

# Nepean Blue Mountains - PHN Pilots and Targeted Programs

## 2023/24 - 2027/28

### Activity Summary View



## PP&TP-GCPC - 1 - 2025-26 Greater Choice for At Home Palliative Care Activities



### Activity Metadata

**Applicable Schedule \***

PHN Pilots and Targeted Programs

**Activity Prefix \***

PP&TP-GCPC

**Activity Number \***

1

**Activity Title \***

2025-26 Greater Choice for At Home Palliative Care Activities

**Existing, Modified or New Activity \***

Existing



### Activity Priorities and Description

**Program Key Priority Area \***

Population Health

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

Continue the governance arrangement for the Greater Choice for At Home Palliative Care program with key stakeholders. Implement the recommendations in accordance with the findings of the needs analysis and enhance the referral pathways by reviewing the existing Palliative and Supportive Care HealthPathways for the Nepean Blue Mountains Region, and improve access to palliative and supportive care services across the region. Continue to enhance the integration of primary and acute services to improve access to palliative care at home in the Nepean Blue Mountains region including education for primary health care providers. Continue to implement the activities identified within the needs assessment to improve access to quality palliative and end of life care at home.

**Description of Activity \***

Maintain the employment of two FTE staff who will continue to work with the joint PHN/LHD established Palliative and Supportive Care Advisory Committee to implement and progress work according to the recommendations of the needs analysis to improve access to quality palliative and end of life care in the region. Continue to implement the activities identified through the needs assessment including but not limited to:

- Compassionate community activities leveraging the compassionate community work expansion across the region including community connectors, connector points (including pharmacist) and health connectors (practice nurse) capacity building to increase their scope of practice to enhance a health connector role in general practice;
- deliver education and capacity building activities for primary health care providers through national palliative care projects;
- embed programs and measures such as ELDAC and PCOC to improve the quality of palliative care provided in the region;
- enhance communication mechanisms across the health system to support quality palliative and end of life care;
- work with residential aged care homes to improve access to quality end of life care through education opportunities, access to clinical support and advice;
- implement social prescribing to support access to quality palliative care and resources in the region.

The Palliative and Supportive Care HealthPathways will also be reviewed to ensure they reflect the current referral pathways for palliative care in the region. This will occur through engagement of the NBMLHD Palliative and Supportive Care team at the NBMLHD with the HealthPathways GP Clinical Editors to ensure all pathways are up to date and improve access to services for patients in the region.

## Needs Assessment Priorities \*

### Needs Assessment

NBMPHN\_Needs Assessment 2024

### Priorities

Priority	Page reference
Develop and review local referral pathways and guidelines	150
Reducing inequity of access to palliative care services	146
Developing a new model of palliative care	146
Skills and Training Capacity	185
Apply expert knowledge from key sources	144
Improve access to palliative care supports and resources	147
Improve capture of patient experiences of care	127
Strong relationships and Collaboration to leverage local knowledge and ensure coordination.	202
Role of the GP in palliative care	145
Building a more connected palliative care system	145



## Activity Demographics

### Target Population Cohort

Health professionals caring for patients who are palliative and people who are palliative and their carers in the Nepean Blue Mountains Region

**In Scope AOD Treatment Type \*****Indigenous Specific \***

No

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

Yes

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

Engagement with primary care providers; residential aged care homes; general practitioners; NBMLHD Palliative and Supportive Care; HealthPathways Clinical Editors, NSW Ambulance; Community Palliative Care Services and consumers

**Collaboration**

Represented on the Advisory Committee:

Nepean Blue Mountains Palliative and Supportive Care, General Practitioners, NBMLHD, NBMPHN/NBMLHD Palliative and Supportive Care Advisory Committee Primary Care Community Health - Palliative Care NGO providers.

NBMLHD Palliative and Supportive Care team will inform the referral pathways to ensure currency working closely with the GP Clinical Editors.

Capacity building for primary care and community - Nepean Blue Mountains Palliative and Supportive Care

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

04/12/2021

**Activity End Date**

29/06/2029

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



## Activity Commissioning

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

**Not Yet Known:** No

**Continuing Service Provider / Contract Extension:** No

**Direct Engagement:** No

**Open Tender:** No

**Expression Of Interest (EOI):** No

**Other Approach (please provide details):** No

**Is this activity being co-designed?**

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

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

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

**Decommissioning**

**Decommissioning details?**

**Co-design or co-commissioning comments**



## PATP-RNPG - 7 - 500 Nurse Re-Entry Program - general practice placement grant activity



### Activity Metadata

**Applicable Schedule \***

PHN Pilots and Targeted Programs

**Activity Prefix \***

PATP-RNPG

**Activity Number \***

7

**Activity Title \***

500 Nurse Re-Entry Program - general practice placement grant activity

**Existing, Modified or New Activity \***

New Activity



### Activity Priorities and Description

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



## Activity Demographics

### Target Population Cohort

In Scope AOD Treatment Type \*

Indigenous Specific \*

Indigenous Specific Comments

### Coverage

Whole Region



## Activity Consultation and Collaboration

### Consultation

### Collaboration



## Activity Milestone Details/Duration

### Activity Start Date

### Activity End Date

### Service Delivery Start Date

### Service Delivery End Date

### Other Relevant Milestones



## Activity Commissioning

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

**Not Yet Known:** No

**Continuing Service Provider / Contract Extension:** No

**Direct Engagement:** No

**Open Tender:** No

**Expression Of Interest (EOI):** No

**Other Approach (please provide details):** No

**Is this activity being co-designed?**

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

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

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

**Decommissioning**

**Decommissioning details?**

**Co-design or co-commissioning comments**



## PATP-RNPA - 8 - National Administration of the 500 Nurse Re-entry Program



### Activity Metadata

**Applicable Schedule \***

PHN Pilots and Targeted Programs

**Activity Prefix \***

PATP-RNPA

**Activity Number \***

8

**Activity Title \***

National Administration of the 500 Nurse Re-entry Program

**Existing, Modified or New Activity \***

New Activity



### Activity Priorities and Description

**Program Key Priority Area \***

Workforce

**Other Program Key Priority Area Description**

**Aim of Activity \***

The grant is to be administered nationally, and grants will be provided to primary care practices to incentivise the employment of returning nurses. Primary care practices will receive a single lump-sum payment of \$2,000 to support the facilitation of paid, full-time supernumerary supervised practice for provisionally registered ENs, RNs, NP students and qualified NP transitioning to advanced practice in primary care.

Intended outcomes:

- boost the primary care nursing workforce by attracting up to 500 primary care nurses to address workforce shortage.
- build capacity among the primary health care nursing workforce, by promoting the employment of, and providing support to nurses working in primary health care settings
- increase First Nations representation among primary care nurses
- grow a skilled, diverse, motivated, well-distributed and sustainable primary health care workforce – making it easier for all Australians to get affordable care when and where they need it, and
- increase the pool of nurse practitioners in primary health care.

Inclusions:

Placement of eligible re-entry nurses in general practices to complete the supervised practice requirement as decided by Nurse board.

Eligible nurses include:

- have had a lapse in practice of five years or more, or
- have held non-practising registration for five or more years, or
- have never held registration and/or
- have never practised and no longer meet the definition of recent graduate, or
- are no longer on the register.

**Exclusions:**

- recent graduates from a Nursing Midwifery Board of Australia approved entry to practice nursing or midwifery program in Australia who are applying for registration for the first time, or
- people holding student registration.

**Description of Activity \***

Nepean Blue Mountains (NBM) PHN will administer this program nationally and undertake the following activities:

- develop supporting materials for the supervising primary care practices including guides to support the required supervision and fact sheets about the program.
- develop supporting materials for the provisionally registered nurses to support their placement and their pathway to full registration.
- provide information to the PHNs nationally regarding the program and the requirements to support any discussions that occur directly between the primary care practice and the PHN.
- promote the program nationally through several communication channels and partners including social media; Rural Workforce Agencies; APNA; PHNs, Nurse and Midwifery Board to elicit interest from both practices and eligible provisionally registered nurses nationally.
- All PHNs will be provided with promotional material to include in their primary care communications and communication channels to community which will include social media tiles; articles and good news stories to elicit interest.
- when a primary care practice has expressed interest the PHN that the practice resides will be notified to ensure transparency and will provide a status report.
- NBMPHN will work with the PHN contact in each PHN region where a primary care practice and/or nurse has expressed interest to support the uptake of the program and ensure open communication occurs between NBMPHN and the PHN.
- undertake the contractual arrangements including financial allocation directly with the practice and support the engagement between the practice and the provisionally registered nurse including any support required for the placement period.
- report regularly to the Department and the PHN Cooperative (National PHN CEO group) on the progress of the program and distribution of placement including nurse type and placement outcome following completion.
- placement experience and outcome data will also be collected from both the placement practice and the placement nurse.

Distribution of placements will be recorded, tracked and reported to ensure equitable distribution nationally both from a PHN, State and MMM rating.

The AMA 2021 General Practice Nurse Position Statement noted that more than 63% of general practices in Australia employ at least one practice nurse. Using this as a guide based on the distribution of general practices per state the following table will assist to provide an approximation of equitable distribution throughout the project. Noting that many factors will influence this distribution including the location of the provisionally registered nurse.

State General Practices		63% have practice nurse		Re-Entry distribution (n=500)
ACT	105	66	7	
NSW	2258	1423	160	
QLD	1428	900	101	
SA	461	290	33	
TAS	146	92	10	
VIC	1854	1168	132	
WA	693	437	49	
NT	95	60	7	
Total	7040	4435	500	
(Healthdirect data)				

**Needs Assessment Priorities \***

**Needs Assessment**

NBMPHN\_Needs Assessment 2024

**Priorities**

Priority	Page reference
Increase the workforce capacity for Aboriginal and Torres Strait Islander Health Workers / local Aboriginal and Torres Strait Islander Health and Community Services in the NBM region	130

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**Activity Demographics****Target Population Cohort**

National provisionally registered RNs, ENs and Nurse Practitioner students/qualified transitioning to advanced practice in primary care. General Practices nationally willing to accept a re-entry nurse placement.

**In Scope AOD Treatment Type \*****Indigenous Specific \***

No

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

Yes

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

Australian Primary Care Nurse Association (APNA); Rural Workforce Agencies; National PHNs

**Collaboration**

National PHNs and the Department of Health, Disability and Ageing

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

30/06/2025

**Activity End Date**

29/06/2027

**Service Delivery Start Date**

**Service Delivery End Date**

**Other Relevant Milestones**



## Activity Commissioning

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

**Not Yet Known:** No

**Continuing Service Provider / Contract Extension:** No

**Direct Engagement:** No

**Open Tender:** No

**Expression Of Interest (EOI):** Yes

**Other Approach (please provide details):** No

**Is this activity being co-designed?**

No

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

No

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

No

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

No

**Decommissioning**

No

**Decommissioning details?**

**Co-design or co-commissioning comments**



## PP&TP-GP-Ad - 6 - 2025-26 General Practice Grants Program Admin



### Activity Metadata

**Applicable Schedule \***

PHN Pilots and Targeted Programs

**Activity Prefix \***

PP&TP-GP-Ad

**Activity Number \***

6

**Activity Title \***

2025-26 General Practice Grants Program Admin

**Existing, Modified or New Activity \***

Existing



### Activity Priorities and Description

**Program Key Priority Area \***

Workforce

**Other Program Key Priority Area Description**

**Aim of Activity \***

This activity is to establish, administer and manage the Strengthening Medicare-General Practice Grants Program to eligible general practices in the region.

**Description of Activity \***

Establish, administer and manage the Strengthening Medicare-General Practice Grants Program to eligible general practices in the region within the three streams of the program:

1. enhance digital health capability – to fast-track the benefits of a more connected healthcare system in readiness to meet future standards.
2. upgrading infection prevention and control arrangements – to support the safe, face-to-face assessment of patients with symptoms of potentially infectious respiratory diseases (e.g. COVID, influenza)
3. maintain and/or achieve accreditation against the Royal Australian College of General Practitioners (RACGP) Standards for General Practice under the General Practice Accreditation Scheme – to promote quality and safety in general practice.

**Needs Assessment Priorities \***

**Needs Assessment**

## Needs Assessment 2021/22 - 2023/24

**Priorities**

Priority	Page reference
Address the need to improve access to primary healthcare services	306

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**Activity Demographics****Target Population Cohort****In Scope AOD Treatment Type \*****Indigenous Specific \***

No

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

Yes

**Activity Consultation and Collaboration****Consultation****Collaboration****Activity Milestone Details/Duration****Activity Start Date**

18/04/2023

**Activity End Date**

30/12/2024

**Service Delivery Start Date**

**Service Delivery End Date**

**Other Relevant Milestones**



## Activity Commissioning

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

**Not Yet Known:** Yes

**Continuing Service Provider / Contract Extension:** Yes

**Direct Engagement:** Yes

**Open Tender:** Yes

**Expression Of Interest (EOI):** Yes

**Other Approach (please provide details):** Yes

**Is this activity being co-designed?**

No

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

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

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

**Decommissioning**

**Decommissioning details?**

**Co-design or co-commissioning comments**



## PP&TP-EPP - 7 - 2025-26 PHN Pilots and Targeted Programs Endometriosis and Pelvic Pain GP Clinics



### Activity Metadata

**Applicable Schedule \***

PHN Pilots and Targeted Programs

**Activity Prefix \***

PP&TP-EPP

**Activity Number \***

7

**Activity Title \***

2025-26 PHN Pilots and Targeted Programs Endometriosis and Pelvic Pain GP Clinics

**Existing, Modified or New Activity \***

New Activity



### Activity Priorities and Description

**Program Key Priority Area \***

Population Health

**Other Program Key Priority Area Description**

**Aim of Activity \***

The aim of the EPPC is to improve access for women to diagnosis, treatment and management of endometriosis, pelvic pain, and the treatment and management of perimenopause and menopause symptoms. The EPPC will deliver a multidisciplinary team care approach led by general practitioners with nurse navigators enabling appropriate care and management including improved diagnosis timeframes and pain management for patients.

The EPPC will also support capacity building of primary healthcare practitioners to embed the management of endometriosis and pelvic pain, and treatment of perimenopause and menopause symptoms as a core part of the care pathway, thus optimising primary care for these conditions.

**Description of Activity \***

The Endometriosis and Pelvic Pain Clinic (EPPC) plans to undertake the following activities:

- Clinical lead GP to oversee the EPPC
- Increased access to appointments for EPPC patients.
- Bulk bill patients from priority populations.
- Purchase specialised equipment for the clinic
- Provide educational/training opportunities for EPPC workforce

- Conduct education activities for local primary care providers
- Conduct educational activities for patients
- Protected time for a dedicated Nurse Navigator role to assist patients on their health journey
- Develop referral pathways & networks with local specialist and allied health providers, radiology and pathology, local health district.

### Needs Assessment Priorities \*

#### Needs Assessment

Needs Assessment 2025

#### Priorities

Priority	Page reference
Strong relationships and collaboration to leverage local knowledge and ensure coordination	200
Develop and review local referral pathways and guidelines	147
Facilitate navigation of people to match needs and care requirements to appropriate service provision	172



### Activity Demographics

#### Target Population Cohort

The EPPC will provide services for women in the Nepean Blue Mountains region with symptoms of endometriosis, pelvic pain, perimenopause or menopause. The activity will particularly focus on improving access for patients from priority populations and those in underserved communities.

#### In Scope AOD Treatment Type \*

#### Indigenous Specific \*

No

#### Indigenous Specific Comments

#### Coverage

##### Whole Region

Yes



### Activity Consultation and Collaboration

## Consultation

Through our needs assessment and engagement with local women and health providers, we know that there is a lack of access for women in the NBMPHN region to services for endometriosis and pelvic pain, perimenopause and menopause. This is particularly so for women in the Blue Mountains, Hawkesbury and Lithgow local government areas where there are limited specialist services.

We have also engaged with PHNs that have been commissioning clinics in the first tranche to understand their service models and gain insights into the barriers and enablers for improving access and service delivery.

## Collaboration

We are working closely with the new provider to design the service model that will best meet the needs of women in the region. The provider has existing relationships with the local health district and specialist services that will be strengthened and formalised into local HealthPathways to improve access to diagnostic services and treatment. Additionally, the provider will engage with local primary care providers to build capacity in the region to better meet the needs through training.



## Activity Milestone Details/Duration

### Activity Start Date

30/09/2025

### Activity End Date

30/10/2028

### Service Delivery Start Date

9 February 2026

### Service Delivery End Date

30 June 2028

### Other Relevant Milestones



## Activity Commissioning

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

**Not Yet Known:** No

**Continuing Service Provider / Contract Extension:** No

**Direct Engagement:** No

**Open Tender:** No

**Expression Of Interest (EOI):** Yes

**Other Approach (please provide details):** No

### Is this activity being co-designed?

No

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

No

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

No

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

No

**Decommissioning**

No

**Decommissioning details?**

**Co-design or co-commissioning comments**



## PP&TP-EPP-Ad - 8 - 2025-26 PHN Pilots and Targeted Programs Endometriosis and Pelvic Pain GP Clinics - Admin



### Activity Metadata

**Applicable Schedule \***

PHN Pilots and Targeted Programs

**Activity Prefix \***

PP&TP-EPP-Ad

**Activity Number \***

8

**Activity Title \***

2025-26 PHN Pilots and Targeted Programs Endometriosis and Pelvic Pain GP Clinics - Admin

**Existing, Modified or New Activity \***

New Activity



### Activity Priorities and Description

**Program Key Priority Area \***

Population Health

**Other Program Key Priority Area Description**

**Aim of Activity \***

The aim of the EPPC is to improve access for women to diagnosis, treatment and management of endometriosis, pelvic pain, and the treatment and management of perimenopause and menopause symptoms. The EPPC will deliver a multidisciplinary team care approach led by general practitioners with nurse navigators enabling appropriate care and management including improved diagnosis timeframes and pain management for patients.

The EPPC will also support capacity building of primary healthcare practitioners to embed the management of endometriosis and pelvic pain, and treatment of perimenopause and menopause symptoms as a core part of the care pathway, thus optimising primary care for these conditions.

**Description of Activity \***

The Endometriosis and Pelvic Pain Clinic (EPPC) plans to undertake the following activities:

- Clinical lead GP to oversee the EPPC
- Increased access to appointments for EPPC patients.
- Bulk bill patients from priority populations.
- Purchase specialised equipment for the clinic
- Provide educational/training opportunities for EPPC workforce

- Conduct education activities for local primary care providers
- Conduct educational activities for patients
- Protected time for a dedicated Nurse Navigator role to assist patients on their health journey
- Develop referral pathways & networks with local specialist and allied health providers, radiology and pathology, local health district.

### Needs Assessment Priorities \*

#### Needs Assessment

Needs Assessment 2025

#### Priorities

Priority	Page reference
Strong relationships and collaboration to leverage local knowledge and ensure coordination	200
Develop and review local referral pathways and guidelines	147
Facilitate navigation of people to match needs and care requirements to appropriate service provision	172



### Activity Demographics

#### Target Population Cohort

The EPPC will provide services for women in the Nepean Blue Mountains region with symptoms of endometriosis, pelvic pain, perimenopause or menopause. The activity will particularly focus on improving access for patients from priority populations and those in underserved communities.

#### In Scope AOD Treatment Type \*

#### Indigenous Specific \*

No

#### Indigenous Specific Comments

#### Coverage

##### Whole Region

Yes



### Activity Consultation and Collaboration

## Consultation

Through our needs assessment and engagement with local women and health providers, we know that there is a lack of access for women in the NBMPHN region to services for endometriosis and pelvic pain, perimenopause and menopause. This is particularly so for women in the Blue Mountains, Hawkesbury and Lithgow local government areas where there are limited specialist services.

We have also engaged with PHNs that have been commissioning clinics in the first tranche to understand their service models and gain insights into the barriers and enablers for improving access and service delivery.

## Collaboration

We are working closely with the new provider to design the service model that will best meet the needs of women in the region. The provider has existing relationships with the local health district and specialist services that will be strengthened and formalised into local HealthPathways to improve access to diagnostic services and treatment. Additionally, the provider will engage with local primary care providers to build capacity in the region to better meet the needs through training.



## Activity Milestone Details/Duration

### Activity Start Date

30/09/2025

### Activity End Date

30/10/2028

### Service Delivery Start Date

9 February 2026

### Service Delivery End Date

31 June 2028

### Other Relevant Milestones



## Activity Commissioning

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

**Not Yet Known:** No

**Continuing Service Provider / Contract Extension:** No

**Direct Engagement:** No

**Open Tender:** No

**Expression Of Interest (EOI):** Yes

**Other Approach (please provide details):** No

### Is this activity being co-designed?

No

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

No

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

No

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

No

**Decommissioning**

No

**Decommissioning details?**

**Co-design or co-commissioning comments**



## PP&TP-Op - 3 - 2025-26 PHN Pilots and Targeted Programs Operational



### Activity Metadata

**Applicable Schedule \***

PHN Pilots and Targeted Programs

**Activity Prefix \***

PP&TP-Op

**Activity Number \***

3

**Activity Title \***

2025-26 PHN Pilots and Targeted Programs Operational

**Existing, Modified or New Activity \***

Existing



### Activity Priorities and Description

**Program Key Priority Area \***

Other Program Key Priority Area Description

**Aim of Activity \*****Description of Activity \*****Needs Assessment Priorities \***

Needs Assessment

Priorities



## Activity Demographics

### Target Population Cohort

In Scope AOD Treatment Type \*

Indigenous Specific \*

Indigenous Specific Comments

### Coverage

Whole Region



## Activity Consultation and Collaboration

### Consultation

### Collaboration



## Activity Milestone Details/Duration

### Activity Start Date

### Activity End Date

### Service Delivery Start Date

### Service Delivery End Date

### Other Relevant Milestones



## Activity Commissioning

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

**Not Yet Known:** No

**Continuing Service Provider / Contract Extension:** No

**Direct Engagement:** No

**Open Tender:** No

**Expression Of Interest (EOI):** No

**Other Approach (please provide details):** No

**Is this activity being co-designed?**

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

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

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

**Decommissioning**

**Decommissioning details?**

**Co-design or co-commissioning comments**



## PP&TP-DVP - 4 - 2025-26 PHC 4 - Family and Domestic Violence Pilot



### Activity Metadata

**Applicable Schedule \***

PHN Pilots and Targeted Programs

**Activity Prefix \***

PP&TP-DVP

**Activity Number \***

4

**Activity Title \***

2025-26 PHC 4 - Family and Domestic Violence Pilot

**Existing, Modified or New Activity \***

Existing



### Activity Priorities and Description

**Program Key Priority Area \***

Population Health

**Other Program Key Priority Area Description**

**Aim of Activity \***

The Nepean Blue Mountains Recognise, Respond and Refer pilot aims to improve the patient journey for those experiencing or at risk of domestic and family violence (DFV) through integration and coordination of the domestic family violence system and primary care. Wentworth Healthcare Limited (WHL) will continue to work collaboratively with the Nepean Blue Mountains Local Health District (NBMLHD), Safety Action Meeting (SAM) committee members in each LGA, local government, general practitioners and general practice staff, key domestic and family violence stakeholders including people with lived experience and service providers (DCJ and child protection) to deliver the co-designed model to the Nepean Blue Mountains region. The project's Steering Committee was established in 2020 with members representative from both DFV and Primary Care sectors and provides guidance and advice to the projects implementation and activities.

WHL will continue to employ a DFV Integration Coordinator who is responsible for the coordination of services, integration across the sector and provides primary care representation at a local and state level to influence the role of primary care in recognising, responding and referring people who are experiencing or at risk of DFV.

The coordinator will be responsible for building capacity within general practice to embed the RRR model with a whole of practice approach and improve the integration of primary care into the DFV sector. To support the integration, local commissioned 'DFV Linker' workers provide a locality system navigation role, improving appropriate supportive referral pathways for primary care to domestic and family violence services. The Linkers work across the region covering Penrith, Hawkesbury, Blue Mountains and Lithgow LGA's.

### Description of Activity \*

Continue to deliver the Care and Connect ( previously known as Recognise, Respond and Refer) Pilot building on the outcomes of the initial evaluation. This three-pronged approach will demonstrate and align with the objectives of the pilot to ensure consultation and engagement across participating PHNs and will build a body of evidence.

The three pronged approach includes:

1. PHN Domestic and Family Violence (DFV) Integration Officer who provides strategic integration connecting the primary care sector to the DFV sector;
2. Continue to commission 'DFV Linker' workers to work across the DFV service system and connect into general practices as the first point of call for practices and review referral pathways including HealthPathways;
3. Continue to deliver training and workshops to increase the capacity and capability of the primary care sector to recognise, respond and refer those who are experiencing or at risk of DFV.

Domestic and Family Violence Integration Coordinator is responsible for working with the commissioned DFV Linkers to deliver customised training to increase the capacity and capability of workers in primary care settings to recognise, respond and refer those who have experienced or are at risk of Domestic and Family Violence (DFV). The DFV Integration Coordinator facilitates regular community of practice meetings and coordination of key stakeholders in the region. This role is crucial to the integration of primary care and the DFV system and inter-sector collaboration across services to improve access and supporting the patient journey.

Provision of training for general practice will continue to be provided through a whole of practice approach noting the important role that Practice Managers ; Practice Nurses and General Practitioners play in the recognition, response and referral (RRR) process for Domestic and Family Violence (DFV). The training includes: trauma informed practice; communication skills needed to effectively recognise, respond and refer; health impacts of domestic and family violence and the demographic and public health consideration of vulnerable population groups. The RRR training is RACGP accredited and contextualised to the local area, to maximise engagement of practices. A GP Clinical Advisor is engaged to provide advice. The training is delivered in practice by the DFV Integration Coordinator enabling locality connection to the DFV system and the DFV Linker to the practice enhancing the referral relationship between the practice and the 'Linker'. Communication material for practices and the wider community has been developed to assist in creating a safe practice environment that will further enhance the integration of the sector communicating the roles of primary care in the recognition, response and referral of DFV.

The role of the DFV Linker was co-designed with key stakeholders including Local Government across the 4 LGAs, NBMLHD, Hawkesbury Hospital/St John of God, members of the Safety Action Meeting committee, GP Clinical Advisor, those with lived experience, key DFV providers in the region, primary care providers including all role specifications and other identified stakeholders. The pilot project steering committee with key stakeholders including those with lived experience meets bi-monthly to inform the work of the project. The DFV Linkers operate across the systems to operationalise the connection and the DFV system connecting with general practice to improve the navigation of the system with a health care neighbourhood approach supporting a locality response .

The DFV Linker is the face of the DFV services in the general practice environment building a relationship with the general practice staff thereby creating a platform of trust and communication leading to improved referral outcomes. The Linker then meets with the patient in an appropriate and safe place which could be in the general practice. The Linker will refer to the most appropriate service and provide a warm referral when required. This role also provides incidental opportunities for further training and capacity building with general practice staff through a coaching model exemplifying appropriate behaviour when working with people who have experienced or are at risk of DFV. The DFV Linker model is commissioned to a region-wide provider covering all 4 LGAs in the NBM region. The Linkers are allocated as part of the DFV service system and are a direct referral point for general practice.

Referral pathways are included in all communication activities and WHL navigation websites to enhance referral systems across primary care and the DFV sector including <https://myhealthconnector.com.au/> and <https://www.mentalhealthhelp.com.au/> and HealthPathways.

### Needs Assessment Priorities \*

#### Needs Assessment

NBMPHN\_Needs Assessment 2024

#### Priorities

Priority	Page reference
Improve primary care access to domestic family violence, sexual violence, and child sexual assault services for appropriate referral	133



## Activity Demographics

### Target Population Cohort

people who are experiencing domestic and family violence and those seeking behaviour change programs.

### In Scope AOD Treatment Type \*

### Indigenous Specific \*

No

### Indigenous Specific Comments

### Coverage

#### Whole Region

Yes



## Activity Consultation and Collaboration

### Consultation

A Steering Committee has been developed to inform, guide and assist in the implementation of the project. The Steering Committee includes membership from across the four local government areas in the NBM region:

General Practice including a General Practitioner;

Local Health District;

consumer with a lived experience;

practice nurse;

non-government organisations across the domestic family violence sector.

### Collaboration

A consultant was commissioned to facilitate the needs assessment and co-design process to support the implementation of the pilot with the following stakeholders:

- Domestic & family violence services
- General Practices
- Local Health District including IVPRS service
- People with lived experience
- Local SAM's
- Local Government organisations

- Non Local Government organisations
- Greater Western Aboriginal Health Service



## Activity Milestone Details/Duration

### Activity Start Date

14/05/2020

### Activity End Date

28/06/2026

### Service Delivery Start Date

01/07/2020

### Service Delivery End Date

30/06/2026

### Other Relevant Milestones



## Activity Commissioning

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

**Not Yet Known:** No

**Continuing Service Provider / Contract Extension:** Yes

**Direct Engagement:** No

**Open Tender:** No

**Expression Of Interest (EOI):** No

**Other Approach (please provide details):** No

### Is this activity being co-designed?

No

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

Yes

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

No

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

No

### Decommissioning

No

### Decommissioning details?

#### **Co-design or co-commissioning comments**

Co-design activities were held between October and December 2020 and involved surveying the key stakeholders prior to two facilitated co-design workshops which informed the pilot design and implementation. The DFV Linker EOI was released in January and closed at the end of February 2021 with three providers commissioned to deliver the DFV Linker service in the region.

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