BetterHealth NQ

Equity in access to health services and health outcomes for all North Queenslanders

North Queensland First 2000 Days Framework

Tackling Child Development Waitlists through Innovative Models of Care

March 2026

Document Control

Version	Date	Prepared by	Comments
V0.1	19/03/2026	Stephanie Jurkovic	Final draft version endorsed by First 2000 Days Framework Implementation Steering Committee
	25/03/26		Report noted by BHNQ Chief Executive Meeting
V0.2	13/07/2026	Sara Vale	Formatted content onto standard BHNQ template for upload to QHEPS

Approval

The First 2000 Days Framework Implementation Steering Committee, comprising executive representatives from Torres and Cape, North West, Cairns and Hinterland, Townsville, Mackay Hospital and Health Services and Northern Queensland PHN, endorsed the report for escalation to the Better Health NQ Chief Executive Meeting.

At its meeting on 25 March 2026, the Better Health NQ Chief Executive Meeting noted the report's recommendations and resolved to defer implementation pending greater clarity regarding the *Thriving Kids* bilateral agreement, including associated funding, timeframes and implementation implications.

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Executive Summary

North Queensland continues to experience rising demand for paediatric assessment and support, driven by increasing developmental concerns, workforce shortages, and limited specialist access across rural and remote communities. These pressures are contributing to extended waitlists, fragmented pathways, and growing strain on Child Development Services (CDSs) and regional paediatric teams. In response, Better Health North Queensland (BHNQ) has undertaken this review to identify practical, system level opportunities that could strengthen paediatric capability across primary and specialist care.

This work aligns with the national direction outlined in the *Thriving Kids Advisory Group* Final Report, which emphasises the need for earlier identification, stronger primary care capability, and more integrated developmental pathways.

The paper outlines a proposed direction for consideration, centred on four mutually reinforcing activities that may be feasible following further engagement and testing of local readiness:

- Embedding GPs with Special Interest (GPwSIs) in paediatrics within CDSs and general paediatric teams, where appropriate and supported, to expand assessment capacity and improve shared decision making.
- Implementing shared care models supported by regional hubs, where clinically and operationally feasible, to enable a broader range of developmental and behavioural presentations to be managed safely in primary care with paediatric oversight for complex cases.
- Upskilling the broader GP workforce through targeted CPD, structured supervision, and partnerships with PHNs, relevant Queensland Health departments, professional colleges, universities and training providers and local HHSs.
- Extending scope and connectivity across nurse practitioners, allied health, and virtual liaison teams to reduce unnecessary referrals and maintain continuity of care, where this aligns with local capability and interest.

Together, these activities represent potential avenues to reduce pressure on specialist services, strengthen primary care capability, and improve access and equity for children and families across the region.

If endorsed, the immediate next step would be a socialisation phase with GPs, paediatric teams, CDS staff and HHS colleagues to explore levels of interest, test feasibility, and ensure early alignment before progressing to detailed planning. These discussions will help determine which elements are most viable, where bespoke local models may be required, and where regional approaches could offer early, achievable wins.

Although there is no dedicated funding stream for this type of networked paediatric capability work, there are opportunities to make progress by using existing resources more strategically, including vacancy management, targeted realignment of current funding, and coordinated workforce planning across the system. Moving forward will depend on strong executive sponsorship, organisational commitment, and a shared willingness to invest effort and resources where feasible.

All exploratory work will be undertaken within BHNQ's existing staff complement, with any further resource considerations to be informed by the outcomes of the socialisation phase and the level of support identified.

This approach positions North Queensland to identify a feasible, culturally grounded and sustainable way forward that strengthens primary care and improves outcomes for children and families, where this is supported and achievable following further engagement.

1. Introduction

North Queensland faces a growing challenge in managing paediatric outpatient demand, particularly for children and young people requiring long-term review for neurodevelopmental conditions such as Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD). Developmental referrals for ADHD and ASD now dominate waitlists, alongside increasing referrals for other developmental concerns, limiting access for new cases and placing significant strain on specialist capacity across the region (Brisbane North PHN, 2025). Recent reforms expanding GP prescribing rights for ADHD stimulants explicitly aim to reduce referral bottlenecks and waitlists, underscoring the scale of the challenge (Queensland Health, 2025).

This review was initiated as part of the broader work under the North Queensland First 2,000 Days Framework, following recent consultation activities that informed the expansion of the framework and the development of the Year 3 Implementation Plan. It has since been identified as a priority initiative within the Better Health North Queensland (BHNQ) portfolio, reflecting a shared commitment to improving early childhood outcomes and strengthening service integration.

National direction reinforces the need for earlier identification and community based responses to developmental concerns. *The Thriving Kids Advisory* Group *Final Report* highlights the importance of strengthening primary care capability, improving navigation, and reducing fragmentation, issues that are also reflected in North Queensland's service landscape.

Status of this Paper and Consultation Approach

This paper is a draft for consultation, developed to support early discussion and test the feasibility of potential approaches to strengthening paediatric capability across North Queensland. It does not represent a final model or a predetermined direction. Initial consultation has occurred with a limited number of paediatric staff to help inform the development of this concept paper and stabilise the early framing.

The intent is to socialise the emerging concepts with paediatric teams, Child Development Services, general practitioners, PHNs, Aboriginal and Torres Strait Islander Community Controlled Health Organisations, and HHS executives to ensure the work is shaped collaboratively. Feedback from these groups will guide refinement, confirm local priorities, and determine where bespoke or region-specific models may be required. Governance for this exploratory phase sits within the BHNQ portfolio and aligns with the First 2,000 Days Framework Implementation Steering Committee.

A central focus of this exploratory work is to consider how General Practitioners with a Special Interest/Stated Interest (GPwSI) in Paediatrics could contribute within collaborative models that strengthen shared management, support safe discharge pathways, and build sustainable capability across the system. Opportunities for exploration may include embedding GPwSIs within multidisciplinary environments, supporting targeted workforce upskilling, and enhancing the capability

of community based general practice (where appropriate and supported) to improve access and continuity for children and families.

Defining GPwSI in Paediatrics and General Practitioners with an Interest in Child Health

The designation “General Practitioner with Specialist Interest” (GPwSI) is commonly applied to general practitioners who have developed additional expertise in a specific clinical area (such as paediatrics) beyond standard GP training. While not a formal qualification, the term is used within Hospital and Health Services (HHSs) to support workforce planning, service design, and multidisciplinary care pathways (Yellamaty et al., 2019).

Within primary health care settings, there are also general practitioners with a specialist (AHPRA specialist registered) or stated interest in child health. These practitioners provide valuable child health care within the scope of general practice, including routine health checks, immunisations, and management of common presentations. However, they do not necessarily hold advanced paediatric training or operate under specialist supervision. To avoid ambiguity, this report distinguishes these practitioners as ‘GPs with a stated interest in child health’, clearly differentiating them from GPwSI roles that operate within formal HHS governance structures.

1.1 Clarifying GP Roles in Paediatric Pathways

This comparison provides a shared understanding of how GPwSI roles differ from GPs with a stated interest in child health, supporting clarity for later sections of the paper.

Table 1: Role Comparison: HHS-Based GPwSI in Paediatrics and Community Child-Health GPs

Role Comparison: HHS-Based GPwSI in Paediatrics and Community Child-Health GPs		
Feature	**GPwSI in Paediatrics (HHS Based)**	**GP with a Stated Interest in Child Health (Community Practice)**
Employment Model	Employed or contracted by Hospital and Health Services (HHS)	Self-employed or employed within general practice settings and/or Aboriginal and Torres Strait Islander Community Controlled Health Organisations
Team Integration	Embedded in multidisciplinary teams (e.g., Child Development Services (CDS), paediatrics)	Independent practice; may collaborate informally
Case Complexity	Moderate to complex cases with specialist oversight	Mild to moderate cases managed within general practice
Specialist Backup	Direct access to paediatricians and allied health	Variable; depends on referral pathways and local networks
Governance & Protocols	Operates under formal clinical governance and protocols	Practice-dependent; less formal oversight
Training & Supervision	Structured support and supervision available	Often self-directed; may access CPD independently, training level varies

How GPwSI Roles Function Across Settings

In practice, GPwSI roles operate along a continuum that spans community based general practice, multidisciplinary Child Development Services, and paediatric outpatient teams. Within HHS environments, GPwSIs typically manage moderate complexity developmental and behavioural presentations under specialist governance, contributing to assessment, shared decision-making, and review pathways.

In community settings, GPs with a stated interest in child health provide first line care for developmental and behavioural concerns, with variable access to specialist support.

Clarifying these boundaries is essential to ensure that any future GPwSI models strengthen, rather than duplicate existing pathways, and that capability building occurs across the whole system.

2. Systemic Challenges in Paediatric Workforce and Service Delivery

This section outlines key systemic challenges shaping paediatric service delivery in North Queensland. These pressures contribute to extended waitlists, fragmented pathways, and inequitable access, and they provide important context for exploring potential opportunities to strengthen capability across primary and specialist care.

Service Delivery and Access

Children in rural and remote communities continue to face substantial barriers to accessing timely and appropriate paediatric care. Specialist services are concentrated in urban centres, and care pathways between primary care, community health and tertiary services are often fragmented. This lack of integration contributes to delays, duplication, and poorer outcomes for vulnerable populations (AIHW, 2025).

Access pressures are further intensified by broader social and system level factors. Increasing family complexity, including exposure to trauma and domestic violence, drives higher demand for developmental and behavioural support. NDIS and education systems frequently require paediatrician authored assessments and reports, placing additional pressure on specialist services and limiting the role primary care can play in early intervention. These structural constraints reinforce reliance on paediatricians and reduce the system's capacity to provide early, community-based support.

Infrastructure and Resource Limitations

Telehealth remains a critical tool for bridging geographic divides, yet its effectiveness is constrained by inconsistent digital infrastructure, unreliable internet connectivity, and variable technological literacy among providers and families (Smith et al., 2020). National initiatives such as the Rural Health Outreach Fund and MBS Telehealth Services support remote access, but these models are not yet optimised for paediatric care. Without targeted investment in digital capability, including platform integration, clinician training, and culturally responsive design, telehealth risks reinforcing existing inequities rather than reducing them (Australian Government Department of Health, 2024).

Outpatient Service Pressures

Paediatric outpatient services are increasingly constrained by high volumes of long-term review cases, particularly for neurodevelopmental conditions such as ADHD and ASD. Limited confidence and capability within primary care (Kwon et al., 2023), combined with reduced GP involvement in

developmental assessment, prescribing and complex family work, often prevents safe and timely discharge. As a result, new-to-review ratios become distorted, throughput declines and waitlists grow.

These pressures are compounded by rising expectations from NDIS and schools for specialist assessments, as well as broader medicalisation trends that have increased identification of developmental conditions. Non-attendance further reduces clinic productivity, particularly in rural and remote communities where transport, financial constraints and competing family responsibilities are significant barriers (Queensland Audit Office, 2012; McLean et al., 2016).

Economic and Structural Barriers to GP Participation

Several structural and economic barriers limit GP participation in paediatric shared-care models. In regions with low bulk-billing rates, families may face out-of-pocket costs for GP appointments, creating a financial disincentive to shift care from public paediatric services. For GPs, increasing paediatric caseloads can mean forgoing higher-value private billing, reducing the viability of sustained engagement. The current Medicare funding model does not adequately support time-intensive developmental and behavioural consultations, further constraining GP capacity.

Shared-care and GPwSI models also require administrative and business support to establish clinics, manage referrals and coordinate care, functions not routinely available in general practice. Limited GP capacity contributes to referral bottlenecks, with incomplete or poorly prepared referrals complicating categorisation and delaying access to care. Without addressing these economic and operational constraints, GP-led models are unlikely to scale or be sustained, particularly in rural and remote communities.

Workforce Availability and Distribution

The shortage of GPs with paediatric expertise is particularly acute in rural and remote areas of North Queensland. These regions face persistent challenges in attracting and retaining clinicians (AIHW, 2024) due to professional isolation, limited access to supervision and continuing education, and the absence of structured paediatric training pathways. High turnover and burnout further destabilise the workforce, with many GPs managing complex caseloads without adequate support (RACGP, 2025). Limited GP capacity also contributes to referral bottlenecks, with poorly prepared referrals complicating categorisation and delaying access to care. Without targeted strategies to build and sustain paediatric capability in primary care, these gaps will continue to widen—particularly in underserved regions where specialist services are scarce (Hutchinson et al., 2023).

These pressures are not limited to the GP workforce. There is also a limited pipeline of developmental paediatric allied health professionals, including occupational therapists, speech pathologists, physiotherapists, social workers and psychologists. This compounds the challenge of providing comprehensive care for children with developmental and behavioural needs. Strengthening partnerships with local tertiary education providers to offer student placements in child development settings may support future recruitment and succession planning. A robust allied health workforce is essential to complement GP capability and enable multidisciplinary models of care.

However, workforce shortages cannot be addressed without the structural supports required to sustain service delivery. Insufficient funding for public community paediatrics remains a significant barrier to addressing workforce gaps and expanding services. The absence of dedicated funding for leadership roles in community paediatrics further limits the development of sustainable service models and the capacity to drive systemwide improvement. Addressing these funding and leadership gaps is critical to

ensuring the long-term viability of paediatric services and enabling innovation in care delivery. These structural constraints highlight the need for long-term strategies to build paediatric capability, including strengthened training pathways and clearer career progression.

Training Pathways and Capability Development

Efforts to address workforce shortages have included financial incentives, scholarships, and rural placements. The Australian Government's GP Training Incentive Payments program provides salary support for registrars entering community-based practice, while the RACGP's incentivised placement scheme placed 177 registrars in priority areas in 2024, helping to reduce workforce gaps in rural and remote regions (Liotta 2024). While these strategies improve recruitment, they remain largely generalist in nature and lack alignment with paediatric training or structured career pathways.

Current training pathways illustrate this gap. The Royal Australian College of General Practitioners (RACGP) outlines two primary routes within its AGPT: general and rural. While the rural pathway may offer exposure to paediatrics through clinical placements, there is no formal subspecialty track dedicated to paediatric practice. Similarly, the NRGF provides additional skills training in areas such as obstetrics and anaesthetics, but paediatrics is not a core focus. The Advanced Skills Training Posts Program (ASTPP), administered by the Australian College of Rural and Remote Medicine (ACRRM), includes paediatrics as an optional discipline; however, uptake and access vary significantly across regions.

These limitations are compounded by inconsistent supervision and mentoring frameworks, which contribute to professional isolation and hinder the development of paediatric capability. Without cohesive and longitudinal training structures, rural GPs remain under-supported in managing complex developmental conditions—an issue that directly impacts access, equity, and long-term outcomes for children.

Rural generalist and advanced skills pathways provide valuable exposure to acute paediatrics; however, they often offer limited experience in developmental paediatrics, ADHD, ASD and behavioural presentations, which drive the greatest demand. Supervision and mentoring arrangements also vary significantly between regions, contributing to professional isolation and limiting opportunities for GPs to consolidate skills. Strengthening paediatric capability will therefore require structured, longitudinal training, consistent supervision frameworks, and clear progression pathways that recognise paediatric expertise within general practice.

Table 2. Summary: Generalist vs Paediatric-Specific Recruitment and Retention Strategies

Dimension	Generalist GP Retention Strategies	Paediatric-Specific Retention Strategies
Funding & Incentives	• GP Training Incentive Payments (up to $30,000) • Rural relocation grants • Scholarships	• Limited or absent • No dedicated paediatric incentive stream • Ad hoc Continuing Professional Development (CPD) support
Training Pathways	• AGPT general and rural streams • National Rural Generalist Fellowship	• No formal paediatric subspecialty track • Optional Advanced Skills Training (ACRRM & RACGP)

Dimension	Generalist GP Retention Strategies	Paediatric-Specific Retention Strategies
Placement Models	• Incentivised registrar placements in priority areas (e.g., RACGP 2024 scheme)	• No structured paediatric placements • Limited access to paediatric rotations
Supervision & Mentorship	• Generalist supervision via GP supervisors and training posts	• Inconsistent paediatric supervision • Professional isolation in complex cases
Career Progression	• Clear generalist pathways • Fellowship options	• No paediatric-specific career ladder • Limited recognition of paediatric expertise
Service Integration	• Broad primary care integration • Telehealth support for general practice	• Emerging models (e.g., GPwSIP, CDS outreach) • Limited systemic integration
Impact on Child Health Equity	• Indirect benefit via general access	• Direct impact on developmental outcomes • Addresses specialist care gaps

Together, these systemic pressures shape the current landscape of paediatric care in North Queensland and underscore the need for integrated, sustainable models that strengthen capability across primary and specialist services.

3. Overview of North Queensland

Paediatric Service Models in North Queensland – General Summary

Paediatric care across North Queensland Hospital and Health Services (HHSs) is delivered through diverse and region-specific models, reflecting the geography, population needs, and available workforce. While each HHS has its own configuration, several consistent features characterise service delivery across the region:

- Strong local partnerships: Paediatric care is delivered through collaboration between HHS paediatric teams, Child Development Services (CDS), Child and Youth Family Health Services (CYFHS), and primary care providers. These partnerships form the backbone of early identification, assessment and ongoing support for children with developmental and behavioural concerns.
- Multidisciplinary intake and triage: Referrals (typically from GP) are reviewed by allied health professionals, intake officers and paediatricians to ensure children are directed to the most appropriate pathway. In many regions, community health GPs also align with paediatric outreach services through locally developed networks.
- Allied health as first-line support: Developmental and behavioural presentations are often initially managed by allied health teams (speech pathology, occupational therapy, psychology), with paediatricians reserved for complex or high-risk cases.
- Variation in waitlists and service access: Waitlists differ across regions and between paediatric and CDS pathways, influenced by staffing levels, service frequency and local demand. Smaller or

outreach-based services may manage demand internally, while larger centres experience higher referral volumes requiring specialist input.

- Subspecialty and targeted clinics: Larger centres offer subspecialty clinics (e.g., developmental paediatrics, diabetes), whereas smaller services rely more heavily on generalist or shared-care models.
- Outreach and telehealth: Given the vast geography of North Queensland, outreach clinics and telehealth remain essential strategies for improving access in rural and remote communities.
- Shared care and GP-supported models: In some regions, rural generalists and community-based GPs play a central role in child health, supported by paediatricians and allied health where needed.
- Local variation in pathways: Each HHS has developed its own intake structures, referral pathways, and service mix, meaning families may experience different processes depending on location.

Current Paediatric Capability Across the Region

Paediatric capability varies across North Queensland and is shaped by workforce size, service configuration and local training environments.

At North West HHS (NWHHS), services are currently in a period of transition with the establishment of a dedicated Child Development Service. Over the past 12 months, a Developmental Paediatrician has been appointed and planning is underway to develop a cadre of paediatric-trained allied health clinicians — representing a significant shift in local capability. In 2026, total developmental paediatric capacity is projected at 0.75 FTE (0.5 FTE plus 0.25 FTE across two clinicians). There is interest in exploring rural generalist trainee models embedded within Child Development Services, informed by prior experience of one of the Developmental Paediatricians, as a potential strategy to strengthen sustainability and grow local expertise.

In Torres and Cape Hospital and Health Service (TCHHS), paediatric and Child Development Services are delivered by TCHHS and operate in partnership with primary care providers across the region, reflecting a collaborative regional model rather than a single-provider partnership.

Townsville Hospital and Health Service's (THHS) community paediatric team operates with fewer than 3.0 FTE, providing regular outreach across the district and maintaining a strong training and collaboration culture.

Cairns and Hinterland Hospital and Health (CHHHS) Service currently has 2.0 FTE clinical paediatricians and 0.2 FTE Head of Department capacity, with workforce generally aligned to current demand.

Some regions rely on fly-in fly-out (FIFO) clinicians, rotational registrars or international medical graduate (IMG) cohorts, which can affect continuity, cultural context and the development of local developmental paediatric expertise.

Across multiple HHSs, primary care providers report limited confidence and comfort in managing developmental and behavioural presentations. Contributing factors include short appointment times, billing constraints, competing clinical demands and limited exposure to developmental paediatrics during training. These capability gaps influence referral patterns and shape the balance between GP-led, allied health-led and paediatrician-led models of care.

Broader System Drivers Shaping Demand

Across North Queensland, paediatric services are responding to broader shifts in community need and system expectations. Increasing family complexity, including exposure to trauma and domestic violence, has heightened demand for developmental and behavioural support. At the same time, NDIS and education systems increasingly require specialist assessments and reports, placing additional pressure on paediatricians. Reduced GP involvement in developmental assessment, prescribing and complex family work further shifts demand toward specialist services. Changes in medical practice, including increased identification and medicalisation of developmental conditions, have also contributed to rising referral volumes. These factors collectively shape local service models and influence demand across HHSs.

Regional Variation in Workforce and Model Feasibility

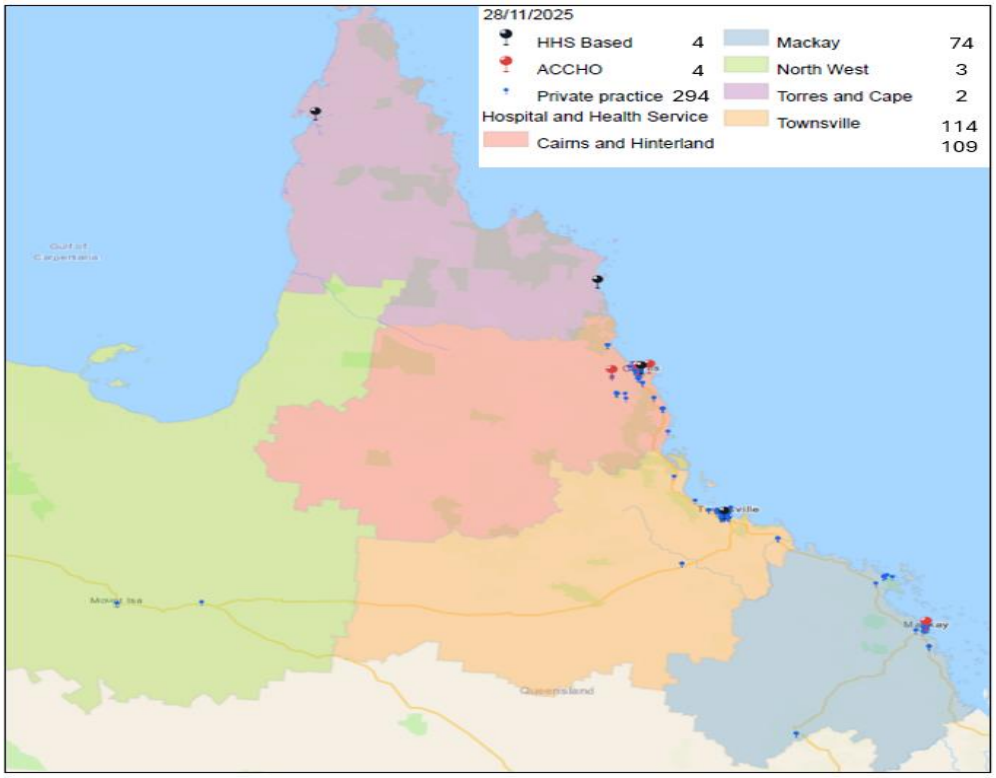
Feasibility varies considerably across North Queensland. Larger centres such as Townsville and Cairns have greater capacity to support GPwSI roles due to established paediatric teams, higher patient volumes and existing multidisciplinary structures. In contrast, North West HHS and parts of Torres and Cape HHS face significant GP shortages, with some communities having more paediatricians than GPs. In these areas, shared care models may require alternative approaches such as virtual hubs, targeted outreach or enhanced allied health-led pathways. Any future model will need to be tailored to local workforce availability, community needs and operational realities.

The Thriving Kids report emphasises the need to strengthen primary care capability to support children with developmental concerns outside specialist services. A GPwSI supported model offers just one mechanism to enhance early assessment, shared care and navigation, aligning with national directions and regional priorities.

The following map shows where general practitioners with special interest/stated interest (GPwSI) in paediatrics are positioned, providing additional capacity and shared care options within the broader system.

3.1 GPwSI in Paediatrics across North Queensland.

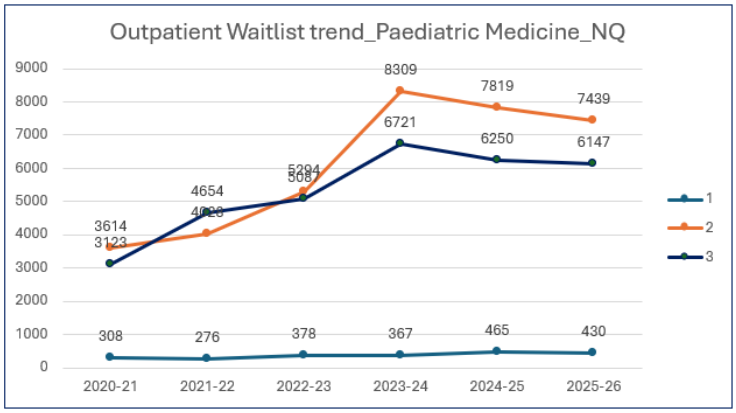
Figure 1: Geographic Distribution of GPs with Special Interest (Paediatrics) Across North Queensland



3.2 Paediatric Waitlists

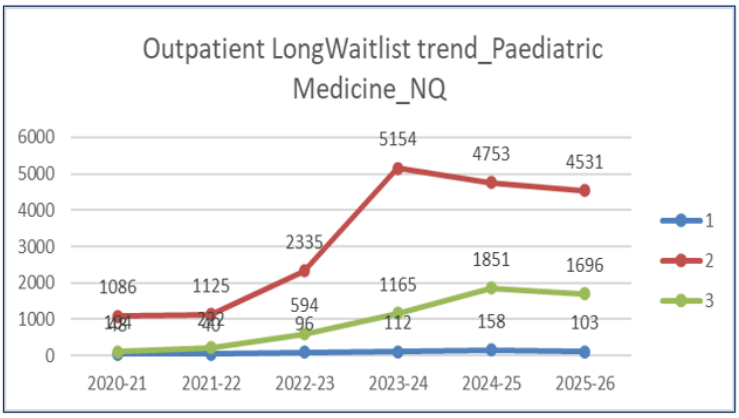
The following tables provide a consolidated view of paediatric demand and service performance across North Queensland, showing how **urgency profiles, long wait cohorts, and average waiting times** vary across the region and where pressure points are most pronounced.

Table 3: Paediatric Waitlist by Urgency Category — North Queensland (FY2020 – Q1, 2025)



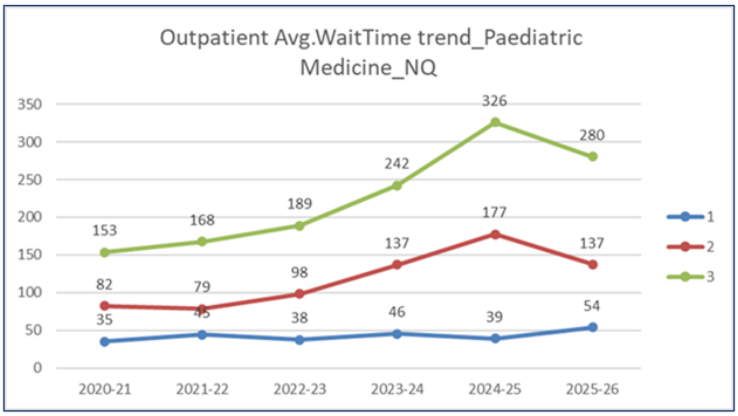
Waitlist numbers peaked across all HHSs in 2023–24 and, while remaining elevated, have begun to decline. In Q1, the total North Queensland waitlist reduced from 14,534 to 14,016 (–3.6% year on year). Improvements were observed across all urgency categories, with Category 1 recording the largest proportional reduction (–7.5%, or 35 patients), Category 2 delivering the greatest numerical decrease (–4.9%, or 380 patients), and Category 3 showing a more modest decline (–1.7%).

Table 4: Paediatric Long Wait Patients — North Queensland (FY2020 – Q1 2025)



Across North Queensland, long wait numbers fell by 432 patients (–6.4% year on year), decreasing from 6,762 to 6,330. Reductions were recorded across all urgency categories, with Category 1 decreasing by 55 patients (–34.8%), Category 2 by 222 patients (–4.7%), and Category 3 by 155 patients (–8.4%).

Table 5: Average Paediatric Waiting Time (Days) — North Queensland (FY2020 – Q1 2025)



In North Queensland, average waiting times for Q1 (July–September 2025-26) improved from 187 to 157 days, representing a reduction of 30 days (–16.0% year on year). This improvement was driven by substantial reductions in Category 2 (–31 days, –22.6%) and Category 3 (–46 days, –14.1%), partially offset by an increase in Category 1 waiting times of 15 days (+37.6%).

The waitlist profile demonstrates a system under sustained strain, with rising average waiting times, entrenched long-wait cohorts and persistent variation across urgency categories signalling that current paediatric capacity is insufficient to meet population need. These pressures reflect structural gaps rather than temporary fluctuations and disproportionately affect regional and rural communities. The mismatch between where demand is highest and where GPwSIs are currently located also indicates that existing capability is not yet aligned with population need.

Strengthening paediatric capacity will therefore require both expanding the number of GPs with advanced paediatric skills and embedding them within shared-care models that enable safe, ongoing collaboration with paediatric specialists. When supported by contemporary models of care—including virtual consultation, hub-and-spoke arrangements and digitally enabled case conferencing—GPwSIs can extend paediatric reach, reduce long waits and stabilise access across North Queensland. Without targeted investment in paediatric capability within primary care, and the models that enable clinicians to work at the top of their scope, the region will continue to face avoidable delays, widening inequities and escalating pressure on specialist services.

4. From Challenges to Solutions: Current Workforce and Service Innovation

Strengthening paediatric capability across North Queensland will require a combination of approaches that build confidence in primary care, enhance specialist support, and improve integration across the system. The following initiatives represent opportunities that may offer value depending on local interest, workforce availability, and operational feasibility. They are not prescriptive solutions but potential avenues for exploration during the socialisation phase.

4.1 Building Paediatric capability in Primary Care

Several existing initiatives provide a foundation for strengthening paediatric skills within general practice. Children's Health Queensland (CHQ) delivers annual masterclasses and targeted continuing professional development (CPD) programs, while the Royal Australian College of General Practitioners (RACGP) has introduced a Paediatric Masterclass for General Practice, covering developmental screening, ADHD, asthma and paediatric dermatology. The Queensland Rural Generalist Pathway (QRGP) also offers paediatric rotations as part of its Advanced Skills Training.

While valuable, these programs tend to be episodic and lack the continuity, structured supervision, and longitudinal support required to sustain paediatric practice—particularly in rural and remote regions. During stakeholder engagement, there may be opportunities to explore how these existing offerings could be strengthened or adapted to support GPs who wish to develop paediatric capability more formally.

Collaborative networks also show promise. Models such as the Brisbane Collaborative Care Pathway and Victoria's Strengthening Care for Rural Children (SC4RC) initiative demonstrate how structured protocols, case conferencing, and secure communication can support shared management of neurodevelopmental conditions. These examples may offer transferable elements for North Queensland, subject to local interest and resource availability.

4.2 Telehealth and Remote Service Innovations

Telehealth remains a critical enabler for improving access to paediatric care across geographically dispersed communities. The Queensland Telepaediatric Service (QTS), established in 2000 as a statewide initiative led by Children's Health Queensland and the University of Queensland, facilitated over 23,000 consultations across 37 paediatric specialties. It significantly improved diagnostic accuracy, reduced unnecessary patient transfers, and enhanced emergency care outcomes in rural and remote areas (Smith et al, 2020). Although its current statewide structure is unclear, elements of its model—such as virtual case conferencing and remote specialist support—may be adaptable to contemporary needs. While Queensland's broader digital health strategies outline a vision for expanding outpatient telehealth, remote monitoring, and clinician support, they do not specifically reference paediatric services. Nonetheless, their emphasis on scalable virtual care models and improved integration provides a policy foundation for re-establishing or adapting paediatric telehealth initiatives to meet the needs of underserved regions (Queensland Health 2021).

CHQ's statewide intake team offers a centralised referral model (CHQ Referral Hub) that contacts families and links them with local services ahead of paediatric appointments. This approach streamlines coordination and could be adapted for remote delivery in partnership with health services in North Qld. CHQ also operates a GPwSIP telehealth model (CHQ Telehealth Overview), currently

limited to metropolitan areas and delivered one day per fortnight. The service uses secure video platforms and is embedded into routine care, with CHQ expressing interest in expanding the model through contracted funding to increase full-time equivalent (FTE) capacity.

Other innovative models demonstrate how telehealth can relieve specialist bottlenecks. The Child Development Service (CDS) at Gold Coast Hospital and Health Service has piloted a pharmacist-led telehealth model for paediatric medication management. This initiative enables virtual follow-ups under indirect paediatric supervision, focusing on dosing reviews and monitoring growth and blood pressure data. It has reduced paediatrician waitlists, increased review capacity, and delivered a 2.2 fold return on investment. With 96% of appointments conducted virtually and strong continuity of care maintained through documentation and communication with GPs and education providers, this model could present a scalable solution for remote regions.

4.3 Multidisciplinary Outreach Services

Outreach is a consistent feature of paediatric care across Northern Queensland, with each HHS adapting its model to local needs. In Torres and Cape Hospital and Health Service (T&CHHS), paediatricians provide regular outreach to remote Indigenous communities, supported by a Child Development Service delivered in partnership with Apunipima Cape York Health Council. Townsville Hospital and Health Service (THHS) extends its CDS to rural towns and Palm Island, combining multidisciplinary outreach with Indigenous health programs and telehealth clinics.

North West Hospital and Health Service (NWHHS) operates a hub and spoke model from Mount Isa, reaching communities such as Doomadgee, Mornington Island, Normanton, and Cloncurry, supported by telehealth enabled child development assessments. Mackay Hospital and Health Service (MHHS) integrates hospital-based paediatrics with telehealth consultations, linking Mackay Base Hospital to Proserpine, Bowen, Sarina, Moranbah, Dysart, and Clermont. Cairns and Hinterland Hospital and Health Service (CHHHS) provide outreach through Atherton, Innisfail, Mareeba, and Mossman, with Cairns Hospital as the referral hub, ensuring coverage from the Torres Strait to Tully.

5. Proposed Collaborative Strategies

The following four strategies reflect potential directions for consideration. They are not recommendations for immediate implementation but options to explore with stakeholders to determine feasibility, local interest, and alignment with existing resources.

1. **Embedding GPwSI in paediatrics into Child Development Services**. Where services see value and workforce interest exists, GPwSIs in paediatrics could be integrated into Child Development Services (CDS) or general paediatric teams to expand assessment capacity and strengthen shared decision-making. GPwSIs could contribute directly to CDS/paediatric intake and triage, assessment and formulation for children with developmental or behavioural delays/differences, management of non-complex comorbidities, and streamlined referral support for children engaged with Child Youth Family Health Services through facilitated referral pathways. Embedding GPwSIs within multidisciplinary environments may help improve flow, reduce burnout and strengthen continuity of care.

   In rural and remote areas, GPwSIs could be embedded within local rural generalist teams, contributing to service provision across all age groups while taking on specific roles in paediatric

outpatient services. This approach aligns with existing rural generalist models and supports more consistent access to developmental and behavioural care in geographically dispersed communities.

Successful implementation of GPwSI models will require adequate resourcing, including dedicated community paediatrician time for supervision, training and clinical governance. Services also identified the need to prioritise coordination roles (such as nurse navigators) to support the growing cohort of vulnerable children and ensure continuity across pathways. Administrative and operational support, including Business Practice Improvement Officer (BPIO) expertise in clinic setup, scheduling and workflow design, will be essential to ensure sustainability and reduce the burden on clinical teams.

BHNQ could explore whether elements of Children's Health Queensland's GPwSIP telehealth model or other South East Queensland initiatives might be adapted for North Queensland contexts, subject to local readiness and resource availability. Importantly, while GPwSIs offer a targeted mechanism to build capability, models should also focus on engaging and supporting all GPs across primary health care settings to strengthen paediatric capability system-wide.

2. **Developing shared care models supported by regional hubs**. A tiered shared-care framework could initially focus on ADHD, where there is already strong support for GP-led management in Queensland. Evidence from similar contexts demonstrates that shared-care models can be effective, and there is strong interest in exploring how these approaches could be adapted for North Queensland. However, implementing shared-care is not straightforward. Success will depend on local workforce capacity, the availability of long-term GPs who can sustain these roles, and the operational realities of general practice—particularly for private GPs who may have limited time for case conferencing and extended consultations.

   Importantly, shared-care models should not be framed as limited to "mild" or "moderate" presentations. GPs remain the primary clinicians for all children, including those with complex developmental and behavioural needs, with paediatric oversight where required. A shared-care approach should therefore support GPs across the full spectrum of presentations, ensuring clear escalation pathways, structured communication, and timely paediatric input for complex cases.

   Any expansion of scope beyond ADHD will require joint review and agreement between paediatric teams, PHNs and general practice to ensure safety, capability and local readiness. It will also be important to explore clinical categories beyond ADHD and ASD—such as Developmental Coordination Disorder (DCD) and Global Developmental Delay (GDD)—to address a broader range of developmental and behavioural needs in the community. Regional hubs could provide case conferencing, virtual support, and structured protocols to guide safe transitions and shared management.

   Collaboration with established pathways—such as the Brisbane Paediatric ADHD Collaborative Care Pathway—may offer transferable learning, pending local interest and operational feasibility. Ultimately, shared-care models should aim to strengthen GP capability, improve access and ensure that children receive coordinated, timely care, while recognising the significant workforce and system challenges that must be addressed for these models to be feasible and sustainable in North Queensland.

3. **Supporting GP upskilling through coordinated education and supervision**. Over recent years, paediatric teams have collaborated with NQPHN and the GPLO teams to deliver paediatric specific education and training. These efforts have been valuable, though their impact has naturally varied due to the ad hoc nature of delivery and competing pressures within general practice. A more structured and sustainable approach would help consolidate and extend this work.

   Recognising the limited capacity of existing GP cohorts, future models should prioritise improved training pathways and the creation of roles that explicitly value paediatric skills. Structured supervision for GPs with an interest in child health is essential to support the development of competent shared-care clinicians—particularly those who may not be able to undertake a full 12-month paediatrics Advanced Skills Training (AST). A coordinated supervision model would help ensure safe practice, reduce professional isolation and provide clear escalation pathways for complex cases.

   Financial and operational barriers also need to be addressed. Developmental and behavioural consultations are time-intensive and often incompatible with standard bulk-billing models. Incentives—potentially supported by Primary Health Networks—could help offset the financial impact of longer appointments and encourage GP participation in this space.

   There may be opportunities for NQPHN and Western Queensland PHN (WQPHN) to lead targeted education and Continuing Professional Development (CPD) initiatives for GPs with a stated interest in paediatrics. BHNQ could support this by working with Queensland Health, professional colleges, universities, training providers and local HHSs to identify scalable and sustainable approaches to capability building. Any future model will need to reflect local workforce interest, supervision capacity and the realities of general practice workload to ensure feasibility and long-term impact.

4. **Extending scope and connectivity.** Nurse practitioners, allied health clinicians and virtual liaison teams may have scope to support follow-up, care coordination and triage, helping to reduce unnecessary referrals and improve responsiveness. A hub-and-spoke model—with Child Development Services (CDSs) as central hubs and primary care as spokes—could be explored where it aligns with local capability and community needs. BHNQ may also consider whether innovations such as pharmacist-led telehealth could be adapted for North Queensland, recognising that uptake would depend on workforce availability, digital infrastructure and local readiness.

   However, extending scope and connectivity is not straightforward. These models are heavily clinician-dependent and require significant detailed planning, including adequate funding, physical space for operations and a stable workforce to ensure sustainability. In regions with highly transient staffing, expanding scope risks further fragmentation of care. Clinicians taking on broader responsibilities may face substantial increases in workload and complexity, which could accelerate burnout and destabilise already stretched teams. Any approach to extending scope must therefore carefully consider workforce availability, retention strategies and the capacity of clinicians to manage increased demand without compromising their wellbeing.

   While there is evidence to support these models in similar contexts, successful implementation in North Queensland will require careful, staged planning and a realistic assessment of local constraints. All components—including funding, space, workforce stability and operational support—must be in place for these models to function safely and sustainably.

Feasibility Considerations

Feasibility will depend on several critical enablers, including dedicated funding for GPwSI roles, supervision and administrative support; physical clinic space; structured training pathways; and sufficient GP workforce stability to support shared-care arrangements. Primary care readiness varies significantly across regions, and private GPs may have limited capacity for case conferencing or extended consultations. These factors must be considered when determining where and how proposed models could be implemented.

6. Recommendations for Sustainable Models

If elements of the proposed direction are supported through socialisation, several system enablers will be required to ensure sustainable implementation. These enablers are not commitments but considerations for future planning, subject to stakeholder agreement, resource availability, and governance approval.

- Strong governance. Oversight could sit with the BHNQ Chief Executive meeting, supported by the First 2,000 Days Framework Implementation Steering Committee. A Paediatric Capability Steering Committee may be considered if stakeholders agreed it would add value.
- Stakeholder engagement. Early and ongoing engagement with general practice, PHNs, potential partners (CHQ, Gold Coast HHS), Aboriginal and Torres Strait Islander Community Controlled Health Organisations (A&TSICCHOs), and families will be essential to test feasibility, codesign pathways, and ensure cultural safety.
- Community co-design and cultural safety. Embedding First Nations leadership and family voice will be critical to ensuring models are culturally grounded and locally relevant.
- Formalising partnerships. Should stakeholders support collaboration with CHQ or Gold Coast HHS, structured agreements may be explored to adapt scalable models such as GPwSIP telehealth or pharmacist-led reviews.
- Strong advocacy for workforce scope and education. BHNQ and PHNs may advocate for paediatric capability building within statewide workforce strategies, including supervision frameworks and expanded-scope roles.
- Policy and funding alignment. Any future model would need to align with state reform priorities and available funding mechanisms. Opportunities for strategic realignment of existing resources may be explored where feasible.
- Operational and Digital Enablers. Sustainable implementation will require consistent operational supports, including standardised referral pathways, shared-care protocols, and clear delineation of roles across primary and specialist care. Digital enablers—such as secure communication platforms, virtual case conferencing, and integrated telehealth workflows—will be essential to support collaboration across geographically dispersed teams. Strengthening these foundations will help ensure that any future models are safe, scalable, and able to deliver consistent outcomes across diverse North Queensland contexts.

Together, these enablers provide the foundation for safe, culturally grounded and sustainable paediatric models across North Queensland.

7. Limitations and Implementation Considerations

While the proposed collaborative strategies offer potential avenues for strengthening paediatric capability across North Queensland, several implementation considerations will need to be explored to determine feasibility, sustainability and local relevance:

- Workforce availability. Embedding GPwSIs and extended-scope roles will depend on local workforce capacity, interest, and recruitment conditions. Any future approach would need to reflect regional workforce realities and tailored retention strategies.
- Primary care engagement and readiness. Success relies on the willingness and capacity of general practitioners to participate in shared-care models and pursue paediatric skill development. Barriers such as competing clinical demands, limited CPD time, and unclear role expectations may require attention through:
  - Clear role definitions and clinical governance structures
  - Funded training, supervision, and incentives for participation
  - Flexible integration pathways that respect practice autonomy
  - Ongoing peer support and specialist backup
  - Early engagement of GPs in service design and co-creation of care pathways to build trust and sustain participation.
- Contracting timelines. Should stakeholders support partnerships with CHQ or Gold Coast HHS, formalising service agreements may require phased negotiation, funding alignment, and governance approvals.
- Infrastructure gaps. Telehealth-enabled models depend on reliable digital infrastructure, which remains variable across remote communities. Addressing these gaps may be necessary before virtual models can be scaled.
- Training lead time. Building paediatric capability in primary care requires sustained investment in supervision, mentoring, and CPD. Outcomes are likely to emerge gradually rather than immediately.
- Community readiness. Service redesign must be co-designed with families and First Nations communities to ensure cultural safety, acceptability, and local relevance.

These considerations do not diminish the value of the proposed strategies. Instead, they underscore the importance of staged implementation, adaptive planning, and ongoing evaluation to ensure that any future model is feasible, culturally grounded, and sustainable across North Queensland.

8. Conclusion

Reducing paediatric waitlists - particularly for ADHD and ASD - will require a shift from fragmented, specialist-centric models toward more integrated, team-based approaches that strengthen primary care while maintaining access to specialist support. The exploratory opportunities outlined in this report reflect potential avenues for improving access, continuity and equity across North Queensland, subject to further engagement and local feasibility.

Embedding GPwSIs within Child Development Services and paediatric teams, where supported, may help expand assessment capacity and enhance shared decision-making. Complementary efforts to support GP upskilling through coordinated education, supervision and partnerships across PHNs, HHSs, professional colleges and training providers could help build sustainable capability within primary care.

Shared-care models supported by regional hubs may offer a structured way to stratify cases by complexity, enabling primary care to manage a broader range of developmental and behavioural presentations with paediatric oversight for complex cases. Extending scope and connectivity across nurse practitioners, allied health clinicians and virtual liaison teams may further reduce unnecessary referrals and strengthen continuity of care, though these models will require careful planning to ensure workforce stability and avoid fragmentation.

Progressing any of these opportunities will depend on strong governance, early and ongoing engagement, and culturally grounded co-design with families and First Nations communities. Importantly, there is no dedicated funding stream for this work; therefore, any advancement will require strategic use of existing resources, coordinated workforce planning and organisational commitment.

This exploratory approach positions North Queensland to identify a feasible, culturally responsive and sustainable way forward—one that strengthens primary care, supports specialist services and improves outcomes for children and families where supported, and achievable following further engagement.

9. Stakeholder Reflections

Stakeholders expressed appreciation for the opportunity to contribute to this work and indicated strong interest in participating in future working groups or advisory networks. They emphasised the importance of culturally safe, community-led design—particularly in rural and remote areas—and the need to clearly define training, supervision and qualification expectations for GPwSI roles. Their reflections highlight a shared commitment to strengthening paediatric capability across North Queensland and provide a strong foundation for collaborative next steps.

References:

Australian Government Department of Health. (2024). *Telehealth*. https://www.health.gov.au/topics/health-technologies-and-digital-health/about/telehealth

Australian Government Department of Health and Aged Care. (2025). *GP Training Incentive Payments*. Australian Government, Canberra. Available at: https://www.health.gov.au/our-work/gp-training-incentive-payments

Australian Government Department of Health and Aged Care. (2025). *Rural Health Outreach Fund*, Australian Government, Canberra. Available at: https://www.health.gov.au/our-work/rural-health-outreach-fund

Australian Institute of Health and Welfare. (2025). *Rural and remote health*. Canberra: AIHW. https://www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health

Brisbane North PHN. (2025). *Care for children with ADHD – a collaborative approach between GPs and paediatricians*. Brisbane: Brisbane North Primary Health Network. https://brisbanenorthphn.org.au/news/care-for-children-with-adhd-a-collaborative-approach-between-gps-and-paediatricians

CHQ. (2024). *Virtual care (telehealth)*. https://www.childrens.health.qld.gov.au/resources/health-services/child-health-service/child-health-service-virtual-care-telehealth

CHQ Referral Hub. (2024). *Refer your patient*. https://www.childrens.health.qld.gov.au/for-health-professionals/refer-your-patient

Clinical Excellence Queensland. (2018). *Early and Quick: Improving Access and Quality of Care for Developmental and Behavioural Paediatrics*. https://www.clinicalexcellence.qld.gov.au/improvement-exchange/early-and-quick-improving-access-and-quality-of-care-for-developmental-and-behavioural-paediatrics

Clinical Excellence Queensland. (2025). *New era for child development in Cape York and Torres Strait*. https://www.clinicalexcellence.qld.gov.au/improvement-exchange/new-era-for-child-development-in-cape-york-and-torres-strait

Gold Coast Hospital and Health Service. (2024). *Child Development Service: Telehealth medication review model* [Internal report, summary available via service website]. https://www.goldcoast.health.qld.gov.au/our-services/childrens-services/child-development-service

Hutchinson, K., Lingam, R., Smithers-Sheedy, H., Bula, K., Collings, D. & Zurynski, Y. (2023). Integrated care for children in rural Australia: Barriers and enablers during early implementation. *International Journal of Integrated Care*, 23(S1). https://doi.org/10.5334/ijic.ICIC23544

Kwon, S., Bhurawala, H., Munoz, A., Kramer, J. & Poulton, A. (2023). General practitioners' attitudes and knowledge about attention-deficit hyperactivity disorder (ADHD): Insights from a survey. *Australasian Psychiatry*, 32(1), 18–22. https://doi.org/10.1177/10398562231211156

Liotta, M. (2024). 'Incentivised training placements reduce registrar shortfall'. *newsGP*, Royal Australian College of General Practitioners. https://www1.racgp.org.au/newsgp/racgp/incentivised-training-placements-reduce-registrar

McLean, S.M., Booth, A., Gee, M., Salway, S., Cobb, M., Bhanbhro, S. & Nancarrow, S.A. (2016). Appointment reminder systems are effective but not optimal: results of a systematic review and evidence synthesis employing realist principles. *Patient Preference and Adherence*, 10, 479–502. https://doi.org/10.2147/PPA.S93046

QRGP. (2024). *Queensland Rural Generalist Pathway*. https://www.careers.health.qld.gov.au/medical-careers/queensland-rural-generalist-pathway

Queensland Audit Office. (2021). *Improving access to specialist outpatient services: Report 8: 2021–22*. Brisbane: Queensland Audit Office. https://www.qao.qld.gov.au/reports-resources/reports-parliament/improving-access-specialist-outpatient-services

Queensland Health. (2021). *Digital Health 2031*. Queensland Health, Brisbane. https://www.health.qld.gov.au/__data/assets/pdf_file/0020/1153910/QH_Digital_Health_2031.pdf

Queensland Health. (2025). *Prescribing ADHD medicines*. Brisbane: Queensland Government. https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/medicines/monitored-medicines/prescribing/adhd-psychostimulants

Royal Australian College of General Practitioners. (2024). *Australian General Practice Training Program: Rural pathway*. https://www.racgp.org.au/education/gp-training/explore-a-gp-career/australian-general-practice-training/australian-general-practice-training-program-rural

Royal Australian College of General Practitioners. (2025). *Placement Incentives*. RACGP, Melbourne. Available at: https://www.racgp.org.au/education/gp-training/gps-in-training/placement-incentives

Royal Australian College of General Practitioners. (2025). *National workforce strategy 2025*. https://www.racgp.org.au/getmedia/520e15b8-3356-4fb8-9f78-44c094285f56/RACGP-national-workforce-strategy-2025.pdf.aspx

Smith, A.C., Thomas, E., Snoswell, C.L., Haydon, H., Mehrotra, A., Clemensen, J. & Caffery, L.J. (2020). Telehealth for global emergencies: Implications for coronavirus disease 2019 (COVID-19). *Journal of Telemedicine and Telecare*, 26(5), 309–313. https://doi.org/10.1177/1357633X20916567

Smith, A.C., Armfield, N.R., Coulthard, M.G., Williams, M.L. & Caffery, L.J. (2020). Queensland Telepaediatric Service: A review of the first 15 years of service. *Frontiers in Digital Health*, 2, Article 587452. https://doi.org/10.3389/fdgth.2020.587452

Yellamaty, V., Ball, L., Crossland, L. & Jackson, C. (2019). General practitioners with special interests: An integrative review of their role, impact and potential for the future. *Australian Journal of General Practice*, 48(9), 639–643. https://www1.racgp.org.au/ajgp/2019/september/general-practitioners-with-special-interests