series targets for GPs, highlighting everyday clinical matters (including HealthPathways). and
    - Face-to-face visits with PHN Primary Care Liaison Officers, who will share HealthPathways information such as flyers and other printed resources during practice visits.

NEEDS ASSESSMENT PRIORITY

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Enablers
Care across the lifespan

5. System Integration

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Population Health

AIM OF ACTIVITY

This activity aims to partner with Hospital and Health Services and other system partners to initiate service integration opportunities that provide alternative health care avenues, reduce hospital presentations better suited to primary care, and assist in decreasing potentially preventable hospitalisations.

DESCRIPTION OF ACTIVITY

The PHN is undertaking a targeted, place-based review of its Core Flexible activities to align future investment and commissioning activities with current team-based models of care with clear, place-based outcomes recognising, that different commissioning approaches are required to reflect the unique needs and strengths of each community.

Building on established, place based multi-disciplinary team activities, this approach will enable people across each Local Government Area in our region to access locally tailored supports, underpinned by equitable and prioritised funding.

This review will ensure that our PHN continues to reduce service silos, centres care around individuals and prioritises preventive health care strategies, to improve health outcomes of local communities through integrated services and supports.

Commissioning will be guided by the PHN's Health Needs Assessment and data intelligence alongside strong sector consultation and multi-agency collaboration, with local priorities shaping service design. These services will then be delivered through coordinated, integrated models of care that bring high quality support closer to home.

It is well recognised that easing pressure on Emergency Departments and providing alternative, low-cost, accessible primary health care solutions are a priority. The PHN will explore alternative practices that have potential to minimise preventable hospitalisations and continue to support the positions of General Practice Liaison Officers to link hospitals directly with General Practices across the region. These positions aim to improve interface and collaborative partnerships between the health service and primary health care by providing input into the planning and development of services at the local level, and ensuring care is integrated across the entire patient journey and appreciating the position operates within a broader Hospital and Health Service (HHS) network of service delivery. These roles also aim to address workforce challenges and supports the junior doctor training pathway to increase General Practice workforce.

A further component of this activity will address gaps in access to timely, clinical care within Residential Aged Care Homes (RACHs) to reduce system pressures and prevent avoidable hospitalisations in the Toowoomba region. The model will strengthen primary care pathways, support early intervention, and improve care coordination for residents at risk of hospital presentation.

The PHN will partner with key stakeholders to co-design and commission targeted initiatives to reduce potentially preventable hospitalisations. Priority populations will include older people and those identified through hospital data as having high presentation rates, with a focus on conditions that can be effectively managed outside the acute setting. Activities will align with identified regional needs and the key actions of the Stronger for Life 2025–2030 strategy.

NEEDS ASSESSMENT PRIORITY

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ACTIVITY CONSULTATION AND COLLABORATION

CONSULTATION

To ensure the vulnerable groups in our region are identified and targeted, consultation with the following key stakeholders will be undertaken:

- QLD State and Federal Government
- Hospital and Health Services (DD and WM HHS)
- Queensland Ambulance Service
- Health Consumers Queensland
- Aboriginal and Torres Strait Islander Medical Services and ACCHOS
- Residential Aged Care Homes
- Homeless Shelters and Soup Kitchens
- Refugee support organisations
- General Practitioners and health professionals
- The Vacseen Project
- Disability services
- Community and religious groups

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6. Sustainable Primary Care

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Workforce

AIM OF ACTIVITY

This activity aims to analyse, develop and implement effective workforce solutions to support the healthcare needs of our PHN's population. The focus of this activity is to ensure that strategies are implemented to facilitate system wide approaches to solving regional workforce challenges and ensure recruitment and retention of a skilled, future-ready workforce through:

- Enabling better access to primary health care.
- Uplifting the quality of primary health care services.
- Addressing sustainability and viability challenges of general practice and the broader primary care workforce, and;
- Tackling workforce shortages at all stages of pipeline i.e. pre-training entry, during training and following training.

DESCRIPTION OF ACTIVITY

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Building on established, place based multi-disciplinary team activities, this approach will enable people across each Local Government Area in our region to access locally tailored supports, underpinned by equitable and prioritised funding.

This review will ensure that our PHN continues to reduce service silos, centres care around individuals and prioritises preventive health care strategies, to improve health outcomes of local communities through integrated services and supports.

Commissioning will be guided by the PHN's Health Needs Assessment and data intelligence alongside strong sector consultation and multi-agency collaboration, with local priorities shaping service design. These services will then be delivered through coordinated, integrated models of care that bring high quality support closer to home.

This activity includes a number of elements, including;

1. Co-designing and implementing a regional workforce plan: Collaborating with system partners and stakeholders to deliver multi-agency initiatives to address GP and other primary care workforce shortages, particularly in regional and remote areas within the region including:
    - the continuation of the General Practice Career Guide within the Darling Downs Health Service that focuses on:
        - Mentoring and supporting junior doctors with a career interest in General Practice.
        - Encouraging these doctors to stay rural and train as General Practitioners.
        - Works with system partners to support the training experience for junior doctors ensuring a seamless journey through their training pathway.
        - the delivery of a GP Business Support Series, targeting GP's and Business Owners.
        - Facilitating regular engagement meetings with system partners including universities, RACGP, ACCRM, Workforce Agencies and Primary Care providers to inform the regional workforce plan, associated activities and opportunities for multi-agency output.
2. Facilitating system wide workforce problem solving: The PHN will continue collaborating with and connecting health professionals together to develop and grow groups, to support place-based and system wide workforce initiatives, including:
    - Place based health care neighbourhoods.
    - Primary Care Collaboratives.

- Local General Practitioner, Practice Nurse and Allied Health networks.

Our PHN facilitates system wide approaches to problem-solving regional workforce challenges which include:

- Assessment of the viability and sustainability of local general practices in our region with a GP stratification project and subsequent scaled support.
- Initiating and supporting a GP Workforce Working Group to provide strategic advice on workforce initiatives (as per activity 1).
- Work in partnership with key stakeholders and system partners to implement our joint regional workforce plan to attract, retain and support primary care workforce, including encouraging medical student / junior doctors to choose general practice career pathways and supporting the General Practice registrar workforce through communities of practice (as per activity 1).
- Supporting communities in need to build capacity to attract and retain workforce.
- Implementing workforce strategies to attract allied health professionals to rural locations.
- Working with system partners to improve access to after hours in primary care and to reduce avoidable emergency department presentations.

3. Data reporting to inform workforce planning: The PHN will engage with health care professionals to enable up to date workforce reporting to the Department and other stakeholders to ensure timely responses to any shortages.

4. Supporting GP placements and pilot programs: The PHN will support relevant system partners to engage General Practices for student placements through promotion and information sharing. This activity also includes facilitating Multidisciplinary Teams Education sessions for Primary Health Care Providers to support current pilot projects and enhance team based care.

5. Delivering/Facilitating and or supporting education and training through the following ways:
    a. Providing education and training programs to ensure general practice staff and allied health have the skills required to support an integrated, person-centred team care approach.
    b. Implementing a region-wide education plan that addresses primary care training and development needs in context of Local Health Needs Assessment and Primary Care Reform Agenda through:
        - Delivering of practice based, local, and PHN region wide education and training initiatives and events based on regional health needs and priorities included an annual GP and Primary Care Education symposium and Allied Health information session.
        - Internal Capacity building PHN staff and external capability development for primary care workforce.
        - Upskilling and promoting Practice Nurses and Practice Managers to work in General Practice settings through quarterly breakfast meetings and monthly practice management education series.
        - Supporting General Practitioners and other Allied Health professionals through immersion and placement programs with health system partners to work at top of scope, including covering costs of transport, accommodation and income.

6. Expanding successful workforce models: The PHN will pilot place-based responses to workforce challenges in identified areas of need, including:
    - Trialling innovative models of practice/supervision to overcome isolation and make rural work attractive.
    - Leveraging technology to fill service gaps through telehealth and virtually connecting urban workforces to rural practices.
    - Co-design new models of care where professionals work to their full scope of practice and non-clinical staff are upskilled (e.g. telehealth, remote technology) to address gaps in rural primary care.
    - Supporting Team Based Care pilot projects
    - Hold quarterly practice nurse and practice manager education / training sessions
    - Ad-hoc training requests as they align with regional needs / demands.

7. Ongoing monitoring and identification of areas of need: Through the function of Primary Care Liaison Officers, the PHN will remain up to date with workforce issues as they arise, and coordinate responses with Health Workforce Queensland, RACGP/ACCRM Department of Health and other stakeholders as required.

8. Build cultural capability across the mainstream primary care workforce and support the Aboriginal Community Control Sector to attract and retain staff through the following activities:

- Provide primary care related scholarships to Aboriginal people to build a culturally appropriate, rural, mainstream primary care sector and Aboriginal Community Controlled Health Organisation workforce.
- Delivering cultural capability training to PHN commissioned service providers, including the development, implementation and evaluation of an online learning platform.

9. Delivery of activities to support primary care provider wellness: Wellness of primary care providers, particularly those servicing rural areas or vulnerable populations, is a priority for the DDWMPHN. Self care and mental health care will be supported through:

    - Mentoring and peer support programs for General Practice Owners / Supervisors, General Practitioners and General Practice Registrars to encourage more General Practitioners to stay and work in the region
    - Facilitating access to EAP programs, GP psychiatry support line and other self care supports for the primary care workforce
    - Facilitating Primary Care Chapter Networking Meetings to in local regions to support connection and collaboration at a local level.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

PRIORITY
Enablers
Partnerships and integration

7. PHN Clinical Referral Pathways

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Population Health

AIM OF ACTIVITY

This Activity aims to support access to the Clinical Pathways Referral tool by Primary Care Practitioners across the Darling Downs and West Moreton PHN region to improve the patient journey, as well as increasing practitioner capability and quality of care. This activity promotes best practice care and enhances clinician awareness of available referral options.

DESCRIPTION OF ACTIVITY

In collaboration with Darling Downs Health and West Moreton Hospital and Health Service, the PHN will continue to review, create, enhance and promote PHN Clinical Referral Pathways. Pages within the current solution HealthPathways, are localised and developed by local General Practitioners as the clinical editors and specialists and used in assessment, management and referral decisions.

The PHN will achieve the aims of this activity through:

- Broad consultation with local Primary Care clinicians, Allied Health, Aged Care and other providers about the gaps and opportunities for enhancement of existing pathways and models of care within our region.
- Develop, review and maintain clinical referral pathway content, ensuring they are up to date and fit for purpose.
- Improving collaboration and integration between the health system and other providers, and service systems.
- Increase awareness, engagement and use of clinical referral pathways by local health care practitioners (including Allied Health, Pharmacy and General Practice) within the Darling Downs and West Moreton regions.
    - This includes promotion at GP and Allied Health Education Events, with particular focus on topical referral pathways.
- Participation on Primary Health Integration Steering Committee meetings.
- Collaboration and sharing clinical referral pathway capabilities and achievements with other PHN Regions.
- Collaboration with Hospital Health Services to support the utilisation and uptake of HealthPathways within the HHS, to streamline and improve intersections between primary and tertiary care.

NEEDS ASSESSMENT PRIORITY

- Joint Regional Needs Assessment 2025/28

PRIORITY
Enablers
Partnerships and Integration

8. Priority Populations

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Population Health

AIM OF ACTIVITY

This activity aims to support vulnerable and marginalised individuals in our region, with a focus on improving outcomes for priority populations in particularly multicultural and Aboriginal and Torres Strait Islander individuals and families across the lifespan. Our region has a higher-than-average population of Aboriginal and Torres Strait Islander peoples, many of whom experience significantly poorer physical and mental health outcomes and lower life expectancy. Additionally, our region faces high infant and child mortality rates, underscoring the importance of culturally safe early intervention and support to improve lifelong health and wellbeing.

DESCRIPTION OF ACTIVITY

The PHN is undertaking a targeted, place-based review of its Core Flexible activities to align future investment and commissioning activities with current team-based models of care with clear, place-based outcomes recognising, that different commissioning approaches are required to reflect the unique needs and strengths of each community.

Building on established, place based multi-disciplinary team activities, this approach will enable people across each Local Government Area in our region to access locally tailored supports, underpinned by equitable and prioritised funding.

This review will ensure that our PHN continues to reduce service silos, centres care around individuals and prioritises preventive health care strategies, to improve health outcomes of local communities through integrated services and supports.

Commissioning will be guided by the PHN's Health Needs Assessment and data intelligence alongside strong sector consultation and multi-agency collaboration, with local priorities shaping service design. These services will then be delivered through coordinated, integrated models of care that bring high quality support closer to home.

To improve health outcomes for our region's priority populations, commissioned services will include culturally responsive, holistic, trauma informed and recovery orientated support services that address the social and emotional wellbeing needs of vulnerable people and communities with place based approaches to reduce health inequity for culturally and linguistically diverse families including interpreter health services as required.

NEEDS ASSESSMENT PRIORITY

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PRIORITY
Priority populations
Enablers

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9. Older People and Palliative Care

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Aged Care

AIM OF ACTIVITY

Our region has a growing demand for complex care and palliative care services and supports for individuals with life-limiting illnesses to receive care in the comfort of their own homes. Through the provision of outreach and innovative services, this activity aims to improve quality of life and dignity in the most appropriate setting for older people. The activity recognises the need for support to remain independent while maintaining choice and control around support needs.

DESCRIPTION OF ACTIVITY

The PHN is undertaking a targeted, place-based review of its Core Flexible activities to align future investment and commissioning activities with current team-based models of care with clear, place-based outcomes, recognising that different commissioning approaches are required to reflect the unique needs and strengths of each community.

Building on established, place based multi-disciplinary team activities, this approach will enable people across each Local Government Area in our region to access locally tailored supports, underpinned by equitable and prioritised funding.

This review will ensure that our PHN continues to reduce service silos, centres care around individuals and prioritises preventive health care strategies, to improve health outcomes of local communities through integrated services and supports.

Commissioning will be guided by the PHN's Health Needs Assessment and data intelligence alongside strong sector consultation and multi-agency collaboration, with local priorities shaping service design. These services will then be delivered through coordinated, integrated models of care that bring high quality support closer to home.

This particular activity assists older people to remain in their chosen place of residence and improve quality of life while partnering with service providers, carers, care agencies and care homes.

This is achieved through commissioned service delivery that provides non-acute care in an appropriate setting for older people, people who require support with high and complex needs, and/or palliation over and above what is currently provided through government funded services My Aged Care and/or Hospital and Health Services. A Nurse Practitioner (NP) care model is utilised to support residents in residential aged care homes (RACHs) with complex needs and assists GPs to facilitate early identification of deterioration and timely intervention for residents. This approach aims to support people who may otherwise require social admission to hospital or escalation to acute care and improving resident health outcomes, both in hours and in the after-hours space. In addition, RACH capability support is provided where possible.

NEEDS ASSESSMENT PRIORITY

- Joint Regional Needs Assessment 2025/28

PRIORITY
Enablers
Care across the lifespan

10. Multi disciplinary Team Care for Chronic Conditions

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Population Health

AIM OF ACTIVITY

This activity aims to reduce the impact of the most prevalent chronic conditions in our community via effective and efficient, goal-oriented, client-centred and evidence-based service delivery for clients who are either at risk of developing or already have a diagnosed chronic condition.

DESCRIPTION OF ACTIVITY

The PHN is undertaking a targeted, place-based review of its Core Flexible activities to align future investment and commissioning activities with current team-based models of care with clear, place-based outcomes recognising that different commissioning approaches are required to reflect the unique needs and strengths of each community.

Building on established, place based multi-disciplinary team activities, this approach will enable people across each Local Government Area in our region to access locally tailored supports, underpinned by equitable and prioritised funding.

This review will ensure that our PHN continues to reduce service silos, centres care around individuals and prioritises preventive health care strategies, to improve health outcomes of local communities through integrated services and supports.

Commissioning will be guided by the PHN's Health Needs Assessment and data intelligence alongside strong sector consultation and multi-agency collaboration, with local priorities shaping service design. These services will then be delivered through coordinated, integrated models of care that bring high quality support closer to home.

This particular activity has been designed using this place-based approach, developed in genuine partnership with system and community partners to ensure the unique characteristics, needs and assets of each community are reflected in the model of care.

Commissioning processes were informed by significant consultation with the sector, ensuring local voices and priorities shaped both the design and delivery of services across the region.

In response to the National Strategic Framework for Chronic Conditions, the PHN has aligned service delivery to include a focus on prevention, early intervention, care coordination and self-management — incorporating health promotion and literacy, self-management support and non-acute clinical interventions. Activities are further aligned to the Joint Regional Older Persons Strategy — Stronger for Life 2025–2030, to support people to live at home with coordinated care for longer.

The commissioned models provide holistic, wrap-around, multidisciplinary services for individuals with a rising risk of additional chronic conditions, those requiring higher levels of support, and those who would benefit from prevention and early intervention. Each model has been tailored to the place in which it operates, reflecting the distinct needs of local communities while maintaining consistency with regional and national strategic priorities.

In the Somerset and Southern Downs regions, commissioned services under this activity provide:

- Care Coordination: to maximise health literacy and access to wrap-around services in a timely manner in an appropriate environment
- Self-Management: Targeted self-management programs to improve the ability of clients to effectively manage their condition and reduce deterioration, exacerbation or complication of their chronic conditions which may require an acute response.
- Health promotion: to better manage risk factors associated with chronic conditions and to reduce the likelihood of converting these risk factors to a chronic condition e.g. increase physical activity, healthy eating choices which includes a behavioural change element, community projects to reduce obesity.

In the Western Downs, Goondiwindi and Inglewood regions commissioned services under this activity provide:

- Provision of services delivered in a GP led multidisciplinary team model by a range of allied health professionals (including but not limited to physiotherapists, podiatrists, exercise physiologists, therapy assistants, diabetes educators, nurses, occupational therapists, dietitians, respiratory nurses, or speech pathologists) and project officers.

Activities are directed across the lifespan in recognition of the impacts to health arising from risk factors prior to birth and throughout childhood including a focus on empowering people to self-manage their health. Darling Downs and West Moreton PHN will continue to partner with key providers to identify evidence-based programmes that target priority populations.

NEEDS ASSESSMENT PRIORITY

- Joint Regional Needs Assessment 2025/28

PRIORITY
Care across the lifespan
Priority health conditions

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11. Early Years

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Population Health

AIM OF ACTIVITY

This activity aims to reduce risk for vulnerable children and their carers and families with a particular focus on priority populations through integrated models of care that target those at-risk and provide health and wellbeing support, including local and regional health practitioners, community organisations and wraparound services that work with them.

The Darling Downs and West Moreton region has a higher birth and fertility rate than the Queensland state average, meaning investment in the health of our young community from preconception to early adulthood has a direct impact and correlation to healthier futures for our whole population.

Through the Early Years Strategy, the PHN is committed to implementing coordinated efforts across the healthcare system with our regional health partners, to ensure infants, children and young people get the right health care in the first days, months and years of life through well-coordinated, accessible and supportive services.

DESCRIPTION OF ACTIVITY

The PHN is undertaking a targeted, place-based review of its Core Flexible activities to align future investment and commissioning activities with current team-based models of care with clear, place-based outcomes, recognising that different commissioning approaches are required to reflect the unique needs and strengths of each community.

Building on established, place based multi-disciplinary team activities, this approach will enable people across each Local Government Area in our region to access locally tailored supports, underpinned by equitable and prioritised funding.

This review will ensure that our PHN continues to reduce service silos, centres care around individuals and prioritises preventive health care strategies, to improve health outcomes of local communities through integrated services and supports.

Commissioning will be guided by the PHN's Health Needs Assessment and data intelligence alongside strong sector consultation and multi-agency collaboration, with local priorities shaping service design. These services will then be delivered through coordinated, integrated models of care that bring high quality support closer to home.

By leveraging system partnerships and regional networks including key stakeholders supporting children and young people who are at risk of adverse health and wellbeing outcomes, Darling Downs and West Moreton PHN will consider enhancements to current mechanisms supporting the health of vulnerable children and young people, including Aboriginal and Torres Strait Islander and other priority populations and families. This activity will:

• Implement an organisational Early Years strategy, focused on the First 2000 days, to ensure an evidence-based, coordinated response.

• Partner with established place-based initiatives throughout the region with an aim to enhance the local community response when supporting families, children and young people.

• Explore opportunities for multicultural multidisciplinary, team-based care by understanding the cultural, linguistic and structural barriers.

• Provide perinatal mental health programs as preventative interventions that could have an impact on the development of bonding after birth and empower parents/caregivers to maximise child development.

• Enhance continuous upskilling of the primary care workforce to improve health outcomes during pregnancy and childhood.

• Explore whole-of-community programs to increase sense of wellbeing in children and their families, including resilience programs delivered within the school setting or within the community. Deliver youth specific sexual and reproductive health services and programs within targeted locations to increase engagement of vulnerable young people.

• Provide change for children and young people through a capability champion program providing innovative activities that ensures better health outcomes for children and their carers, contributing to their wellbeing, self-agency and efficacy.

NEEDS ASSESSMENT PRIORITY

- Joint Regional Needs Assessment 2025/28

PRIORITY
Priority populations
Care across the lifespan

ACTIVITY CONSULTATION AND COLLABORATION

CONSULTATION

Continued consultation and partnerships with regional and local providers and organisations, includes:

• Commissioned Service Providers
• Thriving Queensland Kids
• Aboriginal Medical Services and wrap around supports
• DDHHS and WMHHS
• Primary Care providers

12. Healthy Places

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Population Health

AIM OF ACTIVITY

This Activity aims to improve access to services and resources to increase and/or maintain health status and achieve equity of health outcomes for people who experience health disadvantage in our region. This includes Aboriginal and Torres Strait Islander people, multicultural communities, and people in rural and remote areas of our region who may experience barriers when accessing primary care services.

DESCRIPTION OF ACTIVITY

The PHN is undertaking a targeted, place-based review of its Core Flexible activities to align future investment and commissioning activities with current team-based models of care with clear, place-based outcomes recognising that different commissioning approaches are required to reflect the unique needs and strengths of each community.

Building on established, place based multi-disciplinary team activities, this approach will enable people across each Local Government Area in our region to access locally tailored supports, underpinned by equitable and prioritised funding.

This review will ensure that our PHN continues to reduce service silos, centres care around individuals and prioritises preventive health care strategies, to improve health outcomes of local communities through integrated services and supports.

Commissioning will be guided by the PHN's Health Needs Assessment and data intelligence alongside strong sector consultation and multi-agency collaboration, with local priorities shaping service design. These services will then be delivered through coordinated, integrated models of care that bring high quality support closer to home.

Evidence demonstrates that priority populations and rural and regional communities in our region experience disproportionate and enduring barriers to accessing the health and community services that they need. Difficulties in accessing primary health care may result in delays to early intervention or ongoing treatment, increased morbidity, increased need for hospitalisation and potentially premature deaths.

To address these needs, the PHN provides coordinated access to services that ensure equitable access to health care and community supports for priority populations to achieve better health and wellbeing outcomes, layering specific programs and projects through a co-ordinated and collaborative approach drawing upon data collected through placed based health needs assessments. This also includes providing targeted capability supports for primary care providers where specific gaps have been identified, that will have a direct link to strengthening the quality primary care services.

The PHN also coordinates the delivery of several chronic conditions multi-disciplinary, place based allied health services in rural and remote areas, including the rural towns of Goondiwindi, Inglewood and Chinchilla who experience workforce and access challenges.

In addition, this Activity incorporates the work of the Regional Health Collaborative (RHC), established through the partnership of Darling Downs Health, West Moreton Health and the DDWMPHN. The RHC operates to deliver integrated, system-wide health reform at the local level.

The Collaborative works to formalise coordination of the regional health needs assessment, planning, and coordination activities to identify and address priority health challenges that cannot be effectively resolved by individual organisations.

NEEDS ASSESSMENT PRIORITY

- Joint Regional Needs Assessment 2025/28

PRIORITY
Priority populations
Enablers
Priority health conditions

13. Dementia Consumer Pathway Resource

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Population Health

AIM OF ACTIVITY

The aim of this activity is to develop resources that support people living with dementia to live well in their own homes and community. These resources will enhance the care and support available to people living with mild cognitive impairment or dementia and support their carers and families awareness of and to make informed choices about health and aged care services that may be of benefit to them.

DESCRIPTION OF ACTIVITY

The PHN will develop, review, maintain and enhance localised consumer resources through engagement with Dementia Australia. These resources will be consumer-focused and detail the care and support available for people living with dementia, their carers and families, in their local area, including local, state and federal government, private sector and non-government community-based support.

In addition, our PHN has developed and published an Elders Care Journal in codesign with local Elders in the West Moreton region, and is developing a journal in codesign with Darling Downs Elders that will provide a way for older people with mild cognitive impairment (and their carers) to keep track of appointments, medications and their emotional wellbeing.

We will also work with other priority populations in our region, including local Aboriginal and Torres Strait Islander, LGBTIQ+ and multicultural communities to ensure that the journal is culturally appropriate and representative for the various priority population cohorts.

NEEDS ASSESSMENT PRIORITY

- Joint Regional Needs Assessment 2025/28

PRIORITY
Enablers
Care across the lifespan

ACTIVITY CONSULTATION AND COLLABORATION

CONSULTATION

The Dementia Consumer Resources have been developed with input from Dementia Australia to ensure the resources are both nationally consistent at a high level and reflective of individual services and supports within our PHN region. The consultation with Dementia Australia will also extend to people living with dementia, their carers, friends and families and specifically identify what information they would find useful during or immediately after dementia diagnosis, and what could be incorporated in consumer resources.

Consultation may also include discussions with:

- Dementia peak bodies as appropriate such as Carers Australia, Dementia Support Australia, Dementia Training Australia and the Australian Dementia Network (ADNeT)
- Consumer Groups and Local Networks
- Hubs and Neighbour Centres
- Local Dementia Collaborative

14. Dementia Clinical Referral Pathways

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Population Health

AIM OF ACTIVITY

The aim of the Dementia Clinical Referral Pathways activity is to support and enable health professionals to provide advice, referrals and connections for Australians with dementia to local health and dementia support services in the Darling Downs and West Moreton Region.

DESCRIPTION OF ACTIVITY

The PHN will:

- Continue to work with Dementia Australia to ensure specific support and referral pathways reflect emerging best practice, and appropriate services and supports within the region that allow people living with dementia and their carers and families to live well in the community.
- Continue to develop, enhance and maintain clinical referral pathways for people living with dementia that support General Practice and other local health professionals to provide advice and referral options that are relevant to the needs of our region. This includes consultation with local primary care clinicians, other health, allied health, aged care providers and consumers and will identify current gaps and opportunities in the current model of care.
- Engage General Practitioners and other primary care providers as Clinical Editors to develop, review and/or update existing Dementia Clinical Pathways to ensure alignment with the most up-to-date clinical guidance
- Support increased awareness, use and integration of Dementia Clinical Referral Pathways by local practitioners through activities such as:
    - Web-based promotion of HealthPathways via the PHN website, social media and various digital marketing e-newsletters targeted to health professionals.
    - Promotion of HealthPathways at events such as PHN Meet and Greets, bi-annual GP Education Red Ant Roundup Symposiums and various GP and health professional educational workshops aimed at specific cohorts.
    - Delivery of PHN monthly webinars that will include information regarding HealthPathways aimed at General Practitioners and Allied Health professionals in our region.
    - Development of a podcast series targets for GPs, highlighting everyday clinical matters (including HealthPathways).
    - Face-to-face visits with PHN Primary Care Liaison Officers, who share HealthPathways information such as flyers and other printed resources during practice visits.

NEEDS ASSESSMENT PRIORITY

- Joint Regional Needs Assessment 2025/28

PRIORITY
Enablers
Partnerships and integration

15. Primary Care Engagement, Education, Support & Training Development

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Workforce

AIM OF ACTIVITY

This activity aims to address key priority areas by supporting general practices and other primary care health professionals to deliver high quality, safe, evidence-based care to their communities. This will be achieved through engagement, education, support and training development and focus on the following priorities:

- System response to workforce challenges
- General practice sustainability and viability
- Health system integration
- Modernising primary care through quality improvement and digital innovation
- General practice disaster preparedness

This will be achieved through:

- Clinical engagement and support
- System leadership
- Primary care capability building

DESCRIPTION OF ACTIVITY

The PHN's Primary Care Team will achieve these aims through:

1. System response to workforce challenges:

The PHN will aim to alleviate workforce shortages by supporting recruitment and retention of a skilled, future-ready workforce, through:

- Implementation and ongoing refinement of regional workforce plan
- Facilitation of system wide problem solving to address workforce challenges including ongoing engagement with system partners and stakeholders to inform need
- Utilisation of and supporting of data and health intelligence reporting to inform planning
- Facilitation of GP Pilot Programs and supporting GP placements
- Delivery of education and training to build integrated care skills
- Expansion of successful workforce models
- Supporting the utilisation of WIP in general practice
- Supporting UCC to ensure workforce development

2. General practice sustainability and viability

The PHN will ensure the long term sustainability and effective operations of general practices, and enhance access to quality services through strengthened business models, improved operational efficiency, and workforce and funding stability, through:

- Adoption and implementation of evidence based care / funding models through MDT funding, WIP etc.
- Facilitation of training for integrated, team based care
- Delivery of a GP Business series
- Support of the co-design of and implementation of pilot rural models of care
- Promotion of provider wellbeing including EAP and other mental health resources
- Improved access to after hours services to reduce burden on emergency department

- Implementation of Medicare Taskforce outcomes including voluntary patient registration and associated programs.

3. Health system integration

The PHN will support an integrated primary care sector to improve health outcomes, enhance patient experience, and increase the efficiency and effectiveness of the health system, with better coordination of care, streamlined communication between providers, and a comprehensive approach to addressing patients health needs, through;

- Increasing stakeholder capacity in workforce planning, sustainability and care models through GP and Allied health education
- Increasing stakeholder capacity to co-deliver evidence based care models
- Aligning with PHN teams on workforce and sustainability goals
- Identify service delivery gaps and manage the commissioning process for UCCs and other primary health care services.
- Supporting the roll out of the National Allied Health Engagement Framework

4. Modernising primary care via QI and digtial innovation

- The PHN will support the provision of high quality and innovative primary care, with safe, consistend and data driven care, through;
- Conducting a GP readiness and QI need assessment and subsequent development of a GP stratification system
- Supporting general practice change management including the roll out of Primary Sense and related QI programs
- Supporting primary care to improve IT infrastructure and digital capability
- Promoting digital health tools and use of health data through various digital health upskilling workshops
- Supporting practice accreditation, after hours access, IT uplift and digital reform
- Supporting the enablement of interoperability and information sharing pilots and programs inlcuding but not limited to PCA and MyHealthRecord

5. General practice disaster preparedness

The PHN will ensure preparedness and support continity of essential primary health care services, with minimal disruption to patient care during emergency events (where possible), through;

- Publication and ongoing update of PHN Emergency Response Action Plan and Framework and associated projects involved within framework
- Facilitating a coordinated system response to crises with relevant stakeholders and system partners
- Supporting practices to develop business continuity and disaster plans
- Supporting regional disaster management planning
- Actively engaging in the coordination of region wide disaster response plans with regular communication with external stakeholders including LDMGs, DDMGs, PHUs etc.
- Creating response protocols
- Building regional primary care responses
- Participation in the State Wide Disaster Management Community of Practice with other PHNs

6. Emergency responsiveness

- The PHN works with primary care providers to ensure the region is supported through emergencies through:
- Supporting practices to develop business continuity and disaster management plans
- Funding Emergency Response Planning tools for eligible practices to support business continuity in times of disaster
- Developing and implementing a local PHN Disaster Management Framework
- Participating in a state wide Disaster Management Community of Practice with Queensland PHNs
- Developing a region wide, primary care response to crises and natural disasters.

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NEEDS ASSESSMENT PRIORITY

- Joint Regional Needs Assessment 2025/28

PRIORITY
Enablers
Priority health conditions

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16. Health Systems Improvement

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Population Health

AIM OF ACTIVITY

This Activity aims to provide the resourcing required to:

- Scope, develop, commission, manage, monitor and evaluate activities.
- Complete population health planning including Health Needs Assessment.
- Provide stakeholder engagement and support across health care in the region to identify and design solutions to address relevant health issues.
- Collaborate with regional health services to improve integrated care pathways.
- Ensure PHN staff are appropriately trained, including cultural safety and awareness.
- Manage operational and reporting obligation of the PHN.

DESCRIPTION OF ACTIVITY

Elements of this activity include:

1. Population Health Planning

- Data analysis using multiple qualitative and quantitative platforms such as consumer/ community and stakeholder consultation, general practice information and data, hospital and health services, Departmental data sources, to determine local priorities and potential actions.
- Ongoing review and analysis of data elements for health needs and service gaps with quarterly Health Needs Assessment updates

2. Stakeholder Engagement

- Co-designing activities to address identified needs.
- Consultation for evaluation of implemented activities.
- Consideration for an on-line platform for real-time feedback opportunities.
- Community education and health literacy events.
- Proactively managing relationships with key stakeholders such as Public Health Units, Hospital and Health Services, Other PHNs, Regional Councils and Education providers.
- Membership with community organisations.

3. Health Promotion

- Multi-modal communication platforms including social media
- Health promotion, screening and awareness campaigns

4. Quality Improvement Projects and Education

- Providing education to primary care providers including allied health, pharmacy and general practice
- Consideration to partnerships for annual medical conferences
- Partnering to develop, implement and evaluate innovative models of care for primary care providers including allied health, pharmacy and general practices

5. Project Development and Management

- Developing mechanisms to improve coordination of care
- Ensuring activity development aligns with priorities identified through the Health Needs Assessment
- Monitoring to ensure service is value for money and maintains effectiveness and efficiencies in service provision
- Partnering to develop appropriate outcome measures that demonstrate health care improvements and hospital avoidance initiatives
- Developing partnerships to support a coordinated approach to health care delivery

7. Commissioning Support

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- Following all elements of a quality commissioning framework
- Development of outcome-based commissioning
- Evidence-based service planning
- Procurement and monitoring
- Completing decommissioning impact assessments

8. Performance Management and Compliance

- Maintenance of organisational legislative compliance
- Development of quality management systems
- Ongoing monitoring, evaluation and reporting for Department of Health deliverables

9. Primary Care Support

- Resourcing of primary care engagement team
- Support to allied health service providers, general practices and pharmacies including education and linkage to other local primary care providers and system partners
- Service integration and partnerships
- Delivery of education to primary care providers through scholarships guided by annual Training Needs Analysis and the PHN identified priorities guide and delivered in collaboration with Health Workforce Queensland.
- Support wellness of primary care providers, particularly those servicing rural areas or vulnerable populations. Wellness activities are incorporated within key events such as the Goondiwindi Muster, Dalby Medical Conference and the Red Ant Round-Up Medical Conference.
- Providing Employee Assistance Programs and GP Psychiatry Support Lines to general practice staff

10. Operations

- Appropriate oversight of financial and budgetary matters
- Human resource management and staff performance and development

11. Identification of Workforce Gaps and Development of Local Workforce Plan

- Partnership with Health Workforce Queensland to analyse the workforce needs for the PHN region
- Partnership with Queensland PHN's to input to the National Workforce Prioritisation Project to address GP registrar placements and subsequent workforce pipeline.

12. Enhancing networks and supports for existing primary care providers

- Continuation of networking groups for all primary care professional groups in multiple Local Government Areas, including:
    - Interdisciplinary local health networks with RACH, hospital and primary care stakeholders
    - General Practice Chapters/network
    - Practice nurse networks
    - Practice manager networks
    - Allied health professional networks
    - Online networking groups are being scoped

NEEDS ASSESSMENT PRIORITY

- Joint Regional Needs Assessment 2025/28

PRIORITY
Enablers
Partnerships and integration

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17. Emergency Preparedness

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Population Health

AIM OF ACTIVITY

The aim of this activity is to strengthen the PHNs capacity to effectively manage emergency preparedness, planning, and coordination across primary care within the Darling Downs and West Moreton region. Through this work, our PHN will build a more resilient primary care sector that can respond quickly and effectively to a range of emergency scenarios, ensuring continuity of care and minimising the health impacts on the community.

DESCRIPTION OF ACTIVITY

To strengthen disaster preparedness and planning in our region, our PHN will:

- Implement and maintain up to date emergency preparedness protocols aligned with the Emergency Preparedness Guidelines provided by the Department. These protocols will be reviewed and updated regularly to ensure they reflect current best practices, emerging risks and State and Federal protocols.
- Conduct proactive engagement with key local and district stakeholders such as general practices, local health districts, LDMGs, DDMGs, emergency services, Urgent Care Clinics, public health units, and community health organisations to support collaborative planning and disaster response efforts. Regular communication and coordinated planning with these stakeholders will strengthen local readiness and ensure an aligned approach to emergency situations.
- Integrate and coordinate local health services to support a region-wide response in the event of natural disasters (e.g. bushfires, floods) or public health emergencies (e.g. pandemics, disease outbreaks). This includes ensuring that primary care services are prepared to respond effectively and continue delivering essential healthcare during emergencies.
- Ensure DDWM PHN website is maintained to publicise role in emergency planning, preparedness and coordination including information and links to resources to support primary care in emergency preparedness.
- Support general practices in the region with access to Emergency Response Planning Tool platforms, to ensure primary care are proactive and able to respond to emergency situations.

NEEDS ASSESSMENT PRIORITY

- Joint Regional Needs Assessment 2025/28

PRIORITY
Enablers
Partnerships and integration

18. COVID-19 Vulnerable Vaccination Population - COVID-19 Primary Care Support

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Population Health

AIM OF ACTIVITY

This Activity aims to provide support and facilitate local solutions to support vaccination of vulnerable populations who may have difficulty in accessing COVID-19 vaccination facilities or have low literacy and/or vaccine hesitancy.

DESCRIPTION OF ACTIVITY

This activity involves responding to general and policy-related enquiries about immunisations, facilitating communication between primary care providers, Residential Aged Care Homes (RACHs) and the Department, and sharing Departmental messages as required.

It also includes supporting the connection of priority populations with the primary care sector, offering strategic advice on local issues, and disseminating immunisation information and resources.

Our PHN will continue to:

- Provide guidance and expert advice to General Practices, Aboriginal Community Controlled Health Services (ACCHs), Residential Aged Care Homes (RACH), disability accommodation facilities and governments on local needs and issues.
- Manage enquiries from primary care providers within their region regarding immunisations , ensuring timely and accurate information is provided to support effective program delivery.

This Activity will also support primary care providers and organisations to improve access to immunisation for priority populations in the region, using localised solutions relevant to regional need. These activities will include funding to:

- Development / Distribution of immunisation resources to improve vaccine literacy for the primary care sector and broader community. This may include:
    - community activities aimed at improving community members' understanding and knowledge of pathways to immunisation service providers,
    - Education or skill development for primary health care workforce (immunisation training), and
    - Support the uptake of immunisation in our region through targeted Quality Improvement campaigns around vaccination, including the identification and re-call/remind patients when they are overdue for vaccinations.

NEEDS ASSESSMENT PRIORITY

- Joint Regional Needs Assessment 2025/28

PRIORITY
Enablers
Partnerships and integration

ACTIVITY CONSULTATION AND COLLABORATION

CONSULTATION

To ensure the vulnerable groups in our region are identified and targeted, consultation with the following key stakeholders will be undertaken:

• Darling Downs Health and West Moreton Hospital and Health Service

• West Moreton Hospital and Health Service

- Residential Aged Care Facilities
- Homeless Shelters and Soup Kitchens
- Agricultural employers who engage high volumes of migrant workers
- Refugee support organisations
- General Practitioners and health professionals
- The Vacseen Project
- Disability services
- Community and religious groups
- Other key stakeholders.

E: info@ddwmphn.com.au www.ddwmphn.com.au

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DARLING DOWNS
AND WEST MORETON
An Australian Government Initiative

E: info@ddwmphn.com.au

P: 07 4615 0900

W: www.ddwmphn.com.au

Darling Downs Office

Level 1, 162 Hume Street
(PO Box 81),
Toowoomba QLD 4350

West Moreton Office

Level 5, World Knowledge Centre,
37 Sinnathamby Boulevard,
Springfield Central QLD 4300

Local Integrated
Primary Health Care

ABN 51 605 975 602