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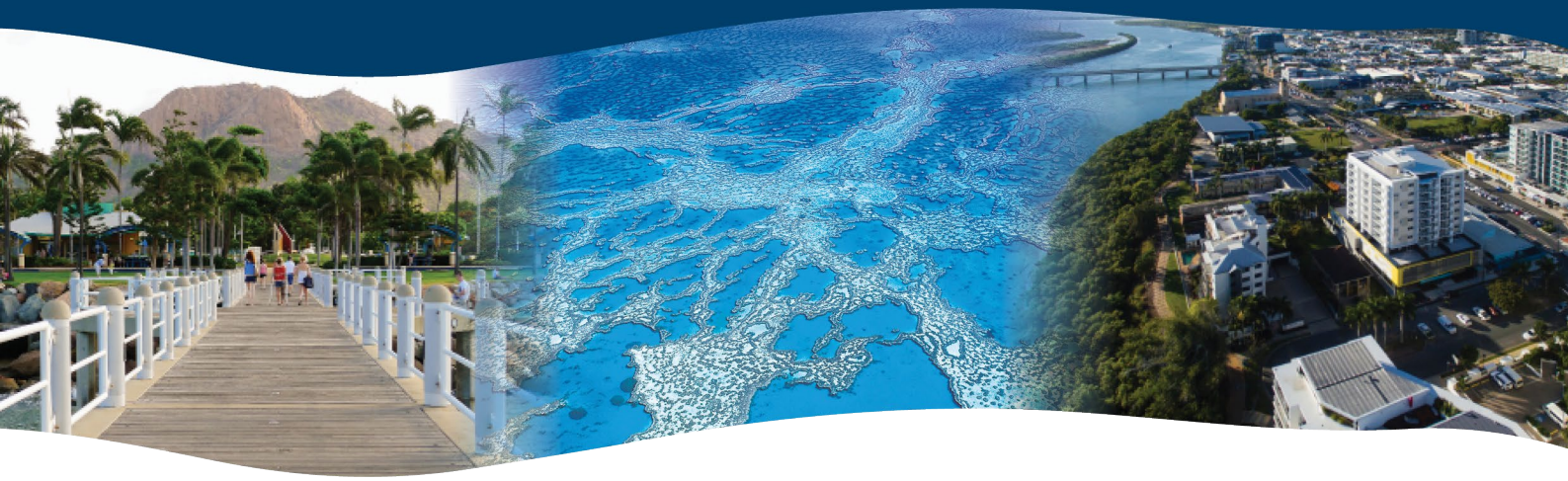

Northern Queensland Primary Health Network

Activity Work Plan

Core funding

2024/25 – 2027/28

Updated January 2026

NQPHN acknowledges the Aboriginal and Torres Strait Islander peoples as Australia's First Nation Peoples and the Traditional Custodians of this land. We respect their continued connection to land and sea, country, kin, and community. We also pay our respect to their Elders past, present, and emerging as the custodians of knowledge and lore.

ISO 9001 QUALITY

Contents

Disclaimer

All activities captured in this Activity Work Plan are identified in the Joint Regional Needs Assessment conducted by Northern Queensland Primary Health Network and have been approved by the Department of Health, Disability and Ageing.

GPIF – 1 – GP Incentive Fund – NQPHN: Isaac Region Thin Markets Proposal

Activity priorities and description

Program key priority areas

Workforce

Aim of activity

Northern Queensland Primary Health Network (NQPHN) will lead the development of a Service System Recovery Plan (SSRP) for the Isaac Region. The SSRP service delivery model will be developed in partnership with key stakeholders Mackay Hospital and Health Service, the Office of Rural and Remote Health, Isaac Regional Council, other key stakeholders in the region, as well as members of the community. The SSRP will inform the design and establishment of a new sustainable service model in the Isaac Region to ensure ongoing access to primary care for communities in the region.

Description of activity

NQPHN will:

- **Stakeholder engagement:** Partner with Mackay Health and Hospital Services, Queensland Health's Office of Rural and Remote Health, and local providers; and confirm support from key partners in working together to build and implement a service system recovery plan and model.
- **Advisory group formation:** Establish a Thin Market Dysart and Issac Region Advisory Group to initiate trusted and strong relationships, provide local guidance, and nuanced support in shaping the development and implementation of a service system recovery plan.
- **Service review:** Conduct a desktop review of the whole of Isaac region's health services and other impacting factors, including documented descriptors of the type and range of services available in the community that may be factorial to implementation.
- **Community consultations:** Engage with key stakeholder and impacted communities to:
  - strengthen understanding of causal factors leading to system failure and identify providers that may be able to contribute to a solution
  - create a space for cross-sector partnerships and inter-connection required for co-creation and solution thinking
  - strengthen acceptance and support for those identified as key players.
- **Plan development:** Develop a Service System Recovery Plan and primary care general practice model for service delivery that identifies and outlines and details the range and mix of services required to ensure the service system sustainable.
- **Codesign:** Collaborate with stakeholders to develop a place-based, locally informed, and community-led primary care service system model.
- **Ongoing consultation:** Ongoing collaboration and coordination with the Department of Health, Disability and Ageing's (DHDA's) Thin Markets Branch.

CF-COVID-VVP – 7 – COVID-19 Vaccination of Vulnerable Populations

Activity priorities and description

Program key priority areas

Population health.

Aim of activity

Northern Queensland Primary Health Network (NQPHN) will support and facilitate local solutions, in collaboration with COVID-19 vaccination providers, including general practice, pharmacy, contracted providers, state health services, and nurse practitioners (as appropriate), to vaccinate vulnerable populations who may have difficulty in accessing COVID-19 vaccines.

These vulnerable groups may include (but are not limited to):

- individuals experiencing homelessness
- people with a disability or who are frail and cannot leave home
- people in rural and remote areas with limited healthcare options
- culturally, ethnically, and linguistically diverse people
- those who are not eligible for Medicare and/or live in an area without access to a state, territory, or Commonwealth vaccination clinic
- aged care and disability workers.

NQPHN will submit a COVID-19 Vaccination of Vulnerable Populations plan, on the provided template, to the COVID Vulnerable Populations Taskforce for review and approval as required.

Description of activity

NQPHN will:

- support general practitioners vaccinating vulnerable people using existing funding mechanisms, such as Medicare Benefits Schedule (MBS) items
- facilitate supplementary funding to reimburse additional and necessary costs incurred in delivering targeted vaccination services for these population cohorts as per Federal Department of Health, Disability and Aged Care directives.

CMDT – 1– Commissioning Multidisciplinary Teams – Administration

Activity priorities and description

Program key priority areas

Population health.

Aim of activity

To improve management of chronic conditions for underserviced communities and reduce avoidable hospitalisations through commissioning of multidisciplinary health care teams to support small and solo general practices in rural locations.

Description of activity

- Design an approach for multidisciplinary teams in the areas prioritised by Northern Queensland Primary Health Network (NQPHN) using health needs and service gap data.
- Commission allied health multidisciplinary team/s to provide holistic patient care.
- Care will be delivered in partnership with primary care practices within NQPHN's rural communities and coordinated with existing services including hospital and health services (HHSs).
- Multi-disciplinary team care will be delivered via individual, shared, and/or group appointments to be adapted to meet local community and patient needs.
- A work-in work-out model will be adopted where required. Depending on the community/individuals' connectivity and preferences, a mix of face-to-face and video conference appointments will be available between times when allied health are available face-to-face in the community.
- Establish reporting processes supported by data collection including both activity and outcomes measures.
- Monitor implementation of activities utilising relevant measures.
- Extend PHNs existing role in general practice to support allied health.

GPACI-GPM – 1 – GP in Aged Care: GP Matching

Activity priorities and description

Program key priority areas

Aged care.

Aim of activity

To enhance the capability and collaboration of general practitioners, practices, and residential aged care homes (RACHs) in delivering high-quality, continuous primary care to older people in aged care, through stakeholder engagement, program design, and communication initiatives.

Description of activity

NQPHN will perform the below activities

- Assess regional needs to inform program design, implementation, and monitoring.
- Engage stakeholders, including RACHs, general practitioners (GPs), general practices, Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Medical Services (AMSs), and culturally and linguistically diverse (CALD) communities.
- Establish and maintain collaborative relationships with primary care providers and aged care homes.
- Develop local implementation processes and effective stakeholder communication strategies.
- Support registration and engagement with MyMedicare for older people in aged care and their care teams.
- Provide guidance to GPs, practices, and aged care staff on the incentive's benefits, requirements, and payments. This may include face to face sessions, workshops, and electronic media.
- Maintain communication with stakeholders through direct outreach and established Northern Queensland Primary Health Network (NQPHN) channels.
- Identify and share examples of best practice care arrangements aligned with national standards.
- Promote awareness and use of approved best practice guidance and tools among GPs, practices, and RACHs.
- Communicate relevant resources, including the Aged Care Quality Standards and The Royal Australian College of General Practitioners (RACGP) clinical guides to stakeholders.
- Support stakeholders to apply best practice approaches in care planning and service delivery.
- Liaise with stakeholders to encourage consistent use of tools and promote knowledge sharing across the sector.
- Direct stakeholders to official resources, including the Department of Health, Disability and Ageing website, for guidance materials and toolkits.
- Collaborate with Department of Health, Disability and Ageing to support ongoing program design and delivery.

WIP-PS – 1 – Workforce Incentive Program (WIP)

Activity priorities and description

Program key priority areas

Workforce.

Aim of activity

To establish a baseline understanding of the current utilisation of the Workforce Incentive Payment Practice Stream (WIP-PS) in the Northern Queensland Primary Health Network (NQPHN) region, identifying barriers for general practices and Aboriginal and Torres Strait Islander Community Controlled Organisations (ATSICCHOs) in accessing available funding based on eligibility. Additionally, assess the health workforce employed under the WIP-PS and the care they provide.

NQPHN will develop strategies to assist practices to increase WIP-PS opportunities, support increased uptake, identification and support of multi-disciplinary teams, and best models of care processes to address community health needs where identified.

Description of activity

Stakeholder engagement

Regularly engage with general practices, Aboriginal and Torres Strait Islander Community Controlled Organisations (ATSICCHOs), and health professionals to raise awareness about the WIP-PS program and its benefits, fostering greater participation.

Resource development and training

Develop and distribute targeted resources, such as toolkits and guidelines, to help practices understand and comply with WIP-PS requirements.

Collaborative partnerships

Work with other Primary Health Networks (PHNs), professional associations, and other stakeholders to facilitate smooth implementation and provide ongoing guidance for practices transitioning to a multidisciplinary care model.

Incentive promotion

Highlight the benefits of WIP-PS funding, including financial incentives for hiring non-general practitioner health professionals, to encourage practices to participate.

MyM – 1 – My Medicare

Activity priorities and description

Program key priority areas

Population health.

Aim of activity

The aim of the MyMedicare program is to improve continuity and quality of care for Australians by fostering stronger relationships between patients, general practices, and their preferred general practitioner (GP).

The program enables patients to voluntarily register with a preferred general practice and GP, ensuring improved coordination of healthcare delivery, particularly for those with chronic conditions or complex health needs.

Through MyMedicare, general practice is further supported to achieve and maintain accreditation allowing GPs to further support patients to receive personalised and consistent care, while healthcare providers better manage patient needs with a focus on preventive, holistic, and team-based care.

Description of activity

Patient and provider engagement

- Conduct awareness campaigns and outreach to encourage general practices and patients to register with their preferred practice and GP.
- Provide education to GPs and practice staff on the benefits of patient registration and how to facilitate it.

Care plan development support

- Provide training and resources to healthcare providers on creating and managing personalised care plans for patients with chronic conditions.
- Promote the use of care coordination tools to streamline follow-up and ongoing care.

Monitor and improve care efficiency

- Utilise data analytics to track MyMedicare registration and care plan effectiveness.
- Provide feedback to practices on ways to increase preventive care and reduce hospital visits for non-urgent conditions.

CF – 1 – Aboriginal and Torres Strait Islander Health Establishment Support

Activity priorities and description

Program key priority areas

Aboriginal and Torres Strait Islander health.

Aim of activity

To increase access to early intervention and preventive health programs in primary care, including the delivery of timely and equitable access to adequate, inclusive, culturally appropriate primary health care for Aboriginal and Torres Strait Islander people and communities.

Description of activity

NQPHN will:

- continue to support the capacity and capability of First Nations service providers to increase access to early intervention and preventive health programs in primary care
- strengthen relationships between Aboriginal Community Controlled Health Organisations (ACCHOs), and Northern Queensland Primary Health Network (NQPHN) to ensure needs are being met
- continue the innovative student assisted community rehabilitation and lifestyle service for Aboriginal and Torres Strait Islander peoples (decommissioned in 2024)
- continue to provide educational opportunities for disease specific upskilling for Aboriginal and Torres Strait Islander Health workers and practitioners, through the development of certified pathways to increase capability and enhance opportunistic health management.

CF – 2 – Maternal and Child Health

Activity priorities and description

Program key priority areas

Population health.

Aim of activity

To improve the health and wellbeing of children and families through access to integrated, coordinated, accessible, and culturally safe maternal and child health services across North Queensland, with a focus on Aboriginal and Torres Strait Islander peoples, people living in rural and remote areas, and those experiencing social and economic disadvantage.

Description of activity

Northern Queensland Primary Health Network (NQPHN) will:

- continue working with partners of the Better Health North Queensland (BHNQ) Alliance and the First 1,000 days Project Working Group to implement the recommendations from the recently developed joint First 1,000 days Framework and implementation strategy for North Queensland
- commission maternal and child health services (First 1,000 days), based on the recommendations from the joint implementation strategy, with a particular a focus on Aboriginal and Torres Strait Islander people, people living in rural and remote areas, and those experiencing social and economic disadvantage
- co-commission and partner (where appropriate) on initiatives which align with the First 1,000 days joint implementation strategy, that interface with upstream prevention activities or tertiary services
- work collaboratively with internal NQPHN teams, including Primary Care Engagement and Workforce Development teams, to address opportunities that emerge from the First 1,000 days Framework and Implementation Plan
- work with subject matter experts to scope and investigate potential models of care to improve immunisation rates and develop collaboratives between primary care, community health, and public health units
- commission services to develop and implement models of care to allow pregnant women to stay on Country with community for as long as practicable
- commission services to address developmental delay in the early years.

CF – 3 – Chronic Conditions

Activity priorities and description

Program key priority areas

Population health.

Aim of activity

To improve the health outcomes of individuals with chronic conditions through increased access to primary health care services, where they are most needed and improve integration between primary, specialist and acute health services, with a focus on people living in rural and remote communities, those experiencing social and economic disadvantage, and Aboriginal and Torres Strait Islander People.

Description of activity

- Utilise the Northern Queensland Primary Health Network (NQPHN) Chronic Conditions Strategy for North Queensland to focus on key priorities as highlighted within the Joint Regional Needs Assessment (JRNA) to inform future commissioning decisions.
- Align the NQPHN Chronic Conditions Strategy (2022) to include a focus on chronic conditions in First Nations people as a priority population group as per NQPHN's commitment to the Better Health NQ Alliance.
- Commission and implement general practice and allied health multidisciplinary primary care initiatives designed in alignment with the NQPHN Chronic Conditions Strategy.
- Utilise the NQPHN Chronic Conditions Strategy (2022) to collaborate on service system support initiatives within the greater NQPHN team.
- Commission health services based on the recommendations from the NQPHN Chronic Conditions Strategy, with a particular a focus on Aboriginal and Torres Strait Islander people, people living in rural and remote areas, and those experiencing social and economic disadvantage.
- Co-commission and partner (where appropriate) on initiatives which align with the NQPHN Chronic Conditions Strategy, that interface with upstream prevention activities, or tertiary services.
- Work collaboratively with internal NQPHN teams, including Primary Care Engagement (PCE) and Workforce Development teams, to address opportunities that emerge from the NQPHN Chronic Conditions Strategy.
- This activity links with and will also be informed by work under the commissioning early intervention activities to support healthy ageing and ongoing management of chronic conditions.

Work and collaboration continue as above for 2025/26 description of activities

- General practices commissioned to develop and implement localised models of care for chronic conditions patients utilising nursing and allied health workforce working in innovative ways.

- Educational opportunities provided for clinical upskilling in collaboration with internal NQPHN teams, including PCE and Workforce Development teams.
- Change management support offered to general practices to adopt primary care reform strategies.

CF – 6 – Health Workforce Development

Activity priorities and description

Program key priority areas

Workforce.

Aim of activity

To develop approaches to address health workforce priorities and build workforce capacity and capability in northern Queensland, in collaboration with key stakeholders, peak bodies, and primary care providers.

In partnership and collaboration with local, state, and national bodies, Northern Queensland Primary Health Network (NQPHN) aims to address the identified health workforce shortages and support new, innovative, and multidisciplinary models of care. This will provide opportunities to support community growth and capacity where it is needed most.

Description of activity

- Enhance primary care provider capabilities and capacity to deliver quality, safe care to at-risk and priority populations as defined in the NQPHN Joint Regional Needs Assessment.
- Continue to facilitate the North Queensland Health Workforce Alliance to improve health workforce quality, capacity, and distribution in northern Queensland.
- Explore, develop, adopt, and participate in initiatives that promote Aboriginal and Torres Strait Islander health workforce parity through training, education, and career pathway development.
- Continue to partner with Health Workforce Queensland in workforce development and enhancement initiatives to improve the optimisation and diversification of the primary care workforce through upskilling existing and new workforce.
- Support primary care providers to recruit clinicians for communities with identified critical health workforce shortages and support the adoption of innovative workforce models and their implementation.
- Support primary care providers to improve the quality of clinical practice through opportunities to access quality education and training to maintain core qualifications and adopt new models of care and versatile healthcare delivery.

CF – 10 – Support for health, care and support related service systems – Cardwell & Cassowary Coast Ph1

Activity priorities and description

Program key priority areas

Population health.

Aim of activity

Northern Queensland Primary Health Network (NQPHN) will commence the development of a Service System Recovery Plan for Cardwell and Mission Beach general practices.

Description of activity

NQPHN will:

- through the Townsville Hospital and Health Service (THHS), commission funding to support health management services into Cardwell Family Practice for the period from 1 January 2024 to 30 June 2025
- through the THHS, commission funding to support health management services into Cardwell Family Practice for the period from 1 July 2024 to 31 June 2025
- through the Cassowary Coast Regional Council, commission funding to support general practice leasing arrangements the cost of locum accommodation for the period from 1 January 2024 to 30 June 2025.

CF – 11 – Clinical Referral Pathways

Activity priorities and description

Program key priority areas

Digital health.

Aim of activity

Content is developed collaboratively by general practitioners, hospital clinicians, and a wide range of other health professionals. Each pathway is evidence-informed, but also reflects local reality, and aims to preserve clinical autonomy and patient choice. HealthPathways serves to reduce unwarranted variation and accelerate evidence into practice.

Northern Queensland Primary Health Network (NQPHN) commissions the four Hospital and Health Service's (HHS's) HealthPathways teams to deliver this activity. Funding is allocated equally across the four HHS regions. The Cairns and Hinterland Hospital and Health Service (CHHHS) and Torres and Cape Hospital and Health Service (TCHHS) pool funding and collaborate on one HealthPathways site as general practice is delivered in the Cape by the TCHHS's Primary Care Centres or Multipurpose Health Centres.

Description of activity

NQPHN contribute funding for each local HHS HealthPathways in northern Queensland - Far North Queensland (Cape and Torres and Cairns and Hinterland), Townsville and Mackay. This funding is used to support the creation, review, and enhance clinical referral pathways.

Each HHS is commissioned to manage and coordinate the following work in accordance with our funding schedule:

- Licence the clinical referral pathways software.
- Consult broadly including with, but not limited to, local primary care clinicians, allied health, aged care providers, other health providers, and consumers about the current gaps and opportunities in models of care.
- Coordinate necessary technical writing and programming.
- Employ clinical editors.
- Develop, review, maintain, and enhance clinical referral pathways content.
- Increase the awareness, engagement, and utilisation of clinical referral pathways by local health care practitioners.
- Collaborate and share clinical referral pathways capabilities and achievement across PHN regions.

Additionally, NQPHN facilitates a HealthPathways Community of Practice (CoP) with the three HealthPathways teams to:

- progress priorities for identification of new clinical pathways to localise
- review current pathways against NQPHN's Joint Regional Needs Assessment
- support planned engagement and education activities for healthcare providers facilitated by the HHSs.

CF – 12 – NQPHN support for health, care and support related service systems – Mission Beach & Cardwell – Phase 2

Activity priorities and description

Program key priority areas

Population health.

Aim of activity

The aim of this activity is to provide a response in Mission Beach to establish a sustainable general practice which can return to operating within the existing legislative, regulatory policy and funding frameworks.

Initially, Northern Queensland Primary Health Network (NQPHN) will stabilise primary care services in Cardwell, and strengthen the primary health service in this region, noting the barriers to sustainability within the current system are complex in this setting. The objective is to stabilise and build a practice that is integrated into a broader service system.

NQPHN will implement the approved Service System Recovery Plan, approved by the Department of Health, Disability and Ageing, for Mission Beach and Cardwell.

Description of activity

An approved Service System Recovery Plan for Mission Beach and Cardwell will be implemented.

Codesign workshops with representatives from general practice, local Hospital and Health Services (HHSs), local government, and Health Workforce Queensland will inform the operational service delivery model in each region. These workshops will focus on developing an operational service delivery model that is specific to each region.

Commissioned funding will support the first twelve months establishment of service, with the aim that both Mission Beach and Cardwell primary care services will be financially sustainable following this period.

CF – 13 – Emergency Preparedness and coordination

Activity priorities and description

Program key priority areas

Population health.

Aim of activity

Build the capacity of primary care to manage emergency preparedness, planning, and coordination across the region in partnership with local hospital and health services (HHSs) and Local Disaster Management Groups (LDMGs).

Description of activity

NQPHN will:

- prepare and maintain emergency preparedness protocols
- establish and maintain relationships with HHSs, LDMGs, and District Disaster Management Groups for the purpose of emergency planning, preparedness, response, and recovery (PPRR)
- facilitate annual workshops across the region, in partnership with key stakeholders, to develop and embed knowledge of PPRR and support plan development for primary healthcare providers to prepare for and respond to natural or health emergencies.

HSI – 2 - Health System Improvement

Activity priorities and description

Program key priority areas

Population health.

Aim of activity

Northern Queensland Primary Health Network (NQPHN) will undertake a broad range of activities to assist in the integration and coordination of health services across our region through population health planning, including the Joint Regional Needs Assessment, systems integration, stakeholder engagement, and practice support activities. These activities will also support the PHN in its commissioning of health services across the region, including through the monitoring and evaluation of all commissioned services.

This activity aims to:

- address the needs of people in NQPHN's local region, including an equity focus
- provide support to general practices and other health care providers to improve quality of care for patients
- improve access to primary health care by patients
- improve coordination of care for patients and integration of health services in the NQPHN region
- operate capable organisations which support the successful delivery of the PHN Program.

Description of activity

NQPHN will:

- Undertake a needs assessment of the NQPHN region, informed by stakeholder engagement and community consultation.
  - Work with the state working group towards a Joint Needs Assessment Framework.
- Conduct a broad range of activities to support health system integration and stakeholder engagement.
  - Influence integration of health systems to improve outcomes relating to mental health, First Nations, population health, health workforce, digital health, aged care, and alcohol and other drugs, as well as any emerging health priorities determined by the Department of Health, Disability and Ageing.
  - Ensure staff are trained in cultural awareness and Aboriginal Community Controlled Health Organisation (ACCHO) guiding principles as appropriate.
- Support general practice with quality care through best practice and accreditation, participation in the NQPHN data program, quality improvement tools, digital health, team-based care, health reform activities, advocacy, workforce education, and training.
- Encourage meaningful use of the population health tool Primary Sense and NQPHN developed general practice data dashboard, leveraging our PHN Primary Health Insights infrastructure.

- Work with the Queensland PHNs to progress and collaborate on statewide initiatives such as the primary health minimum data set, the national operational data set, data linkage, data governance, and artificial intelligence strategies.
- Progress ISO 27001 accreditation.
- Develop healthcare workforce and internal workforce capabilities to improve digital literacy with the aim to increase available insights about our region, increasing maturity to evidence local healthcare improvements and identify improvement opportunities for our region's providers.

HSI – 7 – Aged Care Clinical Referral Pathways

Activity priorities and description

Program key priority areas

Digital health.

Aim of activity

HealthPathways offers clinicians locally agreed information to make the right decisions, together with patients, at the point of care.

HealthPathways is designed and written for use during a consultation. Each pathway provides clear and concise guidance for assessing and managing a patient with a particular symptom or condition. Pathways also include information about making requests to services in the local health system.

Content is developed collaboratively by general practitioners, hospital clinicians, and a wide range of other health professionals. Each pathway is evidence-informed, but also reflects local reality, and aims to preserve clinical autonomy and patient choice. HealthPathways serves to reduce unwarranted variation and accelerate evidence into practice.

Northern Queensland Primary Health Network (NQPHN) commissions the four Hospital and Health Service's (HHS's) HealthPathways teams to deliver this activity. Funding is allocated equally across the four HHS regions. The Cairns and Hinterland Hospital and Health Service (CHHHS) and Torres and Cape Hospital and Health Service (TCHHS) pool funding and collaborate on one HealthPathways site as general practice is delivered in the Cape by the TCHHS's Primary Care Centres or Multipurpose Health Centres.

This activity focuses on the suite of pathways that support older person's health.

Description of activity

NQPHN will:

- contribute funding to the HealthPathways teams across our region to support the creation, review, and enhancement of clinical pathways supporting older person's health
- support the creation, review, and enhancement of clinical pathways supporting older person's health
- educate and consult with primary care practitioners and key stakeholders
- increase awareness, utilisation, and integration of referral pathways
- collaborate broadly with other PHNs sharing pathways where appropriate
- establish an NQPHN HealthPathways Community of Practice (CoP) with our three HealthPathways teams to develop priorities for new and reviewed pathway development aligning with NQPHN priority areas to plan education opportunities and collaborate on resource development.

HSI – 8 – Dementia Consumer Resources

Activity priorities and description

Program key priority areas

Digital health.

Aim of activity

Northern Queensland Primary Health Network (NQPHN) will:

- Consult with consumers living with dementia and Dementia Australia to ensure the consumer pathway resources are both nationally consistent at a high level and reflective of individual services and supports within individual PHN regions.
- Seek feedback from consumers regarding what resource medium works best for them and seek innovative solutions where possible and practical. NQPHN will develop and maintain a region-specific consumer-focused resource which will provide details of the local supports and services available for people living with dementia, their carers and families.
- Continue to promote and increase the awareness, engagement, utilisation, and integration of dementia consumer resources by local practitioners.

Description of activity

NQPHN will continue to promote and increase the awareness, engagement, utilisation, and integration of the NQPHN consumer dementia consumer resource through product launch, social media campaigns, and promotion through community dementia networks and groups.

NQPHN has worked closely with Dementia Australia and WA Primary Health Alliance (WAPHA) who have a similar tool to provide key resources and links.

Local community dementia groups have provided feedback on the page. The URL for the page is www.mycommunitydirectory.com.au/dynamic/dementia-qld

The My Community Info App can be downloaded online from www.mycommunityinfo.com.au. Viewers located within NQPHN will see a Dementia Tile on the app that directs you to the page.

NQPHN will continue to review the page content twice yearly.

HSI – 9 – Dementia Clinical Referral Pathways

Activity priorities and description

Program key priority areas

Digital health.

Aim of activity

HealthPathways offers clinicians locally agreed information to make the right decisions, together with patients, at the point of care.

HealthPathways is designed and written for use during a consultation. Each pathway provides clear and concise guidance for assessing and managing a patient with a particular symptom or condition. Pathways also include information about making requests to services in the local health system.

Content is developed collaboratively by general practitioners (GPs), hospital clinicians, and a wide range of other health professionals. Each pathway is evidence-informed, but also reflects local reality, and aims to preserve clinical autonomy and patient choice. HealthPathways serves to reduce unwarranted variation and accelerate evidence into practice.

Northern Queensland Primary Health Network (NQPHN) commissions the four Hospital and Health Service's (HHS's) HealthPathways teams to deliver this activity. Funding is allocated equally across the four HHS regions. The Cairns and Hinterland Hospital and Health Service (CHHHS) and Torres and Cape Hospital and Health Service (TCHHS) pool funding and collaborate on one HealthPathways site as general practice is delivered in the Cape by the TCHHS's Primary Care Centres or Multipurpose Health Centres.

This activity focuses on pathways developed and review to support GPs with early intervention, diagnosis, and management of patients in cognitive decline.

Description of activity

NQPHN will contribute funding to the HealthPathways teams across our region to support the creation, review, and enhancement of clinical pathways supporting dementia.

- Support the creation, review and enhancement of clinical pathways supporting Aged Care.
- Educate and consult with primary care practitioners and key stakeholders.
- Increase awareness, utilisation, and integration of referral pathways.
- Work closely with Dementia Australia reflecting best practice.
- Collaborate broadly with other PHNs sharing pathways where appropriate.
- Establish an NQPHN HealthPathways Community of Practice (CoP) with our three HealthPathways teams to develop priorities for new and reviewed pathway development aligning with NQPHN priority areas to plan education opportunities and collaborate on resource development.

CF-COVID-PCS – 5 – COVID-19 Primary Care Support

Activity priorities and description

Program key priority areas

Population health.

Aim of activity

To support Australia's COVID-19 Vaccine and Treatment Strategy for the primary healthcare, aged care, and disability sectors. This activity will support the national COVID-19 vaccine program through the primary care sector to build capacity and capability of providers and coordinate communication to the sector. This activity will be provided until 30 June 2026.

Description of activity

Northern Queensland Primary Health Network (NQPHN) will provide guidance and support to, general practices, Aboriginal Community Controlled Health Services, residential aged care homes (RACHs), disability accommodation facilities and governments on local needs and issues related to the COVID-19 Pandemic.

NQPHN will support the Strategy as guided by key stakeholders and industry experts, including local service integration and communication, in liaison with key delivery partners and consistent reporting that will include:

- follow up and engagement with RACHs with low COVID-19 vaccination rates, and assist as required
- coordination of vaccination services to RACHs
- by request, conduct a needs assessment in our region/s followed by a rapid expression of interest process to identify suitable general practices and General Practice Respiratory Clinics (GPRCs) to participate in bespoke sections of the Strategy (for example establishment of additional GPRC sites) and provide advice to the Federal Department of Health on the selection of those sites
- build the capacity and capability of the primary care sector to support COVID-19 activities.

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