

Brisbane North - Core Funding

2025/26 - 2028/29

Activity Summary View



CCP - 1000 - 1.0 - Care Collective



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CCP

Activity Number *

1000

Activity Title *

1.0 - Care Collective

Existing, Modified or New Activity *

New Activity



Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

Emergency Departments (EDs) in North Brisbane and Moreton Bay regions are facing unprecedented growth in demand as the population increases in the Southeast corner of Queensland, coupled with an ageing population requiring better coordination of care in the community and assistance to navigate available options including virtual EDs and Urgent Care Centres to prevent unnecessary presentations to EDs and inappropriate use of acute services.

Within the local Caboolture and Redcliffe regions there is a small cohort of patients who account for a disproportionate number of ED presentations. Frequent Presentation (FP) to ED is typically seen among those patients living with chronic and complex conditions often without a regular general practitioner (GP) relationship or robust and rapid access to a GP, particular after hours

and among those without adequate social support. Frequent presenters also use more healthcare services across hospital and non-hospital services and experience a distinct lack of coordination between these services.

Emergency departments in Caboolture and Redcliffe face rising demand, particularly from a small group of patients who present frequently with chronic and complex conditions.

Many of these patients:

- live with Chronic Obstructive Pulmonary Disease (COPD), heart failure, or debility (e.g. frailty scores of 5+, behaviour related to dementia or falls, mobility issues)
- lack strong links to a GP or coordinated access to care
- experience gaps between hospital and community services.

The Care Collective helps fill these gaps by embedding Complex Care Coordinators (CCCs) in general practice, where they can provide proactive, ongoing care.

The aim of this activity is to reduce emergency department presentations and unplanned admissions and improve patient outcomes and patient experience for frequent presenters to emergency departments living with chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and conditions contributing to debility (e.g. dementia and falls), through the provision of complex care coordination embedded within general practices in Caboolture and Redcliffe.

Description of Activity *

The Care Collective strengthens connections among service providers and boosts general practice capacity in coordinating care for individuals with chronic health conditions.

This is achieved by funding practice nurses to upskill as Complex Care Coordinators (CCCs), who guide clients through their care journey, support client education, provide appropriate referrals to community services, and improve communication among service providers.

The Care Collective program is operational in Caboolture and Redcliffe regions, involving 16 general practices. Care Collective provides training and mentoring for the nurses, enabling them to enhance their knowledge of care coordination.

A Community of Practice provides the opportunity for CCCs to share knowledge and experience and meet other service providers in the region. CCCs are encouraged to embrace the 'Collective' nature of the program and utilise the knowledge of those they work alongside.

The program's open-ended structure allows Complex Care Coordinators to engage holistically and intensively with clients, filling key system gaps and building capacity of general practice to manage complex chronic disease clients. The enhanced provider connections support better health outcomes and lower unnecessary health service use by the cohort.

Innovative features of the Care Collective include:

- Embedding CCCs within general practice settings, rather than using external providers
- Delivering holistic care planning that spans primary, hospital, and community care
- Leveraging community of practice models for peer support and workforce development
- Using GP data systems and ED referrals for proactive identification

The tasks within this activity include:

1. Referrals from Caboolture and Redcliffe emergency departments.
2. Identification of eligible patients within participating practices.
3. Holistic assessment of patients.
4. Development of care plans.
5. Provision of clinical education, support and coaching.
6. Care coordination of services and supports.
7. Communication on patient progress to the GP. Target Cohort: The Care Collective supports individuals living with Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), or debility (e.g. frailty scores of 5+, behaviour related to dementia or falls, mobility issues), who are frequent or likely frequent presenters to the Caboolture and Redcliffe Hospital Emergency Departments.

All participants must be linked with an existing general practice within the catchment area.

Complex Care Coordinators will use practice data systems to identify and enrol new patients who may benefit from the program. Additional eligible patients may also be referred or enrolled through the Team Care Coordination program, hospital discharge planners, nurse navigators at Caboolture and Redcliffe hospitals, and other community, hospital, or healthcare service pathways.

Target Cohort:

The Care Collective supports individuals living with Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), or debility (e.g. frailty scores of 5+, behaviour related to dementia or falls, mobility issues), who are frequent or likely frequent presenters to the Caboolture and Redcliffe Hospital Emergency Departments.

All participants must be linked with an existing general practice within the catchment area. Complex Care Coordinators will use practice data systems to identify and enrol new patients who may benefit from the program.

Additional eligible patients may also be referred or enrolled through the Team Care Coordination program, hospital discharge planners, nurse navigators at Caboolture and Redcliffe hospitals, and other community, hospital, or healthcare service pathways.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Population Health - Health Needs Level 1	2-3
Population Health - Service Needs Level 1	5
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

The Care Collective supports individuals living with Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), or debility (e.g. frailty scores of 5+, behaviour related to dementia or falls, mobility issues), who are frequent or likely frequent presenters to the Caboolture and Redcliffe Hospital Emergency Departments.

All participants must be linked with an existing general practice within the catchment area. Complex Care Coordinators will use practice data systems to identify and enrol new patients who may benefit from the program.

Additional eligible patients may also be referred or enrolled through the Team Care Coordination program, hospital discharge planners, nurse navigators at Caboolture and Redcliffe hospitals, and other community, hospital, or healthcare service pathways.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

No

SA3 Name	SA3 Code
Redcliffe	31305
Caboolture Hinterland	31303
Caboolture	31302



Activity Consultation and Collaboration

Consultation

The Care Collective is a program designed by the Health Alliance, a joint initiative of Brisbane North PHN and Metro North Health. The program was designed in response to challenges with coordination and integration in the health system.

The Care Collective integrates and enhances existing hospital and Primary Health Network (PHN) pathways with Complex Care Coordinator (CCC) roles in General Practice to support better health outcomes and lower unnecessary health service use. It is targeted at people living with chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and conditions that lead to presentations for debility (e.g. dementia and falls).

Relationship building remains the key component of the Care Collective model, requiring continual engagement with Caboolture and Redcliffe Hospital staff, general practices, Complex Care Coordinators, and other referral agencies.

The introduction of Virtual ED, Satellite Hospitals, Rapid Access to Community Care and the Morayfield Accident and Illness Clinic require consultation to review where they will fit in the Care Collective model.

Collaboration

The Care Collective is jointly funded by Metro North Health and the Commonwealth Department of Health, Disability and Ageing and managed by the Health Alliance.

The Institute for Urban Indigenous Health (IUIH) was involved in the co-design process and project governance to ensure that culturally appropriate pathways for Aboriginal and Torres Strait Islanders are developed. Further collaboration includes workshops, and individual consultations.

This work will be part of the existing governance mechanism of the Joint Operations Group between Metro North Health, Brisbane North PHN, and the Health Alliance.



Activity Milestone Details/Duration

Activity Start Date

03/09/2023

Activity End Date

29/06/2026

Service Delivery Start Date**Service Delivery End Date****Other Relevant Milestones****Activity Commissioning**

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: 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?

Yes

Decommissioning

Yes

Decommissioning details?

Funding for this service finishes on 30 June 2026. All 16 practices have been notified and provided with an off-boarding checklist to assist with returning patients to regular care. The final Community of Practice will focus on support for off boarding. Referral sources (esp. emergency department and discharge coordinators) will be notified.

Co-design or co-commissioning comments

The Care Collective is jointly funded by Metro North Health and the Commonwealth Department of Health, Disability and Ageing and managed by the Health Alliance.

The Care Collective is a program designed by the Health Alliance, a joint initiative of Brisbane North PHN and Metro North Health. The program was designed in response to challenges with coordination and integration in the health system. The Care Collective integrates and enhances existing hospital and Primary Health Network (PHN) pathways with Complex Care Coordinator (CCC) roles in General Practice to support better health outcomes and lower unnecessary health service use.

It is targeted at people living with chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and conditions that lead to presentations for debility (e.g. dementia and falls).

Relationship building remains the key component of the Care Collective model, requiring continual engagement with Caboolture and Redcliffe Hospital staff, general practices, Complex Care Coordinators, and other referral agencies. The introduction of Virtual ED, Satellite Hospitals, Rapid Access to Community Care and the Morayfield Accident and Illness Clinic require consultation to review where they will fit in the Care Collective model.



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Care Collective Program	\$0.00	\$650,000.00	\$0.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Care Collective Program	\$0.00	\$650,000.00	\$0.00	\$0.00	\$0.00	\$650,000.00
Total	\$0.00	\$650,000.00	\$0.00	\$0.00	\$0.00	\$650,000.00

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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CMDT-Admin - 1100 - CMDT 1.1 - Commissioning multi-disciplinary teams - Admin



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CMDT-Admin

Activity Number *

1100

Activity Title *

CMDT 1.1 - Commissioning multi-disciplinary teams - Admin

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area ***Other Program Key Priority Area Description****Aim of Activity *****Description of Activity *****Needs Assessment Priorities *****Needs Assessment****Priorities**



Activity Demographics

Target Population Cohort

In Scope AOD Treatment Type *

Indigenous Specific *

Indigenous Specific Comments

Coverage

Whole Region



Activity Consultation and Collaboration

Consultation

Collaboration



Activity Milestone Details/Duration

Activity Start Date

Activity End Date

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

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

Is this activity being co-designed?

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

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

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

Decommissioning

Decommissioning details?

Co-design or co-commissioning comments



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Commissioning Multidisciplinary Teams -	\$162,654.00	\$234,373.78	\$238,800.00	\$62,847.00	\$0.00

Administration					
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Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Commissioning Multidisciplinary Teams - Administration	\$162,654.00	\$234,373.78	\$238,800.00	\$62,847.00	\$0.00	\$698,674.78
Total	\$162,654.00	\$234,373.78	\$238,800.00	\$62,847.00	\$0.00	\$698,674.78

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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MyM - 1000 - MyM 1.0 - My Medicare



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

MyM

Activity Number *

1000

Activity Title *

MyM 1.0 - My Medicare

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area *

Workforce

Other Program Key Priority Area Description**Aim of Activity ***

To ensure that support for meeting accreditation requirements is readily available to general practices, whether they are undertaking accreditation for the first time or undergoing re-accreditation. The aim and activities of this program will focus on meeting Departmental key performance indicators (KPIs) and promoting continuous quality improvement in general practice.

KPI 1: Eligible unaccredited practices are informed about the benefits of accreditation.

Target: 100% of identified unaccredited eligible practices are provided with communications.

KPI 2: Resources and guidance are provided to eligible practices with an aim to increase and/or maintain accreditation.

Target: 100% of identified eligible practices are offered resources and support mechanisms, with additional support provided as needed.

Under the MyMedicare reform, PHNs are required to assist unaccredited practices in their regions to achieve and maintain accreditation as part of the National General Practice Accreditation (NGPA) scheme.

Accreditation is a prerequisite for participation in MyMedicare and other Commonwealth incentives programs. In order for a General Practice or health service to seek accreditation, they must:

1. Provide comprehensive, patient-centred, whole-person and continuous care; and
2. Predominantly* offer general practice services.
3. Be eligible to be accredited as a General Practice.

*More than 50% of the practice GP's clinical time is general practice services in nature, and more than 50% of services for which Medicare benefits are claimed or could be claimed (from that practice) are in general practice (RACGP).

Description of Activity *

Brisbane North PHN worked with a consultant in 2024-2025 to conduct a comprehensive review of its current accreditation support processes.

The review included examining the PHN's current processes, comparing them with those of other PHNs, and ensuring that there is no duplication of services offered by accreditation providers such as QPA and AGPAL.

Additionally, the consultant was tasked with reviewing the new accreditation requirements under MyMedicare and suggesting ways the PHN can support unaccredited practices, particularly small practices, who may wish to undergo accreditation, as well as supporting practices with re-accreditation.

The consultant proposed a strategy which was refined and adapted by the Primary Care accreditation support team, resulting in the Brisbane North PHN's Accreditation Support Strategy 2025.

Under the Accreditation Support Strategy, the PHN's activities now include:

1. Strengthening data management processes to generate insights needed to monitor accreditation status
2. Enabling and supporting practices to navigate to existing accreditation resources from official evidence-based sources
3. Communicating effectively with practices to manage change or updates on the standards via the PHN's website and newsletters
4. Providing tiered levels of accreditation support to general practice so that all practices in the region are aware of the PHN support available and Departmental KPIs are met.

The outputs/deliverables of this accreditation support activity are:

- A practice accreditation database using Power BI, known as a traffic light reporting system to track accreditation status within the region
- A practice navigation process to new accreditation resources or changes to the RACGP's Accreditation standards
- A support process and activities for new practices and practices undertaking accreditation for the first time or practices undergoing re-accreditation
- Regular stakeholder meetings with accreditation agencies to coordinate activities and advocate for general practice support
- Collaborative meetings with other PHNs supporting accreditation
- Network meetings and facilitation or sharing relevant webinars

The objectives of the accreditation support activity are:

- for PHNs to identify and assist unaccredited practices in their regions to work towards accreditation, thereby increasing the number of general practices participating in the NGPA scheme and that they are able to register for Commonwealth funded programs such as MyMedicare, and
- to provide navigation to external resources and support services, or create resources and support mechanisms to assist general practices in achieving and maintaining accreditation throughout each accreditation cycle.

These objectives will be obtained through the following activities:

- Consultant review of Brisbane North PHN's current accreditation processes, comparing them with those of other PHNs, and ensuring that there is no duplication of services offered by accreditation providers such as QPA and AGPAL. This was used as basis for an ongoing accreditation strategic plan.
- Review the new accreditation requirements under My Medicare, including ways the PHN can support unaccredited practices, particularly small practices, who may wish to undergo accreditation.

- Strengthen data management processes to generate insights, update data base of practice accreditation status and develop a dashboard reflecting accreditation due dates and status, tracking accreditation support interactions, and tracking practices sharing data in Primary Sense
- Enable easy access to existing sources of information by assisting practices to navigate to Royal Australian College of General Practitioners (RACGP), Australian General Practice Accreditation Limited (AGPAL, Quality Practice Accreditation (QPA), and Australian Safety and Quality Council (ASQC) resources.
- Communicate effectively with practices to manage change guided by a communication plan reaching out to stakeholders via various channels.
- Provide tiered levels of support which target communication to practices with intensive support when needed and baseline support depending on accreditation status.

The desired outcomes of this activity are:

- General Practices in the region gain or maintain accreditation, eligibility for MyMedicare and other Government incentive schemes, implement quality improvements, streamline operations, enhance patient safety, and benchmark performance against national data.
- The PHN develops, maintains and evaluates a robust database and streamlined process to support the Brisbane North PHN Accreditation Support Strategy 2025.

Target cohort:

The activity aims to target general practices in the Brisbane North PHN region including smaller practices that may now be eligible for accreditation through the MyMedicare healthcare reforms. This includes all GP staff of all ages and has an impact on the patients within these general practices.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Population Health - Service Needs Level 1	5
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

General practices in Brisbane North PHN region including smaller practices and mobile services (non-traditional models) that may now be eligible for accreditation through the MyMedicare healthcare reforms.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

Consulting with AGPAL, QPA and RACGP to understand the support and resources that is provided by them to general practices to prevent duplication of services. AGPAL and QPA may also provide additional training to general practice around non-conformities, the new RACGP's standards for general practices (6th edition) etc.

Collaboration

- Primary Care team at Brisbane North PHN will continue ongoing support to general practices to support accreditation after consideration of new proposed support model.
- Consulting with AGPAL and QPA to understand the support that is provided to general practices to prevent duplication of services.

AGPAL and QPA may also provide additional training to general practice around non-conformities. General Practice

- Various levels of engagement from inform to involve and at design and implementation stages to understand general practice needs as they relate to accreditation and develop or link to resources/approaches to support these needs.



Activity Milestone Details/Duration

Activity Start Date

31/05/2024

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
MyMedicare	\$65,969.40	\$65,969.40	\$21,989.80	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
MyMedicare	\$65,969.40	\$65,969.40	\$21,989.80	\$0.00	\$0.00	\$153,928.60
Total	\$65,969.40	\$65,969.40	\$21,989.80	\$0.00	\$0.00	\$153,928.60

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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CMDT - 1000 - CMDT 1.0 - Commissioning of Multidisciplinary Teams



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CMDT

Activity Number *

1000

Activity Title *

CMDT 1.0 - Commissioning of Multidisciplinary Teams

Existing, Modified or New Activity *

Modified



Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description**Aim of Activity ***

The Commissioning a Multidisciplinary Team (MDT) project was announced as part of the Building a Stronger Medicare package in the 2023/24 budget, with a total of \$77.35 million being made available to Primary Health Networks (PHNs) over 3 years.

PHNs are responsible for commissioning multidisciplinary health care teams to support solo or small general practices or Aboriginal Community Controlled Health Services that are too small to engage their own multidisciplinary workforce through other funding streams. In addition, the approach must also be targeted to people that cannot afford fee paying or co-payment for MDT services.

Brisbane North PHN has commissioned an allied health MDT practice to support diabetes management (pre-diabetes, type 1, type 2 and gestational diabetes) in five general practices in the Strathpine SA3 region (Part A).

The Allied Health Support project (Part B) is exploratory in nature and will involve engaging with Allied Health (AH) service providers and peak bodies to better understand the sector in the Brisbane North PHN (BNPHN) region.

Project activities include: mapping the AH workforce in the Brisbane North PHN region, engaging with providers to assess their support requirements, and co-designing a local implementation plan that aligns with the National PHN Allied Health in Primary

Care Engagement Framework (The Framework), facilitating increased and collaborative ways of working.

The support needs scoping activity will explore networking and engagement opportunities and fostering collaboration between AH service providers and Brisbane North PHN. Participation in the PHN (informal) multi-disciplinary network will be a key part of this work, collaborating with other PHNs regarding opportunities for jurisdictional and national collaboration.

Description of Activity *

Part A - The PHN has commissioned Healthy Lifestyles Australia (the Provider) to support diabetes management in the Strathpine SA3 region. The multidisciplinary allied health team includes diabetes educators, dietitians, exercise physiologists and podiatrists. This team works collaboratively to provide coordinated care for patients. Diabetes (pre-diabetics, type 1, type 2 and gestational) patient referrals are received from five participating solo or small practices within the Strathpine SA3 region. Each selected general practice met the agreed criteria set by the Department (small or solo practice with FTE < 3 within Strathpine SA3, preferably not claiming WIP or if claiming WIP not for allied health). A Memorandum of Understanding (MOU) between the PHN, and each of the participating practices facilitates referrals to Healthy Lifestyles Australia, who manage MDT service delivery.

The following outcomes relate to the general practices participating in the pilot:

- Increase in GP referrals to MDT for patients with pre-diabetes and diabetes
- Increase in MDT services provided to patients with pre-diabetes and diabetes
- Patient satisfaction with the MDT service and experience of care
- GP and MDT members' satisfaction with service and experience of care
- Reduction in the amount of ED presentations for pre-diabetes and diabetes
- Increase in the quality of life for individuals with pre-diabetes and diabetes (EQ-5D-5L)

Part B

- The National PHN Allied Health in Primary Care Engagement Framework (the Framework) developed by the PHN Cooperative recognises that a greater focus on AH in primary care is essential for improving patient access, integration, safety, quality and cost-efficiency across the health system.

The Framework identifies six priority areas (outlined below), that seek to define the scope and role of PHN engagement within AH.

1. Nationally led collaboration
2. Governance and culture
3. Practice engagement
4. Data, quality and digital maturity
5. Workforce and access to Allied Health care
6. Integration, models of care and funding

The Framework recognises that PHN engagement with the AH sector is diverse and constrained by funding, capacity and resourcing challenges, but there is an opportunity to support providers to facilitate integrated patient-centred care with a stronger focus on wellbeing and prevention. The project incorporates the Double Diamond project methodology and will be conducted over six (6) phases from 2024-25 to 2026/27. Ongoing AH support will be provided in 2026-27, with activities informed by stakeholder engagement activities conducted in 2025-26.

The key activities for 2026-27 (Phase 4-6) include:

Phase 4 - thematic analysis and prioritisation of support needs within PHN scope of influence.

Phase 5 - co-design local implementation plan in alignment with The Framework in collaboration with AH Steering Committee and AH Collaborative.

Phase 6 - design and dissemination of local implementation plan, CQI process reflection and key learnings activities.

Target Cohort:

Part A: Solo/small general practices or Aboriginal Community Controlled Health Services in the Strathpine SA3 region, therefore providing residents with access to MDT services for pre-diabetes and diabetes (Type 1, Type 2 and gestational diabetes).

Part B:

- AH providers and primary care practices located in the BNPHN region.
- Consumers of all ages within the region that have accessed (or may access in the future) AH services for prevention, wellbeing and/or chronic condition management.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Population Health - Health Needs Level 1	2-3
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

Part A:

- General practice staff including clinical and non-clinical practice staff
- Allied health professionals working in commissioned allied health practice
- Patients with pre-diabetes, type 1, type 2 or gestational diabetes

Part B: Allied Health Professionals in the Brisbane North PHN region

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

Part A (completed in 25-26FY): -

Consultation will include Aboriginal Community Controlled Health Services in the Strathpine SA3 region.

- Eligibility will include First Nations peoples with pre-diabetes and diabetes who are patients at practices in the Strathpine SA3 region.

Evidence shows a higher prevalence rate of pre-diabetes and diabetes in people who identify as Aboriginal and/or Torres Strait Islander peoples.

Part B (current):

- Consultation and support will include AHs working in Aboriginal Community Controlled Health Services

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

Part A: The PHN engaged with general practices and Aboriginal Community Controlled Health Services in the Strathpine SA3 region to design and identify:

- Requirements for a local MDT service
- Barriers or challenges with commissioning an MDT
- Successful or unsuccessful local MDT models of care
- Workforce Incentive Program (WIP) participation numbers

This local intelligence informed the PHN's Request for Proposal (RFP) documentation and the strategic selection of a suitable MDT provider, Healthy Lifestyles Australia.

Part B: The PHN will engage with AH service providers and peak bodies in the Brisbane North BNPHN region to:

- map the AH workforce.
- identify their support needs, including barriers and enablers to providing patient-centred multidisciplinary/interdisciplinary care.
- prioritise their support needs in alignment with the Framework and PHN scope of influence.
- co-design an implementation plan to address local need, facilitating increased and collaborative ways of working.

Brisbane North BNPHN will also engage consumers in the region to provide feedback on their experiences accessing AH services, identifying barriers and enablers to receiving patient-centred care and suggestions to improve outcomes for patients supported by multidisciplinary/interdisciplinary teams.

In addition, the PHN will engage the Clinical Council for a primary care perspective on providing multidisciplinary/interdisciplinary care.

Collaboration

Part A - Delivery of a MDT service model to support solo/small Strathpine SA3 general practices or Aboriginal Community Controlled Health Services.

Part B:

- Allied Health Steering Committee (strategic project oversight)
- Allied Health Collaborative (service providers)
- Clinical Council (primary care perspective)
- Community Advisory Committee (contribute to development of survey)



Activity Milestone Details/Duration

Activity Start Date

31/05/2024

Activity End Date

29/06/2028

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

Direct Engagement: No

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): Yes

Is this activity being co-designed?

Yes

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

Part A: The PHN will engage with small/solo general practices or Aboriginal Community Controlled Health Services in the Strathpine SA3 region to design and identify:

- Requirements for a local MDT service
- Barriers or challenges with commissioning an MDT service
- Successful or unsuccessful local MDT models of care
- Workforce Incentive Program (WIP) participation numbers

This local intelligence will facilitate the PHN's RFP documentation and the strategic selection of a suitable provider to support the eligible general practices.

Part B: The PHN will engage with AH service providers and peak bodies in the Brisbane North PHN region to:

- map the AH workforce.
- identify their support needs, including barriers and enablers to providing patient-centred multidisciplinary/interdisciplinary care.
- prioritise their support needs in alignment with the Framework and PHN scope of influence.
- co-design an implementation plan to address local need, facilitating increased and collaborative ways of working.

The PHN will also engage consumers in the region to provide feedback on their experiences accessing AH services, identifying barriers and enablers to receiving patient-centred care and suggestions to improve outcomes for patients supported by multidisciplinary/interdisciplinary teams. In addition, the PHN will engage the Clinical Council for a primary care perspective on

providing multidisciplinary/interdisciplinary care.



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Commissioning Multidisciplinary Teams - Commissioning	\$414,000.00	\$499,341.00	\$561,000.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Commissioning Multidisciplinary Teams - Commissioning	\$414,000.00	\$499,341.00	\$561,000.00	\$0.00	\$0.00	\$1,474,341.00
Total	\$414,000.00	\$499,341.00	\$561,000.00	\$0.00	\$0.00	\$1,474,341.00

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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GPACI-GPM - 1000 - GPACI-GPM 1.0 -General Practice in Aged Care Incentive GP Matching



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

GPACI-GPM

Activity Number *

1000

Activity Title *

GPACI-GPM 1.0 -General Practice in Aged Care Incentive GP Matching

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description**Aim of Activity ***

This activity aims to engage and collaborate with residential aged care homes (RACHs), GPs and general practices in order to support older people living in RACHs to access quality primary care.

This includes recruitment and employment of staff to undertake stakeholder engagement, practice collaboration and communication. Objectives:

- Collaborate and engage with RACHs, GPs and practices in our region, including establishing arrangements between stakeholders where appropriate.
- Support the development of processes and strategies to strengthen primary health care service access for people living in RACHs by improving care coordination and engagement between aged care homes and primary care, especially in cases where no relationship currently exists.
- Develop or use existing tools to encourage increased participation in voluntary patient registration enabled through MyMedicare.
- Identify and share examples of best practice arrangements between RACHs, GPs and general practices across the Brisbane North PHN region.

This may include establishing networks to improve capacity and outcomes.

Description of Activity *

The Royal Commission into Aged Care Quality and Safety recommended the development of a new model of primary care to 'encourage the provision of holistic, coordinated and proactive health care for the growing complexity of the needs of people receiving aged care' (Recommendation 56). People living in aged care homes may experience poor continuity of care, and many do not have a regular General Practitioner (GP).

Poor continuity of primary care, meaning the ongoing therapeutic relationship between a patient and their GP, in aged care settings is associated with a higher risk of mortality.

Poor access to primary care can affect an older person's health and wellbeing and puts pressure on the acute health care system. The current remuneration structure and the inconvenience of delivering services within the aged care home has been indicated as a barrier to providing care by general practices. Brisbane North PHN (BNPHN) will undertake the following activities:

- Convene an expert advisory group (EAG) which includes representatives from general practice (including GPs), RACHs and Metro North Health to advise on and codesign activities and resources to strengthen program implementation
- Implement solutions and strategies designed by the EAG to improve access to GPs in RACHs, specifically:

- * Monitoring and promotion of GP and RACH online matching through the Care Provider Connect portal

- * Promotion and dissemination of the bespoke GP-RACH Partnership Resource Kit to support improved general practice / GP and RACH ways of working in the delivery of primary care to residents of RACHs

- Codesign (with the EAG) implementation strategies for the PHN to support development of new partnerships, and improvement of existing partnerships
- Implement or support activities to facilitate intra and inter-disciplinary collaboration (CoPs, digital communities, education evenings)
- Scope current state of First Nations specific policy and access to culturally appropriate Primary Care in RACHs and engage with ACCHOs to identify improvements
- Develop and deliver on-demand videos to provide training and information across the sector and break down siloes
- Evaluate strategies using a PDSA cycle approach
- Continue to monitor GP capacity to service RACHs and RACH access to general practice support
- Build on best practice and evidence based improvement outcomes

Establish collaborative, reciprocal, and formal arrangements with local ACCHS:

- BNPHN has mapped GPs attending RACHs and currently none of the GPs in local ACCHS organisations are attending RACHs.
- BNPHN plans to engage with RACHs on how they currently connect First Nations residents with culturally appropriate care, as well as begin the codesign process on how to improve these connections.

Identify and/or develop culturally safe and appropriate pathways for First Nations RACH residents who request healthcare from within the PHN region:

- The PHN will work with RACHs and our local ACCHS service to develop specific resources for First Nations RACH residents (and their families) regarding access to healthcare, including:

- The Primary Care team Engagement Officers work with General Practice to manage all QI including GPACI and any other My Medicare changes.

- We will continue to work with the Aged Care Learning Collaborative (a RACH special interest GP CoP).

Work in collaboration with residents (and/or their nominated guardians), RACHs providers and practices in the region to develop processes that match RACH residents with an appropriate preferred GP in MyMedicare where they do not currently have one:

- The PHN is developing functionality on the organisational website specifically for GPs seeking patients in RACHs, and RACHs with residents seeking GPs
- Continue to promote and monitor the Care Provider Connect tool (on the PHN website) which connects GPs seeking RACH residents, and RACHs seeking GPs
- Planned education and joint workshops Identify and share examples of best practice arrangements between practices, GPs, ACCHS and RACHs through establishment of networks to improve capacity.
- Will continue with our Aged Care collaboratives
- Will continue to work with the Aged Care Learning Collaborative (a RACH special interest GP Community of Practice)
- Multi-Disciplinary EAG informs BNPHNs work on this activity
- Will continue to deliver the Multi-Disciplinary "masterclass" workshops
- Exploring other digital community building and networking opportunities for various professionals working in RACH

The intended outcomes of the grant opportunity are to:

- increase knowledge of GPs, practices and ACCHS of the GPACI and its benefits to residents of RACHs and providers
- improve reciprocal relationships between GPs and/ or ACCHS and RACHs to facilitate the delivery of quality and continuous primary care services,
- improve the capacity of GPs, ACCHS and practices to deliver quality and continuous care through collaborative learning networks and/formalised arrangements such as Memoranda of Understanding, and the embedding of the Best Practice Guidelines (developed by the Department in 2024).

Target Cohort:

The target population for this activity are people (aged 65 years and older and indigenous people aged 50 years and over) permanently residing in residential aged care homes located in the Brisbane North PHN region.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Population Health - Service Needs Level 1	5
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

The target population for this activity are people (aged 65 years and older and indigenous people aged 50 years and over) permanently residing in residential aged care homes located in the Brisbane North PHN region.

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

This program specifically includes improving access to Aboriginal Community Controlled Health Services (ACCHS) for indigenous residents of RACHs.

The ACCHS in the Brisbane North region are key stakeholders and will be consulted and involved in codesign processes.

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

The project includes stakeholder engagement for the following groups: Brisbane North PHN Clinical Council, Brisbane North PHN Executive Leadership team, Residential Aged Care Homes, General Practices, Residents (and substitute decision makers) or RACHs, Metro North HHS (RADAR, OPEN, SPACE)

These stakeholders will have regular consultation and reporting as required and for key milestones.

Collaboration

The project will be managed by the Lead - RAC Access under authority of the Healthy Ageing Team Manager and under the sponsorship of the Executive Manager, Mental Health and Connected Communities.

The governance group for this activity is the Brisbane North PHN MyMedicare Implementation Committee, which includes members from Healthy Ageing, Primary Care, Communications, and Commissioning, Analytics and Reporting teams. The activity is supported by a Project Officer and an Expert Advisory Group drawn from stakeholder groups.



Activity Milestone Details/Duration

Activity Start Date

31/05/2024

Activity End Date

29/06/2027

Service Delivery Start Date

01/09/2024

Service Delivery End Date

30/06/2027

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

Direct Engagement: No

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): Yes

Is this activity being co-designed?

Yes

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

Codesign activities for this program include:

- stakeholder consultation and workshops
- establishment of working group drawn from GP and RACH sectors
- using established RACH Collaboratives in the region to sense-check solutions, strategies and interventions



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice in Aged Care—GP Matching	\$291,821.00	\$347,935.05	\$170,586.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice in Aged Care—GP Matching	\$291,821.00	\$347,935.05	\$170,586.00	\$0.00	\$0.00	\$810,342.05
Total	\$291,821.00	\$347,935.05	\$170,586.00	\$0.00	\$0.00	\$810,342.05

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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SHA - 1000 - SHA 1.0 - Health Alliance



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

SHA

Activity Number *

1000

Activity Title *

SHA 1.0 - Health Alliance

Existing, Modified or New Activity *

Modified



Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

Service System

Aim of Activity *

By working strategically and collaboratively, taking a systems approach to solving challenges that no organisation can solve on its own, the Health Alliance will ensure that people experience a seamless, integrated and navigable system of care that delivers quality health outcomes.

The current priorities of the Health Alliance include:

- Children in Moreton Bay North with development delay and disabilities (Caboolture Kids Collective): Increase timely access to assessment, treatment and supports for children (and their families) with developmental delay or disability, through the development of a place-based, multiagency approach.
- Strategic Vision for Healthy Ageing: Develop a long-term strategic vision and roadmap for ageing well services and supports in our region.
- Ageing in Place: Develop and trial a place-based approach to ageing well in the community.
- Metro North Health Forum: Review the purpose and audience for the Metro North Health Forum (a joint forum for staff and stakeholders of Metro North Health and Brisbane North PHN, which has been running since 2014).
- Specialist Pain Assistance Network (SPAN) [separately funded]
- Governance of the Health Alliance partnership

Description of Activity *

The Health Alliance represents the shared commitment of Brisbane North PHN and Metro North Health to implement governance mechanisms in line with the National Health Reform Agreement and the roadmap of long-term reform priorities to provide the leadership and resourcing required to implement, as well as create a burning platform for change and provide incentives to sustain.

The Health Alliance jointly funds a General Manager position to coordinate strategic activity between Metro North Health and Brisbane North PHN, establishing a joint committee of each Board to provide a vision for this work and ensure progress.

The Health Alliance has done this by establishing:

- * A clear vision for health in the region
- * Clear governance mechanisms to incentivise stakeholders to work together to effect change.
- * Shared performance measures, structures, reporting, and priorities to enforce collaboration.
- * Genuine commitment to modelling the relationship and approach needed to achieve the long-term reform objectives and minimise system duplication.

The Alliance uses the following approach to health system challenges

- => Bring stakeholders together from across the health sector
- => Developing a shared understanding of the problem inclusive of what matters most for patients
- => Agree a way forward to address the problem
- => Implement place-based collective approaches
- => Working with stakeholders to implement solutions and review progress.

With the Health Alliance project being jointly funded between the Department of Health, Disability and Ageing and Metro North Health, Brisbane North PHN works to ensure value for money and efficiency in costs, primarily the employment of General Manager and Program Manager which are required to coordinate Joint Board Committee and manage ongoing strategic relationships between Brisbane North PHN and Metro North Health, develop business cases to pilot programs and then lead the planning, commissioning, and evaluation of the pilot programs.

Areas of focus for 2025/26 include:

- Children in Moreton Bay North with development delay and disabilities
- Strategic Vision for Healthy Ageing
- Ageing in Place
- Metro North Health Forum
- Specialist Pain Assistance Network (SPAN) [separately funded]
- Governance of the Health Alliance partnership

An itemised list of activities funded:

Activity: Staffing General Manager

Details: Coordinate Joint Board Committee and manage ongoing strategic relationship between PHN and HHS. Successfully develop business cases to pilot programs e.g.:

- Strategic Vision for Healthy Ageing
- Governance of the Health Alliance
- Metro North Health Forum

Activity: Staffing - Program Manager 0.8fte

Details: Lead planning, commissioning and evaluation of pilot programs e.g.:

- Children in Moreton Bay North with development delay and disabilities
- Strategic Vision for Healthy Ageing

Activity: Staffing - Projects Coordinator 0.2fte

Details: Coordinates project delivery including:

- Ageing in Place
- SPAN [0.6fte separately funded]

Activity: Local planning

Details: Local forums bringing stakeholders from across the system together to understand issues, design and test sustainable solutions

Target Cohort for Health Alliance: The activities under the Health Alliance are targeted to the following population groups: - children - older people - people experiencing chronic pain - health and community service decision makers and providers

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

Target Cohort for Health Alliance: The activities under the Health Alliance are targeted to the following population groups: - children - older people - people experiencing chronic pain - health and community service decision makers and providers.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

Extensive stakeholder engagement and consultation has taken place to support the Alliance work. Consultation will be ongoing throughout the life of the activities.

Collaboration

The PHN will jointly fund and implement this activity with Metro North Health. A Joint Board Committee (JBC), drawing membership from both the PHN and Metro North Health, alongside the two Chief Executive Officers, provides the strategic

direction of the Health Alliance and holds overall governance for the work.

The JBC is an important mechanism, providing shared governance, joint identification of issues and a collaborative response to health challenges that no organisation can solve on its own.



Activity Milestone Details/Duration

Activity Start Date

30/12/2021

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: 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?

Yes

Decommissioning

Decommissioning details?

Co-design or co-commissioning comments

Extensive stakeholder engagement and consultation has taken place to support the Alliance work. Consultation will be ongoing throughout the life of the activities.



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Strategic Health Alliance	\$325,000.00	\$175,000.00	\$0.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Strategic Health Alliance	\$325,000.00	\$175,000.00	\$0.00	\$0.00	\$0.00	\$500,000.00
Total	\$325,000.00	\$175,000.00	\$0.00	\$0.00	\$0.00	\$500,000.00

Funding From Other Sources - Financial Details

175000

Funding From Other Sources - Organisational Details

\$175,000 in 2025/26 is provided by Metro North Health.



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
Updated for Paul's Feedback	V2	Amalia Savini	24/06/2026



CF - 2100 - CF 2.1 - Clinical Pathways (Health Pathways)



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

2100

Activity Title *

CF 2.1 - Clinical Pathways (Health Pathways)

Existing, Modified or New Activity *

Modified



Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

Service System

Aim of Activity *

Brisbane North PHN leads the HealthPathways (HP) project in partnership with Queensland Health and Metro North Health. Using the New Zealand based platform of HealthPathways, Brisbane North PHN is leading the development and review of a suite of localised clinical management and referral pathways which are evidence-based and suited to the preferences and services available in the region.

Through consultation with Metro North Health Specialists and other subject matter experts, the pathways are developed by GPs for GPs and focus on a comprehensive range of priority clinical areas including chronic disease, aged care and mental health conditions. Using an integrated approach to skills development, the Pathways are matched to our GP education program, and their use is promoted through the PHN via the GP Link publication and Primary Care Engagement team & CQI activities. Pathways are responsive to emerging issues such as disaster and pandemic management or introductions of new laws (e.g. termination of pregnancy, VAD), making them a valuable support tool for quality improvement in clinical practice.

The PHN will continue to work with health practitioners to expand, update and maintain the suite of clinical pathways which are easily accessible on desktop or mobile devices via the Brisbane North HealthPathways website. Localised Pathways are inclusive of referral options specific to Aboriginal and Torres Strait Islander and multicultural services.

The Brisbane North team will continue to collaborate with the other Qld HealthPathways teams to share resources and coordinate the development and reviews of shared pathways as per the governance established by the Queensland HealthPathways Coordinators' Network and supported by Queensland Health (Clinical Excellence Queensland). The KPIs are set on the assumption that the current discussions about 'pathway sharing by default' will result in statewide teams agreeing and planning for sharing by default from July 2026.

Description of Activity *

A) Activities conducted that provide evidence that Brisbane North PHN is developing, reviewing, maintaining and enhancing Clinical Referral Pathways contact that supports local health professionals to provide advice and referrals relevant to the needs of our region:

The Brisbane North PHN HealthPathways team plans and prioritises the development of new Clinical Referral Pathways based on:

- Budget allocation
- Consultation with Metro North Health as a partner and to identify which pathway may assist the Hospital and Health Service (HHS) in addressing some of their pressure points
- Consultation with the GP Liaison Officer (GPLO) network and feedback from end users (primary care providers)
- State-wide opportunities and priorities.

The team of Clinical Editors and Project Officer constantly monitors information shared from various sources (other HealthPathways team in the Australian HealthPathways community, other PHN teams, local HHS, GPLO network, local community services) about guideline updates, system and services changes to ensure new information is updated as relevant on the HealthPathways platform.

B) Planned consultation with local primary care practitioners, consumers and other relevant stakeholders:

New HealthPathways are prepared by Clinical Editors using available evidence and best practice clinical guidelines, ensuring the incorporation of Qld Health Clinical Prioritisation Criteria (when available) to improve referral quality and prompt access to care for patients.

Drafts are reviewed by subject matter experts (SME) (most often a local public specialist but can sometimes be a Queensland Clinical Network or peak body clinician) before being published on the pathways platform to ensure quality of clinical content and alignment with local processes.

Existing pathways are formally reviewed on a three (3) year cycle, or sooner to reflect any guidelines change or in response to feedback. The Brisbane North HealthPathways team is an active member of the Qld HealthPathways Network (comprising of Qld Health, Streamliners, other Qld Regional HealthPathways teams and GPLO representatives) and we collaborate with other Qld Regional HealthPathways teams to share the workload and improve efficiencies.

C) Approaches to support increased awareness, utilisation and integration of Clinical Referral Pathways by local practitioners: The Brisbane North HealthPathways team uses the following strategies to increase awareness and use of the HealthPathways tool:

- Presentation at every local RACGP Registrar training event;
- Communication to General Practitioners and general practice staff with regular HealthPathways segment in the PHN's weekly 'GP Link' e-newsletter, to share HealthPathways news such as newly published or reviewed pathways or website content spotlights and navigation tips;
- Practice visits for demonstrations on request;
- Integration with the PHN's Primary Care Engagement Officers, such as Digital Health and GP Smart Referral, and GPLOs to cross-promote benefits of each program's tools and increase engagement;
- Integration of HealthPathways where applicable in supported Quality Improvement activities offered by the PHN's Primary Care Practice Support team;
- Attendance as stall holder or presenter to any relevant primary care education event or forum organised by our PHN or partners.

D) Clear attribution of the different sources of funding utilised by the activity: Brisbane North PHN has allocated our Clinical HealthPathways funding for FY25-26 as follows:

Allocation of FY25-26 funds are stated in Planned Expenditures of this activity as well as BSV.

The allocation of funding for FY26-27 is as follows:

CF 2.1 - Clinical Pathways Health Pathways: \$442,971.12

CF 2.2 - Clinical Pathways – Aged Care: \$0

CF 2.3 - Clinical Pathways – Dementia: \$0

Whilst there is no dedicated funding assigned to activity CF 2.2 and CF 2.3 in FY26-27, we are able to deliver maintenance of these activities utilising overarching funding from CF 2.1.

Activity CF 2.1 encompasses costs for all three HealthPathways activities including localisation of pathways and promotion of pathways. Licensing fees are covered by Queensland Health for all Queensland PHNs. In addition, we receive funding from our local HHS to support HealthPathways.

Target Cohort: Population of all ages within Brisbane North PHN region seeking primary care services with potential for referral to the public health system.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Population Health - Health Needs Level 1	2-3
Population Health - Service Needs Level 1	5
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

All of population seeking primary care services with potential for referral to the public health system

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Brisbane Inner	30501
Sherwood - Indooroopilly	30403
Redcliffe	31305
Caboolture Hinterland	31303
The Hills District	31401
Kenmore - Brookfield - Moggill	30402
The Gap - Enoggera	30404
Sandgate	30204
Chermside	30202
Brisbane Inner - West	30504
Nundah	30203
Narangba - Burpengary	31304
North Lakes	31402
Brisbane Inner - North	30503
Bribie - Beachmere	31301
Strathpine	31403
Bald Hills - Everton Park	30201
Caboolture	31302



Activity Consultation and Collaboration

Consultation

The PHN continues to consult on ongoing development of the Pathways program with the following stakeholders:

- general practitioners in the PHN region
- allied health practitioners in the PHN region
- specialists in the PHN region
- Children's Health Queensland Hospital and Health Service
- Metro North Hospital and Health Service. The Pathways program will continue to work with the Metro North Hospital and Health Service and primary healthcare providers to prioritise pathways that will have the highest impact on preventable hospital admissions.

Collaboration

The project is overseen by the PHN/Metro North Health Collaborative who report to the Joint Operational Group (JOG) as MNH contribute funding to the overall program income. Qld HealthPathways Network is overseen by Qld Health and has a TOR and pathway sharing governance.



Activity Milestone Details/Duration

Activity Start Date

29/06/2024

Activity End Date

29/06/2027

Service Delivery Start Date**Service Delivery End Date****Other Relevant Milestones****Activity Commissioning**

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

Direct Engagement: No

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): Yes

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

The PHN continues to consult on ongoing development of the Pathways program with the following stakeholders:

- general practitioners in the PHN region
- allied health practitioners in the PHN region
- specialists in the PHN region
- Children's Health Queensland Hospital and Health Service

- Metro North Hospital and Health Service. The Pathways program will continue to work with the Metro North Hospital and Health Service and primary healthcare providers to prioritise pathways that will have the highest impact on preventable hospital admissions.



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$641,162.81	\$553,771.80	\$442,971.12	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$641,162.81	\$553,771.80	\$442,971.12	\$0.00	\$0.00	\$1,637,905.73
Total	\$641,162.81	\$553,771.80	\$442,971.12	\$0.00	\$0.00	\$1,637,905.73

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details

Brisbane North PHN also received a contribution of \$125,420 from Metro North Health in 2025/26 towards the HealthPathways program. In addition to this contribution, licensing fees were paid for by Queensland Health.



Summary of activity changes for Department

Activity Status

Submitted

Subject	Description	Commented By	Date Created
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CF - 2200 - CF 2.2 - Clinical Pathways - Aged Care



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

2200

Activity Title *

CF 2.2 - Clinical Pathways - Aged Care

Existing, Modified or New Activity *

Modified



Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description**Aim of Activity ***

Information about the activities under the general Referral Pathways Program (HealthPathways) is covered in CF – 2100 – CF 2.1 – Clinical Pathways (Health Pathways). This Activity Work Plan relates to the HealthPathways activities specifically relating to Aged Care.

Fragmented patient care and inconsistent referral practices lead to poorer health outcomes. HealthPathways aim to improve patient management and patient experience by ensuring the right care is delivered at the right time in the right place by ensuring clinicians have ready access to up-to-date clinical and local services and referral information.

HealthPathways improve referral quality and timeliness by providing GPs with easy to access localised information for the clinical management, services options and referral guidelines for the Metro North area and state-wide services.

This activity aims to improve patient outcomes by; reducing variation in care, enabling timely access to the correct care, enabling GPs to practice at the top of their professional scope and by promoting the implementation of state-wide public system referral guidelines. It will also support primary care clinicians, older people and their carers and families through the provision of accessible information and advice and support to live well in the community.

Description of Activity *

A) Evidence on how your Organisation will develop, review, maintain and enhance Clinical Referral Pathways content specifically for aged care, to support local health professionals to provide advice and referrals relevant to the needs of their region: Brisbane North PHN has a full suite of aged care and dementia related pathways and those are reviewed formally every 3 years and updated in between on an ad-hoc basis as and when guidelines are updated or new evidence, services or resources become available to ensure currency.

The Brisbane North PHN HealthPathways team collaborates with other Qld HealthPathways teams to do this maintenance work to avoid duplication, and with internal Aged Care and Healthy ageing team members and Dementia Australia. The Brisbane North HealthPathways website now includes a complete suite of localised pathways relating to the management, treatment and requests for service for older persons. Examples include (but are not limited to):

- * Before Entering a Residential Aged Care Facility*

- * Carer Stress

- * Comprehensive Medical Assessment for RACFs

- * Depression in Older Adults

- * Antidepressants for Older Adults

- * Elder Abuse and Neglect*

- * Falls Prevention in Older Adults

- * Frailty in Older Adults*

- * Older Adults' Health Assessment

- * Older Adults' Weight and Nutrition

- * Unexpected Deterioration in an Older Adult

- * Behavioural concerns in Older Adults

Therefore, our focus is now on the maintenance and review of those pathways, with only three (3) pathways due for review in FY 25/26 (marked with * in list above) as per our normal 3-yearly cyclical review in line with our Clinical Governance Framework. However as always, pathways are continuously maintained and updated as new best practice evidence emerges, or guidelines are updated.

B) Detail on planned consultation with local primary care practitioners, consumers, and other relevant stakeholders:

Brisbane North PHN is doing this work collaboratively with other Qld HealthPathways teams to ensure Aged-care and Dementia related pathways are maintained appropriately within a state-wide pathway sharing framework as per the governance established by the Qld HealthPathways Coordinators' network, and supported by Qld Health (Clinical Excellence Branch).

The shared suite of aged care Clinical Referral Pathways has been developed in consultation with the Queensland Dementia, Ageing and Frailty (QDAF) Clinical Network, Queensland Health Residential Aged Care Facility Acute Support Service, and Queensland State-wide Older Persons Mental Health Alcohol and Other Drugs (SOPMHOD) Network. Locally, we also engage with our GP Liaison Officer (GPLO) team.

C) Approaches on how your Organisation will support increased awareness, use and integration of Clinical Referral Pathways by local practitioners:

The Brisbane North PHN HealthPathways team promotes relevant aged care and dementia pathways via numerous mechanisms including: At education events organised by our PHN teams and via the GPLO team (e.g. at the annual aged care forum organised by Brisbane North PHN).

Specifically targeting GPs and Practices who are active in providing GP services to Residential Aged Care Homes and involved with the GP in Aged Care Incentives (GPACI) program. The GPACI work within the PHN will soon be supporting training for GPs in RACHs

and we will ensure the relevant Aged Care Clinical Referral HealthPathways are included in that. Pathway reviews are published in our PHN's weekly newsletter for GPs (GPLink), and pathway links are added to any relevant related news article. In addition, our HealthPathways team members offer on-demand in-person or remote demonstrations of the platform.

D) Clear attribution of Aged Care Clinical Referral Pathways funding (separate to that used for the dementia specific clinical referral pathways) utilised by the activity:

Allocation of FY25-26 funds are stated in Planned Expenditures of this activity as well as BSV.

The allocation of funding for FY26-27 is as follows:

CF 2.1 - Clinical Pathways Health Pathways: \$442,971.12

CF 2.2 - Clinical Pathways – Aged Care: \$0

CF 2.3 - Clinical Pathways – Dementia: \$0

Whilst there is no dedicated funding assigned to activity CF 2.2 and CF 2.3 in FY26-27, we are able to deliver maintenance of these activities utilising overarching funding from CF 2.1.

Activity CF 2.1 encompasses costs for all three HealthPathways activities including localisation of pathways and promotion of pathways. Licensing fees are covered by Queensland Health for all Queensland PHNs. In addition, we receive funding from our local HHS to support HealthPathways.

Target Cohort: Older Australian (over 65's or over 55 for First Nations people) seeking primary care services with potential for referral to the public health system and Aged Care services within Brisbane North PHN region.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Population Health - Health Needs Level 1	2-3
Population Health - Service Needs Level 1	5
Service System - Service Needs Level 1	5
Older Persons - Service Needs Level 2	9



Activity Demographics

Target Population Cohort

Older Australian (over 65's or over 55 for First Nations people) seeking primary care services with potential for referral to the public health system and Aged Care services.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Brisbane Inner	30501
Sherwood - Indooroopilly	30403
Redcliffe	31305
Caboolture Hinterland	31303
The Hills District	31401
Kenmore - Brookfield - Moggill	30402
The Gap - Enoggera	30404
Sandgate	30204
Chermside	30202
Brisbane Inner - West	30504
Nundah	30203
Narangba - Burpengary	31304
North Lakes	31402
Brisbane Inner - North	30503
Bribie - Beachmere	31301
Strathpine	31403
Bald Hills - Everton Park	30201
Caboolture	31302



Activity Consultation and Collaboration

Consultation

Feedback is routinely sought from GPs about the utility of pathways and how they can be improved. The project is overseen by the PHN/Metro North Health Collaborative who report to the Joint Operational Group (JOG) as MNH contributes approximately 20% of the overall program income. Qld HealthPathways Network is overseen by Qld Health and has a TOR and pathway sharing governance.

Collaboration

Brisbane North PHN is doing this work collaboratively with other Qld HealthPathways teams to ensure Aged-care and Dementia related pathways are maintained appropriately within a state-wide pathway sharing framework as per the governance established by the Qld HealthPathways Coordinators' network, and supported by Qld Health (Clinical Excellence Branch).



Activity Milestone Details/Duration

Activity Start Date

29/06/2024

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

Direct Engagement: No

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): Yes

Is this activity being co-designed?

Yes

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

Co-design work is undertaken between the PHN, GPLOs, Metro North HHS, Specialists, GPs Queensland Health, Streamliners - New Zealand.



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$23,134.41	\$14,914.73	\$0.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$23,134.41	\$14,914.73	\$0.00	\$0.00	\$0.00	\$38,049.14
Total	\$23,134.41	\$14,914.73	\$0.00	\$0.00	\$0.00	\$38,049.14

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Submitted

Subject	Description	Commented By	Date Created
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CF - 2300 - CF 2.3 - Clinical Pathways - Dementia



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

2300

Activity Title *

CF 2.3 - Clinical Pathways - Dementia

Existing, Modified or New Activity *

Modified



Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

Service System

Aim of Activity *

Information about the activities under the general Referral Pathways Program (HealthPathways) is covered in CF – 2100 – CF 2.1 – Clinical Pathways (Health Pathways).

This Activity Work Plan relates to the clinical HealthPathways activities specifically relating to Dementia.

Fragmented patient care and inconsistent referral practices lead to poorer health outcomes. HealthPathways aim to improve patient management and patient experience by ensuring the right care is delivered at the right time in the right place by ensuring clinicians have ready access to up-to-date clinical and local services and referral information.

HealthPathways improve referral quality and timeliness by providing GPs with easy to access localised information for the clinical management, services options and referral guidelines for the Metro North area and state-wide services.

This activity aims to improve patient outcomes by; reducing variation in care, enabling timely access to the correct care, enabling GPs to practice at the top of their professional scope and by promoting the implementation of state-wide public system referral guidelines. It will also support primary care clinicians, people living with dementia and their carers and families through the provision of accessible information and advice and support to live well in the community.

Description of Activity *

A) Specific action your organisation will take to develop, continually improve and update through frequent review, and maintain dementia specific support and referral pathways content (including timelines) as new services and best practice evidence for dementia care evolves:

Brisbane North PHN has a full suite of aged care and dementia related pathways and those are reviewed formally every three (3) years and updated in between on an ad-hoc basis as and when guidelines are updated or new evidence, services or resources become available to ensure currency.

The Brisbane North PHN HealthPathways team collaborates with other Qld HealthPathways team members to do this maintenance work to avoid duplication and the extensive networks outlined in question B) above, and with the internal Aged Care and Healthy Ageing team and Dementia Australia.

B) Details of continued work with Dementia Australia to ensure dementia specific support and referral pathways reflect emerging best practice and appropriate services and supports within the region:

Localised Brisbane North HealthPathways already include pathways relating to:

- * Cognitive Impairment and Dementia
- * Behavioural and Psychological Symptoms of Dementia
- * Medications for Dementia
- * Dementia Support Services.

Brisbane North PHN is working collaboratively with PHNs across Queensland and the NT to further develop and share Dementia related HealthPathways. Members of Brisbane North PHN attend the regular updates meetings provided by Dementia Australia and the Brisbane North HealthPathways team ensures that the Dementia Pathways contain dementia specific consumer resources to be provided to patients and their carers/families during a GP consultation.

C) Details of planned consultation with local primary care providers, people living with dementia and their carers, and other relevant stakeholders:

Dementia related pathways have been developed in consultation with Dementia Australia, QDAF Clinical Network, Queensland Health Residential Aged Care Facility Acute Support Service, and Qld State-wide Older Persons Mental Health Alcohol and Other Drugs (SOPMHOD) Network, and include relevant dementia specific consumer resources to be provided to patients and their carers/families during a GP consultation.

Brisbane North PHN is doing this work collaboratively with other Qld HealthPathways teams to ensure Aged-care and Dementia related pathways are maintained appropriately within a state-wide pathway sharing framework as per the governance established by the Queensland HealthPathways Coordinators' network, and supported by Queensland Health (Clinical Excellence Branch).

D) Specific actions that will be taken to continue to promote and increase the awareness, engagement, utilisation and integration of dementia specific support and referral pathways by local health care practitioners:

The PHN will continue to increase awareness of dementia specific referral pathways and support services by promoting Dementia specific HealthPathways in our regular GP newsletter (GP Link), via our Aged care consortium, and at any relevant upcoming education events (e.g. GPLO events for GPs).

E) Actions you will take if there are barriers to reporting requirements (KPIs, 12m reporting and evaluation) in accordance with the Policy guidance available from PHN program Resources and Guides and the Core Funding Schedule:

Internal systems and processes are in place to enable reporting against requirements. Pathway and page views are captured through Google Analytics. We do not anticipate any barriers to the reporting requirements, and will ensure deliverables are recorded, met and reported on, as per usual processes. In the event of unforeseen challenges (e.g. staff changes) we will ensure adequate handover and training occurs.

F) Details of continued collaboration across PHN regions in development and sharing of dementia specific support pathway

information:

As previously outlined, dementia related pathways have been developed in consultation with Dementia Australia, QDAF Clinical Network, Queensland Health Residential Aged Care Facility Acute Support Service, and Queensland SOPMHOD Network, and include relevant dementia specific consumer resources to be provided to patients and their carers/families during a GP consultation. Brisbane North PHN is doing this work collaboratively with other Queensland HealthPathways teams to ensure Aged-care and Dementia related pathways are maintained appropriately within a state-wide pathway sharing framework as per the governance established by the Queensland HealthPathways Coordinators' network, and supported by Queensland Health (Clinical Excellence Branch).

Localised Brisbane North HealthPathways already include the following dementia-related pathways:

- * Cognitive Impairment and Dementia
- * Behavioural and Psychological Symptoms of Dementia
- * Medications for Dementia
- * Dementia Support Services.

None of these pathways are due for review in FY 25-26 (they were reviewed in FY 23-24), however, a PHN representative will continue to attend the regular meetings organised by Dementia Australia to ensure we stay abreast of dementia care evolution (new best-practice evidence, guideline updates, new or updated services) and ensure the pathways are maintained accordingly within an acceptable timeline (generally within 1 month of service updates, and within 3 months of clinical update requiring Subject Matter Expert involvement).

G) Clear attribution of Dementia Support Pathway funding (separate to that used for all other health pathways) utilised by the activity for reporting purposes including Variance Reporting.

Allocation of FY25-26 funds are stated in Planned Expenditures of this activity as well as BSV.

The allocation of funding for FY26-27 is as follows:

CF 2.1 - Clinical Pathways Health Pathways: \$442,971.12

CF 2.2 - Clinical Pathways – Aged Care: \$0

CF 2.3 - Clinical Pathways – Dementia: \$0

Whilst there is no dedicated funding assigned to activity CF 2.2 and CF 2.3 in FY26-27, we are able to deliver maintenance of these activities utilising overarching funding from CF 2.1.

Activity CF 2.1 encompasses costs for all three HealthPathways activities including localisation of pathways and promotion of pathways. Licensing fees are covered by Queensland Health for all Queensland PHNs. In addition, we receive funding from our local HHS to support HealthPathways.

Target Cohort: Older Australian (over 65's or over 55 for First Nations people) seeking primary care services with potential for referral to the public health system and Aged Care services in the Brisbane North PHN region.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Population Health - Health Needs Level 1	2-3
Population Health - Service Needs Level 1	5
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

Older Australian (over 65's or over 55 for First Nations people) seeking primary care services with potential for referral to the public health system and Aged Care services in the Brisbane North PHN region.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Brisbane Inner	30501
Sherwood - Indooroopilly	30403
Redcliffe	31305
Caboolture Hinterland	31303
The Hills District	31401
Kenmore - Brookfield - Moggill	30402
The Gap - Enoggera	30404
Sandgate	30204
Chermside	30202
Brisbane Inner - West	30504
Nundah	30203
Narangba - Burpengary	31304
North Lakes	31402
Brisbane Inner - North	30503
Bribie - Beachmere	31301
Strathpine	31403
Bald Hills - Everton Park	30201
Caboolture	31302



Activity Consultation and Collaboration

Consultation

Dementia related pathways have been developed in consultation with Dementia Australia, QDAF (Qld Dementia, Ageing and Frailty) Clinical Network, Qld Health Residential Aged Care Facility Acute Support Service, and Qld SOPMHOD Network, and include relevant dementia-specific consumer resources to be provided to patients and their carers/families during a GP consultation. Feedback is routinely sought from GPs about the utility of pathways and how they can be improved.

Collaboration

Brisbane North PHN is doing this work collaboratively with other Qld HealthPathways teams to ensure Aged-care and Dementia related pathways are maintained appropriately within a state-wide pathway sharing framework as per the governance established by the Qld HealthPathways Coordinators' network, and supported by Qld Health (Clinical Excellence Branch).

Brisbane North PHN will also ensure that the Dementia pathways contain dementia specific consumer resources to be provided to patients and their carers/families during a GP consultation.



Activity Milestone Details/Duration

Activity Start Date

29/06/2024

Activity End Date

29/06/2027

Service Delivery Start Date**Service Delivery End Date****Other Relevant Milestones****Activity Commissioning**

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

Direct Engagement: No

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): Yes

Is this activity being co-designed?

Yes

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

Co-design work is undertaken between the PHN, GPLOs, Metro North HHS, Specialists, GPs, Queensland Health, and Streamliners - New Zealand.



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$11,310.16	\$7,291.64	\$0.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$11,310.16	\$7,291.64	\$0.00	\$0.00	\$0.00	\$18,601.80
Total	\$11,310.16	\$7,291.64	\$0.00	\$0.00	\$0.00	\$18,601.80

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Submitted

Subject	Description	Commented By	Date Created
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CF - 3100 - CF 3.1 - School readiness for Aboriginal & Torres Strait Islander children



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

3100

Activity Title *

CF 3.1 - School readiness for Aboriginal & Torres Strait Islander children

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area *

Aboriginal and Torres Strait Islander Health

Other Program Key Priority Area Description

Aim of Activity *

Aboriginal and Torres Strait Islander children are entering prep developmentally behind other children. The Brisbane North PHN Health Needs Assessment determined that Aboriginal and Torres Strait Islanders are priority populations that need priority support and resourcing.

The Institute for Urban Indigenous Health (IUIH) will provide development screening and subsequent appropriate intervention to develop skills for school readiness at Koobara Kindergarten and C&K Caboolture Kindergartens.

The IUIH therapists will also work alongside the early childhood staff to embed sustainable workplace practices to enhance learning opportunities for children and their families. The program facilitates linkages to local primary healthcare services to ensure improved health outcomes for Aboriginal and Torres Strait Islander children aged 0–4.

Description of Activity *

The Institute for Urban Indigenous Health (IUIH) delivers developmental screening and targeted early intervention to support school-readiness skills for children attending Koobara Kindergarten and C&K Caboolture Kindergarten.

IUIH therapists work alongside early childhood educators to embed sustainable, culturally safe practices that enhance learning

opportunities for children and strengthen engagement with families. The program also facilitates strong linkages with local primary healthcare services to improve health outcomes for Aboriginal and Torres Strait Islander children aged 0–4. Program activities are delivered within the kindy environment, where Occupational Therapists and Speech Pathologists collaborate with children, educators and families to provide:

- Individual developmental screening
- Report writing
- Correspondence to parents and GP
- Linking and developing pathways to other health services i.e. hearing health services
- Ear, Nose and Throat specialists, audiology
- Skills development programs for all children including Tools for School Program
- Individual and group therapy
- In service and upskilling of early childhood staff
- Parent information sessions on developmental skill development
- Promotion of Kindy through IUIH Deadly Kindies program
- Employment and training of student allied health professionals.

Target Cohort: Aboriginal and Torres Strait Islander Children at Kindergarten aged 0-4 in the Brisbane North PHN Region.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Aboriginal and Torres Strait Islander Health - Health Needs Level 1	2-3
Aboriginal and Torres Strait Islander Health - Service Needs Level 1	3,5
Children's Health - Service Needs Level 1	4
Children's Health - Health Needs Level 1	3



Activity Demographics

Target Population Cohort

Aboriginal and Torres Strait Islander Children at Kindergarten aged 0-4 in the Brisbane North PHN Region.

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

This activity works specifically with the only Aboriginal and Torres Strait Islander kindergarten in the region and another kindergarten that has a high population of Aboriginal and Torres Strait Islander children. The activity has been co-designed with kindergartens and Aboriginal and Torres Strait Islander service providers and will be delivered with an Aboriginal and Torres Strait Islander Health Service.

Coverage

Whole Region

No

SA3 Name	SA3 Code
Caboolture Hinterland	31303
Sandgate	30204
Chermside	30202
Nundah	30203
Narangba - Burpengary	31304
Bribie - Beachmere	31301
Bald Hills - Everton Park	30201
Caboolture	31302



Activity Consultation and Collaboration

Consultation

The PHN has engaged with following stakeholder groups in the development and management of this activity, conducting regular meetings and communication:

- early childhood education providers
- Koobara Kindergarten
- Institute for Urban Indigenous Health
- Aboriginal Community Controlled Health Services
- allied health practitioners.

Collaboration

The PHN will engage the Institute for Urban Indigenous Health to deliver the activity.

Other external stakeholders that will be involved in the implementation of the activity include:

- Koobara Kindergarten
- Children & Kindergarten (C&K)
- Aboriginal and Torres Strait Islander allied health practitioners
- Aboriginal Community Controlled Health Services in the PHN region
- local Aboriginal and Torres Strait Islander community members and families.
- IUIH
- Occupational Therapists and Speech Pathologists work with children and staff to deliver:
 - Individual screening
 - Report writing
 - Correspondence to parents and GP
 - Linking and developing pathways to other health services i.e. hearing health services
- Ear, Nose and Throat specialists, audiology
- Skills development programs to all children
- Tools for School Program
 - Individual and group therapy
 - In service and upskilling of early childhood staff



Activity Milestone Details/Duration

Activity Start Date

29/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: 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?

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

This program was co-designed with IUIH and C&K Caboolture and Koobara Kindergartens. The PHN has engaged with following stakeholder groups in the development of this activity:

- early childhood education providers
- Koobara Kindergarten
- Institute for Urban Indigenous Health
- Aboriginal Community Controlled Health Services
- allied health practitioners.



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$236,657.45	\$237,713.36	\$238,309.19	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$236,657.45	\$237,713.36	\$238,309.19	\$0.00	\$0.00	\$712,680.00
Total	\$236,657.45	\$237,713.36	\$238,309.19	\$0.00	\$0.00	\$712,680.00

Funding From Other Sources - Financial Details



Summary of activity changes for Department

Activity Status

Submitted

Subject	Description	Commented By	Date Created
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CF - 3200 - CF 3.2 - School readiness for children - YouThrive



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

3200

Activity Title *

CF 3.2 - School readiness for children - YouThrive

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description**Aim of Activity ***

The program will aim to provide a smoother transition from kindergarten to prep for at risk children. It will also aim to improve children's developmental readiness for school by identifying children aged 3-5 who are experiencing developmental delays and providing occupational therapy, speech pathology, psychological services and other support services for children and their parents.

This includes screening assessments, discipline-specific developmental assessments, centre/clinic-based intervention, carer sessions and professional development for early childhood educators.

The aim was to improve children's developmental readiness for school by identifying children aged 3–5 who may be experiencing developmental delays and providing occupational therapy, speech pathology, psychological services and other supports for children and their parents/caregivers. This includes screening assessments, discipline-specific developmental assessments, centre/clinic-based intervention, carer sessions and professional development for other child based services in the region.

Description of Activity *

The right preparation for a successful transition into schooling can foster a positive relationship with lifelong learning. Families, carers and early childhood educators play a significant role in supporting a child to be fully prepared for school, which can begin

well before a child's first day at Prep.

Early identification of children who may need additional support and assisting them in achieving key developmental milestones will ensure all children are given the best opportunity to thrive. Without this support, developmental delays that are not identified early can impact not only a child's educational experience, but can impact their future health and wellbeing.

The program was designed between Youthrive, Act for Kids, Micah Projects, Caboolture Child Health Services and World Wellness Group and submitted to the PHN through a Request for Proposal process to address the need identified in assisting children achieve key developmental milestones and ensuring all children are given the opportunity to thrive. The program will offer occupational therapy, psychology and speech pathology services to children aged 3-5 years.

The service will include screening assessments, discipline-specific developmental assessments, centre-based/clinic-based and outreach child-focused interventions, caregiver coaching sessions and professional development opportunities for educators.

This service is offered in collaboration with Micah Projects' Young Mothers for Young Women programs in Caboolture and Redcliffe. Caboolture East, South and West have been identified by the Brisbane North PHN as priority populations. Caboolture is an identified area of need, with limited allied health therapy services for children and young people.

The model also includes assessment and intervention services for 3–5-year-old children and families living within the broader Brisbane North PHN region, to be delivered from Youthrive clinics based in Everton Hills and North Lakes. Accordingly, the proposed model provides specialist therapy services to meet the identified early intervention needs of families living in all suburbs identified by Brisbane North PHN, to improve young children's educational engagement and long-term health and development outcomes. Youthrive will utilise existing relationships within the community as well as look to establish new relationships with community service providers and work collaboratively to identify suitable referrals from the target population group within the top twelve suburbs in the PHN region (with the highest number of children experiencing developmental vulnerabilities in at least two domains of the Australian Early Development Census). Services will be provided two days per week through school terms.

The program will be delivered from Youthrive's Everton Hills and North Lakes clinics.

The work undertaken in this activity will include:

- Intake and allocation
- Developmental screening and assessment
- Individualised goal setting
- Therapeutic intervention: occupational therapy, speech therapy and psychological therapies to build school-readiness skills - In-home therapy and support
- Parent focused interventions: coaching and capacity building to empower families to support their child's development
- Playgroup support: attendance at Wellspring Children and Families Hub Redcliffe and Caboolture twice a week.

Attendance at other playgroups or childcare centres if capacity allows

- Professional development to playgroup staff
- Cultural case consultation: in partnership with WWG to support any families that are from culturally and linguistically diverse backgrounds

Target Cohort:

Children aged between 3-5 years (and in some cases 2 years) showing signs of developmental delay in the Brisbane North PHN region.

The program works collaboratively with Micah Projects in Caboolture and Redcliffe at the Young Mothers for Young Women program, and the Caboolture Child Health team, and can offer appointments in the Youthrive clinic at North Lakes and Everton Hills.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Population Health - Health Needs Level 1	2-3
Children's Health - Service Needs Level 1	4
Children's Health - Health Needs Level 1	3
Population Health - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

Children aged between 3-5 years (and in some cases 2 years) showing signs of developmental delay. The program works collaboratively with Micah Projects in Caboolture and Redcliffe at the Young Mothers for Young Women program, and the Caboolture Child Health team, and can offer appointments in the You thrive clinic at North Lakes and Everton Hills.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Caboolture Hinterland	31303
Sandgate	30204
Chermside	30202
Nundah	30203
Narangba - Burpengary	31304
Bribie - Beachmere	31301
Bald Hills - Everton Park	30201
Caboolture	31302



Activity Consultation and Collaboration

Consultation

The PHN will engage with following stakeholder groups in the development of this activity:

- early childhood education providers
- allied health practitioners
- Metro North Health
- Child and Youth community organisations
- Youthrive
- MICAHA
- Children's Health Queensland Hospital and Health Service

Collaboration

Fortnightly PHN implementation meetings were established between September 2024 and January 2025. Now regular program monitoring is in place. As the program expands to kindy, additional collaboration meetings may be required with Youthrive, MICAHA and Children's Health Queensland Hospital and Health Service.



Activity Milestone Details/Duration

Activity Start Date

30/06/2024

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

Direct Engagement: No

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): No

Is this activity being co-designed?

Yes

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

The program was designed between Youthrive, Act for Kids, Micah Projects, Caboolture Child Health Services and World Wellness Group and submitted to the PHN through a Request for Proposal process.



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$339,667.58	\$264,417.61	\$342,038.27	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$339,667.58	\$264,417.61	\$342,038.27	\$0.00	\$0.00	\$946,123.46
Total	\$339,667.58	\$264,417.61	\$342,038.27	\$0.00	\$0.00	\$946,123.46

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Submitted

Subject	Description	Commented By	Date Created
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CF - 3300 - CF 3.3 - School Readiness Flexible - Caboolture Kids Collective



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

3300

Activity Title *

CF 3.3 - School Readiness Flexible - Caboolture Kids Collective

Existing, Modified or New Activity *

Modified



Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

The Caboolture region is ranked in the bottom 10 percent of suburbs across Australia in terms of socioeconomic advantage. There are approximately 14,000 children in the region, with approximately 25.6% of children in Moreton Bay developmentally vulnerable, higher than the Queensland average. Children with developmental delay or disability and their families in the Moreton Bay/Caboolture region have a range of needs shaped by both their specific circumstances and broader service access challenges common in outer metropolitan and regional areas. Based on available evidence and patterns seen in similar Australian communities, their needs can be summarised as follows:

1. Timely Identification and Diagnosis

* Early and accessible developmental screening and assessments (e.g. speech, OT, paediatrics).

* Long waitlists for diagnostic services (e.g. autism assessments) delay intervention.

2. Coordinated, Family-Centred Support

* Navigation support to help families understand and access services like NDIS, health, and education. *Case coordination or key worker roles to link medical, educational, allied health, and community supports.

3. Access to Local Services

- * Limited availability of specialist services in Caboolture and surrounding areas, especially for:
- * Speech pathology, occupational therapy, psychology, developmental paediatrics.
- * Behavioural supports and early childhood intervention programs.
- * Challenges travelling to Brisbane or Sunshine Coast for care due to cost, time, or transport barriers.

4. Inclusive Education and Childcare

- * Need for inclusive early learning settings that support children with developmental needs.
- * Support for schools to meet the needs of students with disabilities (e.g. aides, Individual Learning Plans).
- * Additional support for transitions between early childhood, school, and post-school options.

5. Support for Families and Carers

- * Emotional, mental health, and respite support for parents/carers under strain.
- * Peer support groups and culturally appropriate services, especially for Aboriginal and Torres Strait Islander and CALD families.
- * Help for families dealing with socioeconomic disadvantage or housing instability.

6. Culturally Safe and Equitable Services

- * Services that are responsive to Aboriginal and Torres Strait Islander families and other diverse communities.
- * Need for better outreach to families who are disengaged or unaware of available supports.

7. Systemic Integration and Advocacy

- * Gaps between health, NDIS, education, and community services create fragmentation.
- * Need for advocacy and systems that enable children to get the right support at the right time without families having to fight for it.

Need:

Children's Health

Other Needs:

The activity will aim to increase timely access to assessment, treatment and supports for children (and their families) with developmental delay or disability, through the development of a place-based, multiagency approach.

Description of Activity *

The activity will increase and enhance timely access to assessment, treatment, and supports for children (and their families) who have development delay or disability. The target cohort is children within the Brisbane North PHN Moreton Bay region, aged 0-9 years with developmental delays or disabilities, and their families.

The activity will undertake the following tasks:

Discover

- Review data, research and grey-literature and speak with stakeholders to better understand the problem, its causes and possible solutions.

Define

- Reframe the problem based on new understandings gained through the discovery phase.

Develop

- Together with stakeholders develop an action plan that addresses the problem.

Deliver

- Implement the action plan, with regular reviews and refinements.

A report on the findings of the discovery phase will be produced, summarising key issues and possible solutions.

A multi-stakeholder action plan will then be developed and agreed.

Specific actions in the plan will not be known until after the co-design process.

A service navigation website is currently in development with promotional materials for this also being prepared internally. A Family Fun Day is being coordinated with Metro North Hospital and Health Service to provide families with identification of the

range of service providers in the local area.

The co-design process:

This activity has been selected by the Joint Board Committee of Metro North Health and Brisbane North PHN, based on the findings of the Joint Regional Needs Assessment. It also builds on earlier work commissioned by Brisbane North PHN to develop a business case and community support for a collective-impact style approach to addressing the needs of children and young people in Caboolture.

A Partnership Group will be established with key stakeholders to develop and oversee the activity.

Key Priority Area:

Population Health Target Geographic Areas: Moreton- Bay North

HHS Hospital Catchment: Caboolture/Kilcoy Target populations

– Community of interest: Child and youth Disability Target Populations

- Age Groups: 0-4 5-14

Target Population description:

Children 0 - 9 (and their families) who are developmentally delayed or disabled, living in the Moreton Bay region. Health

Professionals: Allied Health General Practice Other Specialists

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Population Health - Health Needs Level 1	2-3
Children's Health - Service Needs Level 1	4
Children's Health - Health Needs Level 1	3
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

Children 0 - 9 (and their families) who are developmentally delayed or disabled, living in the Moreton Bay region.

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

While not an Indigenous specific activity, the higher numbers of Aboriginal and Torres Strait Islander young people in the region, and the higher percentage of Aboriginal and Torres Strait Islander young people with developmental delay or disability means Indigenous specific issues will be key.

Coverage

Whole Region

No

SA3 Name	SA3 Code
Redcliffe	31305
Caboolture Hinterland	31303
Narangba - Burpengary	31304
North Lakes	31402
Bribie - Beachmere	31301
Strathpine	31403
Bald Hills - Everton Park	30201
Caboolture	31302



Activity Consultation and Collaboration

Consultation

This activity has been selected by the Joint Board Committee of Metro North Health and Brisbane North PHN, based on the findings of the Joint Regional Needs Assessment.

It also builds on earlier work commissioned by Brisbane North PHN to develop a business case and community support for a collective-impact style approach to addressing the needs of children and young people in Caboolture.

A Partnership Group has been established with key stakeholders to develop and oversee the activity.

Collaboration

A Partnership Group has been established with key stakeholders to develop and oversee the activity.



Activity Milestone Details/Duration

Activity Start Date

30/06/2025

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: Yes

Continuing Service Provider / Contract Extension: No

Direct Engagement: No

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): No

Is this activity being co-designed?

Yes

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

This activity has been selected by the Joint Board Committee of Metro North Health and Brisbane North PHN, based on the findings of the Joint Regional Needs Assessment.

It also builds on earlier work commissioned by Brisbane North PHN to develop a business case and community support for a collective-impact style approach to addressing the needs of children and young people in Caboolture. A Partnership Group has been established with key stakeholders to develop and oversee the activity.



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$128,735.08	\$16,698.45	\$0.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$128,735.08	\$16,698.45	\$0.00	\$0.00	\$0.00	\$145,433.53
Total	\$128,735.08	\$16,698.45	\$0.00	\$0.00	\$0.00	\$145,433.53

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Submitted

Subject	Description	Commented By	Date Created
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CF - 4000 - CF 4.0 - Social Prescribing



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

4000

Activity Title *

CF 4.0 - Social Prescribing

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description**Aim of Activity ***

Brisbane North PHN undertook our Health Needs Assessment in 2021-2022 which identified gaps as well as identified solutions that the PHN may be able to progress to address these.

For numerous gaps, stakeholders identified that social prescribing would help to address them (e.g. supporting community in accessing preventative health services through relationships and trust; patient empowerment including via peers).

Social prescribing is a process where a healthcare provider refers a patient to a Link Worker/Navigator who assesses their needs and provides a non-medical prescription to improve their health and wellbeing. For example, this might be to a social activity; to information or guidance; to a community group; or to learning and skills.

Evidence suggests that consumers feel community services and programs could support their health and wellbeing, and GPs believe referral to such programs could improve outcomes.

Yet most GPs do not have links to appropriate services, and a majority don't discuss such approaches as part of patient management. Social prescribing has been identified in Australia's Primary Health Care 10 Year Plan 2022-2032 as an important initiative to improve health.

Following on from the co-design, tender process and implementation of the service in previous financial years and taking into

account the positive first signs from the service set up and interim evaluation report, the PHN decided to extend the pilot for another FY (in 2024-25) and expand it to include the Redcliffe Hospital catchment.

This decision was taken in a positive policy context as the Department of Health and Ageing was working on a National Feasibility Study of Social Prescribing in the Australian Context in a bid to establish a framework for developing Social Prescribing in Primary Care across Australia. The draft report from this feasibility positioned PHNs as a strong partner for commissioning social prescribing services best adapted to their communities.

With indications that there may be some dedicated funding to PHNs for social prescribing activities, the PHN decided to continue this program for another FY (2025-26), and now into FY 2026-27 following the positive final evaluation report (data to June 2025) and official release of the National Feasibility Report (November 2025).

Description of Activity *

Based on the health needs assessment, it was decided to focus a social prescribing pilot on the Caboolture region which has high proportions of populations in need.

There is a range of ways that social prescribing could be implemented in Caboolture and therefore a co-design process was undertaken to identify the most appropriate options, which were then commissioned. The process also identified groups for inclusion in the process and local services for a Link Worker to refer them into.

The Caboolture pilot is also considering scalability and evidence for a broader social prescribing rollout. This activity undertook a literature review of social prescribing models in Australia and overseas. Following this review, the PHN procured and supported a co-design agency to work with consumers and stakeholders in Caboolture to identify groups and services for inclusion in the model.

The activity commissioned a provider to deliver the social prescribing model to meet the needs, including provision of a Link Worker to refer consumers into local non-medical services to support evidence for a broader social prescribing rollout an evaluation of the service is being undertaken.

The region for service delivery was extended beyond Caboolture to include the Moreton Bay North and Redcliffe- North Lakes sub-regions.

Activities undertaken for 25-26 will include:

- Continued contract management of the commissioned service provider.
- Direct delivery of the social prescribing service by Link Workers/Navigators with holistic psychosocial assessment on intake to co-create a person-centred, goal-directed plan according to each person's goals, needs and choices, to support the person to access safe and appropriate services or activities, with periodic follow up and review of plan.
- Data is collected by the service provider and shared for reporting and continuous improvement purposes.
- Evaluation to support evidence for a broader social prescribing rollout.
- Networking and participation in any relevant conferences, research or consultation to contribute to the development of Social Prescribing models and policies nationally.
- Ongoing community engagement and promotion of the service to referrers, consumers, and community services.

Target Cohort:

The target cohort for this activity is people aged 18+ within the Brisbane North PHN region. Specifically, the Moreton Bay North and Redcliffe-North Lakes sub-regions. Due to the dual funding source, it is a requirement that 35% of accepted referrals are for older Australians (those aged over 65 or over 50 for First Nations people).

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Population Health - Health Needs Level 1	2-3
Population Health - Service Needs Level 1	5
Service System - Service Needs Level 1	5
Older Persons - Service Needs Level 2	9



Activity Demographics

Target Population Cohort

People aged 18+. Certain groups are most likely to benefit from social prescribing and should be targeted, including people experiencing mental health issues, people with chronic physical conditions and multi-morbidity, people experiencing social isolation including young people and older people. Due to the dual funding source, it is a requirement that 35% of accepted referrals are for older Australians (those aged over 65 or over 50 for First Nations people).

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

The Link Workers will receive cultural sensitivity training and service access by First Nations people will be monitored.

Coverage

Whole Region

No

SA3 Name	SA3 Code
Caboolture Hinterland	31303
Narangba - Burpengary	31304
Bribie - Beachmere	31301
Caboolture	31302



Activity Consultation and Collaboration

Consultation

The PHN engaged an agency to co-design the social prescribing model and to work with consumers and stakeholders in the Caboolture region as part of this process.

Stakeholders consulted as part of the design and/or implementation include the PHN's Caboolture and Redcliffe Collaborative, Metro North Hospital and Health Service, Children's Health Queensland Hospital and Health Service, the Institute of Urban

Indigenous Health, and Moreton Bay Regional Council.

Collaboration

The PHN engaged an agency to co-design the social prescribing model and to work with consumers and stakeholders in the Caboolture region as part of this process.

Stakeholders consulted as part of the design and/or implementation include the PHN's Caboolture and Redcliffe Collaborative, Metro North Health, Children's Health Queensland Hospital and Health Service, the Institute for Urban Indigenous Health, and Moreton Bay Regional Council.

A Steering Committee comprising of members from MNH, Moreton Bay and Sommerset Councils, GP Liaison Officer Program and the PHN led by the Integrated Care team, oversees the activities.



Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

Direct Engagement: No

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): No

Is this activity being co-designed?

No

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

Yes

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

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

The PHN engaged an agency to co-design the social prescribing model and to work with consumers and stakeholders in the Caboolture region as part of this process.

Stakeholders consulted as part of the design and/or implementation include the PHN's Caboolture and Redcliffe Collaborative, Metro North Health, Children's Health Queensland Hospital and Health Service, the Institute for Urban Indigenous Health, and Moreton Bay Regional Council.



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$269,650.67	\$270,854.21	\$271,532.69	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$269,650.67	\$270,854.21	\$271,532.69	\$0.00	\$0.00	\$812,037.57
Total	\$269,650.67	\$270,854.21	\$271,532.69	\$0.00	\$0.00	\$812,037.57

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Submitted

Subject	Description	Commented By	Date Created
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CF - 4100 - CF 4.1 - Bilateral State Wide Planning



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

4100

Activity Title *

CF 4.1 - Bilateral State Wide Planning

Existing, Modified or New Activity *

Modified



Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description**Aim of Activity ***

The aim of this work is to support the QLD PHNs to engage with Queensland and Commonwealth partners to address the emerging priorities as identified for Qld PHNs. Due to the nature of the funding with shifting emerging priorities. Governance is provided by the QPHN Collective It has been collectively agreed by Qld PHNs that the first priority will be to engage and procure consultancy services to support the development of a strategic vision for implementing data sharing and linkage between primary care and secondary care data

Activities that have been identified to support this partnership include developing demonstrator projects and prioritise needs (for example, joint regional needs assessment, primary care data collection).

Description of Activity *

\$500,000 of funding was provided from the Commonwealth in 2023/24 financial year and is currently held with Brisbane North PHN on behalf of Queensland PHNs for thought leadership work to support the Queensland- Commonwealth Partnership (QCP).

Since the last update to this AWP, the Queensland Commonwealth Partnership has been disbanded. To continue with the intent of this work, the Queensland PHNs have continued to work on a number of jointly identified priorities with Queensland Health, noting that additional prioritisation is taking place currently.

It has been collectively agreed by Qld PHN CEOs that a portion of this funding will be utilised to engage and procure consultancy services to support the development of a strategic vision for implementing data sharing and linkage between primary care and secondary care data. Initial priority activities that have emerged for Queensland PHNs include: Prepare Collaborative Data Sharing Agreement that can be utilised by all PHNs

- Develop Primary Care MDS for sharing
- Development of Legal pathways guidance for sharing and linkage
- Clearly identifying the Primary Benefits Realisation to support the use of data extraction

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Population Health - Service Needs Level 1	5
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

Queensland-Commonwealth Partnership (QCP) including Commonwealth Department of Health and Aged Care, Queensland PHNs Collective (7 Qld PHNs) and Queensland Health.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

The QCP provided one of the consultation mechanisms to identify priority projects to support the shared QCP work agenda.

Qld PHNs collaborated through workshops in 2024–25 (facilitated by DCI Consulting for PC CDS; GCPHN-led for Benefits Plan). Draft artefacts iterated with representatives from all seven Qld PHN data/digital leads. The proposal has been endorsed by the Qld PHN CEO Collective. Key stakeholders have been consulted and provided feedback on their need for improved access to standardised primary care data that Qld PHNs collect, including: Qld Department of Health, Queensland Hospital Health Services, Queensland Aboriginal and Islander Health Council and the Institute of Urban Indigenous Health.

Collaboration

- Queensland Health
- Commonwealth Department of Health and Aged Care
- 7 QPHNs



Activity Milestone Details/Duration

Activity Start Date

07/02/2024

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

This is one identified priority under the QCP agenda, with no project plan developed due to the nature of the funding and specific project deliverables by 30 June 2027.

Due to the ongoing nature of shifting and emerging priorities with QCP, the end date is 30 June 2027, as there will be other projects and priorities identified out of the remaining funds.



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

Direct Engagement: Yes

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): No

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$477,500.00	\$413,950.00	\$0.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$477,500.00	\$413,950.00	\$0.00	\$0.00	\$0.00	\$891,450.00
Total	\$477,500.00	\$413,950.00	\$0.00	\$0.00	\$0.00	\$891,450.00

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Submitted

Subject	Description	Commented By	Date Created
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CF - 4300 - CF 4.3 - Norfolk Island - Mental Health Services Flexible Funds



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

4300

Activity Title *

CF 4.3 - Norfolk Island - Mental Health Services Flexible Funds

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area *

Mental Health

Other Program Key Priority Area Description

Aim of Activity *

As per guidance from the Commonwealth, \$44,000.000 (GST Inclusive) Core Flexible Funding was offered towards maintaining mental health services on Norfolk Island. Using these funds, BNPHN will aim to provide a dedicated Primary Care Team Engagement Officer will support the multipurpose health service at the Norfolk Island Health Residential Aged Care Services (NIHRACS) General Practice.

This will be done by increasing the efficiency and effectiveness of primary health care services for patients, particularly those at risk of poor health outcomes, by ensuring they have access to digital health tools and technologies, coaching, resources, project opportunities and clinical audit tools to drive continuous quality improvement (CQI) activities.

The Engagement Officer will also work to identify collaboration opportunities with mainland stakeholders, including Metro North Health (MNH).

Description of Activity *

Norfolk Island is located in a unique remote location with a small population (approx. 2200 people). From 1 January 2022, Metro North Health (MNH) has become the local Hospital and Health Service (HHS) for Norfolk Island.

The transition to referral pathways and programs is unique and needs to be done with sensitivity by building a strong relationship

with NIHRACS General Practice who will need support to access and navigate MNH systems, digital health, quality improvement, and government and PHN initiatives.

Prior to 2015, there was no Medicare and people would avoid going to a GP, therefore work is required to support the management of a high burden of chronic disease and low health literacy and a multiculturally diverse population (Pitcairn descendants).

Longitudinal genomics studies by Queensland University of Technology (QUT) show a high rate of diabetes and cardiovascular disease on Norfolk Island. NIHRACS General Practice has a very traditional medical model

- the General Practice is located within the same building as the Hospital and Aged Care Services and all services are accessed via the General Practice building which can cause privacy issues.

Work undertaken by the Primary Care Team Engagement Officer will include:

- Developing a strong relationship with Norfolk Island stakeholders
- Attending bi-monthly meetings with NIHRACS, Metro North Norfolk Island Support Program (MN NISP) and the Team Leader I Priority Communities
- Facilitate bi-monthly meetings with NIHRACS staff - On island visits as required
- Provision of relevant resources - Collaboration with MN NISP to ensure the coordination of patient care and referral pathways are working effectively
- Provision of access to education, training and networking opportunities
- Coaching and support in planning and implementing CQI activities relevant to their practice - Inclusion in the delivery of the Primary Care team's Accreditation Support Program
- Proactively engage and respond to practice enquires and requests for support
- Regular communications - Deliver digital health education sessions and troubleshooting
- Provide CQI training, coaching and resources - Provide CQI and data quality training events, projects and support
- Provide general practice accreditation support

Target Cohort:

Residents and visitors of all ages of Norfolk Island accessing primary care medical services.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Mental Health - Health Needs Level 1	2
Population Health - Service Needs Level 1	5
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

Residents and visitors of all ages of Norfolk Island accessing primary care medical services.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

No



Activity Consultation and Collaboration

Consultation

This work will involve collaboration and close working relationships with the Priority Communities team and Metro North Norfolk Island Support Program (NISP). Any associated funding for this work will be via the contract with Priority Communities.

Collaboration

Norfolk Island Health and Residential Aged Care Services (NIHRACS) - Primary care Support Metro North Norfolk Island Support Program (MN NISP) - Collaboration to support Norfolk Island General Practice



Activity Milestone Details/Duration

Activity Start Date

30/06/2025

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$348,840.00	\$0.00	\$308,840.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$348,840.00	\$0.00	\$308,840.00	\$0.00	\$0.00	\$657,680.00
Total	\$348,840.00	\$0.00	\$308,840.00	\$0.00	\$0.00	\$657,680.00

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Submitted

Subject	Description	Commented By	Date Created
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CF - 4400 - 4.4 - General Practice Sustainability



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

4400

Activity Title *

4.4 - General Practice Sustainability

Existing, Modified or New Activity *

New Activity



Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

Service System

Aim of Activity *

General practice in Australia is facing escalating pressures from workforce shortages, financial strain, rising operational costs, and a rapidly changing policy and reform environment.

In the Brisbane North PHN region, these challenges are particularly acute among solo and small (2-3 Full time equivalent GPs) general practices.

Since 2023, 16 such practices have closed, often citing financial instability or difficulty recruiting GPs/GP retirement, and many corporate owned practices have also merged.

A further five practices are currently flagged as “at risk”, either due to GP shortages or other operational concerns. The Practice Catalyst tool is a practice self-assessment tool designed to help practices identify their strengths, pressure points, and priorities across areas like governance, workforce, operations, and sustainability.

After completing the assessment, practices receive a personalised action plan with practical next steps and relevant resources.

Brisbane North PHN receives aggregated data, allowing us to better tailor support and investment leading to more equitable and efficient use of finite resources. Brisbane North PHN's Primary Care team will be launching the Practice Catalyst tool in 2026 to triage the needs of general practices and offer tailored support to improve their viability and sustainability.

The data gathered in this project will provide a baseline to guide the support we provide to general practices in response to the needs identified.

Description of Activity *

Outputs delivered for this activity will include:

- Region-wide sustainability heat map
- Percentage engagement of the practices with the Practice Catalyst tool and receiving a personalised action plan with practical next steps
- Percentage engagement of the practices with Cubiko and coaching sessions
- Standardised dataset for evaluation and planning for future activities
- Benchmarking against regional averages - Sending the Practice Catalyst assessment tool to all active practices in the region via eDM.
- The tool (Practice Catalyst) will stratify practices into three zones of survival, stable and leading.
- Each practice will receive a customised action plan upon completion.
- Those in the survival zone will be contacted about their eligibility to receive Cubiko licences with conditional agreement.
- After allocation of Cubiko licences, training and coaching support will be provided to the general practice most in need for the duration of the 12-month licences.
- The result of the assessment will be used to tailor the Continuous Quality Improvement activities and prioritise training opportunities provided to General Practices.

Target Cohort: All general practices in the Brisbane North PHN Region.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Population Health - Health Needs Level 1	2-3
Workforce - Health Needs Level 1	3
Population Health - Service Needs Level 1	5
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

All general practices in the Brisbane North PHN Region.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

Support with promoting initiative to general practices (in consultation with Rebbeck Consulting).

Collaboration

- Ongoing monitoring of practice uptake of the tool
- Frequent follow up via QI&D Engagement Officers
- Comprehensive and timely co-branded communication plan



Activity Milestone Details/Duration

Activity Start Date

28/02/2026

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: No

Direct Engagement: Yes

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): No

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$128,735.08	\$0.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$128,735.08	\$0.00	\$0.00	\$0.00	\$128,735.08
Total	\$0.00	\$128,735.08	\$0.00	\$0.00	\$0.00	\$128,735.08

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Submitted

Subject	Description	Commented By	Date Created
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CF - 4500 - CF - 4.5 - ECCQ Health Navigation and Multi-Cultural Living Well Program



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF

Activity Number *

4500

Activity Title *

CF - 4.5 - ECCQ Health Navigation and Multi-Cultural Living Well Program

Existing, Modified or New Activity *

New Activity



Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description

Aim of Activity *

Australian Culturally and Linguistically Diverse (CALD) communities have a high prevalence of chronic diseases compared with the Australian-born population.

The 'Health of Queenslanders' (2014) reports that Queenslanders born in non-English speaking countries have a 25% higher death rate from diabetes than the Australian-born population. Hospitalisation rates for a number of conditions are also higher for those born in Oceania, North Africa, and the Middle East compared with Australian-born Queenslanders.

In addition Samoans, Tongans, Fijians and Australian South Sea Islanders have a higher hospitalisation rate for many conditions, including chronic diseases. A 2013 study conducted with CALD communities by Brisbane North PHN and the Multicultural Development Association (MDA) found that after hospital discharge many CALD patients feel uncertain about their health conditions and how to seek ongoing support for chronic disease management in their community.

This highlights the need for culturally responsive service coordination between hospital and primary health service providers. The purpose of the Health Navigation and Multi-Cultural Living Well Program is to increase occasions of health support provided to disadvantaged groups, specifically the Culturally and Linguistically Diverse (CALD) community, where complex factors impact people, carers and service providers both after hours and at other times.

This will be achieved by providing culturally responsive health services to individuals and small groups and coordinating health related services for the CALD population. ECCQ will work to address gaps in After Hours service arrangements and improve service integration within the Brisbane North PHN region.

Key program objectives include:

- Increase the efficiency and effectiveness of After Hours Primary Health Care for patients, particularly those with limited access to health services
- Improve access to After Hours Primary Health Care through effective planning, coordination and support for population based After Hours Primary Health Care

Description of Activity *

The program implements an evidence-based chronic disease prevention and self-management healthy lifestyle program for CALD people living in Brisbane North communities.

It focuses on risk assessment, follow-up and self-management support. It incorporates a self-management framework underpinned by adult learning principles to encourage behaviour change and promote health and well-being.

The program will:

- Improve the health literacy of CALD communities to access health information and build individual capacity to use health information effectively
- Develop an effective referral pathway between primary health service providers and ECCQ to improve service delivery for CALD clients who are identified with a medium or high-risk of chronic disease.
- Contribute to reducing avoidable hospital admissions for CALD communities by providing effective self-management support in the community.

By the end of the program timeframe (2026), target CALD communities in the Brisbane North area will have:

- increased numbers of CALD clients who have received culturally responsive chronic health screening
 - improved the health literacy of the target communities • received better coordinated health services
- Trained and qualified bi-lingual community health workers will run culturally responsive 1:1 or small group chronic disease prevention and management education sessions.

Each eligible participant will receive:

- 2-3 x culturally responsive health education sessions (1-2 hrs per session)
- Education session topics include:
 - o Health Screening
 - o Chronic Disease Health Education
 - o Understanding the Australian Health Care System
 - o Nutrition and Physical Activity
- Follow-up phone calls to participants
- Referral to local GPs (if participants do not currently have access to a local GP)
- Supported visits to GPs (if required)
- Identify and update or develop culturally tailored evidence-based content of a chronic disease and diabetes self-management education sessions for target CALD communities
- Implement project promotional activities including organising health-focused events for CALD communities and using local media, sourced by target groups
- Identify CALD participants and those who do not meet eligibility criteria for My Health for Life program and work in partnership with their local primary health service providers to enhance their health literacy, self-management skills and promote their overall health and well-being using culturally tailored and simplified English/in language resources
- Conduct health risk assessment screenings and relevant education to other CALD communities through project promotional activities or where resources available and opportunities arise

Target Cohort: The program works with CALD people who are classified as medium-high risk for chronic disease or those already diagnosed with a chronic disease.

Needs Assessment Priorities *

Needs Assessment

Priorities

Priority	Page reference
Population Health - Health Needs Level 1	2-3
Culturally and Linguistically Diverse Communities - Health Needs Level 1	2
Population Health - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

The program works with CALD people of all ages who are classified as medium-high risk for chronic disease or those already diagnosed with a chronic disease.

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

ECCQ works in partnership with Aboriginal and Torres Strait Islander organisations. They will seek advice on how to best support a resident who identifies as Aboriginal and Torres Strait Islander as required.

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

Brisbane North PHN has continued to engage with key stakeholders across the community and acute healthcare sectors across the PHN region. This includes health professionals (including GPs), community representatives and consumers.

Priority populations and services types confirmed at initial co-design workshops held in 2016 have been refined through a process of continued consultation. Brisbane North PHN has consulted with the following stakeholders in the development of this specific activity:

- Micah Projects
- Queensland Injectors Health Network
- Brisbane South PHN
- Mater Refugee Health

- Metro North Hospital and Health Service
- Ethnic Communities Council Queensland
- Multicultural Development Australia.

Collaboration

Brisbane North PHN will continue to collaborate with Ethnic Communities Council (ECCQ) of Queensland.

The role of ECCQ is to engage and inform the PHN in delivering culturally appropriate services for people who are often hard to reach and are disengaged with current health services.



Activity Milestone Details/Duration

Activity Start Date

30/06/2023

Activity End Date

29/06/2026

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

Direct Engagement: No

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): No

Is this activity being co-designed?

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

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

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

Decommissioning

Decommissioning details?

This program is being transitioned under the new Multicultural Access Program funding for FY 24-25. The activity has ceased under the Core schedule and is now submitted as an activity for the Multicultural After Hours schedule.

However due to the decommissioning component of this activity, Core Flexible funds have been approved by Department to allocate against this activity to assist with transition of decommissioning services.

Co-design or co-commissioning comments

Brisbane North PHN has continued to engage with key stakeholders across the community and acute healthcare sectors across the PHN region. This includes health professionals (including GPs), community representatives and consumers.

Priority populations and services types confirmed at initial co-design workshops held in 2016 have been refined through a process of continued consultation. Brisbane North PHN has consulted with the following stakeholders in the development of this specific activity:

- Micah Projects
- Queensland Injectors Health Network
- Brisbane South PHN
- Mater Refugee Health
- Metro North Hospital and Health Service
- Ethnic Communities Council Queensland
- Multicultural Development Australia.



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$75,000.00	\$0.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Bilateral Statewide Planning	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Strategic Health Alliance	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$75,000.00	\$0.00	\$0.00	\$0.00	\$75,000.00
Total	\$0.00	\$75,000.00	\$0.00	\$0.00	\$0.00	\$75,000.00

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Submitted

Subject	Description	Commented By	Date Created
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HSI - 1100 - HSI 1.1 - Quality in General Practice



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

1100

Activity Title *

HSI 1.1 - Quality in General Practice

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description**Aim of Activity ***

This activity aims to support general practice staff and clinicians to provide high-quality care for their patients, improving the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes.

This aim will be achieved through targeted initiatives, tailored coaching, access to resources, and project opportunities that drive continuous quality improvement (CQI) to enhance the efficiency of supporting general practices in quality improvement activities including clinical audits and using practice data to support improved patient care.

Description of Activity *

This activity will increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes by ensuring that general practices have access to quality improvement activities and are operating according to standards set by the Royal Australian College of General Practitioners.

The PHN will engage general practices in CQI activities through:

- delivery of the PHN's CQI program in collaboration with the Quality Improvement and Reform team
- identifying and supporting practices to develop within each of the CQI engagement zones

- providing support and coaching to practices in planning and implementing CQI activities relevant to their practice delivered via varied mediums (e.g. face-to-face, virtual or phone etc)
- supporting the delivery of projects and initiatives that focus on improving patient outcomes e.g. Multicultural Health, Cancer Screening, MyMedicare (Chronic Disease Management, Better Access and Buil Billing PIP).
- delivery of the Population Health PIP QI 10 QIM's report
- continued training and education (meaningful use) in the PHN's population management and clinical audit tool , Primary Sense
- participating in the National Improvement Network Cooperative (NINCo) which aims to provide a nationally recognised and consistent approach to CQI support for primary health care providers
- supporting the implementation and delivery of Networking events for general practice staff
- providing support to general practice as per CQI practice engagement strategy (Primary Care Team Ways of Working 2025)

Delivering outputs such as :

- CQI resources; Practice Development Matrix, CQI templates, Practice Support website and support, Micro Videos, CQI program
- CQI coaching and support provided to practice staff
- CQI training opportunities for practice staff
- CQI project and initiative delivery supported by the Engagement team (PHN led projects/partnerships/research projects/supporting role)

Target cohort:

This activity is targeted at general practice staff and their patients of all ages within practices located throughout the Brisbane North PHN region.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Population Health - Health Needs Level 1	2-3
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

This program targets general practice staff and the patients that receive services from those practices in the North Brisbane and Moreton Bay region.

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

Work collaboratively with IUIH Integrated Team Care program and support uptake of cultural awareness training and indigenous health activities such as IHI and CTG CQI activities.

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

The PHN surveys GPs in the region to understand their quality improvement support needs.

The Primary Care engagement team works with practices to consult on the types of QI activities required and to be implemented.

Collaboration

The PHN will collaborate with various stakeholders such as general practice education providers and accrediting bodies to ensure the support provided to general practices is appropriate, relevant and up to date.

To maintain practice quality, the PHN will also collaborate with the following organisations:

- Australian General Practice Quality and Improvement
- GPA Accreditation Plus
- Royal Australian College of General Practitioners.

Collaboration within internal stakeholder teams will also involve working with the Commissioning, Analytics and Reporting (CAR) team for reporting and evaluation.

The Primary Care team will work across both of its sub-teams

- 1) Engagement team and 2) Development team to achieve the intended outcomes.



Activity Milestone Details/Duration

Activity Start Date

29/06/2024

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

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

Yes

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

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

The PHN surveys GPs in the region to understand their quality improvement support needs.



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Systems Improvement	\$150,962.80	\$150,962.80	\$150,962.80	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Systems Improvement	\$150,962.80	\$150,962.80	\$150,962.80	\$0.00	\$0.00	\$452,888.40
Total	\$150,962.80	\$150,962.80	\$150,962.80	\$0.00	\$0.00	\$452,888.40

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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HSI - 1200 - HSI 1.2 - eHealth Support



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

1200

Activity Title *

HSI 1.2 - eHealth Support

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area *

Digital Health

Other Program Key Priority Area Description**Aim of Activity ***

Digital health plays a key role in general practice and there is a need to support practices with new and existing digital health technologies from awareness through to adoption and sustainable implementation.

This activity aims to assist general practice to be digitally enabled and integrated, while ensuring the awareness of adopting and using digital tools and programs including My Health Record, Health Provider Portal (HPP)/The Viewer, MyMedicare, Secure Messaging, Electronic Referrals (GPSR) and PRODA to support business operations and improved patient outcomes.

Activities also support the technical aspects of the PHN's data extraction and clinical audit tool, Primary Sense, within General Practices. These activities will assist in the coordination of patient care, particularly where patients are in contact with more than one component of the health system.

Description of Activity *

The PHN will assist general practice to improve digital health usage and compliance, including usage of My Health Record, MyMedicare, secure messaging and eReferral systems (GPSR).

These activities will assist in the coordination of patient care, particularly where patients are in contact with more than one

component of the health system.

The outputs of the products delivered include:

- > support and resources are provided to practices in response to topics identified by Practice Support Coordination and knowledge base

- > digital health initiatives to be included in monthly Practice Link newsletter communication to general practices in our region

- > quarterly planning process to include digital health priorities

- > digital health included as core part of CQI activities

- > Primary Sense installation and ongoing support

- > promote opportunities for interoperability and digital health initiatives that support improved care across health systems

- > digital health initiatives are actively promoted by the Primary Care team

- > Digital Health Engagement Officer/s are trained and knowledgeable in digital health systems

- > Internal team's Digital Health Community of Practice (CoP)

- > collaboration with MNHHS and Integration to progress relevant work

Achieving this work by:

- > regular team meetings to assess, plan and review digital health initiatives

- > supporting practices to achieve and maintain Digital Health compliance, including meaningful use of the My Health Record and Provider Connect Australia (PCA), MyMedicare and Provider Digital Access (PRODA)

- > work with Metro North Hospital and Health Service (MNHHS) and the Integrated Care Team to assist the set up and make best use of secure messaging including clinical document architecture (CDA), Health Provider Portal (HPP), eReferral templates and Electronic Referrals including GP Smart Referrals (GPSR) to ensure clinical information is shared appropriately, efficiently and accurately between care providers

- > support general practices in the use of telehealth, particularly video and associated item numbers

- > support general practices in the use of PRODA for accessing Practice Incentive Program (PIP), Workforce Incentive Program (WIP), MyMedicare, GP Aged Care Incentive (GPACI), (Australian Immunisation Register (AIR), National Authentication Service for Health (NASH) certificates etc.

- > support general practices to install and maintain Primary Sense as a necessary foundation towards meaningful use.

Target Cohort:

This activity target population is aimed at all general practices and general practice staff in the Brisbane North region, with a focus on initiatives that ultimately impact and benefit the populations they serve which is all ages within the Brisbane North region.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

All general practices and staff in the Brisbane North region, with a focus on initiatives that ultimately impact and benefit the populations they serve of all ages in the Brisbane North region.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments**Coverage****Whole Region**

Yes

**Activity Consultation and Collaboration****Consultation**

The PHN has consulted with the Clinical Council and Community Advisory Committee on these e-health support activities.

Collaboration

The PHN will collaborate with various stakeholders such as secure messaging providers, telehealth supported technology vendors, the Australian Digital Health Agency and the Metro North Hospital and Health Service to ensure the best support is provided to general practices for them to take advantage of digital health technology and systems.

GPSR, HPP/The Viewer, Health Pathways, secure messaging and components of MyHR and Provider Connect Australia initiatives are delivered in close partnership with the Integrated Care team.

This work will involve collaboration and a close working relationship with the Commissioning, Analytics and Reporting (CAR) team. eg; Primary Sense installations and support

The Digital Health role will work across both of the Primary Care Team sub-teams -

- 1) Engagement team and
- 2) Development team to achieve the intended outcomes. eg MyMedicare and NCSR registrations Electronic Referrals (GPSR), HPP/The Viewer, Health Pathways, secure messaging - eReferral template updates, My Health Record and Provider Connect Australia initiatives are delivered in close partnership with MNHHS and Integrated Care team.

**Activity Milestone Details/Duration****Activity Start Date**

29/06/2024

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

Direct Engagement: No

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): Yes

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

N/A



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Systems Improvement	\$113,222.11	\$113,222.11	\$113,222.11	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Systems Improvement	\$113,222.11	\$113,222.11	\$113,222.11	\$0.00	\$0.00	\$339,666.33
Total	\$113,222.11	\$113,222.11	\$113,222.11	\$0.00	\$0.00	\$339,666.33

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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HSI - 1300 - HSI 1.3 - Workforce Support



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

1300

Activity Title *

HSI 1.3 - Workforce Support

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area *

Workforce

Other Program Key Priority Area Description**Aim of Activity ***

This activity aims to build the capability of the primary care workforce in the North Brisbane and Moreton Bay region through networking and training / education opportunities.

This activity includes both clinicians and administrative staff in primary care with a focus on non-GP staff e.g. practice managers, receptionists, nurses, Aboriginal and Torres Strait Islander health workers and allied health providers.

While there are numerous professional development opportunities for GPs, a gap has been identified in training and development of general practice administrative staff and networking opportunities for nurses and practice managers.

Feedback from practices has also been overwhelming that education opportunities for administration staff are in demand.

During the last three years, COVID-19 restrictions have impacted the opportunities for face-to-face networking and training opportunities. This activity aims to identify and address workforce needs, in particular sub regions or professional cohorts to ensure sustainable provision of primary care through general practice across the Brisbane North PHN region.

Description of Activity *

The PHN will facilitate ongoing professional development of general practitioners and staff of general practice, including practice managers, receptionists, nurses, Aboriginal health workers and allied health providers, through the provision of accredited training programs, clinical audits and by providing assistance to general practice in areas where there may be identified workforce shortages.

The PHN will also provide assistance to general practice through the provision of the HealthPathways program to ensure best practice clinical pathways are available, ensuring that patient care is well coordinated, efficient and effective.

This activity will assist the PHN in increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and will also improve the coordination of care to ensure patients receive the right care in the right place at the right time.

This activity will support the primary healthcare sector by undertaking the following work:

- schedule, promote and facilitate bi-annual general practice network and training meetings in the Brisbane North region (to include all practice staff practice managers, nurses and administration)
- identify training opportunities for practice nurses, practice managers and administration staff
- deliver education and training sessions that focus on identified needs
- review and monitor the suite of training micro-video topics to check relevance and applicability to general practice staff regarding high performing PHC
- a suite of training micro-videos is relevant to the needs of, and supports the general practice workforce
- training and education to support emerging health system needs

Target Cohort: The activity will target General Practices, their staff and other primary care providers in the North Brisbane and Moreton Bay region to assist the population of all ages within the Brisbane North region.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Workforce - Health Needs Level 1	3
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

This activity is targeted at the health workforce, including clinical and administrative general practice staff, including practice managers, receptionists, nurses, Aboriginal health workers and allied health providers

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

- standardise inclusion of Aboriginal and Torres Strait Islander Health Workers in training flyers and EOIs
- ensure workforce activities are culturally appropriate

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

The PHN consults with practice managers and administrative staff to determine appropriate training topics.

In addition consultation is undertaken with nurses and practice managers to determine suitable scheduling of networking events and planning for topics.

The Australian Primary Care Nurses Association (APNA) and the Australian Association of Practice Managers (AAPM) are consulted to determine available level of support for networking events.

Collaboration

The PHN will collaborate with various stakeholders such as education providers, the Royal Australian College of General Practitioners in relation to conducting clinical audits and the Metro North Hospital and Health Service in relation to the development of best practice and localised clinical pathways.



Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

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?

Yes

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

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

Consult with practice managers, administrative and clinical staff to determine appropriate training topics Consult with nurses and practice managers to determine suitable scheduling of networking events and planning for topics



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Health Systems Improvement	\$113,222.11	\$113,222.11	\$113,222.11	\$0.00	\$0.00
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Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Systems Improvement	\$113,222.11	\$113,222.11	\$113,222.11	\$0.00	\$0.00	\$339,666.33
Total	\$113,222.11	\$113,222.11	\$113,222.11	\$0.00	\$0.00	\$339,666.33

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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HSI - 2100 - HSI 2.1 - Support for the PHNs commissioning process



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

2100

Activity Title *

HSI 2.1 - Support for the PHNs commissioning process

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description**Aim of Activity ***

This activity aims to support Brisbane North PHN (the PHN) activities through high quality commissioning processes including stakeholder engagement, needs assessment and evaluation. Health needs assessment and stakeholder engagement provide the evidence base that allow for the co-design and development of activities that are targeted to populations most in need.

Commissioning and procurement support also ensures that services are procured and monitored in a way that ensures value for money and the best outcomes for our community.

Program evaluation measures the effectiveness of PHN activities and recommends strategies to ensure the PHN achieves stated outcomes.

This commissioning activity is a critical part of health systems improvement and supports the PHN at an organisational and activity level across all activities undertaken by the PHN.

Description of Activity *

The activity involves a cycle of commissioning which forms the ongoing continuous learning and development process in four key stages: assessment, co-design, delivery and evaluation.

Local community needs are identified through an assessment process, involving the analysis of population health data and community consultation to develop the evidence base.

Activities that are targeted to populations most in need are co-created through extensive stakeholder engagement processes.

This engagement is vital to all aspects of the PHN's commissioning cycle and facilitates collaboration and coordination in the delivery of the PHN's activities and strategic goals. Engagement processes are embedded in business as usual practice and supplemented by targeted co-design workshops at key intervals throughout the commissioning cycle. Inclusive processes are also used to decide how best to implement identified activities, either through direct intervention or the procurement of services. Services are procured through fair and transparent processes.

Activities are evaluated using ongoing monitoring and reporting of both process and outcome measures and evaluation plans, which are developed for all PHN activities include:

- objectives
- program logic
- evaluation questions
- performance metrics and indicator frameworks
- data collection tools and protocols.

Evaluation plans are designed to be consistent with contracted deliverables associated with individual activities and are developed in line with the PHN evaluation framework and PHN performance framework. Evaluation outcomes are used to inform further assessment and planning. These activities take place at both a strategic level and on an individual activity level.

Target Cohort: This activity will cover all people of all ages living the Brisbane North PHN region.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Mental Health - Service Needs Level 1	3-5
Population Health - Health Needs Level 1	2-3
Aboriginal and Torres Strait Islander Health - Health Needs Level 1	2-3
Aboriginal and Torres Strait Islander Health - Service Needs Level 1	3,5
Children's Health - Service Needs Level 1	4
Alcohol and other Drugs - Service Needs Level 1	4
Women's Health - Service Needs Level 1	4
Women's Health - Health Needs Level 1	3
Workforce - Health Needs Level 1	3
People Living with Disability - Health Needs Level 1	3
Children's Health - Health Needs Level 1	3
Culturally and Linguistically Diverse Communities - Health Needs Level 1	2
Mental Health - Health Needs Level 1	2
Culturally and Linguistically Diverse Communities - Service Needs Level 1	5
People Living with Disability - Service Needs Level 1	5
Population Health - Service Needs Level 1	5
Service System - Service Needs Level 1	5
Older Persons - Service Needs Level 2	9



Activity Demographics

Target Population Cohort

This activity will cover all people of all ages living the Brisbane North PHN region.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Brisbane Inner	30501
Sherwood - Indooroopilly	30403
Redcliffe	31305
Caboolture Hinterland	31303
The Hills District	31401
Kenmore - Brookfield - Moggill	30402
The Gap - Enoggera	30404
Sandgate	30204
Chermside	30202
Brisbane Inner - West	30504
Nundah	30203
Narangba - Burpengary	31304
North Lakes	31402
Brisbane Inner - North	30503
Bribie - Beachmere	31301
Strathpine	31403
Bald Hills - Everton Park	30201
Caboolture	31302



Activity Consultation and Collaboration

Consultation

The PHN regularly consults with the Clinical Council and Community Advisory Committee about its commissioning process. Additionally, the PHN conducted a review with providers and other stakeholders of commissioning processes.

Collaboration

The PHN will collaborate closely with a range of stakeholders in delivery of this activity, including:

- Metro North Hospital and Health Service
- Metro North Hospital and Health Service's Public Health Unit
- general practices operating within the PHN region
- community healthcare providers operating within the PHN region
- consumers
- peak bodies and not-for-profit organisations. The HNA process is to be conducted in consort with MNHHS development of their LANA.

The two organisations share data and insights to develop the two documents as complementary. Within QLD, all PHNs participate in a community of practice for commissioning activities, regularly seeking advice and improvement on processes including the HNA, procurement, evaluation and reporting.



Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

Direct Engagement: No

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): Yes

Is this activity being co-designed?

Yes

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

The PHN regularly consults with the Clinical Council and Community Advisory Committee about its commissioning process. Additionally, the PHN conducted a review with providers and other stakeholders of commissioning processes.



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Systems Improvement	\$660,662.15	\$812,149.27	\$817,526.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Systems Improvement	\$660,662.15	\$812,149.27	\$817,526.00	\$0.00	\$0.00	\$2,290,337.42
Total	\$660,662.15	\$812,149.27	\$817,526.00	\$0.00	\$0.00	\$2,290,337.42

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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HSI - 2200 - HSI 2.2 - Primary health care integration



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

2200

Activity Title *

HSI 2.2 - Primary health care integration

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description**Aim of Activity ***

This activity aims to enhance patient outcomes by improving the transfer of information between Metro North Health, general practice and other primary healthcare providers, such as allied health and pharmacy, to encourage a holistic and integrated approach to enhancing multidisciplinary patient care. Disconnected care between primary and tertiary providers underpins poor health outcomes for the community.

By enhancing this communication, it is intended that people experience seamless care between general practice, hospital and allied health. The GP Liaison Officer (GPLO) team works towards system improvements in areas identified by Metro North Health and Brisbane North PHN as priority specialties.

Currently the GPLOs are focused on the condition specific areas of women's health, rheumatology, gastroenterology, genetics, chronic disease, mental health and aged care projects and COVID-19.

Efforts to achieve better connected care are based on improving the communications between hospital services and GPs for example; clinical referrals, handover and transfer of care between settings, developing new models of shared care and facilitating access to specialist advice.

Description of Activity *

Brisbane North PHN (the PHN) will support and facilitate the use of a range of communication strategies including digital health tools to encourage integrated care across the primary healthcare sector. Digital tools include the secure messaging, e-referral and My Health Record platforms that have been endorsed for implementation by health professionals for the catchment area.

The PHN will provide a service navigation support service for health professionals, giving easy access to up-to-date referral information into community-based support services.

Through the provision of service navigation, the PHN aims to increase the efficiency and effectiveness of referrals into local services, particularly for the benefit of patients at risk of poor health outcomes. Working with a range of stakeholders the PHN will continue to facilitate Metro North Hospitals collaborative groups and promote engagement in various project working groups with the aim of enhancing communication and monitoring and sharing outcomes.

The PHN will also continue collaboration and engagement with Children's Health Queensland Hospital and Health Services. In summary these activities will support the primary health care sector through:

- promote uptake and provide support for selected digital health platforms
- facilitate the analysis of general practice data regarding referrals to allied health services
- support to improve communication between general practice and allied health practices to undertake effective clinical handover using secure messaging
- support for allied health, pharmacies and specialists to access digital health systems and tools such as My Health Record
- participation in a range of hospital collaboratives and project steering groups to help support system integration
- provide up-to-date and easily accessible service navigation for health professionals through the PHN Service Navigator
- providing a regular platform for communicating key organisational priorities and progress updates
- identifying opportunities for shared initiatives to achieve a more integrated approach to patient management and health service delivery.

The collaborative meetings are an Integrated Care Program activity that provide a forum for Brisbane North PHN, stakeholder hospitals and Metro North Health's Women's, Children and Families Clinical Stream, and Private providers to share information and initiatives that affect the patient journey across the care continuum.

Currently there are collaborative meetings between the PHN and:

- Children's Health Queensland
- Metro North Health
- Uniting Care Hospitals
- Women's, Children and Families Clinical Stream
- Allied Health Professionals Network

Target Cohort: All patients of all ages being referred into public health services by community referrers within the Brisbane North region.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Population Health - Health Needs Level 1	2-3
Population Health - Service Needs Level 1	5
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

All patients of all ages being referred into public health services by community referrers within the Brisbane North PHN region.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Brisbane Inner	30501
Sherwood - Indooroopilly	30403
Redcliffe	31305
Caboolture Hinterland	31303
The Hills District	31401
Kenmore - Brookfield - Moggill	30402
The Gap - Enoggera	30404
Sandgate	30204
Chermside	30202
Brisbane Inner - West	30504
Nundah	30203
Narangba - Burpengary	31304
North Lakes	31402
Brisbane Inner - North	30503
Bribie - Beachmere	31301
Strathpine	31403
Bald Hills - Everton Park	30201
Caboolture	31302



Activity Consultation and Collaboration

Consultation

The PHN consults with our Clinicians' Advisory Group and Clinical Council to inform the primary health care integration activities. Activities are jointly managed through the PHN/Metro North Health Collaborative. Oversight, consultation and governance are provided by the Joint Operational Group (JOG).

Collaboration

The PHN will collaborate with all types of primary healthcare providers to encourage multidisciplinary patient care. This includes collaboration through a number of collaborative groups consisting of clinicians in both the primary and tertiary care sectors.

The PHN will continue to participate in the following collaborative groups and project working groups:

- Children's Health Queensland Collaborative
- Metro North Health /PHN Joint Operational Group
- Metro North Health / Brisbane North PHN Collaborative
- General Practice Liaison Officer State-wide Network Planning Group
- Women's and Newborn Services Collaborative
- GPs with a Special Interest (GPwSI)
- Wound Care Management group



Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

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

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

N/A



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Systems Improvement	\$461,086.90	\$475,841.68	\$478,992.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Systems Improvement	\$461,086.90	\$475,841.68	\$478,992.00	\$0.00	\$0.00	\$1,415,920.58
Total	\$461,086.90	\$475,841.68	\$478,992.00	\$0.00	\$0.00	\$1,415,920.58

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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HSI - 3100 - HSI 3.1 - Program Costs



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

3100

Activity Title *

HSI 3.1 - Program Costs

Existing, Modified or New Activity *

Modified



Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

N/A

Aim of Activity *

This activity reflects the funding that is used to support staff and non-staff costs attributed to key HSI functions within the Brisbane North PHN including health workforce innovations, sector collaboration, commissioning, analytics and reporting functions to support the commissioning of services.

Description of Activity *

This activity supports the following strategic HSI functions:

support the commissioning of services

undertake needs assessment and service planning.

support system integration activities – such as collaboration with State/Territory governments and Local Hospital Networks/Hospital and Health Services.

develop and maintain resources for health providers.

support the capacity and capability of health workforce, including general practice support.

HSI Program costs is made up of staff and non-staff costs (e.g. professional development and consultants fees which are used to support training activities and build the capacity and capability of the health workforce (further detail is provided below). HSI helps deliver the following functions: executive management of HSI programs, commissioning, analytics and reporting, practice support, health workforce innovation, service navigation, sector collaboration, quality systems co-ordination and communication activities.

The commissioning, analytics and reporting activities span the full commissioning cycle and are organised around the following key focus areas:

Governance and Policy Uplift: Developing and updating policies and procedures for procurement, contracting, and conflict of interest management. This includes implementing procurement workflows and conducting a review of working groups and communities of practice to ensure alignment with strategic objectives.

Capacity Building and Training: Delivering commissioning training and staff development activities, including co-design, contract management guidance, and Data Steward training. These activities aim to build a skilled, knowledgeable workforce capable of delivering high-quality commissioning outcomes.

Needs Assessment and Planning: Undertaking the Joint regional needs assessment (JRNA) and Producing JRNA Snapshots to inform regional health priorities and supporting the development and submission of Activity Work Plans (AWPs) that align to community health needs and organisational objectives.

Reporting and Performance Measurement: Preparing Board reports, clinical governance reports, annual reports, and DHDA 12-month reports. The team is also implementing the new Performance Measurement and Reporting Framework (PMRF).

Data Systems and Technology: Completing Privacy Impact Assessments, enhancing provider access to dashboards, delivering process automation solutions, and implementing PHASES data linkage with Primary Sense to improve data quality and accessibility.

Collaboration and Innovation: Working with other PHNs and partners to realise the benefits of Primary Sense, share best practices, and explore new ways of displaying data insights to support evidence-based decision making.

In addition, the Core Funding Schedule outlines that in relation to Practice Support, PHNs need to:

Adopt best practice methods to support general practice to improve the quality of care

Promote and improve the uptake of practice accreditation

Assist practices in the understanding and meaningful use of digital health systems in order to streamline the flow of relevant patient information, including across the local health provider community

Develop health information management systems to inform quality improvement in health care, specifically, the collection and use of clinical data within practices.

General practice teams report ongoing gaps in practical, role-relevant training, especially for administration staff and non-GP clinical staff. Practices also value face-to-face learning and networking for practice managers and nurses. This portfolio focuses on high-impact practice domains (for example: triage, wound management, chronic disease management, care planning, mental health, accreditation, and practice incentive programs). Stronger capability in these areas supports safer care in general practice and helps reduce avoidable escalation to hospital care.

General Practice and other primary care providers in the North Brisbane and Moreton Bay region:

have access to training and events that build capability to meet community needs

have access to networking opportunities that support shared learning across practices

improve leadership, improvement and change capability in practice teams

strengthen core practice capability in priority domains that reduce avoidable escalation to hospital care

The Primary Care team supports general practices to be informed, capable and responsive in meeting the health needs of our community. Our Practice Support team maintains a strong commitment to staying abreast of the latest information, guidelines and evidence to ensure the advice and assistance provided to practices is current, accurate and aligned with best practice. General practice support is provided through a dedicated Practice Support phone number, email and website, with escalation to specialist team members across digital health, accreditation, immunisation support, workforce development, primary care reform and continuous quality improvement (CQI) as required. General practices are informed and receive regular and trusted communication via numerous forms, including our weekly GP Link and monthly Practice Link publications.

All general practices in the Brisbane North region have access to a suite of PHN supported accreditation resources and activities. Our model provides structured, end to end support. To ensure the education we provide is of the highest quality, specialised expertise is often sought. This includes inviting representatives from accreditation bodies and other subject matter experts/consultants to deliver training that supports compliance, quality improvement, and best practice care. General practice training and education is focused on whole of practice to build skills and strengthen workforce capability. These address not only clinical topics but also the broader operational environment essential to effective general practice functioning. Recognising that nonclinical staff often have fewer formal development opportunities than clinical staff, we place particular emphasis on supporting this group. Clinical skills training is also provided, with programs tailored to nurses, GPs and frontline staff. These opportunities expose participants to new models of care, emerging clinical practices, and practical tools that broaden skills and strengthen workforce capability. The result is a more knowledgeable, confident and adaptable primary care workforce, equipped with reliable resources and a strong professional network.

Digital health support is provided to general practices to ensure they are digitally enabled, compliant, and integrated within the broader primary care system (e.g. PRODA, HPOS, MyHealthRecord, MyMedicare, Primary Sense, Provider Connect Australia, e-referrals). By strengthening digital capability, practices are better positioned to streamline clinical workflows, reduce administrative burden, and enhance the continuity, safety, and coordination of patient care. Brisbane North PHN works closely with Metro North Health to improve referral processes both in and out of hospital settings. This partnership supports patients to receive coordinated, connected care and that general practices have the digital tools and systems needed to support seamless transitions across the health system.

We support general practices to leverage meaningful data insights through Primary Sense, a data extraction and population health management tool designed to help practices understand their patient cohort and drive targeted quality improvement initiatives. We provide ongoing training and education to ensure practices are confident in using Primary Sense and their clinical information systems effectively. This includes support to: 1) Interpret patient level and population level data, 2) Apply insights to inform clinical decision making. 3) Identify priority areas for quality improvement, and 4) Monitor outcomes over time

Primary Sense is also used to drive our planned Continuous Quality Improvement (CQI) initiatives which aim to equip practices with the tools, knowledge, and confidence to embed sustainable, whole of practice improvement processes. Practices are supported to set their own goals and improvement activities, tailored to their unique context, patient population, and operational capacity. Both Primary Sense and clinical information systems are used to collect and analyse data, review progress, and evaluate the impact of changes.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

This activity reflects the program costs within the HSI funding stream.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

This activity has been created in order to attribute the budget line item for program costs to within the HSI funding stream.

Collaboration

This activity has been created in order to attribute the budget line item for program costs to within the HSI funding stream.



Activity Milestone Details/Duration

Activity Start Date

30/06/2020

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

Direct Engagement: No

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): Yes

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

N/A



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Systems Improvement	\$389,485.12	\$440,600.00	\$443,517.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Systems Improvement	\$389,485.12	\$440,600.00	\$443,517.00	\$0.00	\$0.00	\$1,273,602.12
Total	\$389,485.12	\$440,600.00	\$443,517.00	\$0.00	\$0.00	\$1,273,602.12

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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HSI - 3200 - HSI 3.2 - General Practice Data Extraction



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

3200

Activity Title *

HSI 3.2 - General Practice Data Extraction

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

Service System

Aim of Activity *

Quality improvement is an essential part of general practice and these improvements must be informed by data. Not all practices have the means to collect and analyse their data.

The PHN responds to this need by providing a data extraction tool that cleans, aggregates and reports the data back to practices in a meaningful way such that quality improvements can be enacted. General practices otherwise do not have visibility over their relative benchmarking to other nearby practices and the broader PHN region.

The Health Data Project supports the capacity and capability of health workforce, including general practice to access quality patient data and practice population information and to assist them to understand their own practice data. This project facilitates benchmarking across the region, tracking of PIPQI measures (including data submission) and enables population health assessment at the PHN level. This data extraction informs targeted quality improvement activities undertaken by the primary care team.

Description of Activity *

- successfully support the transition for all practices on Health Data Project to new extraction software (Primary Sense - where compatible)

- monitoring the collection of data and produce quarterly reports for each practice with a data sharing agreement
- supporting key initiatives in the PHN with provision of de-identified aggregated data
- providing data to support internal planning for the PHN with a specific focus on PC and GPLO teams
- updating and distributing shared data agreements
- meeting PIP QI data reporting requirements
- supporting the delivery of the clinical audit program
- supporting PC general practice training and education around meaningful use of health data - providing aggregated data to a range of agreed programs
- reviewing and updating the 10 Improvement measure report (Primary Sense) - ensuring process in place to support practice compliance with PIP QI
- supporting PC team QI activities and projects as required
- providing quarterly data submission to AIHW
- continuing to review, update and maintain best practice extraction, reporting and use of primary health care data

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Service System - Service Needs Level 2	8
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

All patients who attend a general practice in our region. The Health Data Project provides specific data for older persons and Aboriginal and Torres Strait Islander patients.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

This activity works closely with the Primary Care team to deliver reports and develop QI activities, other PHNs to develop consistent reports across the SEQ region, NINCO, and the National Data Governance Committee.

General practitioners are consulted in the utility of the reports developed and disseminated and all practice staff are engaged with to ensure their satisfaction with the product and its outputs.

Collaboration

Brisbane North PHN is working as a group of 14 PHNs transitioning from PenCS to Primary Sense. This activity is led by the PHI team at WAPHA. There is a national Steering Committee.

There is an internal Steering Committee to facilitate the transition of data extraction tool to Primary Sense. Subsets of this group also inform the development of the health data reports. Collaboration is undertaken with AIHW and the DoHAC to ensure that reports and submissions are meeting the specified requirements and are of acceptable data quality.



Activity Milestone Details/Duration

Activity Start Date

30/06/2020

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

Direct Engagement: No

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): Yes

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

N/A



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Systems Improvement	\$514,177.68	\$546,964.00	\$550,585.07	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Systems Improvement	\$514,177.68	\$546,964.00	\$550,585.07	\$0.00	\$0.00	\$1,611,726.75
Total	\$514,177.68	\$546,964.00	\$550,585.07	\$0.00	\$0.00	\$1,611,726.75

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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HSI - 3300 - HSI 3.3 - People



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

3300

Activity Title *

HSI 3.3 - People

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

N/A

Aim of Activity *

This activity reflects the funding that is used to support the staff responsible for key HSI functions within the Brisbane North PHN including health workforce innovations, sector collaboration, knowledge, planning and performance.

Description of Activity *

HSI people is made up of staff that deliver the following functions for the PHN: executive management of HSI programs, knowledge planning and performance, practice support, health workforce innovation, service navigation, sector collaboration, quality systems co-ordination and communication activities.

Needs Assessment Priorities ***Needs Assessment**

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
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Service System - Service Needs Level 1	5
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Activity Demographics

Target Population Cohort

This activity has been created in order to attribute the budget line item for people within HSI stream. Target cohort is: staff that deliver the following functions for the PHN: executive management of HSI programs, knowledge planning and performance, practice support, health workforce innovation, service navigation, sector collaboration, quality systems co-ordination and communication activities.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

This activity has been created in order to attribute the budget line item for people within HSI stream.

Collaboration

This activity has been created in order to attribute the budget line item for people within HSI stream.



Activity Milestone Details/Duration

Activity Start Date

30/06/2020

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: Yes

Direct Engagement: No

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): Yes

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

N/A



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Interest - Core	\$631,535.84	\$317,013.79	\$160,000.00	\$0.00	\$0.00
Health Systems Improvement	\$2,573,794.92	\$2,363,595.78	\$2,018,636.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Interest - Core	\$631,535.84	\$317,013.79	\$160,000.00	\$0.00	\$0.00	\$1,108,549.63
Health Systems Improvement	\$2,573,794.92	\$2,363,595.78	\$2,018,636.00	\$0.00	\$0.00	\$6,956,026.70
Total	\$3,205,330.76	\$2,680,609.57	\$2,178,636.00	\$0.00	\$0.00	\$8,064,576.33

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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HSI - 4000 - HSI 4.0 - Disaster Management and Planning



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

4000

Activity Title *

HSI 4.0 - Disaster Management and Planning

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

Service System

Aim of Activity *

PHNs are well equipped to coordinate a localised primary care response, delivering care where and when it is needed, reducing pressure on the acute sector, and ensuring a coordinated and effective primary care emergency health response.

Diligent planning and preparedness are key to realising this capability.

BNPHN takes a risk-based approach to enhance disaster resilience and build capacity across the 299 General Practices, 86 Residential Aged Care Homes (RACHs), and 3 Urgent Care Clinics (UCCs) within the BNPHN footprint.

The aim of the Disaster Management and Planning activity plan is to:

- Coordinate: Support and coordinate the primary care sector preparedness and response to a disaster
- Build capacity: Assist high risk local primary care providers in emergency planning, response and recovery
- Continuity of access: Support local primary care providers to plan for operations during emergencies
- PHN Planning: further develop internal systems and processes to support disaster management in our region

By supporting the continuity of primary health care services throughout the region the PHN aims to ensure urgent access to, and coordination of, primary health care services.

Rapid re-establishment of RACHs, general practice, pharmacy, allied health, and mental health, where these services have been disrupted, is critical to community functioning and recovery.

Description of Activity *

Activities include:

- Integrate health needs in natural disasters and other health emergencies as part of the PHNs existing cycle of Needs Assessments.
- Publicise PHNs role in emergency planning, preparedness, coordination. Include information on their website about PHN role and functions in health emergency planning and preparedness.
- Communicate health emergency preparedness information to primary care practitioners and service providers in the region.
- Engage with relevant local, regional and jurisdictional emergency management bodies/committees as part of the health emergency/disaster planning and preparedness functions.
- Establish and maintain collaboration with MNH on health emergency/disaster planning and preparedness. This coordinated planning will help ensure the provision of optimal community support across the primary and acute care sectors in the event of an emergency/disaster.
- Establish and maintain collaboration with Aboriginal and Torres Strait Islander health and community organisations in relation to disaster planning and response.
- Collaborating with local primary care providers taking a risk based approach to disaster preparedness (E.G. RACHs, General Practices, Urgent Care Clinics, Mental Health Centre's, Pharmacy Guild etc).
- Support the primary care sector in responding to potential emergency infections disease events.
- Consider relevant natural disaster scenarios such as bushfires, floods, and heatwaves in emergency preparedness protocols to support continuity of access to existing primary care services, workforce capacity, infrastructure resilience, guidance for public and clinicians, targeted support for vulnerable populations.
- Conduct post-disaster reviews following significant emergency/disaster events to identify successful strategies and areas for improvement.

Target Cohort:

Primary care services and organizations including:

- RACHs
- General Practices
- Commissioned Service Providers
- Other Community Organizations
- Pharmacies
- Urgent Care Clinics (UCCs)
- General population

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Service System - Service Needs Level 2	8
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

Primary care services and organizations including: - RACHs - General Practices - Commissioned Service Providers - Other Community Organizations - Pharmacies - Urgent Care Clinics (UCCs) - General population

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

Work with PHN executive team and wider PHN team to implement systems and processes to support disaster management within the Brisbane North PHN.

Work with Metro North Health Disaster Management team to align approaches and collaborate in disaster management space
Work with Department of Health, Disability and Ageing to support primary care sector disaster management and resilience building.

Collaboration

Brisbane North PHN will work with Metro North Health Disaster Management Team and Department of Health, Disability and Ageing State Office to ensure alignment of plans and collaborate on capacity building for the region.



Activity Milestone Details/Duration

Activity Start Date

30/06/2025

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: No

Direct Engagement: Yes

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): No

Is this activity being co-designed?

Yes

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

Work with Metro North Health Disaster Management Team and Department of Health, Disability and Ageing State Office to ensure alignment of plans and collaborate on capacity building for the region.



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Systems Improvement	\$0.00	\$60,000.00	\$60,000.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Systems Improvement	\$0.00	\$60,000.00	\$60,000.00	\$0.00	\$0.00	\$120,000.00
Total	\$0.00	\$60,000.00	\$60,000.00	\$0.00	\$0.00	\$120,000.00

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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HSI - 5100 - HSI 5.1 - Data Governance



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

HSI

Activity Number *

5100

Activity Title *

HSI 5.1 - Data Governance

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area *

Population Health

Other Program Key Priority Area Description**Aim of Activity ***

Brisbane North PHN (the PHN) recognises that data is a strategic asset that has value to the entire organisation. Data is the foundation of our planning, decision-making and operational functions.

The PHN relies on strong data governance to perform its functions effectively and maintain the trust of its data providers, data recipients and stakeholders in acquiring, handling, using, and releasing data.

The purpose of the Data Governance Committee is to provide data governance across the PHN by embedding best practice methods for handling data and bringing to life the Data Governance Framework and associated policies and procedures. The Committee also acts as the mechanism to review, consider, and provide recommendations for all data sharing requests received by the PHN from external entities.

The process for this work is outlined in the PHN Data Sharing Policy. Brisbane North PHN achieved ISO 27001 accreditation in 2021 and continues to undertake regular Information Security audits to ensure ongoing compliance and to maintain this accreditation.

As an organisation, we passed an ISO 27001 re-accreditation audit in February 2024. We have a mature Information Security Management System with policies and procedures integrated in to all our activities that help ensure the confidentiality, integrity,

and availability of our information systems.

Description of Activity *

The Data Governance Committee is comprised of the Data Sponsor, the Data Custodian, the Privacy Officer, and all Brisbane North PHN Data Stewards, as well as the Information Services Manager.

The working group is responsible for making recommendations to the Executive Management Team regarding data and data governance related matters.

The Data Sponsor of the Data Governance Committee reports to the Executive Management Team.

The Data Governance Committee is responsible for ensuring:

- Compliance with relevant legislation, regulations, and standards
- Clear roles and responsibilities in relation to data management
- Confidence and capability in the quality, completeness, accuracy, reliability, and currency of all PHN data assets
- Efficient systems for collecting, storing, using, sharing, protecting, and disposing of data
- Monitoring emerging technologies and opportunities to ensure ongoing improvement and maturity
- Protection of data, via adherence to industry standard PHN policies and procedures and ongoing communication, education, and training with staff - Focus on organisation wide data maturity uplift.

Rigorous consideration of all data sharing requests received from external entities, via adherence to relevant legislation and PHN policies and procedures, with recommendations provided to the Data Custodian.

- Risks are identified and mitigated, including those associated with compliance, security, access, privacy, continuity, management, and cost
- Meaningful interpretation and reporting of data; and
- Information sharing across the data stewards and organisation to support quality improvement.
- Incorporation of Primary Health Insights as a core part of the secure infrastructure used for analysis and reporting with the tasks and activities taken to uplift the use of PHI reported back to the Data Governance Committee.
- Ongoing oversight of compliance to ISO27001 industry standards around data handling and security protocols. The group's target cohort is the Brisbane North PHN Region population and their data.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Workforce - Health Needs Level 1	3
Population Health - Service Needs Level 1	5
Service System - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

Brisbane North PHN Region population

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

Indigenous Data Sovereignty as a focus area for the Data Governance Committee. The committee also has a number of responsibilities identified under the Reconciliation Action Plan (RAP).

Coverage

Whole Region

Yes



Activity Consultation and Collaboration

Consultation

National Data Governance Committee (NDGC) Indigenous Data Sovereignty and Governance Steering Group (IDSG)
– Brisbane North PHN is represented on many data governance committees including the NDGC and IDSG.

Collaboration

- National Primary Health Insights Team (Western Australia Primary Health Alliance)
- National Data Governance Committee (NDGC)
- Brisbane North PHN is represented on many data governance committees including the NDGC
- Australian Institute of Health and Welfare
- Actively contribute to the governance around specific programs such as the provision of the PIP QI eligible dataset for national reporting. - Indigenous Data Sovereignty and Governance Steering Group (IDSG)



Activity Milestone Details/Duration

Activity Start Date

29/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: No

Direct Engagement: No

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): Yes

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

N/A



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Systems Improvement	\$100,000.00	\$100,000.00	\$100,000.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dementia Consumer Pathway Resource	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
HealthPathways	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Core Flexible	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
General Practice Support	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Health Systems Improvement	\$100,000.00	\$100,000.00	\$100,000.00	\$0.00	\$0.00	\$300,000.00
Total	\$100,000.00	\$100,000.00	\$100,000.00	\$0.00	\$0.00	\$300,000.00

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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CG - 1000 - People



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CG

Activity Number *

1000

Activity Title *

People

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area ***Other Program Key Priority Area Description****Aim of Activity *****Description of Activity *****Needs Assessment Priorities *****Needs Assessment****Priorities**



Activity Demographics

Target Population Cohort

In Scope AOD Treatment Type *

Indigenous Specific *

Indigenous Specific Comments

Coverage

Whole Region



Activity Consultation and Collaboration

Consultation

Collaboration



Activity Milestone Details/Duration

Activity Start Date

Activity End Date

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

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

Is this activity being co-designed?

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

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

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

Decommissioning

Decommissioning details?

Co-design or co-commissioning comments



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$462,332.10	\$382,986.21	\$500,000.00	\$0.00	\$0.00
Corporate	\$645,427.85	\$647,247.33	\$624,993.38	\$0.00	\$0.00

Governance Funding					
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Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$462,332.10	\$382,986.21	\$500,000.00	\$0.00	\$0.00	\$1,345,318.31
Corporate Governance Funding	\$645,427.85	\$647,247.33	\$624,993.38	\$0.00	\$0.00	\$1,917,668.56
Total	\$1,107,759.95	\$1,030,233.54	\$1,124,993.38	\$0.00	\$0.00	\$3,262,986.87

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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CG - 2000 - Office



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CG

Activity Number *

2000

Activity Title *

Office

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area ***Other Program Key Priority Area Description****Aim of Activity *****Description of Activity *****Needs Assessment Priorities *****Needs Assessment****Priorities**



Activity Demographics

Target Population Cohort

In Scope AOD Treatment Type *

Indigenous Specific *

Indigenous Specific Comments

Coverage

Whole Region



Activity Consultation and Collaboration

Consultation

Collaboration



Activity Milestone Details/Duration

Activity Start Date

Activity End Date

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

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

Is this activity being co-designed?

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

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

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

Decommissioning

Decommissioning details?

Co-design or co-commissioning comments



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Corporate Governance Funding	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Interest - Core	\$300,000.00	\$300,000.00	\$300,000.00	\$0.00	\$0.00
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Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Corporate Governance Funding	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Interest - Core	\$300,000.00	\$300,000.00	\$300,000.00	\$0.00	\$0.00	\$900,000.00
Total	\$300,000.00	\$300,000.00	\$300,000.00	\$0.00	\$0.00	\$900,000.00

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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CG - 3000 - Board



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CG

Activity Number *

3000

Activity Title *

Board

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area ***Other Program Key Priority Area Description****Aim of Activity *****Description of Activity *****Needs Assessment Priorities *****Needs Assessment****Priorities**



Activity Demographics

Target Population Cohort

In Scope AOD Treatment Type *

Indigenous Specific *

Indigenous Specific Comments

Coverage

Whole Region



Activity Consultation and Collaboration

Consultation

Collaboration



Activity Milestone Details/Duration

Activity Start Date

Activity End Date

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

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

Is this activity being co-designed?

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

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

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

Decommissioning

Decommissioning details?

Co-design or co-commissioning comments



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Corporate	\$322,361.40	\$399,168.40	\$401,516.27	\$0.00	\$0.00

Governance Funding					
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Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Corporate Governance Funding	\$322,361.40	\$399,168.40	\$401,516.27	\$0.00	\$0.00	\$1,123,046.07
Total	\$322,361.40	\$399,168.40	\$401,516.27	\$0.00	\$0.00	\$1,123,046.07

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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CG - 4000 - Clinical Councils



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CG

Activity Number *

4000

Activity Title *

Clinical Councils

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area ***Other Program Key Priority Area Description****Aim of Activity *****Description of Activity *****Needs Assessment Priorities *****Needs Assessment****Priorities**



Activity Demographics

Target Population Cohort

In Scope AOD Treatment Type *

Indigenous Specific *

Indigenous Specific Comments

Coverage

Whole Region



Activity Consultation and Collaboration

Consultation

Collaboration



Activity Milestone Details/Duration

Activity Start Date

Activity End Date

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

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

Is this activity being co-designed?

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

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

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

Decommissioning

Decommissioning details?

Co-design or co-commissioning comments



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Corporate	\$39,520.00	\$40,236.00	\$40,472.66	\$0.00	\$0.00

Governance Funding					
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Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Corporate Governance Funding	\$39,520.00	\$40,236.00	\$40,472.66	\$0.00	\$0.00	\$120,228.66
Total	\$39,520.00	\$40,236.00	\$40,472.66	\$0.00	\$0.00	\$120,228.66

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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CG - 5000 - Community Advisory Committees



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CG

Activity Number *

5000

Activity Title *

Community Advisory Committees

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area ***Other Program Key Priority Area Description****Aim of Activity *****Description of Activity *****Needs Assessment Priorities *****Needs Assessment****Priorities**



Activity Demographics

Target Population Cohort

In Scope AOD Treatment Type *

Indigenous Specific *

Indigenous Specific Comments

Coverage

Whole Region



Activity Consultation and Collaboration

Consultation

Collaboration



Activity Milestone Details/Duration

Activity Start Date

Activity End Date

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

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

Is this activity being co-designed?

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

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

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

Decommissioning

Decommissioning details?

Co-design or co-commissioning comments



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Corporate	\$24,875.53	\$38,000.00	\$38,223.51	\$0.00	\$0.00

Governance Funding					
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Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Corporate Governance Funding	\$24,875.53	\$38,000.00	\$38,223.51	\$0.00	\$0.00	\$101,099.04
Total	\$24,875.53	\$38,000.00	\$38,223.51	\$0.00	\$0.00	\$101,099.04

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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CG - 6000 - Other



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CG

Activity Number *

6000

Activity Title *

Other

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area ***Other Program Key Priority Area Description****Aim of Activity *****Description of Activity *****Needs Assessment Priorities *****Needs Assessment****Priorities**



Activity Demographics

Target Population Cohort

In Scope AOD Treatment Type *

Indigenous Specific *

Indigenous Specific Comments

Coverage

Whole Region



Activity Consultation and Collaboration

Consultation

Collaboration



Activity Milestone Details/Duration

Activity Start Date

Activity End Date

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

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

Is this activity being co-designed?

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

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

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

Decommissioning

Decommissioning details?

Co-design or co-commissioning comments



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Corporate	\$200,213.66	\$135,000.00	\$135,794.07	\$0.00	\$0.00

Governance Funding					
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Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Corporate Governance Funding	\$200,213.66	\$135,000.00	\$135,794.07	\$0.00	\$0.00	\$471,007.73
Total	\$200,213.66	\$135,000.00	\$135,794.07	\$0.00	\$0.00	\$471,007.73

Funding From Other Sources - Financial Details

Funding From Other Sources - Organisational Details



Summary of activity changes for Department

Activity Status

Accepted

Subject	Description	Commented By	Date Created
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CF-COVID-PCS - 1000 - COVID-19 Primary Care Support



Activity Metadata

Applicable Schedule *

Core Funding

Activity Prefix *

CF-COVID-PCS

Activity Number *

1000

Activity Title *

COVID-19 Primary Care Support

Existing, Modified or New Activity *

Existing



Activity Priorities and Description

Program Key Priority Area *

Other (please provide details)

Other Program Key Priority Area Description

COVID-19 Primary Care Support

Aim of Activity *

This Activity will assist PHNs and the Primary Care team to provide support and facilitate local solutions to vaccinate vulnerable populations (inc. Culturally and Linguistically Diverse, Aboriginal and Torres Strait Islander, homeless and vulnerably housed, homebound, non-Medicare eligible), who may have difficulty in accessing COVID-19 Vaccines, in collaboration with COVID-19 vaccination providers including general practice, pharmacy, contracted providers, state health services and nurse practitioners (as appropriate).

The Primary Care team will support GPs in mainstream practices and Aboriginal Medical Services (AMSs) in sending reminder/recalls through supported CQI activities and work in partnership with locals AMSs and GPs in mainstream practices to promote vaccination awareness, uptake and increase access. Activities will be supported utilising rollover funds from Vulnerable Peoples COVID Vaccination program 22 - 24 (\$215,000).

This plan is associated with additional work supported by the Priority Communities team at Brisbane North PHN regarding Flu Vaccination in Vulnerable Populations.

Description of Activity *

Vulnerable populations may have increased risk factors to contract/pass on COVID and to be more seriously affected by COVID

illness.

Primary Health Networks (PHNs) are well placed to support and coordinate local solutions in their regions and facilitate urgent vaccination of vulnerable populations in collaboration with COVID-19 vaccination providers including general practices, pharmacies, Aboriginal Community Controlled Health Services (ACCHS), contracted providers and state health services (if applicable and in accordance with local legislative frameworks).

This funding allows for PHNs to continue to commission primary care vaccination providers to support and coordinate activities in their regions that enable the delivery of vaccinations to vulnerable populations.

These targeted, short-term local solutions should continue to supplement existing activities and arrangements (such as state and territory focused approaches) and other vaccination pathways and sites (if applicable and in accordance with local legislative frameworks), not to replace or duplicate them.

Brisbane North PHN has consulted with the following stakeholders in the development of this specific activity:

- Micah Projects
- Queensland Injectors Health Network
- QLD Health

Brisbane North PHN will carry out the following activities:

- Homeless and insecurely housed: commission health providers specialised in working with this population group to deliver vaccination via outreach and community vaccine clinics.
- Non-Medicare eligible people: reimburse GPs who vaccinate people who are not eligible for Medicare.
- Homebound people: support people/carers to find a GP or pharmacist who will do a home visit for vaccination, and if one can not be found, commission a local provider to deliver vaccines.
- Kilcoy and surrounds: work with local stakeholders to promote vaccination and increase accessibility for people living in and around Kilcoy region.

Culturally and Linguistically Diverse: commission CALD organisations to:

1. promote vaccination within their communities,
 2. support people to get vaccinations, and
 3. where viable hold free community vaccine clinics.
- Children 5-11: support GPs in reminder/recall activities through supported CQI activities to increase childhood vaccination rates.

- First Nations and vulnerable populations:

1. support GPs in mainstream practices in sending reminder/recalls through supported CQI activities.
 2. Work in partnership with locals AMSs to promote vaccination awareness, uptake and increase access.
 3. Work in partnership with local GPs to promote vaccination awareness, uptake and increase access.
 4. Support AMSs in sending reminder/recalls through supported CQI activities. - Communication: ongoing promotion of vaccination awareness, information on vaccination sites, and facilitation of access to relevant resources.
- This activity includes a carryover of \$228,000 and is included in this AWP submission to reflect this.

Target Cohort:

Ages 15+ including Culturally and Linguistically Diverse communities, Aboriginal and Torres Strait Islander people, people who are homeless or in insecure housing, people who are housebound or would find it difficult to get to a vaccination center, disabled, aging populations, immunocompromised, people living in the regional areas, people who are not eligible for Medicare.

Needs Assessment Priorities *

Needs Assessment

North Brisbane and Moreton Bay Joint Regional Needs Assessment 2025-27

Priorities

Priority	Page reference
Population Health - Health Needs Level 1	2-3
Culturally and Linguistically Diverse Communities - Health Needs Level 1	2
Culturally and Linguistically Diverse Communities - Service Needs Level 1	5
Population Health - Service Needs Level 1	5



Activity Demographics

Target Population Cohort

Ages 15+ including Culturally and Linguistically Diverse communities, Aboriginal and Torres Strait Islander people, people who are homeless or in insecure housing, people who are housebound or would find it difficult to get to a vaccination center, disabled, aging populations, immunocompromised, people living in the regional areas, people who are not eligible for Medicare.

In Scope AOD Treatment Type *

Indigenous Specific *

Yes

Indigenous Specific Comments

Support is provided by the PHN to General Practices with a high percentage of First Nation's people. This includes the practices proactively reaching out to First Nations patients and taking steps to promote vaccination awareness, uptake and increase access.

The PHN will also work in partnership with AMSs to promote vaccination awareness, uptake and increase access.

Coverage

Whole Region

No

SA3 Name	SA3 Code
Brisbane Inner	30501
Redcliffe	31305
Caboolture Hinterland	31303
The Gap - Enoggera	30404
Sandgate	30204
Brisbane Inner - West	30504
Nundah	30203
Narangba - Burpengary	31304
North Lakes	31402
Brisbane Inner - North	30503
Bribie - Beachmere	31301
Strathpine	31403
Bald Hills - Everton Park	30201
Caboolture	31302



Activity Consultation and Collaboration

Consultation

- Brisbane North and South PHNs have worked together in planning some of the historical COVID activity, given we share many of the same vaccine providers.
- Existing PHN funded providers who specialise in CALD and homeless communities have been engaged to deliver and support vaccination delivery.
- Commissioning Queensland Injectors Health Network (QIHN) to deliver vaccines at community vaccines clinics
- Partnering with The Benchmark Group and Australian Primary Health Care Nurses Association (APNA) to provide training services.

Collaboration

- Brisbane North PHN will continue to collaborate with Queensland Injectors Health Network (QIHN). The role of all these organisations is to engage and inform the PHN in delivering appropriate outreach vaccination clinics/services.
- Brisbane North PHN will manage Service Agreements and Grant Agreements via Folio and under the organisations Policy's.
- Brisbane North PHN will entrust the training providers (Australian Primary Health Care Nurses Association (APNA) and The Benchmark Group) with the management of student agreements, course enrolments and completion requirements.
- Participant and Practice participation in activities by Expression of Interest (EOI) and agreeance to terms outlined in EOI documentation.
- Invoicing for Financial remuneration and reimbursement for activities undertaken



Activity Milestone Details/Duration

Activity Start Date

30/01/2021

Activity End Date

29/06/2026

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones



Activity Commissioning

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

Not Yet Known: No

Continuing Service Provider / Contract Extension: No

Direct Engagement: Yes

Open Tender: No

Expression Of Interest (EOI): No

Other Approach (please provide details): No

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments



Activity Planned Expenditure

Planned Expenditure

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
COVID-19 Primary Care Support	\$499,199.20	\$401,734.45	\$0.00	\$0.00	\$0.00

Totals

Funding Stream	FY 24 25	FY 25 26	FY 26 27	FY 27 28	FY 28 29	Total
Interest - Core	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
COVID-19 Primary Care Support	\$499,199.20	\$401,734.45	\$0.00	\$0.00	\$0.00	\$900,933.65
Total	\$499,199.20	\$401,734.45	\$0.00	\$0.00	\$0.00	\$900,933.65

Funding From Other Sources - Financial Details

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Funding From Other Sources - Organisational Details

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Summary of activity changes for Department

Activity Status

Submitted

Subject	Description	Commented By	Date Created
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