WA Primary Health Alliance PHN Core Perth North 2024/25 - 2027/28 Activity Summary View

Approved by the Australian Government Department of Health, Disability and Ageing, Dec 2025

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CF 8000 COVID-19 Vaccination of Vulnerable Populations

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

CF-COVID-VVP

Activity Number

8000

Activity Title

CF 8000 COVID-19 Vaccination of Vulnerable Populations

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

The activity aims to support and coordinate local solutions that enable the delivery of COVID-19 vaccinations to vulnerable populations including older members of the multicultural community, residential aged care home residents, people with a disability, those without access to Medicare, and individuals who cannot access or have difficulty accessing the vaccine through existing mechanisms.

Description of Activity

This CF8000 Activity ceased 31 December 2024 with underspent funds being populated into the new CF-VVP-PCS 8010 activity with previously approved Primary Care Support activity information and planned expenditure. CF-VVP-PCS 8010 Activity end date will be 30 June 2026.

The Primary Health Network (PHN) will continue to consult and collaborate with key stakeholders to ensure COVID-19 vaccination activities are responsive and dynamic in response to community need.
Analysis of WAPHA needs assessment and other data indicates that the focus locations to target vulnerable populations are SA3s Swan, Wanneroo, and Stirling. Swan is also likely to be a priority location to work with Aboriginal communities and services to increase COVID-19 vaccination rates. Residential aged care facilities (RACFs) in Perth North PHN with COVID-19 vaccination rates of 0-30 per cent full coverage will also be a priority population.
The PHN will:
1. Collaborate with COVID-19 vaccination providers including general practice, pharmacy, PHN contracted providers, state health services and nurse practitioners to enable access of the COVID-19 vaccination to vulnerable people in identified priority locations.

2. Facilitate partnerships and work with local government, community organisations and Aboriginal Community Controlled Health Services on tailored solutions to suit local context.
3. Communicate existing relevant COVID-19 assessment and vaccination funding mechanisms for vaccination services to GPs and health professionals.
4. Explore innovative strategies to enhance vaccination rates among target cohorts, leveraging the expertise of pharmacists and registered vaccination providers. This will include initiatives such as outreach services and educational events tailored to address prevalent barriers hindering COVID-19 vaccine uptake.
5. Build the capacity of key providers (e.g., RACFs, general practice, pharmacies, nurses, and Aboriginal Community Controlled Health Services) to provide sustainable vaccination services to vulnerable community members.

The activity will be guided by the WAPHA Stakeholder Engagement Framework which has been developed by the organisation to set clear standards and expectations for staff and external stakeholders.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable access to aged care services that support independent living and healthy ageing at home (Metro).	52
Support primary health care providers deliver best-practice mgmt to people with diabetes &build capacity for patient self-mgmt, by enabling access to multidisciplinary, integrated, allied care (Metro)	10

Activity Demographics

Target Population Cohort

Populations identified as having difficulty accessing COVID-19 vaccines include (but is not limited to):
• Those who are experiencing homelessness, including those living on the streets, in emergency accommodation, boarding houses or between temporary shelters.
• People with a disability or who are frail and cannot leave home.
• People in rural and remote areas with limited healthcare options, including those who cannot travel to a regional centre.
• Culturally, ethnically and linguistically diverse people, especially asylum seekers and refugees and those in older age groups who may find it difficult to use other vaccination services.
• Those who do not have a Medicare card or are not eligible for Medicare.
• Aged care and disability workers, with consideration to all auxiliary staff working on-site.
• Aboriginal and Torres Strait Islander people.
• Any other vulnerable groups identified as requiring dedicated support to access vaccinations.

With lower COVID-19 vaccination rates than that of the general population, this sector will continue to be the focus of the Vulnerable Populations Vaccination Program. To support this, engagement with General practice, Aboriginal Community Controlled Health Organisations (ACCHOs), community and non-government organisations and state health will continue.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The PHN consulted with and continues to engage with a range of stakeholders in the planning and delivery of the Vulnerable Populations Vaccination Program, including but not limited to:
- General Practice
- WA Department of Health
- Aboriginal Community Controlled Health Organisations
- Residential Aged Care Facilities
- Community Organisations
- Commissioned Services
- Local Government
- Education Institutions
- Peak Bodies

Collaboration

The PHN is working with WA Department of Health, General Practitioners, Community Organisations, Aboriginal Community Controlled Health Organisations, Residential Aged Care facilities and Education Institutions to identify vulnerable people within their area, that have limited access to COVID-19 vaccination and information. These stakeholders will be directly involved in facilitating access to and administering COVID-19 vaccinations and information.

Activity Milestone Details/Duration

Activity Start Date

08/09/2021

Activity End Date

30/12/2024

Service Delivery Start Date

09/09/2021

Service Delivery End Date

31/12/2024

Other Relevant Milestones

Activity Work Plans	Due 30/04/25
Multi-year Needs Assessment	Due 15/11/24

Activity Completion Report	Due 14/01/25
Twelve Month Performance Report	Due 30/09/25
Financial Acquittal Report	Due 30/09/25

Activity Commissioning

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

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
COVID-19 Vaccination of Vulnerable Populations	$925,814.31	$1,555,294.15	$0.00	$0.00	$0.00	$2,481,108.46
Total	**$925,814.31**	**$1,555,294.15**	**$0.00**	**$0.00**	**$0.00**	**$2,481,108.46**

MyM 2500 - My Medicare

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

MyM

Activity Number

2500

Activity Title

MyM 2500 - My Medicare

Existing, Modified or New Activity

New Activity

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

This activity enables WAPHA to identify and assist unaccredited practices in Perth North PHN (PNPHN) to work towards accreditation, thereby increasing the number of general practices accredited, and the number of practices eligible for MyMedicare and other Commonwealth funded programs.
The new RACGP definition of general practice for accreditation purposes has broadened the opportunity for some non-traditional general practices to become accredited to the RACGP standards. WAPHA will work with those practices to inform of the rationale and benefits of accreditation, and the practical application of the 5th edition standards to their specific type of practice.

The intended outcomes of this activity are:
· An increase in general practice accreditation.
· Improvements in safety and quality.
· Improved access of general practice to Commonwealth funded programs such as MyMedicare.

Description of Activity

Background:
General practice accreditation is independent recognition that practices meet the requirements of the governing national industry Standards. Accreditation means a practice is meeting minimum safety and quality standards.26 In Australia the National General Practice Accreditation (NGPA) scheme supports the consistent assessment of general practices against the Royal Australian College of General Practitioners (RACGP) Standards for General Practice 5th Edition (the Standards).

The definition of a general practice for the purpose of accreditation was broadened by RACGP in April 2024, meaning that previously ineligible services may now fit the eligibility criteria to become accredited.

Accreditation against the RACGP Standards for general practice is a pre-requisite for general practices to access the Commonwealth Practice Incentives Program (PIP), Workforce Incentives Program (WIP) and MyMedicare financial incentives, which support health professionals and practices to deliver quality, multidisciplinary care, enhance capacity and improve access.

Core funding supports the operations of WAPHA to develop resources and supports to assist the unaccredited practices in Perth North PHN to achieve accreditation where desired, which is a prerequisite for participation in MyMedicare.
Practice support includes (but is not limited to):
• Assistance for general practices going through accreditation or accreditation processes.
• Provision and access to resources and information to assist with preparation for accreditation.
• Assistance maintaining conformance to the accreditation standards.
• Reducing or resolving barriers to accreditation.

Roles and Responsibilities
WAPHA's Primary Care Portfolio, which works across the three WA PHNs, is responsible for delivering the My Medicare accreditation activity. An executive sub-committee oversees all PNPHN population health activity including MyMedicare to ensure it aligns with funding requirements and guidance, and WAPHA's Strategic Plan 2023-2026.

Key Activities
Stakeholder Engagement
• Undertake an analysis of the accreditation status and eligibility of all general practices in PNPHN.
• Targeted engagement with non-accredited general practices to understand barriers and enablers to accreditation.
• Managing expectations of general practices regarding WAPHA's role in accreditation support.

Building Capacity
• Promote the broadened definition of general practice and the benefits of accreditation.
• Promote available resources and education opportunities to increase knowledge and understanding of the accreditation process and requirements.
• Information will be provided about eligibility and requirement for MyMedicare registration, along with other PIP/WIP incentives.
• Provide Quality Improvement support to practices who are interested in seeking accreditation.

Monitoring
• Maintain accurate general practice accreditation data within CRM.
• Activity data collection and reporting.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary health care providers in managing complex care cases for patients with mental and physical comorbidities (Metro)	10
Support primary health care providers to refer to appropriate mental health services, including telehealth-enabled services (Metro).	9
Support primary health care providers to provide culturally appropriate chronic disease management for Aboriginal people living with chronic disease and build capacity for patient self-mgmt (Metro).	44

Activity Demographics

Target Population Cohort

Unaccredited general practices located within Perth North PHN

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The PHN will engage the following organisations or groups to support implementation of this activity:
• General practices, both accredited and non-accredited.
• Engagement with RACGP.

Collaboration

The PHN will continue to build on established relationships with key stakeholders, including:
• RACGP.
• Department of Health, Disability and Ageing.

Activity Milestone Details/Duration

Activity Start Date

31/05/2024

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2024

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/06/26,30/06/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27

Final Report Due 30/09/27

Progress reports including:
· List of general practices in your region working towards accreditation under the National General Practice Accreditation Scheme.
· List of withdrawn general practices and reason for withdrawal under the National General Practice Accreditation Scheme
· List of unaccredited general practices under the National General Practice Accreditation Scheme

PQF indicators:
· P3 Rate of general practice accreditation
· P4 Support provided to general practices and other health care providers

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Activity Commissioning

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

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
MyMedicare	$0.00	$109,949.00	$21,989.80	$21,989.80	$0.00	$153,928.60
Total	**$0.00**	**$109,949.00**	**$21,989.80**	**$21,989.80**	**$0.00**	**$153,928.60**

GPACI-GPM 3020 - GP in Aged Care: GP Matching

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

GPACI-GPM

Activity Number

3020

Activity Title

GPACI-GPM 3020 - GP in Aged Care: GP Matching

Existing, Modified or New Activity

New Activity

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

The General Practice in Aged Care Incentive (GPACI) - GP Matching initiative provides funds for Perth North Primary Health Network (PNPHN) to work in collaboration with Residential Aged Care Homes (RACHs), General Practitioners (GPs), practices, and Aboriginal Community Controlled Health Services (ACCHSs) to develop processes, relationships and networks to increase access of older people living in RACHs to primary care services.

To this end, PNPHN's objectives are to:
• Collaborate and engage with aged care home providers, GPs and general practices and ACCHSs in their region, including establishing arrangements between stakeholders where appropriate.
• Develop processes and strategies to connect and establish relationships between older people living in aged care homes and aged care homes with primary care especially in cases where no relationship currently exists. This includes providing support to facilitate visits to older people living in aged care homes to encourage continuity of care.
• Develop or use existing tools to support stakeholders to sign up and appropriately use the MyMedicare platform.
• Identify and share examples of best practice arrangements between aged care home providers, GPs and general practices and ACCHS in your region, this may include through establishment of networks to improve capacity.

The activities undertaken by PNPHN aim to:
• Increase the knowledge of GPs, and general practice and ACCHS staff working in the Perth North region of the incentive and its benefits to older people living in aged care homes and residential aged care providers.

• Improve reciprocal relationships between GPs, general practices and ACCHS in Perth North and residential aged care providers to facilitate the delivery of quality and continuous primary care services.
• Improve the capacity of GPs, general practices and ACCHS in Perth North to deliver quality and continuous care through collaborative learning networks and/formalised arrangements, and the embedding of Best Practice Guidelines and Tools.

Description of Activity

Background
GEN Aged Care 2024 Aged Care Service list identifies 103 RACHs in PNPHN at 30 June 2024. These sites provide approximately 8,575 residential places for older people living across the PHN region. Consistent with the findings from the Royal Commission into Aged Care Quality and Safety and Strengthening Medicare Taskforce, some of these residents can experience inconsistent or a lack of access to primary care services.

Roles and responsibilities
WA Primary Health Alliance's (WAPHA's) Primary Care Portfolio, which works across the three WA PHNs, is responsible for delivering the PNPHN GP Matching activity. An executive sub-committee oversees all PNPHN aged care activity including GP Matching to ensure it aligns with funding requirements and guidance, and WAPHA's Strategic Plan 2023-2026.

An activity lead guides the design, coordination, development, implementation and evaluation of the GP Matching activities. The GPACI is promoted by WAPHA, at a State and PNPHN level through established relationships and mechanisms with WA Department of Health, North and East Metropolitan Health Services, the Department of Health and Ageing, WA Local Network, Aboriginal Health Council of WA, and key aged and primary care sector stakeholders.

Targeted place-based GP Matching activities are/will be undertaken by the Activity Lead, and by/with the support of WAPHA's primary care support, Practice Assist, Quality Improvement Coaches, Regional Integration Managers and Digital Health team members in prioritised locations These activities build on the established and trusted relationships with RACHs, GPs and general practice and ACCHSs employees. A program logic guides activities.

Key activities
1. Stakeholder engagement and collaboration.
• Engagement with individuals and small group forums in prioritised locations, will inform activity design and identify RACHs and primary care providers (including ACCHSs) willing to participate in activities.
• Existing relationships such as those established via practice support, Practice Assist and the PHN's RACH Telehealth, Afterhours planning and COVID Vaccination activities will be maintained.
• Existing/new relationship development and engagement will be prioritised in areas of high need, with collaborating providers.
• Activities will align with WAPHA's Cultural Competency Frameworks (Aboriginal, Multicultural, and LGBTIQA+, Equity and Diversity).
• Recording engagement activities in WAPHA's Stakeholder Relationship Management system.

2. Needs analysis will identify the extent of issues, barriers, opportunities, priority populations (Aboriginal and Multicultural) and locations, and local context (such as workforce availability) and inform activity design, implementation, and monitoring.
• Barriers, and best practice examples will be shared with the Department of Health and Aged Care and PHNs via the National PHN MyMedicare Project Team and related forums.
• Managing expectations and demand will be required due to the anticipated volume of need across PNPHN. Assistance will be available via Practice Assist and a webpage which will direct stakeholders to the Department of Health and Aged Care developed best practice resources.

3. Building capability and understanding
• Participation in GPACI related national discussions/forums.

• Information/education will be provided to primary care providers (including ACCHSs) and RACHs about the GPACI process, requirements and benefits, including resident MyMedicare registration information via practice support staff, Practice Assist and webinars.
• Assistance and advice will be provided to support GPs and general practice/ACCHS initial MyMedicare registration and GPACI payment requirements.
• Department of Health, Disability and Ageing provided/authorised information and resources (best practice guidelines and tools) will be shared via WAPHA's existing communication channels (including newsletters and webpages).
• Resources will be developed/refined as/if required.
• Webpages which connect providers to the Department of Health, Disability and Ageing, information will be maintained.

4. Program design and implementation
• Relationships between primary care and RACH providers include encouraging the development of business processes to facilitate GP and resident connection, and adoption of agreements which outline roles and accountabilities will be facilitated.
• The GP Matching activities will connect to and build on PNPHN activities being undertaken to deliver My Medicare support for general practice accreditation.
• WAPHA will leverage existing partnerships and practice support functions that are well established and access real-time data analytics to inform best practice and opportunities for quality improvement and efficiencies.
• Access to culturally appropriate information and resources to support RACH residents having a choice in their provider will be promoted.

5. Monitoring and evaluation
• Establishing and maintaining indicator data collection processes.
• Data collection, analysis, and reporting.
• Ongoing engagement with the Department of Health, Disability and Ageing and the National PHN MyMedicare Project Team.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support health care and aged care providers in delivering patient-centered culturally appropriate care (Metro)	53
Support primary health care providers (incl. general practices, allied health and aged care services) to effectively manage chronic conditions for older people and promote health ageing at home(Metro)	54
Support the mental health of older people and assist primary care providers to identify older people who may need additional support or referrals to services (Metro).	28

Activity Demographics

Target Population Cohort

Primary care workforce, particularly GPs, and practice/RACH staff in priority locations within the Perth North PHN in their role / possible role as providers primary care service providers to RACH residents.
Residential aged care provider executives and managers, and RACH staff that coordinate care in facilities.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consultation has or is planned to occur with:
• WA Department of Health Intergovernmental Relations and Aged and Community Teams.
• WA GP Panel – Special Interest Group: Care of the older person members.
• Department of Health and Aged Care WA, Local Network.
• North and East Metropolitan Health Service], relevant hospitals such as, Fiona Stanley Hospital and Consider Home Over Inpatient Care Every (CHOICE) Teams/ aged care leads.
• WA Virtual Emergency Department (WAVED).
• General Practitioners and general practices in the target locations, and others outside of the target population that may be able to assist in the model development or service delivery.
• Residential Aged Care providers. More in depth engagement will occur with RACHs in areas of need.
• Aboriginal Health Council of WA.
• ACCHSs in the target location, where Aboriginal people are living in the RACHs and the ACCHS is providing a service (Derbarl Yerrigan and Moorditj Koort).
• National MyMedicare Project Team.
• PHN Aged Care leads.
• Ageing Australia (formerly ACCPA) (WA State Manager).
• Aged Health /McClean Health representatives.

A stakeholder engagement and communication plan guides PNPHN activities.

Collaboration

PNPHN will collaborate with stakeholders and providers to ensure activity requirements are delivered.

These will include prioritising willing/receptive providers in areas where there is high need:
• GPs and general practice/ACCHS employees that seek assistance with MyMedicare registration and GPACI linkage, and an interest in providing primary care services to RACH residents.
WAPHA staff will collaborate to:
o Provide the requested assistance to increase MyMedicare registration and GPACI linkage.
o Connect GPs wishing to provide services in RACHs to RACHs.
• GPs, general practice/ACCHS employees and RACH leads to facilitate greater connection and relationship development related to the GPACI.

At a national level WAPHA collaborates with members of the National MyMedicare Project team and other PHN representatives to share examples of innovative models of care, lessons learnt, and barriers and opportunities.

Activity Milestone Details/Duration

Activity Start Date

31/05/2024

Activity End Date

29/06/2027

Service Delivery Start Date

01/06/2024

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/04/26, 30/04/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27
Final Report	Due 30/09/27

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
General Practice in Aged Care–GP Matching	$0.00	$142,155.00	$142,155.00	$142,155.00	$0.00	$426,465.00
Total	**$0.00**	**$142,155.00**	**$142,155.00**	**$142,155.00**	**$0.00**	**$426,465.00**

CMDT 5320 - Commissioning Multidisciplinary Teams

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

CMDT

Activity Number

5320

Activity Title

CMDT 5320 - Commissioning Multidisciplinary Teams

Existing, Modified or New Activity

New Activity

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

As part of the 2023-24 federal budget Strengthening Medicare Reform measures, the Department of Health and Aged Care announced $77.35 million for PHN's to commission multidisciplinary teams (MDT) into general practice.
The purpose of this grant opportunity is to strengthen the role PHNs play in commissioning multidisciplinary health care teams to improve the management of chronic conditions and reduce avoidable hospitalisations.

The objectives of the grant opportunity are to:
• Design an approach for multidisciplinary team services in the PHN region based on:
o Identification of, and consultation with, small or solo general practices or Aboriginal Community Controlled Health Services that are unable to engage a multidisciplinary team through other funding streams.
o Identification and prioritisation of areas of need in underserved or financially disadvantaged communities (such as treating chronic conditions and injuries, coordinating care for priority patients, mobilising social supports for at risk patients).
• Successfully commission multidisciplinary teams that address the prioritised need in the region, with a focus on supporting smaller general practices that do not have the size or scale to engage the range of health professionals required to provide effective multidisciplinary care.
• Extend PHNs' existing role in general practice to support to private allied health, nursing and/or midwifery practices.
• Establish reporting processes supported by data collection and data management practices, including both activity and outcome measures.

• Monitor implementation of the activity, utilising relevant outcome measures, and develop adjustments to the approach if required.

The intended outcomes of the grant opportunity are to:
· Increase access to allied health, Aboriginal Health Worker/Practitioner, nurse practitioner, nursing, and/or midwifery services to provide person-centred care for Australians that improves health outcomes and reduces avoidable hospitalisations, particularly in relation to chronic disease.
· Improve attraction and retention of allied health, Aboriginal Health Worker/Practitioner, nursing, nurse practitioner and midwifery professionals in the primary care sector by increasing access to practice support from PHNs.

Description of Activity

Background
The Strengthening Medicare Taskforce report (Dec 2022) and Australia's Primary Health care 10-Year Plan (Mar 2022) both highlight the importance of a multidisciplinary approach to primary care, to meet the increasingly complex care needs of Australians. This is further explored in the 2024 Health of the Nation report which indicates that a well-resourced, multidisciplinary primary healthcare team has the capacity to coordinate high quality care and ensure patients care achieve the best possible health outcomes.

Rationale
Australians seek care from a range of different health professionals across primary care and other care settings, which can mean that accessing appropriate care can become complex and disconnected. Our current funding mechanisms reward episodic care and fast throughput which creates disproportionate barriers for more vulnerable populations: Aboriginal Australians, people with chronic and complex conditions, people with mental health issues, people from culturally and linguistically diverse backgrounds and people on low incomes. Connection and collaboration through coordinated multidisciplinary care teams can improve engagement and access and deliver better outcomes to help people better manage their own health.

WA Primary Health Alliance (WAPHA) will develop and successfully commission a multidisciplinary team-based approach to primary care in a Perth North PHN area of need.

Roles and Responsibilities
WAPHA's Primary Care Portfolio, which works across the three WA Primary Health Networks (PHN's) is the Lead portfolio responsible for the delivery of multidisciplinary teams into general practice. A dedicated Activity Lead will provide ongoing coordination, engagement and monitoring. The Commissioned Services Portfolio lead the procurement element of this activity and will provide contract management and program improvement support.

Key Activities - Commissioning:
The successful implementation of an effective and localised multidisciplinary team-based service will be influenced by following phased activities:
Planning and engagement
• Analysis of population, workforce and practice data to determine priority locations for service delivery
• Consultation with WAPHA GP advisory panel and Commissioned Service Provider panel regarding need and access to MDT, and exploration of opportunities and challenges.
• Recruitment of a dedicated Activity Lead to coordinate ongoing activities including developing relationships with peak bodies, ongoing support to CSP and general practices and other practice support activities.
• Targeted consultation with general practices and health Service Providers within identified priority locations in Perth North PHN, to determine gaps and opportunities in local primary care workforce and implementation of MDT, and appetite for participation in activity.
Procurement and co-design
• Procure a service provider to engage a number of health professionals – type to be determined through general practice consultation – to provide a shared, visiting MDT to a selection of general practices within Perth North PHN.
• Support selected general practices and the commissioned service provider to develop a model of MDT care that will address the needs of the local community, including how to measure the success of the initiative by identifying key performance measures.

Implementation
• Continued engagement with commissioned service and general practices, both formally and informally, to ensure opportunities for iterative changes and adaptation of service to local needs.
• Support local integration of MDT service into the broader local health environment

Proposed Activities – Practice Support:
To support general practice, commissioned services and primary health professionals, WAPHA will leverage existing partnerships and practice support functions that are well established and access real-time data analytics to inform best practice and opportunities for quality improvement and efficiencies. The Activity Lead will coordinate these activities with support of established practice-facing teams.
Activities may include but are not limited to:
• Engage and build relationships with Peak organisations for allied health, nursing, nurse practitioners, midwives and Aboriginal health professionals.
• Maintain close relationships with CSP's and participating general practices
• Establish a Learning Group or similar forum to enable primary care providers to identify challenges, participate in interdisciplinary approaches/learning, review practice and subsequent outcomes, share approaches/learnings and align to and inform the ongoing development of the MDT approach.
• Identify opportunities for further education and/or quality improvement which may include analysis of a particular patient cohort, clinical workflows or opportunities for local integration with other health services.
• Analyse and provide feedback to CSP regarding PREM and PROM, as well as clinician experience (practice and CSP) data, to allow for the collaborative development of solutions and improvements to the MDT service.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable access to best-practice management for people with chronic heart failure (Metro).	10
Support primary health care providers deliver best-practice mgmt to people with diabetes &build capacity for patient self-mgmt, by enabling access to multidisciplinary, integrated, allied care (Metro)	10
Support primary health care providers to implement effective health interventions for those living with overweight and obesity (Metro).	10
Support primary health care providers in managing complex care cases for patients with mental and physical comorbidities (Metro)	10
Support primary health care providers in identifying and supporting smokers to cease or reduce their tobacco consumption (Metro).	35

Activity Demographics

Target Population Cohort

Patients of participating general practices within the SA2 locations of Balga-Mirrabooka, Girrawheen, Marangaroo, Alexander Heights-Koondoola, Nollamara - Westminster.

Indigenous Specific

No

Coverage

Whole Region

No

SA3 Name	SA3 Code
Wanneroo	50503
Stirling	50502

Activity Consultation and Collaboration

Consultation

The PHN will continue to build on established relationships with key stakeholders, including:
GP Advisory Panel
Service Provider Panel
Internal locally based WAPHA staff
Targeted general practices within the priority locations
Allied health peak bodies
WACHS
WAPHA internal and place-based teams
Health Service Providers

Collaboration

The PHN will continue to build on established relationships with key stakeholders:
WAPHA internal and place-based teams
Selected general practices – GP's, practice managers, practice nurses
Commissioned service provider
WACHS

Activity Milestone Details/Duration

Activity Start Date

31/05/2024

Activity End Date

29/06/2028

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/04/26, 30/04/27, 30/04/28
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26, 15/11/26
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27, 30/09/28
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27, 30/09/28
Final Report	Due 30/09/28

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: Yes
Expression Of Interest (EOI): No
Other Approach (please provide details): No

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Commissioning Multidisciplinary Teams - Administration	$0.00	$228,953.34	$231,717.33	$234,530.33	$0.00	$695,201.00
Commissioning Multidisciplinary Teams - Commissioning	$0.00	$552,500.00	$560,500.00	$568,500.00	$0.00	$1,681,500.00
Total	**$0.00**	**$781,453.34**	**$792,217.33**	**$803,030.33**	**$0.00**	**$2,376,701.00**

WIP-PS 7000 - Workforce Incentive Program

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

WIP-PS

Activity Number

7000

Activity Title

WIP-PS 7000 - Workforce Incentive Program

Existing, Modified or New Activity

New Activity

Activity Priorities and Description

Program Key Priority Area

Workforce

Aim of Activity

In the 2023-24 federal budget, the Department of Health and Aged Care announced a range of activities which were aimed at implementing the recommendations from the Strengthening Medicare Taskforce Report. The Workforce Incentive Program-Practice Stream (WIP-PS) is a current Department of Health and Aged Care incentive to assist general practices to employ non-medical health professionals (nurses, midwives, allied health, Aboriginal Health professionals) to encourage a multidisciplinary team-based approach to primary care.

This activity aims to:
• Understand current utilisation of WIP-PS in Perth North PHN (PNPHN).
• Identify and provide additional support to practices addressing gaps in WIP-PS knowledge.
• Identify different models of multidisciplinary care supported by the WIP-PS to address community need, and the key factors that enable or inhibit these models and to share learnings.
• Identify the range of activities nurses and allied health professionals undertake in primary care supported by the WIP-PS.
· Increase general practice participation in the WIP-PS.
· Improve patient outcomes by improved access to multidisciplinary care in communities.
· Identify best practice models of care supported by WIP-PS.
· Have general practices providing sustainable, quality multidisciplinary team care.

Description of Activity

Background
The Workforce Incentive Program-Practice Stream (WIP-PS) provides financial incentives to eligible general practices, Aboriginal Community Controlled Health Services (ACCHS) and Aboriginal Medical Services (AMS) to engage a range of health professionals including nurses, midwives, allied health professionals and Aboriginal and Torres Strait Islander health workers and health practitioners.
In 2023-24, a review was undertaken by the Department of Health, Disability and Ageing as part of the Strengthening Medicare Reform measures, to analyse the effectiveness and impact of the current Practice incentive and Workforce Incentive payments. This activity will provide local insights into the utilisation of the WIP-PS, gaps in knowledge about the incentive and different models of care practices are implementing supported by WIP-PS.

Rationale
Australians seek care from a range of different health professionals across primary care and other care settings, which can mean that accessing appropriate care can become complex and disconnected. Our current funding mechanisms reward episodic care and fast throughput which creates disproportionate barriers for more vulnerable populations: Aboriginal Australians, people with chronic and complex conditions, people with mental health issues, people from culturally and linguistically diverse backgrounds and people on low incomes. Connection and collaboration through coordinated multidisciplinary care teams can improve engagement and access and deliver better outcomes to help people better manage their own health.

Perth North PHN will undertake activities to better understand what types of health professionals are employed within general practice, what types of tasks they undertake and what types of models of care are being implemented with the support of WIP-PS.
WAPHA will deliver a range of activities in Perth North PHN, including:
• Stakeholder engagement, practice collaboration and communication.
• Data collection, reporting and analysis.
• Implementation of strategies for enhancing multidisciplinary models of care in practices.

Roles and Responsibilities
WAPHA's Primary Care Portfolio, which works across all three WA Primary Health Networks (PHN's), is the lead portfolio responsible for undertaking the WIP-PS activity. The Primary Care Navigation and Quality Improvement teams work together to engage with and support general practices in their understanding and application of the WIP-PS, with the support of the Primary Care Learning team.

Key Activities
Perth North PHN will:
Initial Data collection and analysis
• Review Department WIP-PS data, internal CRM data and Primary Sense general practice data to identify practices both approved and not approved for the WIP-PS, as well as practices who engage non-medical workforce.
• Identify priority locations within Perth North PHN where general practices may benefit from additional support to understand and apply multidisciplinary care and the utilisation of WIP-PS.
• Identify general practices where multidisciplinary care is taking place.

General practice engagement
There are two streams of delivery within this funding:
1. Engage with general practices who are already utilising the WIP-PS, to assist them to identify practice gaps and opportunities to improve multidisciplinary care.
2. Engage with general practices who do not currently utilise the WIP-PS but who are eligible, to provide resources and information about the benefits of multidisciplinary care and the WIP-PS for supporting comprehensive person-centred care in the community.

General practice education
• Provide educational opportunities to assist practices utilising the WIP-PS -topics may include but are not limited to opportunities and challenges of multidisciplinary care, and enhance multidisciplinary workflows to support patient care and business efficiencies.
• Provide educational opportunities to general practices that are eligible for but not yet utilising the WIP-PS, promoting the purpose of the incentive, eligibility, value proposition to practice and patients, and application process.
General practice support
• Provide support to implement quality improvement activities that enhance or expand multidisciplinary team care.
• Provide support to implement quality improvement activities that build practice team capacity to participate in multidisciplinary team care.
Case Studies
Through already established relationships, WAPHA will identify general practices who are already utilising the WIP-PS to implement multidisciplinary care and engage with those practices to document the challenges and benefits of their model of care and how the WIP -PS assists them to maintain this type of service.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary health care providers deliver best-practice mgmt to people with diabetes &build capacity for patient self-mgmt, by enabling access to multidisciplinary, integrated, allied care (Metro)	10
Enable access to integrated care pathways that address both mental and physical health concurrently (Metro)	10

Activity Demographics

Target Population Cohort

Target population for the WIP-PS activity are general practices, ACCHS and AMSs, with activities specifically targeted at:
1. General practices who are not currently utilising or approved for the WIP-PS.
2. General practices utilising the WIP-PS.

PNPHN will prioritise those general practices delivering services to the most vulnerable patient cohorts including Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people, older persons, people living in rural and remote areas and people experiencing socioeconomic disadvantage.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The PHN will engage the following organisations or groups to support implementation of this activity:
Internal
- Regional Integration Managers
- Primary Care teams
- Data and analytics team

External
- General practices
- Aboriginal Community Controlled Health Services
- Aboriginal Medical Services
- Services Australia
- Department of Health and Aged Care

Collaboration

The PHN will continue to build on established relationships with key stakeholders:
- Aboriginal Health Council of WA
- General practices
- ACCHS and AMSs
- Rural Health West

Activity Milestone Details/Duration

Activity Start Date

31/05/2024

Activity End Date

29/06/2025

Service Delivery Start Date

01/09/2024

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Activity Work Plans	Due30/04/25
Annual Activity Needs Assessment	Due 15/11/24
Twelve Month Performance Report	Due 30/09/25
Financial Acquittal Report	Due 30/09/25
Final Report	Due 30/09/25
Departmental Survey and Online Forums	Due 15/06/25

PHNs must participate in a Departmental survey and online forums in 2024-25 to provide updates on PHN support to general practices and general practice participation in the Workforce Incentives Program – Practice Stream.

The final report will:
• Identify if and how outcomes were achieved, including justification of the outcome measures utilised for practices.
• Current utilisation of WIP-PS in PHN region.
• How practice support was implemented and any barriers to implementation.
• PHN method of engagement with practice. Could include insights, support/education that has been offered, employment types, numbers and percentage of practices, types of engagement such as seminars, surveys, workshops, phone, visits.
• How multidisciplinary team services were improved through support, including changes made to implement better models of care.
• Identify barriers to practices utilising WIP-PS.
• Suggestions on potential areas for improvements to WIP-PS policy to support more effective multidisciplinary primary care in communities.
• Provide examples of models and case studies of effective multidisciplinary care to address patient needs and outline the types of support provided to practices to implement and integrate these models.
• Identify the total eligible expenditure incurred.

Activity Commissioning

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

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Workforce Incentive Program-Practice Stream	$0.00	$101,064.50	$0.00	$0.00	$0.00	$101,064.50
Total	**$0.00**	**$101,064.50**	**$0.00**	**$0.00**	**$0.00**	**$101,064.50**

CF 1000 - Managing Chronic Conditions

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

CF

Activity Number

1000

Activity Title

CF 1000 - Managing Chronic Conditions

Existing, Modified or New Activity

Existing

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

The WA Primary Health Alliance (WAPHA) Managing Chronic Conditions Program aims to improve patient access to primary health care, provide coordinated care, reduce potentially preventable hospitalisations, and strengthen patient self-management for people with chronic conditions.
The key objectives are to:
• Improve patient experience.
• Improve health outcomes.
• Improve health literacy and self-management.
• Increase interagency /cross sector connection, integration, and collaboration.
• Strengthen chronic conditions management in primary care.
• Minimise chronic conditions preventable hospitalisations and Emergency Department presentations.
• Improve health equity and primary health care outcomes for priority populations.
• Locate place-based services in priority community locations.

The chronic conditions targeted by this program include diabetes; respiratory conditions such as Chronic Obstructive Pulmonary Disease (COPD) and asthma; obesity, chronic pain, and cardiovascular conditions, such as Chronic Heart Failure (CHF).

Description of Activity

Background
Almost half of Australians (47% 11.6 million people) were estimated to have one or more of 10 selected chronic conditions in 2020–2021.
In Western Australia, chronic conditions and injury cause the highest burden of disease than any other diseases.

The Health and Wellbeing of Adults in Western Australia 2022 survey indicated the prevalence of the following chronic conditions for adults over the age of 16 years in the North and East metropolitan regions:

The percentage of the population diagnosed with Asthma in the PNPHN is 19.3% and East Metropolitan region 21.8%. The percentage of the population diagnosed with Diabetes (priority SA3 locations including Swan, Bayswater-Bassendean, and Kalamunda) is 7.8% and in the East Metropolitan region is 11.8%. The percentage of the population with respiratory diseases other than asthma is 4.4% and in the East Metropolitan region 5.1%. The percentage of population diagnosed with heart disease (priority SA3 locations being Swan, Wanneroo, Bayswater-Bassendean) is 8.5% and in the East Metropolitan region is 7.5%. The percentage of the PHN who have suffered from a stroke is 2.1% and in the East Metropolitan region is 2.4%, whilst 33% of the PHN are living with obesity (priority SA3 locations include Swan, Wanneroo and Mundaring).

The survey indicated that there were also high incidences of lifestyle behaviours that increase individual risk of developing chronic diseases such as high cholesterol, high blood pressure and lower levels of physical activity.

While nine out of ten (90.3%) adults in WA used primary health services within the past 12 months (2022), only 14% of people had accessed a GP chronic disease management plan (WAPHA needs assessment), identifying significant opportunities to improve chronic conditions care and manage risk factors in general practice and other primary health care services commissioned by WAPHA.

Rationale

Chronic disease is a major contributor to health burden in Australia and some people are disadvantaged due to inequitable access to resources needed to address risk to health and/or have an increased susceptibility to adverse health outcomes. This includes regional, rural and remote residents, LGBTIQA+ and multicultural community members, older adults and Aboriginal people who experience higher risk of chronic health conditions.

People who live in lower socioeconomic circumstances face much poorer health outcomes, with diabetes 2.6 times as high and coronary heart disease and stroke 2.2 times as high compared to people in the highest socioeconomic group. Perth North PHN has pockets of significant disadvantage including Swan, Wanneroo and Perth City SA3.

The WA Sustainable Health Review 2019 noted that:

- Approximately 190,000 of the one million attendances to WA Emergency departments (ED) in 2017–18 could have been potentially avoided with treatment in primary care or community settings.
- Seven per cent of all hospital admissions in 2017–2018, costing an estimated $368 million, were potentially preventable with appropriate care and management outside of hospitals,
- Chronic diseases were responsible for 73 per cent of deaths in Australia with $715 million of hospital costs in WA attributed to chronic conditions in 2013.

Some regions in Perth North PHN have had high rates of lower urgency Emergency Department presentations such as Swan and Mundaring SA3s.

This suggests that there are opportunities to support primary health care providers to manage chronic conditions in priority Perth North PHN communities and build capacity for patient self-management (WAPHA Needs Assessment 2022-2024).

Key Activities

The Perth North PHN Managing Chronic Conditions Program provides care coordination and nursing and allied health services, tailored to the needs of those members of the community experiencing disadvantage through the following activities:

- COPD Supported Discharge works in collaboration with Asthma WA's COPD Community Based Care service, to provide clinical care coordination to individuals with chronic obstructive pulmonary disease (COPD), who are non-oxygen dependent, within one week of discharge from hospital due to a COPD related admission. The service connects the patient to primary care including facilitated connection to general practice, with the aim of establishing more effective care in the community and reduced hospital admissions. The service recruit's patients from eight metropolitan hospitals.

• COPD Community Care works in collaboration with the Silver Chain COPD Supported Discharge service, to provide community support and education to individuals with COPD recently discharged from hospital due to a COPD related admission. The service supports clients to engage with primary care including facilitated connection to general practice, with the aim of establishing more effective care in the community and reduced hospital admissions.
• Primary Care at Home provides primary health care to people at risk of poor health outcomes and who have difficulty accessing appropriate primary health care services, including those currently engaged with community and social services. The service takes healthcare into the homes of some of Perth's more disadvantaged communities, whether that be a house, hostel, or community residential facility. The service provides health assessment, treatment, development of an individualized care plan and connection to a general practitioner.
• Persistent Pain Program aims to help persistent pain sufferers improve self-management of their pain through expert education, individual case management, support, goal setting and improved use of community healthcare services. The program also aims to build the capacity of the primary health sector in identified locations to provide improved chronic pain management. The program is designed so that participants can explore a range of different strategies for living well leading to:
o Reduced reliance on medication for pain management.
o Reduced requirements for emergency care.
o Participants not requiring referral to a higher level of hospital-based care.

• Country to City – Improving Patient Transitions Project focuses on the coordination of health and other care elements and to improve the health journey of ITC clients across WA and support providers to apply continuous quality improvement to the Country to City – including but not limited to the service model, standardised processes and improving communication, information sharing and discharge planning.

The PHN will continue to develop and maintain close working relationships with contracted service providers and will formally review services to determine:
• How well targeted and efficient services are.
• How effective services and systems are in relation to patient reported experiences and patient reported health outcomes service/system integration.
• Service sustainability including provider experience/governance/formal accreditation against industry standards (including financial support required) and service cost effectiveness.
• Integration with the Strengthening Medicare reforms.

The PHN uses a diverse range of data collection methods to evaluate the performance of services and inform any necessary actions, including:
• Patient level episode and service contact data.
o Using the WA Primary Health Alliance Performance Management Framework (PMF), the PHN measures and tracks providers' performance against specified PMF indicators relating to health equity, patient-reported experiences and outcomes and cost effectiveness.
• Provider reports formally reviewed at 6 month and 12-month intervals.
• Referral agency feedback.
• Commissioned Services Reporting Portal for nominated managing chronic condition service providers.

A comprehensive review of all PHN chronic conditions activities mid 2024 commenced, due for completion in mid-2025. This review will inform service planning for future chronic conditions services. Performance indicators for chronic condition services have been implemented from 1 July 2023, along with improved frequency and depth of activity and outcome reporting.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable access to best-practice management for people with chronic heart failure (Metro).	10
Support primary health care providers to implement effective health interventions for those living with overweight and obesity (Metro).	10
Support primary health care providers to provide culturally appropriate chronic disease management for Aboriginal people living with chronic disease and build capacity for patient self-mgmt (Metro).	44

Activity Demographics

Target Population Cohort

People who require primary care services, who may be disadvantaged and require additional support to manage their chronic condition. This includes:
• Individuals with a complex chronic condition or multiple morbidities.
• Individuals experiencing socio-economic disadvantage.
• Individuals with limited or no access to required care through other services.
• Aboriginal people.
• Individuals who identify as lesbian, gay, bisexual, transgender, intersex, queer, asexual and other sexually or gender diverse.
• Culturally and linguistically diverse populations.

Indigenous Specific

No

Coverage

Whole Region

Yes

SA3 Name	SA3 Code
Swan	50403
Wanneroo	50503
Perth City	50302

Activity Consultation and Collaboration

Consultation

Ongoing consultation with service providers occurs through contract management, the chronic conditions care community of practice, service providers connect newsletters and meetings.

The review of the chronic conditions care program also included engagement with the following key stakeholders where relevant:
- WAPHA staff members.
- General practitioners and general practice staff.
- Other relevant primary care providers including allied health professionals and commissioned service providers
- Australian Government Department of Health, Disability and Ageing (including other PHNs).
- State Departments of Health and Health Service Providers
- Aboriginal Community Controlled Health Services
- Other key service providers e.g., Silver Chain, Asthma Foundation, Diabetes WA, Heart Foundation
- Cohorts of possible service users.

Collaboration

Stakeholders were provided with an opportunity to:
- Provide feedback on barriers and opportunities and priorities to be addressed in relation to chronic care conditions primary care services in Perth North PHN.
- Identify opportunities to enhance person and family centred care, integration and collaboration between the primary care, acute health systems and other sectors.
- Recommend activities for future commissioning and workforce development.

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2019

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plan	Due 30/04/25, 30/04/2026, 30/04/2027
Annual Activity Needs Assessment	Due, 15/11/25, 15/11/26
Twelve Month Performance Report	Due, 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due, 30/09/25, 30/09/26, 30/09/27

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Core Flexible	$1,706,462.18	$1,859,479.64	$1,332,693.00	$1,372,673.79	$0.00	$6,271,308.61
Total	**$1,706,462.18**	**$1,859,479.64**	**$1,332,693.00**	**$1,372,673.79**	**$0.00**	**$6,271,308.61**

CF 2000 - Developing System Capacity/ Integration

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

CF

Activity Number

2000

Activity Title

CF 2000 - Developing System Capacity/Integration

Existing, Modified or New Activity

Existing

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

The key aim of the Developing System Capacity and Integration is to support the primary health care sector by:
• Providing general practitioners and primary health care clinicians with an online health information portal (Clinician Assist WA) to assist with management and appropriate referral of patients when specialist input is required.
• Facilitating integrated holistic services to reduce the impact of chronic disease by providing enablers for service and patient level integration.
• Providing general practice with access to platforms that support patient centred care through the extraction and analysis of general practice data.
• Providing general practice, clinical, and business teams with access to critical business information in a timely, safe, and secure manner.

Description of Activity

Background
The WAPHA Strategic Plan 2023-2026 commits the organisation to ensuring the best value for money through commissioning integrated primary health services that build capacity, capability and sustainability and measurably improve health outcomes. To meet this commitment, WAPHA supports the provision of tools to support secure digitally enabled health care, continuous improvement and development of integrated primary health care services.

Key principles for an integrated health system include:
• Comprehensive services across the care continuum from health promotion to primary and tertiary level care as well as cooperation between health and social care organisations.

• A patient centred approach, accessibility, minimal duplication of key services.
• Standardisation with a focus on multidisciplinary care.
• Performance management.
• Efficient information systems.

Rationale
Australia is facing an ageing and growing population with an increasing prevalence of complex chronic conditions and higher expectations for quality care. Health budgets are limited and require healthcare to be delivered equitably and be cost effective. An integrated health system that builds capacity is critical to ensuring sustainability and a focus on flexibility and adaptation to the local context. There is no one size fits all model or process that guarantees success however, literature reviews indicate the above key principles build an integrated health system over time.
WAPHA will consistently review and enhance enabling technologies that deliver critical business information and guidance to General Practitioners, as well as Clinical and Business teams, in a timely, safe and secure manner.

Key activities
To support the overarching aim of this AWP, WAPHA delivers the following activities:
1. Delivery of Clinician Assist WA (replacing HealthPathways as an interim solution pending Department of Health and Aged Care decision)
Clinician Assist WA is a web-based tool designed to guide general practitioners (GPs) and other health professionals in making appropriate, patient-focused decisions, particularly regarding the management of a variety of patient presentations and the local referral process. It offers primary care clinicians locally agreed information to make the right decisions, together with patients, at the point of care.
It is designed and written for use during primary care consultation. It provides detailed clinical pathways which are locally agreed upon and evidence-based guidance for assessing and managing patient presentations. Clinician Assist WA content is tailored to specific regions, providing localised information about referral options, services available in the area, and local management guidance. The development of Clinician Assist WA content often involves collaboration between GPs, specialists, subject matter experts and other health professionals. The content is regularly reviewed and updated to reflect the latest research and changes in clinical practice.
The future of Clinical Assist WA is contingent upon the Department of Health, Disability and Aged Care's decision regarding the funding of a National Clinical Referral platform for use by all Primary Health Networks (PHNs) under AWP CF-PHI-5060. The determination of this funding will dictate the subsequent actions required by WAPHA:
1) Approval for a national platform is backed by funding outlined in AWP CF-2000 with additional funds necessary to support the development of a WA-specific version.
2) A national platform is unsupported, requiring investment to make the interim platform fit for purpose.

Perth North PHN also purchased the license to access the GPBook Specialist Directory via a widget embedded within the Clinician Assist WA website. This provides up to date, accurate information to general practitioners about private specialists within the PHN region, with the ability to search by practitioner name, specialty, gender, language, telehealth availability, and billing.
2. Commissioned Services Reporting Portal (CSRP)
WAPHA aims to develop a comprehensive data set and create performance dashboards for all commissioned services. This will enable access to accurate, timely and high-quality performance data which will enable:
• Data-driven decisions that will provide better value for money commissioning and improved provider performance management.
• Deliver better value services in line with WAPHA's Performance Management Framework.
• Improved data security and governance.
• Monitoring and evaluating standards and capabilities to ensure that commissioned services are effective and efficient, and meet the needs of the community.
3. Primary Care Reporting Portal
WAPHA is investing in the development of the Primary Care Reporting Portal. It is an encrypted platform with validated access control enabling a safe and secure method of delivery and access for all general practices sharing data. With access to real-time reporting of practice information, key reports, insights, and other data, WAPHA has developed and provided performance dashboards to general practices within this portal, supporting the monitoring and improvement of their performance as well as ensuring the delivery of value-based services.
WAPHA will continually enhance this platform by implementing self-service administration and the development

of additional reports that support general practice.
4. Primary Sense installation and ongoing management and continuous improvement.
Primary Sense is a population health management, clinical decision support and data extraction tool that helps GPs deliver the right care to patients at the right time. WAPHA has purchased the Primary Sense license, managed implementation across the PHN and developed continuous improvement strategies. The license allows WAPHA to extract general practice data for practice analysis and aggregates general practice data for service planning, reporting and population health needs.
As WAPHA's data extraction tool of choice, the cost of Primary Sense will be fully subsidised for all general practices in WA and WAPHA continues a roll out of Primary Sense software to all general practices in the region.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable access to best-practice management for people with chronic heart failure (Metro).	10
Support primary health care providers deliver best-practice mgmt to people with diabetes &build capacity for patient self-mgmt, by enabling access to multidisciplinary, integrated, allied care (Metro)	10
Support primary health care providers to implement effective health interventions for those living with overweight and obesity (Metro).	10
Increase childhood immunisation rates for regions not meeting national immunisation targets, particularly in locations increased risk of poor health outcomes related to SDOH (Metro)	10
Improve the rates of cancer screening to reduce avoidable deaths from cancer, particularly in in locations with increased risk of poor health outcomes related to social determinants of health (Metro).	9

Activity Demographics

Target Population Cohort

The Perth North PHN population, including WAPHA's priority community groups such as Aboriginal, LGBTIQA+ and multicultural community members, those experiencing homelessness, those experiencing family domestic sexual violence, those with a disability and older people.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The Perth North PHN will continue liaison with the following stakeholders:
- General practices
- General practitioners
- Community and commissioned service providers
- WA Health Service Providers
- Residential Aged Care Facilities
- Aboriginal Community Controlled Health Services

Collaboration

Ongoing engagement with key stakeholders will occur to ensure that the services and activities are meeting the needs of the community and service providers.

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2019

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/04/26, 30/04/2027
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Core Flexible	$535,243.97	$732,058.82	$687,849.15	$566,174.05	$0.00	$2,521,325.99
Total	**$535,243.97**	**$732,058.82**	**$687,849.15**	**$566,174.05**	**$0.00**	**$2,521,325.99**

CF 2010 - PHN Clinical Referral Pathways

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

CF

Activity Number

2010

Activity Title

CF 2010 - PHN Clinical Referral Pathways

Existing, Modified or New Activity

Existing

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

This activity will:
• Develop, maintain, and enhance clinical and referral pathways on the Clinician Assist WA website (formerly HealthPathways) content relevant to the Primary Health Network (PHN).
• Enhance linkages between primary health care services, other providers, and relevant services.
• Improve the patient journey and health outcomes.
• Increase clinician capabilities and the quality of care provided.

This activity aims to:
• Develop, review, enhance and maintain content on the Clinician Assist WA website.
• Maintain the relationship with the website developers to support the operation and administration of the Clinician Assist WA website.
• Increase the awareness of, engagement with, and utilisation of Clinician Assist WA by primary care clinicians in the region.
• Provide and increase awareness of current best practice guidance for a wide range of primary care patient presentations.
• Enhance clinician awareness of and access to local referral options and services for patients.
• Improve collaboration with and integration across health care and other systems.

Description of Activity

Clinician Assist WA content is developed, reviewed and enhanced as appropriate to the health needs of the Perth North PHN. Content is for use by clinicians during consultation with patients, supporting patient assessment and management, and referral to local services and supports.

Clinical and referral webpage development, enhancement, review and maintenance will include the following activities:
· Consultation with subject matter experts, peak bodies, and clinicians.
· Mapping, documenting and maintaining currency of local support and referral service information.
· Engaging with the website developers to ensure the website remains available, functional, secure and, maintained and to provide technical support as required.
· Literature review, drafting and editorial activities.
· Monitoring, reviewing, and improving existing website content to ensure currency, accuracy and consistency with best practice.
· Identification of information gaps in the Clinician Assist WA library and subsequent consideration for new page developments or incorporation of information into an existing page/s as required.
· Identification and escalation of gaps in care/service availability, for consideration to support health system improvements.
· Identification and inclusion of reputable resources suitable for health professionals and patients.
· Development and delivery of targeted educational activities, supporting the awareness and integration of Clinician Assist WA into clinical practice.
· Promoting newly published and/or reviewed pages, in addition to audience specific content, to a wide range of health professionals.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable early intervention and monitoring activities to reduce early entry into residential care and support older people in living independently for as long as possible (Metro).	52
Enable access to best-practice management for people with chronic heart failure (Metro).	10
Support primary health care providers deliver best-practice mgmt to people with diabetes &build capacity for patient self-mgmt, by enabling access to multidisciplinary, integrated, allied care (Metro)	10
Support primary health care providers to implement effective health interventions for those living with overweight and obesity (Metro).	10
Support primary health care providers in managing complex care cases for patients with mental and physical comorbidities (Metro)	10
Support primary health care providers (incl. general practices, allied health and aged care services) to effectively manage chronic conditions for older people and promote health ageing at home(Metro)	54
Improve the rates of cancer screening to reduce avoidable deaths from cancer, particularly in in locations with increased risk of poor health outcomes related to social determinants of health (Metro).	9
Support primary health care providers to refer to appropriate mental health services, including telehealth-enabled services (Metro).	9
Support the mental health of older people and assist primary care providers to identify older people who may need additional support or referrals to services (Metro).	28
Support primary health care providers in identifying and supporting smokers to cease or reduce their tobacco consumption (Metro).	35

Activity Demographics

Target Population Cohort

The activities will focus primarily on general practitioners, in addition to other health professionals including primary care clinicians and allied health professionals practicing in the Perth North PHN.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consultation will continue to occur with the following key stakeholders:
• General practitioners and other health professionals
• Consumer representatives or people with lived experience (if applicable to the topic), limited
• Health service providers
• WA Department of Health
• Clinician Assist WA Users (GPs practicing in WA; and other registered clinicians and some non-clinicians (approved case by case)
• Other PHN regions across Australia

The PHN promotes Clinician Assist WA to specific audiences at conferences (e.g., RACGP annual conference, Rural Health West Conference), through internally and externally produced written communications and articles (e.g., WAPHA publications GP Connect and Practice Connect; Medical Journal of Australia; Medical Forum).

The PHN delivers education and training to those working in general practice (and other clinicians) to:
• Provide an overview of the Clinician Assist WA website and support users to maximise integration into their clinical practice.
• Launch new and newly reviewed Clinician Assist WA content in conjunction with other PHN initiatives and in collaboration with SMEs, HSPs and peak bodies (e.g., Dementia Care in General Practice, Eating Disorders event, Transgender health and gender diversity webinar series).

Collaboration

Developing relationships and collaborating with key stakeholders including peak bodies and provider organisations improves coordination, integration, and continuity of care at the aged care, health, primary care interfaces.
Key stakeholders, in addition to those listed above, include:
· Royal Australian College of General Practitioners.
· Subject Matter Experts (SMEs) Including hospital clinicians, non-general practitioner medical specialists, allied health practitioners, nurses etc.).
· Consumer representatives, GPs, peak bodies (e.g. Diabetes WA, Australasian Society of Clinical Immunology and Allergy (ASCIA)) to:
    o Inform clinical and referral website content.
    o Provide representation and specialist expertise in working groups related to Clinician Assist WA development and/or review.

· Clinician Assist WA website developers - The PHN is supported by and collaborates with the website developers who built the Clinician Assist WA website and now provide ongoing technical and website maintenance support.
· Other stakeholders as they are identified.

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2022

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/04/26, 30/04/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27
Final Report	Due 30/09/27

Activity Commissioning

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

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
HealthPathways	$230,887.80	$285,939.24	$318,704.82	$324,125.21	$0.00	$1,159,657.07
Total	**$230,887.80**	**$285,939.24**	**$318,704.82**	**$324,125.21**	**$0.00**	**$1,159,657.07**

CF 2011 - Aged Care Clinical Referral Pathways

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

CF

Activity Number

2011

Activity Title

CF 2011 - Aged Care Clinical Referral Pathways

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Aged Care

Aim of Activity

In response to the Royal Commission into Aged Care Quality and Safety, Primary Health Networks (PHNs) have been funded to undertake clinical and referral pathway activities specific to aged care, including:
• Developing, enhancing, and maintaining clinical and referral pathways on the Clinician Assist WA website (formally HealthPathways) specific to aged care and the PHN region.
• Enhancing linkages between primary health care services, other providers, and relevant services.
• Improving the patient journey and health outcomes.
• Increasing clinician capabilities and the quality of care provided.

Within the Perth North PHN (PNPHN) region, the activity aims to:
• Develop, review, enhance and maintain aged care related content on the Clinician Assist WA website.
• Maintain the relationship with the website developers to support the operation and administration of the Clinician Assist WA website.
• Increase the awareness of, engagement with, and utilisation of aged care related content on the Clinician Assist WA website by primary care practitioners in the region.
• Increase awareness of and promote current best practice care for older adults.
• Enhance clinician awareness of and access to local referral options and services.
• Improve collaboration and integration across health care and other systems.

Description of Activity

Background
Clinician Assist WA content is developed, reviewed, and enhanced, as appropriate to meet the health needs of the PHN. Content is for use by clinicians during consultation with patients, supporting patient assessment and management, and referral to local services and supports.

Nineteen older adult and six Dementia pathways are live and localised for WA and the PNPHN region. One pathway was localised, and six pathways were reviewed in 2022. Eleven pathways were reviewed in 2023 (two pathways were reviewed and merged into another pathway and the two standalone pathways were decommissioned). The review of the remaining seven pathways is planned for completion by 30 June 2025.

Rationale
Today's Western Australians aged 65 and over are generally living longer and healthier lives than previous generations, and the population of older people is growing. Age is an important determinant of health and people aged 65 years and over are more likely to have complex and/or chronic conditions as well as comorbidities. Moreover, geriatric syndromes later in life (usually after the age of 85 years) including pressure ulcers, incontinence, falls, and delirium have substantial implications for quality of life as well as health care utilisation.

In 2021, there were over 170,000 people aged 65 years and over in Perth North PHN, representing about 16% of its population, similar to the state rate (Australian Bureau of Statistics, 2021a). This population is expected to increase by approximately 36% to 218,258 in 2030.

Roles and responsibilities
WAPHA's Clinician Assist Team within the Primary Care Portfolio, which works across the three WA PHNs, is responsible for the delivery of the Aged Care Clinical Referral Pathways initiative. An executive sub-committee oversees all PNPHN aged care activity including the Aged Care Clinical Referral Pathways initiative to ensure it aligns with funding requirements, guidance, and WAPHA's Strategic Plan 2023-2026.

In addition to demonstration and education sessions led by the Clinician Assist team, place-based integration managers and practice navigation and quality improvement teams also promote the use of the Clinician Assist WA website with general practice and relevant Aboriginal Community Controlled Health Service staff. A program logic guides the initiative.

Key activities
This activity will:
• Increase the awareness of, engagement with, and utilisation of aged care related content on Clinician Assist WA by primary care practitioners in the region.
• Increase awareness of and promote current best practice for the care of older adults.
• Enhance clinician awareness of and access to local referral options and services.
• Improve collaboration and integration across health care and other systems.

Clinical and referral webpage development, enhancement, review, and maintenance will include the following activities:
• Consultation with subject matter experts, peak bodies, and clinicians.
• Mapping and documenting local support and referral services for the target population.
• Engaging with the website developers to ensure the website remains available, functional, secure and maintained and to provide technical support as required.
• Monitoring, reviewing, and improving existing website content, ensuring currency, accuracy, and consistency with best practice.
• Identification of any information gaps in the Clinician Assist WA library and consideration of new page development or incorporation of information into existing page/s as required.
• Identification and inclusion of relevant resources for GPs and health professionals to share with patients.
• Promoting newly published and/or reviewed pages to health professionals, in addition to delivering demonstrations and education to support the uptake of the Clinician Assist WA website.
• Maintaining the technical support agreement and relationship with the website developers to support the operation and administration of the Clinician Assist WA website.

https://www.wapha.org.au/wp-content/uploads/2023/08/12661_WAPHA_Needs-Assessment_Perth-North_FA.pdf

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable early intervention and monitoring activities to reduce early entry into residential care and support older people in living independently for as long as possible (Metro).	52
Support people living with dementia and their carers to navigate the aged care system and access appropriate services (Metro).	53
Support primary health care providers (incl. general practices, allied health and aged care services) to effectively manage chronic conditions for older people and promote health ageing at home(Metro)	54
Support the mental health of older people and assist primary care providers to identify older people who may need additional support or referrals to services (Metro).	28

Activity Demographics

Target Population Cohort

The activities will focus primarily on general practitioners, in addition to local primary care clinicians and allied health professionals.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consultation has and will continue to occur with the following key stakeholders:
• General practitioners and other primary health professionals
• Consumer representatives or people with lived experience (if applicable to the topic) limited
• Health Service Providers
• WA Department of Health
• Clinician Assist WA users
• Other PHN regions across Australia
The PHN promotes Clinician Assist WA to specific audiences at conferences (e.g., RACGP annual conference, Rural Health West Conference) and through internally and externally produced written communications and articles (e.g., WAPHA publications GP Connect and Practice Connect; Medical Journal of Australia; Medical Forum).

The PHN delivers education and training to those working in general practice (and other clinicians) to:
• Provide an overview of the Clinician Assist WA website and support user to maximise integration into their clinical practice.
• Launch new and newly reviewed Clinician Assist WA content, in conjunction with other PHN initiatives and in collaboration with subject matter experts, Health Service Providers and peak bodies (e.g., Dementia Care in General Practice).

Collaboration

Developing relationships and collaborating with key aged care stakeholders including peak bodies and provider organisations improves coordination, integration, and continuity of care at the aged care, health, primary care interfaces.

Key stakeholders, in addition to those listed above include:
• Royal Australian College of General Practitioners.
• Subject Matter Experts, including hospital clinicians, non-GP medical specialists, allied health practitioners, nurses, peak bodies (e.g., Diabetes WA, Trans, Gender Diverse and Non-Binary Health) to:
    o Collaborate on clinical and referral website content.
    o Provide representation and specialist expertise in working groups related to Clinician Assist WA development and/or review.
• Clinician Assist WA website developers
The PHN is supported by and collaborates with the website developers who built the Clinician Assist WA website and now provide ongoing technical and website maintenance support.
• Other stakeholders as they are identified.

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/06/2025

Service Delivery Start Date

01/07/2022

Service Delivery End Date

30/06/2025

Other Relevant Milestones

• Seven Aged Care pages planned for/currently under review, with completion by 30 June 2025.
• Activity Work Plan due 30/04/25
• 12 Month Performance Report due 30/09/25
• Financial Acquittal Report due 30/09/25
• Needs Assessment: confirm it is current by 15/11/24

Activity Commissioning

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

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
HealthPathways	$61,570.08	$76,250.46	$0.00	$0.00	$0.00	$137,820.54
Total	**$61,570.08**	**$76,250.46**	**$0.00**	**$0.00**	**$0.00**	**$137,820.54**

CF 2012 - Dementia Support Pathways

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

CF

Activity Number

2012

Activity Title

CF 2012 - Dementia Support Pathways

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Aged Care

Aim of Activity

In response to the Royal Commission into Aged Care Quality and Safety, Primary Health Networks (PHNs) are funded to undertake clinical and referral pathway activities specific to aged care and dementia.

The Dementia Clinical Referral Pathways activity will develop and enhance Western Australia's Primary Health Network's (PHNs) Clinician Assist WA content specific to dementia; enhance linkages between primary health care services; other providers and relevant services; improve the patient journey and health outcomes; and increase practitioner capabilities and the quality of care provided in the Perth North PHN (PNPHN) region.

The activity aims to:
• Improve dementia awareness within the PHN local community, including risk reduction strategies.
• Improve dementia knowledge within the primary care workforce to support clinicians in diagnosing and referring people for diagnosis and/or providing ongoing supports at all stages of the dementia journey.
• Facilitate more timely diagnosis, including referral to diagnostic services.
• Enable earlier consumer access to post-diagnostic supports and services.
• Increase referrals from GPs to relevant post-diagnostic supports, such as Alzheimer's WA, Dementia Australia, My Aged Care, Carer Gateway, community support programs and services and allied health.
• Ensure that people with dementia, their family, and carers are supported throughout the dementia journey.
• Maintain (where possible, improve) the quality of life for people with dementia, their family, and carers.

Description of Activity

Background
Clinician Assist WA content is developed, reviewed, and enhanced as appropriate to meet the health needs of the PHN.

Content is for use by clinicians during consultation with patients, supporting patient assessment and management, and referral to local services and supports.

The development and review of the WA Primary Health Alliance's Dementia Clinical and Referral Pathways (available on the Clinician Assist WA website) stream was completed on 20 December 2022. Pathways have since been maintained, publishing ad hoc updates as required, until their next scheduled formal review (scheduled to commence in 2026).

Rationale
In 2021, there were over 170,000 people aged 65 years and over in Perth North PHN, representing about 16% of its population, similar to the state rate (Australian Bureau of Statistics, 2021a). This population is expected to increase by approximately 36% to 218,258 in 2030.

It is estimated that in 2022, 39,481 people were living with dementia in WA, 16,317 lived in the PNPHN region. The population of people with dementia is expected to continue to grow, and it is estimated that the number of people with dementia in Australia will more than double from 2022 (401,300) to 2058 (849,300).

Dementia is the second leading cause of death in Australia, and leading cause of death in women.
Early dementia diagnosis is essential in assisting people to live their best life through treatment of symptoms, early access to relevant health and support services, and planning. Evidence shows that early intervention can delay disease progression, minimise hospitalisations by coordinating care, improves the quality of life of the person living with dementia (and their carers/family) and delays entry to residential care.

Roles and responsibilities
WAPHA's Clinician Assist team within the Primary Care Portfolio, which works across the three WA PHNs, is responsible for the delivery of the Dementia Clinical Referral Pathways activity. An executive sub-committee oversees all PNPHN aged care activity including the Dementia Clinical Referral Pathways activity to ensure it aligns with funding requirements, guidance, and WAPHA's Strategic Plan 2023-2026.

In addition to demonstration and education sessions led by the Clinician Assist team, place-based integration managers and practice navigation and quality improvement teams also promote the use of the Clinician Assist WA website with general practice and relevant Aboriginal Community Controlled Health Service staff. A program logic guides the initiative.

Key activities
From 2024 onwards PNPHN will:
• Maintain the clinical dementia Clinician Assist WA content until next formal review.
• Update and maintain existing referral content, as new services for dementia care are established.
• Continue to promote and increase the awareness of, engagement with, and utilisation of content related to dementia found on the Clinician Assist WA website, including consumer resources relevant to the local context.
• Continue to work with Dementia Australia and Alzheimer's WA to ensure Clinician Assist WA content reflects emerging best practice and the available services and supports within the region.
• Continue to collaborate across PHN regions as required to support, maintaining consistency and currency of content.

https://www.wapha.org.au/wp-content/uploads/2023/08/12661_WAPHA_Needs-Assessment_Perth-North_FA.pdf

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable early intervention and monitoring activities to reduce early entry into residential care and support older people in living independently for as long as possible (Metro).	52
Support people living with dementia and their carers to navigate the aged care system and access appropriate services (Metro).	53
Support primary health care providers (incl. general practices, allied health and aged care services) to effectively manage chronic conditions for older people and promote health ageing at home(Metro)	54

Activity Demographics

Target Population Cohort

The activities will focus primarily on general practitioners, in addition to local primary care clinicians and allied health professionals.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consultation from 2024 onwards will occur with the following key stakeholders (as required):
- General practitioners and other health professionals
- Dementia Australia
- Dementia Australia WA
- Older Adults Health Network
- Alzheimer's WA
- Health Service Providers
- WA Department of Health
- Clinician Assist WA users
- Other PHN regions across Australia

The PHN promotes Clinician Assist WA to specific audiences at conferences (e.g., RACGP annual conference4, Rural Health West Conference) and through internally and externally produced written communications and articles (e.g., WAPHA publications GP Connect and Practice Connect; Medical Journal of Australia; Medical Forum).

The PHN delivers education and training to those working in general practice (and other clinicians) to:
• Provide an overview of the Clinician Assist WA website and support users to maximise integration into their clinical practice.
• Launch new and newly reviewed Clinician Assist WA content, in conjunction with other PHN initiatives and in collaboration with subject matter experts, Health Service Providers and peak bodies (e.g., Dementia Care in General Practice).

Collaboration

Developing relationships and collaborating with key aged care stakeholders including peak bodies and provider organisations improves coordination, integration, and continuity of care at the aged care, health, primary care interfaces.

Key stakeholders, in addition to those listed above include:
• Royal Australian College of General Practitioners.
• Subject Matter Experts, including hospital clinicians, non-GP medical specialists, allied health practitioners, nurses etc.), consumer representatives, other peak bodies (e.g., Dementia Support Australia) to:
    o Collaborate on clinical and referral website content.
    o Provide representation and specialist expertise in working groups related to Clinician Assist WA s development and/or review.
• Clinician Assist WA website developers.
The PHN is supported by and collaborates with the website developers who built the Clinician Assist WA website and now provide ongoing technical and website maintenance support.
• Other stakeholders as they are identified.

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/06/2025

Service Delivery Start Date

01/07/2022

Service Delivery End Date

30/06/2025

Other Relevant Milestones

The current relevant milestones include:
• Activity Work Plan due 30/04/25
• Twelve Month Performance Report due 30/09/25
• Financial Acquittal Report due 30/09/25

Activity Commissioning

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

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
HealthPathways	$15,392.52	$19,062.62	$0.00	$0.00	$0.00	$34,455.14
Total	**$15,392.52**	**$19,062.62**	**$0.00**	**$0.00**	**$0.00**	**$34,455.14**

CF 2020 - Dementia Consumer Pathway Resources

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

CF

Activity Number

2020

Activity Title

CF 2020 - Dementia Consumer Pathway Resources

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Aged Care

Other Program Key Priority Area Description

Aim of Activity

In response to the Royal Commission into Aged Care Quality and Safety, Primary Health Networks (PHNs) were funded to undertake a range of activities specific to aged care. This includes the development of Aged Care and Dementia Clinical Referral Pathways and the development and maintenance of dementia consumer resources.

This Activity Work Plan describes Perth North Primary Health Network's (PNPHN's) approach to delivering the Dementia Consumer Resource activity.

The aim of the Dementia Consumer Resource activity is to enhance the ongoing care and support to people living with dementia, their carers, and families to support them to plan ahead and better navigate living with dementia, ultimately to support people living with dementia to live well in the community for as long as possible.

For the funding period PNPHN will develop and maintain a consumer-focused dementia resources which detail the post-diagnostic care and support available for people living with dementia, their carers, and families, including local, state, and federal government, private sector, and community-driven support, in the PHN region.

This activity will be undertaken with input from Dementia Australia to ensure the Dementia Consumer Resources are both nationally consistent at a high level and reflective of individual services and supports within individual PHN regions.

Description of Activity

Background
In partnership with My Community Directory WA Primary Health Alliance established the Dementia Community Services and Support Finder for the three WA PHNs. This resource, tailored for individual regions, was published on 18 December 2022.

The development of the resource was informed by consultation with local primary care clinicians, allied health, aged care providers and consumers to determine the current gaps and opportunities in the model of care for people living with dementia. Further consultation and promotion of the resource has occurred during 2023/24 and 2024/25.

In March 2024, the Dementia support and services related information previously hosted by My Community Directory was moved to a WA Primary Health Alliance (WAPHA) Dementia consumer resources webpage. National, state, and local resources and service links continue to be available.

Rationale
In 2021, there were over 170,000 people aged 65 years and over in PNPHN, representing about 16 per cent of its population, similar to the state rate (Australian Bureau of Statistics, 2021a). This population is expected to increase by approximately 36 per cent to 218,258 in 2030.

The Australian Institute of Health and Welfare reports:
• The rate of dementia rises quickly with age – from less than one person with dementia per 1000 Australians aged under 60, to 71 per 1000 Australians aged 75–79, and then to 429 per 1000 Australians aged 90 and over.
• Approximately 67per cent of people with dementia live in the community.

It is estimated that in 2021, 37,963 people were living with dementia in WA, 15,640 lived in the PNPHN region and around 60 per cent were female. The population of people with dementia is expected to continue to grow, it is estimated that the number of people with dementia in Australia will more than double from the year 2022 (401,300) to the year 2058 (849,300).

Carers of people with dementia have consistently reported not knowing where to get assistance or what is the next practical step following a dementia diagnosis.

roles and responsibilities
WAPHA's Primary Care Portfolio, which works across the three WA PHNs, is responsible for the delivery of the Dementia Consumer resources via a dedicated activity lead. An executive sub-committee oversees all PNPHN aged care activity including the Dementia Consumer resources activity to ensure it aligns with funding requirements, guidance, and WAPHA's Strategic Plan 2023-2026.

Place-based regional integration managers and practice navigation and quality improvement teams promote the use of Dementia Consumer resources with clinicians and their local networks. A program logic guides the initiative.

In 2024 WAPHA partnered with Linkwest, the WA peak association for community resource centres, for Linkwest and their community resource centre members to review the webpage and provide information about any other related resources in their local communities. The webpage was then updated to include the additional support and referral resources.

Key activities
For the term of the funding Perth North PHN will:
• Evaluate, maintain and where necessary improve / update relevant consumer resources.
• Monitor the use of the webpage.

• Continue to promote and increase the awareness, engagement, and utilisation of dementia relevant consumer resources by local health care practitioners.
• Continue to promote the resource to people living in the PHN region and relevant forums.
• Work with Dementia Australia and other PHNs, where relevant to ensure:
o Resources are updated in a nationally consistent manner, and
o Continued access to Dementia Australia resources, via the WAPHA Dementia consumer resources webpage.
• Continue to collaborate across PHN regions in sharing of consumer resource information.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable access to aged care services that support independent living and healthy ageing at home (Metro).	52
Support people living with dementia and their carers to navigate the aged care system and access appropriate services (Metro).	53

Activity Demographics

Target Population Cohort

The target populations are:
• General practitioners, local primary care clinicians and allied health professionals.
• People seeking advice about Dementia and the resources and services that are available to assist them.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consultation has occurred with and will continue to occur with the following key stakeholders (as required):
• Consumer representatives
• Carers Australia
• General practitioners and other health professionals
• Dementia Australia

- Dementia Australia WA
- Older Adults Health Network
- Alzheimer's WA
- Health Service Providers
- WA Department of Health
- Other PHN regions across Australia
- Linkwest and community resource member organisations

The Dementia Community Resources are promoted at relevant forums and via social media.

Collaboration

Developing relationships and collaborating with key aged care stakeholders including peak bodies and provider organisations improves coordination, integration, and continuity of care at the aged care, health, primary care interfaces.

Collaboration has and will continue to occur (as relevant) with:
- Linkwest and community resource member organisations. Dementia Australia
- Dementia Australia (WA)
- Alzheimer's WA
- Other stakeholders as identified such as providers of relevant services

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Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/06/2025

Service Delivery Start Date

01/07/2022

Service Delivery End Date

30/06/2025

Other Relevant Milestones

- Activity Work Plan due 30/04/25
- Twelve Month Performance Report due 30/09/25
- Financial Acquittal Report due 30/09/25
- Needs Assessment: confirm it is current by 15/11/24

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Dementia Consumer Pathway Resource	$10,258.06	$5,032.26	$0.00	$0.00	$0.00	$15,290.32
Total	**$10,258.06**	**$5,032.26**	**$0.00**	**$0.00**	**$0.00**	**$15,290.32**

CF 4000 - Healthy Weight

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

CF

Activity Number

4000

Activity Title

CF 4000 - Healthy Weight

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

To build knowledge, skills and confidence of primary healthcare professionals in the early detection and primary care interventions to prevent chronic disease. This will be achieved through a targeted strategy to improve how overweight, and obesity are identified and addressed with patients through early intervention and management in general practice.

Early intervention and management pathways for overweight and obesity have been developed to support general practitioners and other primary health care professionals and their patients, with innovative, scalable, and sustainable approaches, programs, and tools for weight management.

Primary healthcare practitioners are encouraged to identify, engage, and regularly communicate with members of the multidisciplinary team to provide coordinated support for their patients with weight related health concerns. This includes dietitians, practice nurses, exercise physiologists and psychologists as well as evidence based and accessible healthy lifestyle programs.

The project encourages primary healthcare professionals to take a sensitive and supportive approach, free from weight stigma when communicating with patients about weight. WA Primary Health Alliance will focus on creating sustainable behaviour change for general practitioners other practice staff and allied health professionals and patients.
This work aligns to the WA Healthy Weight Action Plan 2019-2024 in partnership with WA Department of Health and the Health Consumers' Council WA, from a primary care perspective.

Description of Activity

The overweight and obesity management strategy in general practice includes the following strategies and actions:

1. The provision of evidence-based tools for the management of weight and prevention of obesity for general practice, including:
• Surveys conducted with general practitioners, practice nurses and allied health professionals working in general practice regarding gaps, barriers, and opportunities for better management of overweight and obesity in general practice.
• Development of a practice toolkit for general practitioners including synthesis and applicability of current guidelines.
• The use of Chronic Disease Management Plans via the Medicare Benefits Schedule (MBS) for people with complex obesity, where clinically appropriate.
• General practitioners and general practitioner registrar education regarding prevention, identification, and guidance of support options for people living with obesity. Awareness of the impact of weight bias, stigma and inequity is also addressed, and information is provided on how to reduce this in practice.
• The use of PDSA (Plan, Do, Study, Act) cycles of continuous quality improvement (coaching and support from the WAPHA practice support team).

2. The provision of information and advice on referral pathways in general practice, including:
• Up to date information on local programs and services for general practices.
• Further development and promotion of Clinician Assist WA, referral and management pathways for weight management for adults, childhood obesity and bariatric surgery.

3. General practice support includes:
• Training in difficult conversations – scripting and support for general practitioners using the Australian National Health Service and WA Health resources.
• Assistance with uptake of MBS items that can assist in weight management and obesity.
• General practitioner training events (informative and academic), focused on general practice continuous professional development (CPD) streams on sensitive conversations, empowering behaviour change, reducing weight stigma and care management including multidisciplinary team care.

4. WA Healthy Weight Action Plan 2019-2024:
• In alignment with Strategy 1 of the WAHWAP, to ensure the successful operation of The Weight Education and Lifestyle Leadership (WELL) Collaborative through enabling a dedicated project coordination function, which aims to allow integrated, coordinated overweight and obesity associated planning and action across WA.

The PHN recognises the impact COVID-19 had on the community, primary health care and commissioned service activity. With services having returned, monitoring and service impact assessment will continue, to ensure the PHN continues to meet the aims of the activity and the needs of the priority target groups.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary health care providers deliver best-practice mgmt to people with diabetes &build capacity for patient self-mgmt, by enabling access to multidisciplinary, integrated, allied care (Metro)	10
Support primary health care providers to implement effective health interventions for those living with overweight and obesity (Metro).	10

Support primary health care providers in managing complex care cases for patients with mental and physical comorbidities (Metro)	10

Activity Demographics

Target Population Cohort

The target population of this activity includes WA Primary Healthcare Professionals (GPs, practice nurses, allied health professionals and general practice staff) and those who work with patients with weight related health issues and chronic conditions.

Indigenous Specific

Yes

Indigenous Specific Comments

Stage 2 of the project involved the development of resources to add to the existing SHAPE website to assist healthcare professionals to support Aboriginal patients. This activity included consultation with Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Healthcare workforce and general practices. Collaboration with Diabetes WA for the development of educational videos to support General Practice in addressing weight management in Aboriginal populations across WA.

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Phase 1 of the project consulted general practice clinicians, such as general practitioners, practice nurses, dietitians, and exercise physiologists to understand the barriers to weight management in general practice. The results of this consultation indicated that clinicians would benefit from evidence-based tools and resources in one accessible location.

The project convened a clinical content working group to contribute to guiding development of the clinical content and formulation of messaging for the branding campaign. The working group comprised of general practitioners, a psychologist, dietitians, the WA Department of Health and the Health Consumers' Council. Stages 2 and 3 of the project include the addition of resources to support healthcare professionals to assist Aboriginal patients, people experiencing food insecurity and children with higher weight and their families. Consultation with a variety of stakeholders has been completed, to inform Stage 2 deliverables. Consultation for Stage 3 was conducted from July 2024 – October 2024 to inform Stage 3 deliverables.

Development and maintenance of relationships with key stakeholders in the planning and delivery of the healthy weight related initiatives, has been ongoing throughout the duration of the project, including, but not limited to:
• WA Department of Health

- WA Health Consumers' Council
- Health Service Providers (i.e. EMHS)
- WA general practices
- Royal Australian College of General Practitioners WA
- Diabetes WA
- Cancer Council WA
- Aboriginal Community Controlled Health Organisations
- Curtin University
- WA Centre for Rural Health

Collaboration

Stakeholders with direct involvement in the design and implementation of the project deliverables include, but are not limited to:

- WA Department of Health
- WA Health Consumers' Council
- WA Country Health Service
- Health Service Providers (i.e. EMHS)
- WA general practices
- Royal Australian College of General Practitioners WA
- Diabetes WA
- Cancer Council WA
- Aboriginal Community Controlled Health Organisations
- Child and Adolescent Health Service
- Curtin University
- Benchmarque Group RTO

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2025

Service Delivery Start Date

01/07/2019

Service Delivery End Date

31/12/2025

Other Relevant Milestones

Stage 3 includes adding further resources to the SHAPE website, to assist health care professionals to support children living with overweight and obesity and their families living in Western Australia (July 2024 – December 2025).

- Activity Work Plan due 30/04/25
- Twelve Month Performance Report due 30/09/25
- Financial Acquittal Report due 30/09/25
- Needs Assessment: confirm it is current by 15/11/24
- Final 12-month Performance Report and financial acquittal for 1 July 2024 to 30 June 2025 due 30/09/25

Activity Commissioning

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

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Core Flexible	$57,427.00	$66,666.67	$0.00	$0.00	$0.00	$124,093.67
Total	**$57,427.00**	**$66,666.67**	**$0.00**	**$0.00**	**$0.00**	**$124,093.67**

CF 5000 - Strengthening general practice in WA: Comprehensive Primary Care

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

CF

Activity Number

5000

Activity Title

CF 5000 - Strengthening general practice in WA: Comprehensive Primary Care

Existing, Modified or New Activity

Existing

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

The Strengthening General Practice in WA; Comprehensive Primary Care (Strengthening General Practice) activity aims to strengthen and improve the primary care response and access to general practice using the foundations of the Comprehensive Primary Care (CPC) program aligned with the Quintuple Aim for Healthcare Improvement and the Bodenheimer Building Blocks for high performing primary care.

The activities delivered will utilise data driven quality improvements with a focus on enhanced leadership and team-based care which are:
• Patient centred – shared decision making that respects personal goals and provides support to patients to self-manage.
• Skilled, integrated and multi-disciplinary, where teams work to the top of their scope, in partnership with patients.
• Data informed, with embedded continuous quality improvement and best practice decision making to improve population health and access to care.
• Integrated wherever possible with allied health and the public and private hospital sector.
• Improved models of care and customer service encourage patient loyalty to their general practitioner and the practice maximising their care outcomes.
• Sustainable, utilising business models which are adaptable to changes in the health system and patient needs.

This activity complements the existing practice support offered through the Primary Health Network (PHN) Core Operational funding stream activities for HSI 1010 - General Practice Support.

Description of Activity

Background:
While Australia's primary healthcare system delivers some of the best health outcomes in the world, there are significant challenges if it is to remain viable, effective and efficient in meeting Australia's rapidly changing needs. Challenges include barriers to access for some groups in the community, in addition to rising costs to both system and consumers, an ageing population, increased rates of chronic disease, an over-reliance on hospital-based care and rising levels of inequality.

The Australian Primary Health Care 10 Year Plan 2022-2032 and the Strengthening Medicare Taskforce Report (2022), have both informed how WA Primary Health Alliance (WAPHA) continues to support general practices, with a focus on the ability of practices to adapt and respond to current and emerging health policy and reform in an effective and sustainable manner, in alignment with the Quintuple Aim.

In 2018 the Australian Government funded PHNs to support general practice staff and clinicians to provide high quality care for patients, particularly those at risk of poor health outcomes. The ongoing Commonwealth funding to support general practice has seen activities becoming iterative in nature, adapting to the maturation of general practices, and in response to the changing Australian primary health environment. WAPHA's support focuses on the ability of practices to adapt and respond to current and emerging health policy and reform in an effective and sustainable manner, in alignment with the Quintuple Aim.

Rationale:
While Perth North PHN is relatively advantaged compared to other parts of Western Australia, the WAPHA Needs Assessment 2025-27 identified that people residing in the regions of Wanneroo, Stirling and Swan within the Perth North PHN have higher risk factors for poorer health outcomes and avoidable inequities related to social determinants of health.

Bayswater-Bassendean has the lowest access to primary health care relative to need (80 per cent lower than all SA3's in WA), followed by Perth City and Stirling (70 per cent lower that all WA SA3's). Poor access relative to need for general practice services highlights the need for more GP workforce in the area.
WAPHA will continue to support general practices within Perth North PHN to build their capacity and efficiency to provide best practice primary health care through the following activities.

Key activities:
The Strengthening General Practice funding enables WAPHA to continue to deliver and expand Comprehensive Primary Care and Enhanced practice support initiatives within the Perth North PHN to practices serving the most vulnerable populations.

Utilising the Bodenheimer model 10 Building Blocks of high performing primary care to provide targeted, efficient activities, general practices will be supported to:
• Lead and develop practice teams to effectively engage in an evidence-based, phased process of practice transformation utilising Quality Improvement (QI) processes grounded in Institute for Healthcare Improvement (IHI) methodologies.
• Improve continuity of care with allied health, tertiary and secondary services through integrated models of multi-disciplinary team-based care, data sharing, integrated care plans and specialist in-reach programs.

Have an opportunity to influence, co-design and trial models of care and incorporate existing local services that:
• Are integrated, local and supported by a multi-disciplinary team.
• Are tailored to meet the needs of individual practices and patients.
• Build on existing and/or introduce new and innovative models of care that reflect national and international best practice.
• Are scalable, sustainable, and adaptive to future changes.
• Improve continuity and coordination of care to improve health and social outcomes for patients.
• Build practices' capacity and capability to deliver responsive patient-centred care, which empowers patients to take an active role in the management of their own health.

• Promote both formal and informal collaboration opportunities to support knowledge sharing, professional development, problem-solving, and collegiality.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary health care providers deliver best-practice mgmt to people with diabetes &build capacity for patient self-mgmt, by enabling access to multidisciplinary, integrated, allied care (Metro)	10
Increase childhood immunisation rates for regions not meeting national immunisation targets, particularly in locations increased risk of poor health outcomes related to SDOH (Metro)	10
Improve the rates of cancer screening to reduce avoidable deaths from cancer, particularly in in locations with increased risk of poor health outcomes related to social determinants of health (Metro).	9
Enable access to culturally appropriate alternative options to Emergency Departments for Aboriginal people (Metro).	44

Activity Demographics

Target Population Cohort

Primary health provider organisations (including private general practice, ACCHO's, AMS's, allied health entities) located in identified priority areas of need and who are working with vulnerable populations, and the primary healthcare professionals engaged within these organisations.

Organisations located in geographical areas with a large proportion of vulnerable population groups will be prioritised.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Stakeholder engagement has been undertaken with:
• Previous naïve enquiry with primary care workforce.

- Regional and local primary care services including general practice.
- Consultation with WAPHA GP Advisory Panel.

Collaboration

Collaboration has occurred with:
- Private general practices, Aboriginal medical services
- General practitioners
- Practice managers
- Practice nurses
- Allied health providers
- Pharmacists
- Data officers – administrators
- Regional integration managers

Activity Milestone Details/Duration

Activity Start Date

31/12/2022

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2024

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Annual Activity Work Plans	Due 30/04/25, 30/04/26, 20/04/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27

Activity Commissioning

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

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Core Flexible	$191,410.38	$196,385.84	$482,217.48	$79,893.33	$0.00	$949,907.03
Total	**$191,410.38**	**$196,385.84**	**$482,217.48**	**$79,893.33**	**$0.00**	**$949,907.03**

CF 6010 - GP Urgent Care Network Public Awareness and Education Campaign

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

CF

Activity Number

6010

Activity Title

CF 6010 - GP Urgent Care Network Public Awareness and Education Campaign

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

The Medicare UCC policy was developed by the Australian Government to ease the pressure on hospital Emergency Departments and give Australian families more options to see a suitably qualified and skilled healthcare professional when they have an urgent but not life-threatening need for care. All Medicare UCCs are required to provide bulk-billed services, be open during extended business hours and accept walk-in patients for specified urgent care presentations.

In 2019 WA Primary Health Alliance partnered with the WA Department of Health (WADoH) to pilot a service to address behavioural change encouraging people to choose primary care over hospital options. The optimal urgent care model was identified as a General Practice Urgent Care Network (GPUCN), with membership for existing general practices demonstrating direct action towards integrated urgent care, supported by development and implementation of a public awareness campaign to improve urgent care awareness and knowledge, and demonstrated use of the GPUCN.
The pilot ended in 2021.

As of 29 January 2025, five practices were participating in the GPUCN in the Perth North PHN. Following the implementation of the Medicare UCC program and without additional funding, the GPUCN has transitioned to a business as usual (BAU) model.

Description of Activity

.To support the delivery of urgent care servicing training will be commissioned for general practice staff. Training will be available for all UCC staff covering several key topics including:
• Splinting and immobilisation

• Triage – for frontline and clinical staff
• IV Cannulation
• De-escalation
• Wound management
The PHN may also assist with printing of posters and signage to be displayed at local ED's promoting the UCC to encourage a change in patient behaviour and increased awareness of the alternative pathway.

The Primary Health Network (PHN) will continue to work with the existing GPUCN to understand the current capacity within the network and establish services to assist with reducing ED demand. The PHN will explore opportunities to strengthen relationships with local hospitals and general practices to promote the GPUCN and where required, the commissioned services may be modified, and additional services commissioned to help the PHN to continue to meet the aims of the activity and the needs of the priority target groups.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable access to culturally appropriate alternative options to Emergency Departments for Aboriginal people (Metro).	44

Activity Demographics

Target Population Cohort

General practitioners, practice nurses and other administration staff who manage the reception desk. Health care consumers in general.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The PHN consulted with and continues to consult with a variety of stakeholders including:
• Hospital emergency department teams
• WA Health management
• GP Urgent Care network
• National Health Service Directory
• Health Direct

Consultation occurred with the GPUCN to understand the current capacity within the network and where the PHN can support practices to deliver Urgent Care services. The PHN are working in collaboration with WA Health to explore opportunities to link the GPUCN with ED Diversion activities and initiatives such as the Virtual Emergency Medicine service, strengthen relationships with local hospitals and general practices to promote the GPUCN and where required, the commissioned services may be modified, and additional services commissioned to help the PHN to continue to meet the aims of the activity and the needs of the priority target groups.

Collaboration

The PHN will continue to build on established relationships with key stakeholders.

WA Department of Health, Department of Health and Aged Care, Medicare Urgent Care Clinics and the GPUCN contribute to the design of the activity through feedback and data analysis on presentations to urgent care clinics and identifying skill gaps in clinic staff.
The Benchmarque Group as RTO design course content and relevant accreditation for delivery of procedural skills workshops.

Activity Milestone Details/Duration

Activity Start Date

31/12/2022

Activity End Date

29/06/2027

Service Delivery Start Date

01/01/2023

Service Delivery End Date

30/06/2027

Other Relevant Milestones

• Activity Work Plans	Due 30/04/25, 30/04/26
• Annual Activity Needs Assessment	Due 15/11/25
• Twelve Month Performance Report	Due 30/09/25, 30/09/26
• Financial Acquittal Report	Due 30/09/25, 30/09/26

Activity Commissioning

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

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Core Flexible	$150,000.00	$72,000.00	$50,000.00	$50,000.00	$0.00	$322,000.00
Total	**$150,000.00**	**$72,000.00**	**$50,000.00**	**$50,000.00**	**$0.00**	**$322,000.00**

HSI 1000 - Health Systems Improvement

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

HSI

Activity Number

1000

Activity Title

HSI 1000 - Health Systems Improvement and Interest

Existing, Modified or New Activity

Existing

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

Health Systems Improvement funding is provided to enable Primary Health Networks (PHNs) to enhance the integration and coordination of primary health care services by undertaking data analysis and working strategically with local communities, clinicians, service providers, government agencies and other stakeholders to:
• Identify and prioritise health care needs through population health planning.
• Commission and monitor safe, high quality and culturally appropriate services.
• Determine health priorities and vulnerable cohorts, with the aim of improving access to primary care for those most at risk of adverse health outcomes.
• Assess and realise opportunities for joint commissioning arrangements with strategic partners.
• Progressively improve system performance, health outcomes and the quality and safety of primary care services.
• Ensure primary health care gains and potential are understood and utilised at regional, state and national levels.
• Underpin PHN and Government reform related decisions and activities with advanced digital health and data analytics capability which can facilitate partnership approaches.
• Direct resources to where they are most needed and where they will have the greatest impact.

Description of Activity

WA Primary Health Alliance (WAPHA) is the operator of three Primary Health Network regions - Perth North, Perth South and Country WA. As a statewide agency, WAPHA is well positioned to systemically improve the quality, standard and connection of primary health care services across WA.
Strategic planning activities include:
• Leveraging WAPHA's statewide remit to consider and address system-wide issues of equity and access and progress actions to address local, regional, state, and national priorities.
• Understanding and interpreting Australian Government Guidance and health policy reform and translating it for application within the local primary health care context.

• Progressing the strategic objectives of the National Health Reform Agreement and 10-year primary health care plan by working with the State-funded health system to continuously improve health outcomes and address inequity in WA.
• Continued leadership of the national PHN Cooperative and collaboration with other PHNs to ensure collective value and impact is optimised and PHN effectiveness is enhanced through sharing models of care, learnings, and resources.
• Progression of PHN priorities for action in response to Strengthening Medicare Taskforce recommendations and ongoing strategic leadership as a member of the Taskforce. Demonstrating commitment to joint planning, shared accountability, and co-commissioning through formalised relationships with partners/system managers including the WA Mental Health Commission and Health Service Providers.
• Working with other state-wide agencies, such as the Aboriginal Health Council of WA, Mental Health Commission, and the Departments of Health and Communities to ensure that primary health care is appropriately represented to shape the direction of the WA health system and deliver better connected, patient-centred, high quality, innovative and sustainable care.
• Collaboration with training organisations, professional colleges, and health workforce agencies to plan for the future of the primary health care workforce and improve workforce capability.
• Cultivating local relationships and engaging with relevant stakeholders to coordinate care and develop pathways appropriate to local needs. This includes developing, trialling and evaluating integrated care precincts to attend to unmet need and reduce duplication, gaps and fragmentation in services.
• Planning, developing, and maintaining agile, comprehensive, primary health care pandemic and disaster response and management capabilities and coordinating a strong primary health care response to deliver care where and when it is needed.
• Joint advocacy on behalf of primary health care stakeholders to influence primary health care reform and decision making.
• Leading the development of evidence based, innovative, best practice models of primary health care and evaluating initiatives against the Quintuple Aim.
• Developing the cultural competence and capability of WAPHA and commissioned primary health care services to better meet the needs of priority communities through the development and implementation of the Multicultural Competence and Capability Framework, an Aboriginal Cultural Competence and Capability Framework, and the LGBTIQA+ Equity and Inclusion Framework.
• Articulate the role and scope of WA Primary Health Alliance in disaster and emergency management and build capacity of general practice and commissioned service providers for business continuity and emergency preparedness and response.
Managing and monitoring the performance of WAPHA team members to encourage ongoing improvement and continuous professional development, contributing to the maturity and functionality of the organisation.
Data Analytics activity includes:
• Increasing data and analytics capacity and capability for WAPHA.
• Assigning appropriate data governance roles and responsibilities.
• Reducing exposure to information risk that would negatively impact WAPHA's ability to meet program objectives, as well as impose appropriate confidentiality restrictions to effectively manage disclosure risks and appropriately safeguard personal and private information.
• Improving data quality to ensure the provision of accurate and reliable information.
• Developing WAPHA's data and analytics capacity with appropriate training and infrastructure.
• Taking a systemic approach to the use of evidence; drawing critical insights to drive continual improvement in primary health care.
• Maturing WAPHA's approach to data sharing and linkage through formal governance arrangements with key stakeholders.
Digital Health activities include:
• Working across the primary health care system to enhance readiness for digital health adoption, and to improve workforce participation and confidence in digital health.
• Implementing programs leveraging Digital Health technology that support the objectives of the Quintuple Aim and health priorities.
• Encouraging and influencing the use of specific digital health applications, such as My Health Record and Clinician Assist WA (previously Health Pathways WA).
• Assisting health care providers to understand and make meaningful use of digital health technology and collaborate with partners to pilot and innovate in the delivery of quality health care services.

• Prioritising good data governance, security, privacy and consent principles that facilitate positive digital health outcomes.
• Supporting primary health care providers to improve data quality and undertake data driven decision making and quality improvement.
• Taking a future focused approach to understanding opportunities for primary health care in virtual care, point of care testing and e-prescribing, for example.
Population Health Planning activity includes:
• Identifying primary care needs and priorities by triangulating multiple supply and demand data sets at a geographically granular level, integrating this with contextual local intelligence.
• Providing insights for activity planning based on health, demographic and workforce data, identifying potential geographical locations where limited resources can be most effective in collaboration with our external partners.
• Identifying priority populations to target for WAPHA's activities, including those experiencing economic disadvantage, Aboriginal people, Culturally and Linguistically Diverse (CALD) people, LGBTQI+ people, older people and other groups at risk of poor health outcomes or access barriers.
Commissioning activity includes:
• Identifying opportunities for state-wide and place-based joint planning and coordinated commissioning.
• Developing and utilising frameworks to apply a consistent state-wide and locally tailored approach to the design, commissioning, monitoring and evaluation of outcome-based interventions to address prioritised health and service needs.
• Ensuring that commissioned primary health care services in WA are evidence based, meet local identified population health needs effectively and efficiently and are sustainable.
• Working with commissioned primary health care services to improve cultural competence, capability, equity and inclusion of priority population groups including Aboriginal people, LGBTQIA+ and multicultural communities.
• Continuing to monitor and respond to emerging trends in health and service needs.
• Managing performance of contracted providers through a relationship-based approach and monitoring and evaluating the impact of commissioned programs.
• Designing and commissioning services that remove duplication, foster connection, and strive for seamless patient care.
The WA Primary Health Alliance Commissioning cycle for both state-wide and place-based services involves:
• Planning - to identify local needs and service gaps based on data and service analysis and consultation with key stakeholders.
• Designing - using best practice models and with local and state-wide service providers and stakeholder to develop appropriate service responses.
• Procurement -using a range of approaches based on an analysis of the marketplace including expressions of interest (EOIs), requests for proposal and requests for tenders.
• Monitoring and Review - outcome-based contracts and reporting are developed and implemented across WA Primary Health Alliance. The implementation of the Performance Management Framework will occur with clinical mental health services the first to get standardised mental health indicators followed by other programs such as drug and alcohol, Aboriginal health and chronic conditions.
• Evaluating - the performance of services is evaluated, and it is determined whether, and to what extent, a reshaping of the structure of supply is required.

The Perth North PHN continues to focus on managing performance (applying sound principles of relationship management) of contracted providers including reviewing/monitoring and evaluating services to determine how well targeted and efficient services are. It will achieve this utilising a diverse range of data collection methods (i.e. provider reports, referral agency feedback, patient opinion) that, for each of the commissioned services, will provide the PHN with the information to: assess improvements to health outcomes, help shape future service provision and/or seek alternative commissioning activity.
This activity will assist the PHN to:
• Understand how effective services and systems are in relation to patient experience and patient health outcomes with focus on the efficacy of treatment to deliver a positive patient outcome.
• Improve service/system integration, service sustainability including provider experience/governance and findings of formal evaluation (if conducted externally).
• People with, or at risk of, developing chronic and complex health issues This includes mental disorders, problematic and harmful alcohol and drug use, chronic conditions and complex co-morbidities – for example, obesity and chronic heart failure.

• Communities experiencing enduring disadvantage This includes some older people, Aboriginal and Torres Strait Islanders, Culturally and Linguistically Diverse communities, LGBTQIA+ communities, people in poverty or deprivation, and socially and culturally marginalised groups.
• People at risk of developing significant health issues This includes earlier intervention and management for people with co-existing chronic conditions and complex care needs in general practice, with emphasis on data driven quality improvement and research to identify innovative solutions to support prevention activities.
• Communities facing gaps in the health system This includes integrating primary health care, and our commissioned services, into the local health environment through effective partnerships. Utilising data informed assessments about health priorities to better address the needs of Western Australians.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable access to age-appropriate digital health services (Metro)	52
Enable access to best-practice management for people with chronic heart failure (Metro).	10
Support primary health care providers to implement effective health interventions for those living with overweight and obesity (Metro).	10
Enable access to integrated care pathways that address both mental and physical health concurrently (Metro)	10
Enable access to culturally appropriate alternative options to Emergency Departments for Aboriginal people (Metro).	44

Activity Demographics

Target Population Cohort

• People with, or at risk of, developing chronic and complex health issues This includes mental disorders, problematic and harmful alcohol and drug use, chronic conditions and complex co-morbidities – for example, obesity and chronic heart failure.
• Communities experiencing enduring disadvantage This includes some older people, Aboriginal and Torres Strait Islanders, Culturally and Linguistically Diverse communities, LGBTQIA+ communities, people in poverty or deprivation, and socially and culturally marginalised groups.
• People at risk of developing significant health issues This includes earlier intervention and management for people with co-existing chronic conditions and complex care needs in general practice, with emphasis on data driven quality improvement and research to identify innovative solutions to support prevention activities.
• Communities facing gaps in the health system This includes integrating primary health care, and our commissioned services, into the local health environment through effective partnerships. Utilising data informed assessments about health priorities to better address the needs of Western Australians.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The PHN utilises strategic partners, special interest panels, reference groups and targeted community consultation to inform the planning, design, delivery and monitoring of activities. Key stakeholders include commissioned service providers, peak bodies, primary care practitioners, state and local government, health service providers, health professionals, consumers and people with lived experience.

Collaboration

The PHN's member organisations provide the Board with direct insight into the local primary care landscape and current operating environment, sharing priorities, strategies and progress in the delivery of health outcomes. They also share information on topics of mutual interest and work collaboratively to develop joint proposals and advocacy statements supporting our vision. Member organisations include the Royal Australian College of General Practitioners (WA), Rural Health West, WA Department of Health, Mental Health Commission WA, Western Australian Council of Social Service, Health Consumers' Council, Western Australian Local Government Association, Community Employers WA and the Australian College of Rural and Remote Medicine.

The PHN also has formal partnership arrangements in place to support coordination, collaboration and joint action on shared priorities.
with the:
- WA Mental Health Commission
- Australian Digital Health Agency
- Aboriginal Health Council of WA
- Health Service Providers

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2026

Service Delivery Start Date

01/07/2019

Service Delivery End Date

30/06/2026

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/04/26
Annual Activity Needs Assessment	Due 15/11/25
Twelve Month Performance Report	Due 30/09/25, 30/09/26
Financial Acquittal Report	Due 30/09/25, 30/09/26

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Health Systems Improvement	$2,738,671.70	$3,064,153.85	$2,850,287.76	$2,856,367.45	$0.00	$11,509,480.76
Total	**$2,738,671.70**	**$3,064,153.85**	**$2,850,287.76**	**$2,856,367.45**	**$0.00**	**$11,509,480.76**

HSI 1010 - General Practice Support

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

HSI

Activity Number

1010

Activity Title

HSI 1010 - General Practice Support

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

To build capacity and capability of WA general practice to work in an integrated manner within the health system and respond to Commonwealth Department of Health and Ageing policy direction and reforms.

The activity includes two initiatives:
• Support general practice staff and clinicians, and other providers of primary health care to provide high quality and evidence-based care for their patients, including preventive and proactive activities with a focus on those at risk of poor health outcomes, to improve population health and equity of access
• Enabling general practice to provide holistic care to their patient population through data driven quality improvement initiatives and by leveraging technology. Consistent with the Quintuple Aim of the Patient Centred Medical Home model the activity will be underpinned by Bodenheimer's ten building blocks of high performing primary care.

Description of Activity

General Practice Support will be provided to all staff working in general practice and where appropriate in primary care. This encompasses multidisciplinary staff including general practitioners, practice managers, practice nurses, allied health practitioners and support staff.

Support to general practice staff and primary care
Support will be provided via several channels.
• The Practice Assist website (www.practiceassist.com.au) allows general practice staff to search through a comprehensive library of information, resources, templates, and factsheets on a variety of topics.

They will be able to search for upcoming education events and webinars, find information on research studies and surveys, and links to the Practice Connect newsletter. Ongoing work includes reviewing and maintaining the website keeping content up to date. It also includes generating or curating new content in line with identified needs, feedback and new policy or programs.

• The Practice Assist helpdesk provides non-clinical support by phone and email to all general practice staff with an aim to respond to simple queries within one business day and more complicated queries within three business days, this may include liaising with subject matter experts within the Primary Health Network (PHN).

• Practice support staff regularly provide more in-depth support and coaching, centred around quality improvement and practice needs. They also provide and navigate to information and support on a range of topics including accreditation, cancer screening and immunisation. This in-depth support can occur virtually or face to face.

• Articulate the role and scope of WA Primary Health Alliance in disaster and emergency management, and build capacity of general practice and commissioned service providers for business continuity and emergency preparedness and response.

• Inform, educate, and utilise quality improvement tools to increase practice uptake of bowel, breast and cervical cancer screening programs, and interventions to improve childhood, Aboriginal, adolescent, and adult immunisation coverage.

• Contribute to service directories containing information that practices require when making referrals to specialist and community-based services. These include Clinician Assist WA referral, National Health Service Directory and My Community Directory.

• Networking and education events are facilitated to allow practice managers and practice nurses to share lessons both of what works well and the challenges they experience. Updates regarding primary health reform measures and new information are also provided through these forums.

• Webinars and Community of Practice forums for general practitioners and other general practice staff around reforms and priority subjects identified by the PHN and GPs.

• Informing and updating practices on Commonwealth health policy initiatives such as Strengthening Medicare reforms (including MyMedicare), Practice Incentives Program (PIP) Quality Improvement (QI) incentive and Workforce Incentive Program (WIP) to support understanding and access.

• Connecting general practices with quality, evidence-based services to support their patient needs in their catchment areas, including WA Primary Health Alliance's commissioned services.

• Data analysis regarding the practices' screening targets and service delivery to enable their continuous improvement.

• Education on the use of Clinician Assist WA to support clinical decision making and referrals by clinicians to increase positive patient outcomes.

• Inform, educate and support the use of digital health platforms, such as telehealth and ePrescribing, within practice to address access and equity challenges for vulnerable patient cohorts.

Data driven quality improvement.

Enabling practice transformation will have a whole of general practice approach to support data driven quality improvement activities to improve the health outcomes of the practice population. This will be achieved by:

• Providing access to a highly advanced business intelligence toolset (including data extraction) software at no cost to practices who have a data sharing agreement with the Primary Health Network.

• The business intelligence tool set will support general practices to make timely decisions regarding better health care for their respective populations. This data supports service and business planning, reporting and population health needs.

• Providing ongoing training and support to leverage the business intelligence suite of tools.

• Providing data reports to practices and assisting in their interpretation and application providing support and coaching to set up a QI team to undertake regular QI activities, assisting general practices to register and actively participate in digital health platforms including My Health Record (MYHR) and secure messaging.

• Providing support and training to embed recall and reminder processes in practice.

• Providing support and training for the QI practice incentive program.

• Assisting practices to embed the ten (10) building blocks of high performing primary care in line with the Quintuple health aims.

Data governance enhancements

Invest in improvements to WAPHA's data management capacity to protect the confidentiality, integrity and accessibility of information, guided by the ISO/IEC 27001 Standard. This will be achieved by:

• Funding a dedicated position within the PHN to lead the development of an ISO 27001-compliant Information Security Management System (ISMS). This includes enhanced definition of information management roles and responsibilities, information security risk assessment and treatment.
• Procurement of certification services and, as required, consultant support in the development of a compliant ISMS.
• Dedicated project management support to ensure best practice information management is embedded in organisational culture through appropriate governance, change management strategies, staff training and communications as part of the preparation for ISO 27001 certification and ongoing ISMS maintenance and improvement.
• Purchase of standards and of technology supports (e.g., risk management software) and other tools as determined necessary by the ISO 27001 Steering Committee to enable best practice Information Security Management practices.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary health care providers deliver best-practice mgmt to people with diabetes &build capacity for patient self-mgmt, by enabling access to multidisciplinary, integrated, allied care (Metro)	10
Increase childhood immunisation rates for regions not meeting national immunisation targets, particularly in locations increased risk of poor health outcomes related to SDOH (Metro)	10
Improve the rates of cancer screening to reduce avoidable deaths from cancer, particularly in in locations with increased risk of poor health outcomes related to social determinants of health (Metro).	9
Enable access to culturally appropriate alternative options to Emergency Departments for Aboriginal people (Metro).	44

Activity Demographics

Target Population Cohort

General practice and primary health sector

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Perth north PHN has established engagement with the following stakeholders:
- Primary Care workforce
- Regional and local primary care services including general practice.
- Rural Health West
- Consultation with WAPHA GP Advisory Group

Collaboration

Collaboration has occurred with:
- Private general practices, Aboriginal medical services
- General practitioners
- Practice managers
- Practice nurses
- Allied health providers
- Pharmacists
- Data officers – administrators
- Regional integration managers

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2019

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/04/26, 30/04/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27
Final Report	Due 30/09/27

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Health Systems Improvement	$435,128.38	$449,708.60	$429,190.64	$429,190.64	$0.00	$1,743,218.26
Total	**$435,128.38**	**$449,708.60**	**$429,190.64**	**$429,190.64**	**$0.00**	**$1,743,218.26**

HSI 1020 - Clinician Assist WA

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

HSI

Activity Number

1020

Activity Title

HSI 1020 - Clinician Assist WA

Existing, Modified or New Activity

Modified

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

• To develop, enhance, maintain and promote Clinician Assist WA - a website targeted at general practitioners (GPs) (and other health professionals), providing best practice clinical guidance and local patient referral information specific to WA. The result is patient care that is well coordinated, efficient and effective.
• To develop and deliver targeted demonstrations and activities, supporting the awareness of, engagement with, and utilisation of Clinician Assist WA and how to maximise integration into practice.

Clinician Assist WA supports a multidisciplinary approach to patient care, providing information to general practitioners (GPs) (as the primary target audience), and other healthcare professionals (including primary care clinicians and allied health professionals).

The Clinician Assist WA team works collaboratively with Health Service Providers, the WA Department of Health, Subject Matter Experts (SMEs), peak bodies and consumers (limited), in addition to general practice, to inform the resulting clinical and referral content. This collaboration also contributes towards population health planning through the identification and escalation of care and service gaps.

Description of Activity

Clinician Assist WA provides high quality, evidence based, clinical and referral guidance for clinicians working in general practice to reference during patient consultations.

The Clinician Assist WA team consists of clinical editors who are supported by coordinators and a leadership team. The team develops, reviews and maintains content, and develops and delivers educational events and materials related to Clinician Assist WA.

The main activities of the team include:
• Identifying, prioritising and developing new clinical (and non-clinical) and referral pages.
• Reviewing and maintaining existing content.
• Facilitating multi-disciplinary working groups which inform website content and identify care and service gaps for escalation.
• Mapping services and incorporating them into new and existing pages.
• Administering and maintaining the Clinician Assist WA website.
• Facilitating consultation activities in conjunction with WA Department of Health – Health Networks.
• Preparation and delivery of reports related to engagement and usage.
• Demonstrating the use of and providing targeted education about how to maximise the integration of Clinician Assist WA into clinical practice.
• Facilitating Clinician Assist WA promotional activities.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable early intervention and monitoring activities to reduce early entry into residential care and support older people in living independently for as long as possible (Metro).	52
Enable access to aged care services that support independent living and healthy ageing at home (Metro).	52
Enable access to best-practice management for people with chronic heart failure (Metro).	10
Support primary health care providers deliver best-practice mgmt to people with diabetes &build capacity for patient self-mgmt, by enabling access to multidisciplinary, integrated, allied care (Metro)	10
Support primary health care providers to implement effective health interventions for those living with overweight and obesity (Metro).	10
Support primary health care providers in managing complex care cases for patients with mental and physical comorbidities (Metro)	10
Improve the rates of cancer screening to reduce avoidable deaths from cancer, particularly in in locations with increased risk of poor health outcomes related to social determinants of health (Metro).	9
Support primary health care providers to provide culturally appropriate chronic disease management for Aboriginal people living with chronic disease and build capacity for patient self-mgmt (Metro).	44
Support the mental health of older people and assist primary care providers to identify older people who may need additional support or referrals to services (Metro).	28
Support primary health care providers in identifying and supporting smokers to cease or reduce their tobacco consumption (Metro).	35

Activity Demographics

Target Population Cohort

General practitioners are the primary audience of this activity, in addition to clinicians working in/supporting the provision of primary healthcare (e.g. Practice Nurses, Allied Health professionals) practicing in the Perth North PHN.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The PHN engages numerous stakeholders to support progression of the Clinician Assist WA Program including:
• WA Department of Health
• Health Service Providers (HSPs)
• Clinician Assist WA Users
• General practitioners and other primary health professionals
• Other PHNs across Australia

The PHN promotes Clinician Assist WA to specific audiences at conferences (e.g., GP24, Rural Health West Conference), through internally and externally produced written communications and articles (e.g. WAPHA publications GP Connect and Practice Connect; Medical Journal of Australia; Medical Forum)

The PHN delivers education and demonstrations related to Clinician Assist WA to clinicians working in general practice, primary care and other services as relevant.

Collaboration

The PHN collaborates with the following stakeholders to support progression of the Clinician Assist WA Program:
· WA Department of Health
· Royal Australian College of General Practitioners
· Subject Matter Experts (SMEs) including hospital clinicians, non-GP medical specialists, allied health practitioners, nurses etc.)
· Consumer representatives, GPs, Health Service Providers, Peak Bodies (e.g., Diabetes WA, Australasian Society of Clinical Immunology and Allergy (ASCIA)) to:
o Inform clinical and referral website content,
o Provide representation and specialist expertise in working groups related to Clinician Assist WA content development and/or review.
• Clinician Assist WA website developers. The PHN is supported by and collaborates with the website developers who built the Clinician Assist WA website and now provide ongoing technical and website maintenance support.
Other stakeholders as they are identified.

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2019

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/04/26, 30/04/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27
Final Report	Due 30/09/27

Activity Commissioning

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

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Health Systems Improvement	$138,986.19	$143,643.32	$137,089.59	$137,089.59	$0.00	$556,808.69
Total	**$138,986.19**	**$143,643.32**	**$137,089.59**	**$137,089.59**	**$0.00**	**$556,808.69**

HSI 2000 - Stakeholder Engagement and Communication

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

HSI

Activity Number

2000

Activity Title

HSI 2000 - Stakeholder Engagement and Communication

Existing, Modified or New Activity

Existing

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

Communications and stakeholder engagement activities aim to establish and nurture strong and purposeful relationships with the diversity of stakeholders in primary care.

Establishing and maintaining trusting and purposeful relationships is essential to achieving our vision of better health, together.

The strength of our relationships with stakeholders enables us to work collaboratively with others and to engage a diversity of knowledge, skills and experience through all aspects of commissioning and practice improvement.

Demonstrating and maintaining a positive reputation is essential as an approach to managing risks for WA Primary Health Alliance as a local commissioner, and for risks to the Primary Health Network (PHN) program.

Description of Activity

Communications and Marketing
The PHN will continue to communicate WAPHA's purpose and work by delivering high quality written and digital communications both internally and externally, to demonstrate impact, innovation and achievement.
This work is underpinned by:
• Strategic marketing and communications: undertake planned and deliberate activities to market and communicate our purpose, work and value.
• Brand management: build and maintain a consistent corporate image.
• Media relations: facilitate favourable, accurate and timely media coverage.

• Government relations: inform elected members about the work of the PHN via in person visits and information packs.
• Issues Management: identify and manage contentious issues/protect WAPHA's reputation.
• Internal communications: facilitate the delivery of information and encourage two-way conversation to engage team members and help them do their jobs.

Priorities 2025 - 2026 include:
• Using strategic communications approaches and key messages aligned with the WA Primary Health Alliance Strategic Plan 2023 – 2026 to reach our priority stakeholders and those with a latent/ emerging interest in our work to ensure they understand how we are adding value to the WA and, as the lead PHN for national programs, national health system.
• Continuing to build our audiences and communicate in an increasingly targeted way using segmentation and tailored messaging, and using performance metrics to continuously refine our communication approach and channels to optimise reach and engagement.
• Maturing our digital communications' presence to ensure our voice is heard and that we are part of strategically important online conversations.
• Embedding culturally inclusive language and images across our communication platforms to demonstrate WAPHA's leadership in culturally safe and inclusive practice.
• Maturing the way in which we demonstrate innovation, value to the community and the overall return on investment of the PHN program in WA.

Stakeholder Engagement
Stakeholder engagement plays a critical role in ensuring WAPHA understands and listens to key stakeholders across local community, health care providers, government and other entities. WAPHA's stakeholder engagement aligns to best practice IAP2 international stakeholder engagement methodology allowing WAPHA to build and maintain a holistic understanding of our region's unique health care needs.
WAPHA's Stakeholder Engagement team's purpose is to lead the organisation in implementing quality improvement initiatives, exemplary partnerships and stakeholder relationship management system capability, by empowering employees to achieve best practice stakeholder engagement aligned with PHN strategic priorities.
The Stakeholder Engagement team will continue to
• Lead and coordinate strategies, projects and activities that maintain the integrity of stakeholder engagement approaches across WAPHA.
• Build engagement capacity of employees and empower them to engage effectively with our stakeholders, including in use of digital platforms and enablers such as our stakeholder database and digital engagement platforms.
• Support projects and activities that uphold the cultural security of our stakeholder engagement approaches, ensure stakeholders are well informed and engaged in the development and implementation of our Reconciliation Action Plan and direct the work.
• Identify, facilitate and mature WAPHA's state-wide partnerships and support a strategic approach to the planning and delivery of local stakeholder engagement.

Specific activities include:
WA GP Advisory Panels – a partnership with Rural Health and Royal Australian College of General Practitioners (RACGP) WA to directly engage GPs. WAPHA has a membership database of GPs across the state who register for evening online panel meetings where topics relevant to primary health care are discussed and GPs opinion, insight and expertise is canvassed. Summary papers are drafted following the meetings, with ideas and recommendations shared.

Commissioned Service Provider Panels – WAPHA's commissioned service provider chief executive officers (CEOs) who have registered to be a member of the panel are invited to discuss key issues regarding relevant topic areas with insight, recommendations and summaries provided for action.

WAPHA organisational members – key partner organisations enabling co-funding and primary health care influence across WA.

Organisational members include WA Department of Health, Mental Health Commission, WA Council of Social Services, Rural Health West, RACGP WA, Australian College of Rural and Remote Medicine, Health Consumers' Council and WA Local Government Association. Members meet with and present to the WAPHA Board as well as attend regular meetings with WAPHA Executive Team.

Stakeholder Relationship Management system – a Microsoft Dynamics 365 CRM platform to digitally record and capture stakeholder engagement within the WAPHA team. The system includes – CRM Hub, Customer Voice, Marketing and Events modules to systematically engage with stakeholders.

WAPHA Board Sub-Committee – Strategic Engagement Advisory Committee – board member subcommittee committed to governance assurance for stakeholder engagement across WAPHA.

Health Professionals Network – statewide partnership with Rural Health West and WA Country Health Service to foster education and engagement amongst clinicians working in regional WA.

Reference Groups – formal membership for LGBTIQA+ Reference Group and Multicultural Reference Group. Expression of Interest for development of an Aboriginal Stakeholder Reference Group.

Priorities 2025 - 2026 include:
• Strengthening and embedding commissioning approaches and practices that work towards increasing the opportunities for a collaborative design approach to be applied.
• Increasing the ways in which community, consumers, family, and carers are engaged across the commissioning cycle.
• Implementing the activities as outlined in WAPHA's Stakeholder Engagement Framework, with an emphasis on our digital enablers, including WAPHA's Dynamics 365 Stakeholder Relationship Management digital platform and stakeholder sentiment.
• Ongoing development of the WA GP Advisory Panel, in partnership with Rural Health West and RACGP (WA), to enable external partners to engage with general practitioners in operational and strategic directions setting and policy implementation.
• Maturing partnerships with strategic stakeholders.
• Implementation of WAPHA's LGBTIQA+ Equity and Inclusion Framework as it aligns to Rainbow Tick accreditation.
• Implementation of WAPHA's Aboriginal Cultural Competency and Capability Framework as it aligns to our Innovate RAP.
• Implementation of WAPHA's Multicultural Framework as it aligns to our multicultural needs assessment.

The PHN recognises the impact COVID-19 had on the community, primary health care and commissioned service activity. With services having returned, monitoring and service impact assessment will continue, to ensure the PHN continues to meet the aims of the activity and the needs of the priority target groups.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary health care providers deliver best-practice mgmt to people with diabetes &build capacity for patient self-mgmt, by enabling access to multidisciplinary, integrated, allied care (Metro)	10
Enable access to early screening and treatment for harmful alcohol use (Metro).	36
Enable access to culturally appropriate alternative options to Emergency Departments for Aboriginal people (Metro).	44

Activity Demographics

Target Population Cohort

The target population of this activity will include Perth North WA PHN stakeholders, including general practices, commissioned service providers, government entities, health service providers (hospitals and community health), health, welfare and community service providers (including the Aboriginal sector), community, consumer and carer groups.

Indigenous Specific

Yes

Indigenous Specific Comments

As well as engaging with commissioned service providers which are Aboriginal owned and operated, WAPHA has ongoing engagement with the state's peak Aboriginal organisation and is seeking to stand up an Aboriginal Stakeholder Reference Group. Numerous commitments and activities are documented in our Aboriginal Cultural Competency and Capability Framework, aligning with our Innovate RAP. Additionally, guided by our Welcome to Country and Acknowledgment of Country Policy, we regularly engage with Aboriginal people across the state and acknowledge the Traditional Owners of the lands upon which we work.

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

WAPHA has drawn on the expertise of specialist reference groups of external stakeholders (Multicultural, LGBTIQA+ and Aboriginal) to inform communications and engagement planning and priorities.

Feedback from stakeholders on communications and engagement activities is used to inform continuous quality improvement to ensure content, channels and activities are meeting the needs of stakeholders.

Collaboration

The WA GP Advisory Panel has been established as a partnership with RACGP WA and Rural Health West. RACGP make an in-kind contribution by administering payment to GPs, and all partners play an equal role in setting agendas and actioning comments raised by members.

Activity Milestone Details/Duration

Activity Start Date

30/06/2019

Activity End Date

29/06/2027

Service Delivery Start Date

01/07/2019

Service Delivery End Date

30/06/2027

Other Relevant Milestones

Activity Work Plans	Due 30/04/25, 30/04/26, 30/04/27
Annual Activity Needs Assessment	Due 15/11/25, 15/11/26
Twelve Month Performance Report	Due 30/09/25, 30/09/26, 30/09/27
Financial Acquittal Report	Due 30/09/25, 30/09/26, 30/09/27

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Health Systems Improvement	$246,802.31	$255,072.13	$243,434.45	$243,434.45	$0.00	$988,743.34
Total	**$246,802.31**	**$255,072.13**	**$243,434.45**	**$243,434.45**	**$0.00**	**$988,743.34**

HSI 3000 WA Collaborative Commissioning Partnership (WACCP)

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

HSI

Activity Number

3000

Activity Title

HSI 3000 WA Collaborative Commissioning Partnership (WACCP)

Existing, Modified or New Activity

New Activity

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

Introduction of new funding under item 1.2.5 of the Core Operational and Flexible Funding Schedule enables WA Primary Health Alliance (WAPHA) to facilitate and participate in the WA Collaborative Commissioning Partnership (WA CCP).

The WA CCP is a formal agreement between the Australian Government Department of Health, Disability and Ageing (DHDA), the WA Department of Health (WA DoH), and WA Primary Health Alliance (WAPHA), established to deliver on the WA Joint Statement by working together to build a more efficient and effective integrated health system that improves the health and wellbeing of Western Australians, particularly, with a particular focus on priority populations.
The Partnership will:
• Establish a formalised joint governance structure to deliver against the WA Joint Statement.
• Co-design joint planning and funding frameworks that support integrated commissioning across WA.
• Drive collaborative decision-making and shared accountability for health system performance and outcomes.
• Reduce duplication and fragmentation across primary and acute care services.
Through the WA Collaborative Commissioning Partnership (WA CCP), WAPHA will work with DHDA and WA DoH to deliver targeted activities across key priority areas, each supported by a dedicated Working Group in the following areas:
• Governance, Funding and Planning
• Care in the Community
• Data and ICT

Each Working Group will develop a Workplan, Position Paper, and recommendations to guide Partner collaboration at regional, state, and federal levels. This includes considering shared governance to enable joint ownership, implementation, and evaluation of new and existing programs, projects, and commissioned services.
Activities will target priority populations identified through regional needs assessments, including Aboriginal people; those experiencing or at risk of homelessness; LGBTIQA+ communities; older adults; people facing economic hardship; culturally and linguistically diverse (CALD) groups; rural and remote residents; and people living with disability.
The Partnership's governance members will collaborate with wider stakeholders to co-design practical, locally responsive reforms that reflect community needs and system capabilities.

Description of Activity

Background
In 2023, DHDA initiated the agreement through the negotiations of the National Health Reform Agreement (NHRA) formalising our collaborative relationship with a shared focus on joint planning, collaborative commissioning, and accountability for health outcomes.
Between October 2023 and October 2024, executive-level meetings resulted in formal agreement on a governance structure and priority reform areas. The Partnership draws on successful models from other jurisdictions, particularly NSW and QLD, where integrated governance and funding arrangements across primary and acute care have delivered measurable benefits.
WA CCP aligns with key recommendations 4, 10, 11, 13, and 17 from the WA Sustainable Health Review and leverages existing local governance groups to support system integration. It also supports national policy direction under Australia's Primary Health Care 10 Year Plan 2022–2032, which recognises PHNs as key enablers of collaborative statewide planning.
Rationale
Recent health care reform reports including the Australia's 10 Year Primary Health Care Plan, the Strengthening Medicare Taskforce Report, Productivity Commission Shifting the Dial Report and the Grattan Institute's Mapping Primary Care report call for stronger system integration through bundled funding models, shared governance, and a shift toward value-based, team-led care.

The WA CCP represents a formal collaboration between DHDA, WA DoH, and WAPHA to deliver a high-quality, one health system mindset that reduces duplication and enhances care continuity.
The initiative addresses longstanding fragmentation between primary and acute care by:
• Driving shared accountability for reforms in joint governance, funding, planning, commissioning.
• Aligning with state and national reform agendas to improve efficiency and effectiveness.
• Driving co-designed, person-centred care reflects local priorities.
• Supporting integrated governance through the Partnership Committee, Implementation Oversight Steering Committee, and three Working Groups.
In the long term, the Partnership aims to create conditions for whole-of-system integration and improve health equity by delivering needs-based services, enhancing continuity of care between primary and acute settings, and using technology to improve access
Roles and Responsibilities
Joint responsibility for the delivery of the WA CCP sits with WAPHA's Strategy & Engagement Portfolio, led by the Governance & Project Officer, in collaboration with key Executive and Senior Leaders from Business Services, Commissioned Services, Primary Care and Digital Health Portfolios. These teams work across the three WA PHNs to ensure alignment with WAPHA's Strategic Plan 2023–2026 and will contribute as members on the governance structure.
Oversight of the activity is provided by the WA CCP governance structure, comprising:
• Partnership Committee – provides strategic leadership, facilitates joint decision-making, and endorses deliverables.
• Implementation Oversight Steering Committee (IOSC) – guides the work of the Working Groups and ensures alignment with the Joint Statement.
• Working Groups – develop Workplans, Position Papers, and implementation recommendations for each priority reform area: Governance, Funding & Planning; Care in the Community; and Data & ICT.

The Governance & Project Officer will act as secretariat to the Partnership, responsible for management of governance, project management and coordination, timelines, reporting, and stakeholder engagement planning.
Key Activities
• Coordinate and manage governance processes for the governance structure, including agenda preparation, meeting facilitation, action tracking, and reporting to support consistent joint decision-making and shared accountability.
• Develop Working Group-specific Workplans, Position Papers, and implementation recommendations to inform long-term Partnership objectives.
• Partner with Aboriginal Community Controlled Health Services (ACCHSs), consumers, and rural/remote representatives by embedding them in governance structures and engaging them in consultations on key deliverables.
• Ensure all planning and governance activities align with key policy reforms such as the WA Joint Statement, National Health Reform Agreement (2020–2025), and the WA Sustainable Health Review.
• Facilitate targeted stakeholder engagement informed by community needs and system insights.
• Lead initiatives to improve shared access to data and digital systems across Partner agencies to support informed planning, service design, and performance monitoring.
• Design and deliver the inaugural WA Statewide Forum to review progress, test implementation options, and strengthen alignment of joint priorities across all levels of the health system.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Pilbara).	96
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Goldfields-Esperance).	7
Enable access to coordinated culturally appropriate primary care for Aboriginal people (South West).	119
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Mid West).	72
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Wheatbelt).	142
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Great Southern).	31
Enable access to coordinated culturally appropriate primary care for Aboriginal people (Kimberley).	51

Activity Demographics

Target Population Cohort

• Aboriginal and Torres Strait Islander people
• People experiencing, or are at risk of, homelessness
• LGBTIQA+ people

• Older people
• People experiencing economic hardship
• People from culturally and linguistically diverse (CALD) backgrounds
• People living in rural and remote areas
• People living with disability

Indigenous Specific

Yes

Indigenous Specific Comments

Aboriginal Community Controlled Health Services (ACCHSs), including the Aboriginal Health Council of WA (AHCWA), are actively engaged in the WA Collaborative Commissioning Partnership through:
• Representation on the mid-tier Implementation Oversight Steering Committee and all three priority Working Groups.
• Ongoing consultation in the development of Working Group Position Papers and associated deliverables.
• Participation in an annual Statewide Forum, designed to incorporate ACCHS perspectives and shape the evolution of the Partnership as it matures.

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Stakeholder engagement is a core component of the WA CCP's development and implementation. Key activities include:
• Development and implementation of the WA Joint Statement Stakeholder Engagement and Communications Plan, which outlines a two-stage engagement process:
o Stage 1: Preparation and release of the WA Joint Statement.
o Stage 2: Post-release engagement through communiqués, media releases, and stakeholder forums.
• The annual Statewide Forum planned to gather feedback from ACCHSs, consumer organisations, and broader community stakeholders to inform the ongoing development of the Partnership.
• Consultation with consumer and lived experience organisations, including representatives from LGBTIQA+, disability, and multicultural communities, to ensure diverse perspectives shape the Partnership's direction.
• Periodic stakeholder workshops coordinated by the Implementation Oversight Steering Committee to broaden engagement and promote transparency.
• Multimedia and tailored communications, including executive presentations and communiqués, to share updates and invite feedback from key stakeholders such as Primary Health Networks (PHNs), Health Service Providers, and national programs.

Collaboration

• Department of Health, Disability and Ageing (DHDA)
• WA Department of Health (WA DoH)
• Aboriginal Health Council of WA (AHCWA)
• Health Consumers' Council WA (HCCWA)
• Mental Health Commission (MHC)
• Rural Health West (RHW)
• Health Service Providers (HSPs) – Regional and metropolitan representation.
• Other community-controlled organisations - disability, aged care, CALD

Activity Milestone Details/Duration

Activity Start Date

30/06/2025

Activity End Date

29/06/2025

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Health Systems Improvement	$0.00	$500,000.00	$0.00	$0.00	$0.00	$500,000.00
Total	**$0.00**	**$500,000.00**	**$0.00**	**$0.00**	**$0.00**	**$500,000.00**

HSI 4000 Emergency Preparedness and coordination

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

HSI

Activity Number

4000

Activity Title

HSI 4000 Emergency Preparedness and coordination

Existing, Modified or New Activity

New Activity

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

The introduction of Emergency preparedness and coordination funding under the Health System Improvement stream of the PHN Core Funding Schedule allows WA Primary Health Alliance (WAPHA) to build capacity of primary care to manage emergency preparedness, planning and coordination functions in Perth North PHN by:
• Preparing and maintaining emergency preparedness protocols.
• Updating protocols annually in line with Emergency Preparedness Policy Guidelines provided by the Department of health, Disability and Ageing.
• Engaging regularly with local and district stakeholders relating to emergency preparedness, planning, response, and recovery.
• Integrating and coordinating health services in Perth North PHN regions to prepare for the event of a natural and/or health emergency situation.
In Perth North PHN, WAPHA staff will engage with key local and district stakeholders engaged in emergency response and management, as well as primary health providers to support emergency preparedness and response.
These activities will be undertaken with a focus on general practices and locations which are under-resourced and where there are higher cohorts of people who are hard-to-reach, have inadequate access to primary health care and are most at risk of poorer health outcomes.

Description of Activity

Background

In February 2020 in response to the extreme bushfire season of 2019-2020, which resulted in loss of life, property, wildlife and environmental destruction, a Royal Commission into Natural Disaster Arrangements was established.

The subsequent report recommended that Australian state and territory governments should develop arrangements that facilitate greater inclusion of primary healthcare providers in disaster management, including representation on relevant disaster committees and plans and providing training, education and other supports (Recommendation 15.2).

Joint planning and funding at a local level, including strengthening coordination between Local Health Networks (LHNs) and PHNs is a key reform priority of the National Health Reform Agreement NHRA 2020-25 Addendum, an agreement between Australian, state and territory governments to improve health outcomes for all Australians and ensure our system is sustainable.

The Department of Health, Disability and Ageing Australia's Primary Health Care 10 Year Plan 2022–2032 also identifies that the PHNs have played a vital role in supporting the primary care response through the droughts, bushfires and COVID-19 pandemic of recent years, and seeks to integrate and embed primary health care as a natural and critical part of emergency preparedness and response structures at regional, state and national levels.

Rationale

Primary health care is recognised as an essential and critical part of the health system. Access to these services is relied upon by communities, and building the capacity and capability of these providers to continue to operate during a disaster or emergency is of significant importance. Business as usual is always disrupted during and immediately after disasters or emergencies, however adequate planning and testing of alternative operating arrangements, as well as improving coordination and integration with other local health services will improve the ability of these services to continue to provide essential health care to communities at times of need and severely limited resources.

Roles and Responsibilities

Joint responsibility for the delivery of the Emergency preparedness and coordination activity sits with WAPHA's Primary Care Portfolio, along with the Commissioned Services Portfolio, both of which work across the three WA PHNs. An executive sub-committee will oversee this activity to ensure it aligns with funding requirements and guidance, and WAPHA's Strategic Plan 2023-2026.

Activities will be undertaken by key functions including primary care engagement, learning and development, regional integration and contract and procurement.

Key Activities

Key activities for Perth North PHN include:

- PHN engagement with local emergency management stakeholders
- Support and/or facilitate integration of local services and resources to build capacity to respond to emergencies
- Promotion and publication of best practice emergency preparedness guidelines
- Embedding emergency management requirements as a meaningful and proportionate component of procurement, commissioning and contract management.
- Dissemination of DHDA and WA Health provided emergency and disaster information via established and appropriate communication channels
- Promotion of best-practice tools and resources to support primary health care organisations to prepare and respond to emergency situations
- Promotion of disaster and emergency education and training

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable access to integrated care pathways that address both mental and physical health concurrently (Metro)	10
Enable access to alternative services, including after-hours primary health care (Metro).	10
Support health care and aged care providers in delivering patient-centred culturally appropriate care (Metro).	51
Enable access to culturally appropriate alternative options to Emergency Departments for Aboriginal people (Metro).	44

Activity Demographics

Target Population Cohort

Primary health care organisations including general practices, Aboriginal Community controlled Health Services (ACCHS) and commissioned service providers in Perth North PHN

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Consultation with WA Health, Local Government, RACGP, general practices and ACCHS will be undertaken as required.

Collaboration

- General practices and other primary health care providers
- Aboriginal Community Controlled Health Services
- Commissioned Service Providers
- WA Health
- Local Government Agencies

Activity Milestone Details/Duration

Activity Start Date

30/06/2024

Activity End Date

29/06/2027

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
Health Systems Improvement	$0.00	$0.00	$140,001.01	$40,764.38	$0.00	$180,765.39
Total	**$0.00**	**$0.00**	**$140,001.01**	**$40,764.38**	**$0.00**	**$180,765.39**

CF 5050 - PHN Collaborative Data and Analytics Centre of Excellence

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

CF

Activity Number

5050

Activity Title

CF 5050 - PHN Collaborative Data and Analytics Centre of Excellence

Existing, Modified or New Activity

Existing

Activity Priorities and Description

Program Key Priority Area

Digital Health

Aim of Activity

The objective of this activity is to:
• Bolster the primary care data analytics capability across all Primary Health Networks (PHN) by establishing centralised data and analytics quality and management standards and frameworks.
• Build on the existing investment in Primary Health Insights and enhance PHNs' ability to leverage the platform to deliver consistent and collaborative analytics and reports.
• Enhance PHNs' ability to generate insights, deliver national policy agendas, and plan and evaluate value-based care initiatives locally, regionally and nationally.

Description of Activity

Funded Activity Scope
WA Primary Health Alliance, as the Lead PHN for Primary Health Insights, will continue:
• Research and maintain knowledge of current and future technology trends that support data quality, security, management and analytics.
• Develop data and analytics models on service utilisation, activity modelling and other aspects of PHN services which inform government decisions about resource allocation.
• Develop uniform data and reporting standards and frameworks for PHNs' performance reporting and analysis which then enables benchmarking across the network.
• Leading communities of practice across PHNs and enable peer collaboration on analysing primary healthcare data which supports the sharing and update of health care innovations and improvements across the network.
Purpose:
To utilise allocated funding and maximise the impact of carryover funds by completing and embedding nationally significant data and analytical initiatives, strengthening PHN capability, and ensuring sustainable

transition to business-as-usual operations.
Strategic Objectives:
• Bolster data and analytics capabilities across all PHNs by establishing centralised standard frameworks for data quality, management and analytics.
• Build on the investment in Primary Health Insights (PHI) to enhance PHNs ability to deliver consistent collaborative analytics and reporting.
Funded Activity Scope:
WA Primary Health Alliance, as Lead PHN for PHI, will direct the funds to:
1. Project Coordination and Delivery
Oversee the completion of in-progress national initiatives, ensuring all agreed outcomes are delivered and transitioned into business-as-usual operations.
2. PHOCUS Operations
Sustain and enhance the PHOCUS national performance reporting platform, ensuring all PHNs can efficiently collect, collate, approve, and submit statistical performance data to the Department.
Support ongoing expansion of PHOCUS metrics and reporting capabilities, in line with Departmental requirements and PHN feedback.
Streamline digital reporting processes, reduce duplication, and improve data quality and transparency for PHN program management.
4. Change Management and PHN Engagement
Lead communication and change management activities to support PHNs in adopting new data analytical tools, products, and services.
Identify and mitigate impacts on PHN workflows and capability, ensuring smooth uptake of innovations.
5. Knowledge Transfer and Evaluation
Support post-implementation evaluation, document lessons learned, and disseminate findings across PHNs and the Department.
Inform future digital health investments and strengthen national data and analytical capability.
6. Completion of Key National Initiatives
Finalise onboarding of the Department into PHI for secure data sharing with PHNs.
Implement the national PIP QI data processing and validation solution in collaboration with AIHW.
Scale common data processing frameworks for additional PHN use cases and datasets.
Support PHNs in using PHI's common public datasets for consistent health needs assessment and analysis.
Expected Outputs and Outcomes:
New or improved tools and services within PHI for easier, faster collaboration among PHN data and analytics employees.
Enhanced PHOCUS platform supporting expanded performance reporting and streamlined Departmental submissions.
Standard data models and algorithms for common business needs, enabling benchmarking and shared analytics across PHNs.
Increased data and analytics capability and capacity within all PHNs, through reduced effort for common requirements, enhanced skills, and improved process maturity.
Documented lessons learned and recommendations for future digital health investments.
Development, enhancement and management of a National PHN Performance Reporting Application - PHOCUS (Ongoing)
The process undertaken by PHNs to collect and report on performance data to the Department of Health, Disability and Ageing through PPERS as part of the AWP process is manual, cumbersome, and does not enable the Department to perform any useful analytics, comparisons or reporting. PHOCUS delivered a new national platform to collect, collate, approve, submit and report on statistical performance data from all PHNs for the Department.
This data driven approach enables the Department and PHNs to gain valuable insights, thereby enhancing the management and transparency of the PHN program.as well as work with PHNs and the Department to expand the metric set to be reported and simplify and improve the Department's ability to access and use this information.
Status
• Since going live in June 2023, all 31 PHNs are using PHOCUS to collect and report on PHN performance data across: Performance Management Reporting Framework (PMRF), Urgent Care Clinics (commissioning progress reporting), Commonwealth Psychosocial Support (CPS) Program, Primary Care Access Programs (PCAP) and

Multi Disciplinary Teams (MDT) metric sets.
• The project stage of PHOCUS 1.0 was completed in June 2024, with funding for FY25 obtained under a separate AWP (CF-PHI 5060 – Integrated Digital Enhancement Program.
• Ongoing operational funding for FY27 and beyond, along with funding to implement the additional scope requested by the Department a phased approach for the PHOCUS 2.0 project, has been requested from the Department and is currently under review and consideration.

This additional funding will further reduce the reporting burden on PHNs, maximise digital reporting effectiveness, ensure enhanced data quality and streamline resource allocation by eliminating duplication of effort and resources by consolidating reporting systems used by PHNs., with agreement to provide funding for FY26 only at this stage.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Enable access to integrated care pathways that address both mental and physical health concurrently (Metro)	10
Support primary health care providers in managing complex care cases for patients with mental and physical comorbidities (Metro)	10
Support primary health care providers to refer to appropriate mental health services, including telehealth-enabled services (Metro).	9

Activity Demographics

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

WAPHA continues to consult broadly in supporting PHNs to use and enhance the PHI platform to deliver improved data and analytics capabilities. Key stakeholders that are being engaged in the development and implementation of the detailed Work Plan, and the individual projects within it, include:
1. Australian Commonwealth Department of Health, Disability and Ageing – engaged in the development and review of the purpose and role of this funding, the Department continues oversight through the Steering Committee on an at-least-quarterly basis in approving, reviewing and updating the detailed Work Plan and

progress against it.
2. Australian Institute of Health & Welfare – as the national data custodian for a range of data collections such as PIPQI, AIHW have been engaged to inform, support and give feedback on any data and analytics improvement activity under the detailed Work Plan that relates to PIP QI, and through established communities of practice and user groups are providing feedback on other common data and analytics processes. WAPHA as Lead PHN has been engaging with the AIHW to help identify areas for improvements since late 2020.
3. PHN Cooperative – As part of developing a PHI Strategic Plan, WAPHA engaged with all PHNs through both a national workshop in August 2022 and provision of a Consultation Draft Strategic Plan, that included (but was not limited to) the activity to be funded through the CoE within its scope. This enabled PHNs to examine the proposed work within its larger context alongside existing PHI work. In addition, PHNs have established a new national cross-PHN governance framework under a Primary Health Transformation Coordination Committee (PHTCC) to help ensure that national projects support and do not conflict with each other – this group is now providing closer governance of this work through the DataLeap Program.
4. The PHOCUS Team at WAPHA engages in fortnightly and sometimes weekly consultation with DHDA's Data and Digital Division to support the enhancement and expansion of PHOCUS.

Collaboration

WAPHA is delivering the outputs and outcomes of this Activity as a Lead PHN working with other stakeholders, particularly other PHNs:
* Primary Health Networks – both consultations to identify and prioritise needs, but also engagement and participation of staff from other PHNs in planning and developing the solutions to meet those needs. PHNs engagement includes governance and broad community of practice involvement.
* The Department of Health, Disability and Ageing - Key staff within the Department have been engaged as key consumers of PHN data and analytics products to ensure that PHN data submissions can more effectively support national policy agendas and programs. The DataLeap Program team engage with the PHN Data and Reporting Branch at least monthly on the design and progression of PHOCUS.
* Australian Institute of Health & Welfare – as a key stakeholder in the PIP QI process, the AIHW is being engaged as a collaborator in developing improved approaches for PIP QI submission, as well as other projects where capability and capacity exist.

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/06/2026

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
PHN Collaborative Data and Analytic Centre of Excellence	$1,627,284.67	$1,140,238.11	$0.00	$0.00	$0.00	$2,767,522.78
Total	**$1,627,284.67**	**$1,140,238.11**	**$0.00**	**$0.00**	**$0.00**	**$2,767,522.78**

CF-COVID-PCS 8010 COVID-19 Primary Care Support

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

CF-COVID-PCS

Activity Number

8010

Activity Title

CF-COVID-PCS 8010 COVID-19 Primary Care Support

Existing, Modified or New Activity

New Activity

Activity Priorities and Description

Program Key Priority Area

Population Health

Aim of Activity

The activity aims to provide support for Australia's COVID-19 Vaccine and Treatment Strategy to the primary, aged care, and disability sectors within the Perth North PHN region.
The intended outcomes of this activity are to support and strengthen the primary health system and improve the health outcomes of the community.

Description of Activity

The PHN will advocate best practice approach of the COVID-19 Vaccine and Treatment Strategy to the primary, aged care, and disability sectors by:
• Providing guidance and expert advice to general practices, Aboriginal Community Controlled Services, residential aged care facilities (RACF), disability accommodation facilities and governments on local needs and issues
• Strengthen relationships within RACFs by providing support to coordinate vaccination services, promoting collaboration through educational initiatives, and ensuring residents and staff have efficient access to vaccinations
• Supporting vaccine delivery sites in their operation and ongoing quality control
• Provide guidance and support to increase the COVID 19 vaccination program for vulnerable populations identified through data analysis and stakeholder engagement
• COVID-19 positive people will be managed safely and effectively through primary and community care services.
• Continue to consult and collaborate with key stakeholders to ensure activities are responsive and dynamic in response to primary care needs.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary health care providers deliver best-practice mgmt to people with diabetes &build capacity for patient self-mgmt, by enabling access to multidisciplinary, integrated, allied care (Metro)	10
Increase childhood immunisation rates for regions not meeting national immunisation targets, particularly in locations increased risk of poor health outcomes related to SDOH (Metro)	10
Enable access to culturally appropriate alternative options to Emergency Departments for Aboriginal people (Metro).	44

Activity Demographics

Target Population Cohort

Primary health, aged care, and disability sectors

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

The PHN consulted with and continues to engage with a range of stakeholders to support primary care providers including but not limited to:
- Department of Health and Aged Care
- Other PHNs
- General Practices
- WA Department of Health including public health units
- Aboriginal Community Controlled Health Organisations
- Residential Aged Care Facilities
- Community Organisations
- Commissioned Services
- Local Government
- Education Institutions
- Peak Bodies

Collaboration

The PHN is working with WA Department of Health, General Practitioners, Community Organisations, Aboriginal Community Controlled Health Organisations, Residential Aged Care facilities, Pharmacies and other agencies to support provision of vaccinations to vulnerable people within their area, that have limited access to COVID-19 vaccination and information. These stakeholders will be directly involved in facilitating access to and administering COVID-19 vaccinations and information.

Activity Milestone Details/Duration

Activity Start Date

08/09/2021

Activity End Date

30/12/2025

Service Delivery Start Date

09/09/2021

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Activity Work Plans	Due 30/04/25
12-month performance report	Due 30/09/25
Financial Acquittal Report	Due 30/09/25

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
COVID-19 Primary Care Support	$597,669.04	$954,674.81	$199,243.00	$0.00	$0.00	$1,751,586.85
Total	**$597,669.04**	**$954,674.81**	**$199,243.00**	**$0.00**	**$0.00**	**$1,751,586.85**

CF-PHI 5060 - PHN Shared Data Warehouse Primary Health Insights (PHI)

Activity Metadata

Applicable Schedule

Core Funding - Perth North

Activity Prefix

CF-PHI

Activity Number

5060

Activity Title

CF-PHI 5060 - PHN Shared Data Warehouse Primary Health Insights (PHI)

Existing, Modified or New Activity

Existing

Activity Priorities and Description

Program Key Priority Area

Digital Health

Aim of Activity

WAPHA, as the lead PHN, will continue to enhance and develop digital capability, improved service delivery and transparency across the Primary Health Networks (PHN) leveraging Primary Health Insights (PHI) as its secure backbone.

The aim of this activity is for WAPHA to continue to be a leader in the:
• Enhancement and support of Primary Health Network's (PHN) ability to provide quality, integrated, secure and seamless digital service offerings to health service providers, including commissioned services providers, general practices and eventually allied health care providers.
• Identification and monitoring of clinical outcomes to reliably assess the impact and effectiveness of commissioned services and other funded programs.
• Ability to work more closely with the state health systems and provide more integrated digital service offerings including analytics, data linkage and clinical pathways for practitioners, including change management programs and support.
• Implementation of PHOCUS (Primary Health Operational and Commissioning Unified System) across all 31 X PHN's including the qualitative and quantitative measures, support, change management and reporting at a national level.
• Development of flexible and adaptable digital solutions that can be easily adopted or adapted by other Primary Health Networks (nationally) if desired.
• Drive greater efficiencies across PHNs in the delivery of services and support to its key stakeholders.
• Continuously mitigate cyber risk in the storage and use of primary care data across the Primary Health Networks.

Description of Activity

As the lead PHN, WA Primary Health Alliance will:
• improve the usability and accessibility of digital services by providing streamlined and easier-to-use interfaces for collecting data from, and providing data to, health service providers to improve efficiencies and effectiveness across PHNs
• improve the financial viability and sustainability of digital services by leveraging existing investments in the Primary Health Insights (PHI) platform, and by developing or adopting appropriate and re-usable standards, processes and frameworks
• improve the quality and timeliness of information provided through digital services offerings by implementing new technologies such as Artificial Intelligence to enhance and target the provision of clinically relevant options to clinical practitioners at the point of care, particularly in the use of clinical health pathways
• improve the cyber security and privacy of digital service offerings by enhancing cyber-security controls, processes and standards across all systems
• improve the flexibility and agility of digital service offerings by designing and implementing architectures that facilitate, simplify and speed up the addition of new functionality in response to emerging needs across the health system
• improve the stability and performance of digital service offerings by enhancing the integration, automation, reliability and scalability of application and platform technology capabilities
• improve health system integration by implementing improved data linkage, clinical referral pathways and digital connectivity with national and state health agencies
• improve clinical acceptance and defensibility by undertaking or commissioning reviews, assessments or validation of enhanced tools, methods and outcomes that assist in improving primary care productivity
• improve the frequency and quality of performance reporting via PHOCUS across all PHNs
• improve adoption and support by providing additional documentation, training, user support and change management services to staff from of PHNs, general practices and commissioned service providers

Managed within WAPHA, and working closely with the PHI National Services Team and other participating PHNs across Australia, a detailed work plan will be developed that will identify, prioritise and schedule a range of new and enhanced digital service offerings. These will include existing capabilities such as online portals for commissioned service providers and general practices, data collection from and reporting to general practices, and clinical health pathways information for health practitioners.

The following are provided as an example of the type of current health system issues this Activity will target through the enhancement of relevant digital service offerings:
• Outdated and cumbersome software platform – Health Pathways that is not meeting clinician expectations which is also a costly service offered by private industry.
• Manual processing by PHNs of Excel files and/or the need for paper forms in the collection of performance and contract information from commissioned service providers and GPs.
• The number of different systems that a GP needs to interact with in order toto receive or retrieve clinical information, grants, education and training from PHN, state or national sources.
• Removal of the dependence of the use of Facsimile transmission between health providers.
• The time and effort required to develop and make available specific reports or data collections relevant to population health issues such as disease outbreaks, national immunisations, and targeted interventions for chronic health conditions.
• Inability to link data between primary and acute care or develop full patient journeys.
• Reluctance by general practice and other health service owners to fully adopt digital services due to fears around cybersecurity, privacy, and their legal liabilities.
• Difficulties experienced by general practitioners in adopting new services due to the limited time available during patient visits and limited time available for training.
• Improving transparency of PHNs performance via new reporting platform PHOCUS.
• Difficulties with quickly updating the clinical evidence base for information or advice provided to health practitioners to keep pace with the latest research.

Where feasible, and where doing so will not adversely affect the delivery of outcomes for WAPHA or any other PHN, WAPHA may seek to work collaboratively with one or more PHNs in the design, development, testing or piloting of digital services offerings as a way of improving their re-usability and decreasing the total cost and effort required from other PHNs to adopt or adapt them, if they so desire.

The following projects are underway to be delivered as outcomes of this Activity:

Clinical Referral Pathways (Paused pending funding)

This project aims to deliver a proof of concept for a new clinical referral pathway system and support model that can utilise appropriate Artificial Intelligence capabilities and integrate with existing or future clinical support tools to provide contextual real-time clinical referral pathway options to General Practitioners or other clinicians during a consult. This will significantly improve quality of care and reduce wasted search time by clinicians while with a patient who may have complicated symptoms, and provide more quality consult time with the patient improving primary health care for the community. In addition, there should be significant cost reduction in the application of nationally consistent referral pathways vs. State- or PHN-based pathway development.

Status:

• Feasibility for the Clinical Referral Pathways program was completed in January 2024, and the Department of Health and Aged Care has been provided with a copy of the report, which has also been presented to all PHNs.
• A national co-design process was completed, engaging 90+ general practitioners, 25 PHNs, and expert advisory groups to define the functional and regional requirements for a future Clinical Referral Pathways (CRP) platform.
• A Phase 1 prototype was delivered, enabling testing of agreed design principles, wireframes, and capabilities with end users.
• A comprehensive service model, governance framework, and performance requirements were developed to support future implementation and sustainability of a national CRP solution.
• The viability and benefits of the approach have been demonstrated, with presentation of the proposal to move from a Proof-of-Concept phase to a full development and implementation project currently being drafted.
• Any further development will be subject to funding, either by Participating PHNs or approved carryover, in line with updated PHN priorities.

System Integration and Data linkage (In progress, subject to funding carryover)

This project aims to establish and demonstrate the data linkage capabilities and capacity of PHNs when leveraging existing PHN national applications and infrastructure. The Australian health environment is scattered with various systems and technologies driven by various policies, commercial advantages and poor procurement practices. The opportunity to develop methods, technologies and agreements with various interested health entities including State Health organisations, will allow for a more joined up health system. This approach should be led by PHNs to integrate with commercial and government owned systems that will assist and deliver linked data to inform government and the community of a patient's journeys across various health agencies. Automating data linkage will assist in close to real time understanding of the health system allowing government to plan for future cost based on scientific and current evidence.

Status:

• WAPHA have initiated a pilot project with WA Health and Curtin University to establish a data linkage capability between general practice data (extracted using Primary Sense, which can provide LinXmart privacy-preserving linkage keys) and acute care data. The initial evaluation data used was to evaluate a Chronic Heart Failure (CHF) commissioned program.
• The solution developed, called CoNexus, was successfully tested using over 20 million synthetic records, with linkage completed in less than 8 hours for a total processing cost of ~$400, demonstrating both the potential speed and cost efficiency of the approach.
• The WAPHA project team is working closely with the PHN representative on the National Primary & Acute Care Data Linkage Project to ensure that forum is fully informed of the capabilities being developed, and that the CoNexus system is developed in line with the emerging principles and blueprints coming out of that national agenda.
• As the supplier of Primary Sense, WAPHA has also engaged with other commercial and non-commercial providers of data extraction tools to evaluate and provide feedback into API-based integration offerings being developed by general practice software providers, such as the Halo API. This approach is aiming to ensure that industry-wide approaches are being adopted and that the needs of the practitioners and patients – rather than software providers – is made a priority.
• Completion of this project is subject to approved carryover of funds into FY26, otherwise work completed to date will be archived.

Digital and Data Security (Completed)
This project aims to ensure that new or enhanced software tools and systems built within the security and framework of the PHI platform or dependent on PHI that enable more, easier and quicker data-driven collaboration and integration among PHNs, GP Practices and Commissioned Service Providers. Improved cyber security monitoring, integration and standardisation of data collection, analysis and reporting tools will be used by PHNs that leverage PHI.
Status:
• Undertaken in parallel with WAPHA's internal ISO 27001 certification project, this project identified that additional and separate work would be required to ensure that PHI and other national applications and platforms would be properly covered within the scope of that certification.
• PHI-specific ISO 27001 policies have been developed and approved, and have now been incorporated into WAPHA's ISMS system, in preparation for the formal certification audit.
• To ensure ongoing sustainability of the improved cybersecurity posture, a Process Management Framework to ensure that the policies can be effectively complied with by both WAPHA staff and other PHNs is currently being developed.
• To support cybersecurity awareness across the PHN network, the PHI Services Team developed and ran the "Get Cyber Fit" information campaign during October ("International Cyber Security Awareness Month") across the PHN network. This included targeted information and webinars to run through both cyber incident test scenarios and actual cyber incident response activities undertaken by WAPHA as learning opportunities.
• A secure coding framework and standards have been developed by the PHI Services Team, and implemented for all application and platform development activities, including the use of industry standard code scanning tools to ensure that potential vulnerabilities are identified and addressed prior to testing and release.
• A new Quality Assurance Process, that ensures that – among other things – security requirements are properly tested and proven prior to release has been developed and implemented into standard practice within the PHI Services Team.
• Work has commenced to investigate and prepare for the implementation of Microsoft Purview. The insights and findings from this process will also inform the national implementation of this data governance and data cataloguing solution via PHI. Completion of this work has been funded in FY26 by a drawdown on the PHI Future Fund as approved by the PHI Steering Committee.
• A Process Management Framework has been developed and implemented to enable the consistent and effective identification, design, implementation and review of the processes required to operationalise the approved policies.
PHN Performance Reporting Tools (In Progress – dedicated funding for FY26)
This project aims to ensure full implementation of PHOCUS technology within the PHI Platform including change management and support for the adoption of newly developed national performance indicators that has dynamic report (one demand) capability at a PHN level, collaborative level (State by State) or nationally. PHOCUS will reduce the burden placed on PHNs in reporting to the Commonwealth while offering real time access to data at a PHN level or at a national level.
Status:
• The development of PHOCUS was originally funded under a different AWP (CF 5050).
• Following discussions with the Department in early FY25, it was agreed that funding under this AWP would support ongoing support and continued development of the PHOCUS application during FY25.
• PHOCUS was successfully used by all PHNs to complete the FY24 cycle for the Performance Management Reporting Framework (PMRF) and Commonwealth Psychosocial Support (CPS) metric sets.
• Extensive work in collaboration with the Department has been undertaken to implement the reporting of Primary Care Access Program (PCAP), Commonwealth Psychosocial Program (CPS), and more recently the Multidisciplinary Team Care (MDT) program areas under PHOCUS. The Department recognises the value of PHOCUS and the speed at which new metric sets can be rapidly implemented to collect quantitative data, enabling timely and consistent national reporting across multiple program areas.
• Metric sets for implementing both Urgent Care Clinics (UCCs) and ISO 27001 certification have also been implemented to enable the Department to more effectively monitor PHN rollout and progress of these activities.
• Metric sets for Healthy Aged Care Reporting are still under review and development.

• Over 37 enhancements have been designed, developed, tested and deployed to PHOCUS—including automated notifications, data export and upload tools, improved validation and usability features, and expanded data collections—all aimed at meeting Departmental reporting requirements and improving the end-user experience
• Reporting for data from PHOCUS using interactive Power BI dashboards has been developed and published for all metric sets that have been implemented, allowing PHNs and the Department to easily view overall status, as well as comparison against other PHNs (de-identified for the PHN view).
• Additional user support, documentation and training has been undertaken across the PHN network, and with staff from the Department.
• The Department has provided a letter confirming funding for PHOCUS operations for FY26. Future support and enhancement of PHOCUS will be subject to decisions to be made with the Department regarding funding, governance and operations of the application, process and function.

Artificial Intelligence (AI) (In progress, subject to funding carryover)

The project aims to assess the benefit of new software that provides greater access to the use of artificial intelligence tools that also provides real time data and insights to WAPHA, clinicians and commissioned services in relevant clinical settings. AI will also be integrated across various platforms to assist in better decision making by clinicians and PHN's.

Status:

• An AI policy has been developed and implemented as a prerequisite to establish guiding principles and controls for managing risks associated with AI-related initiatives.
• The M365 CoPilot project at WAPHA has progressed from a successful trial to a full enterprise rollout, with a strong focus on productivity, governance, and user enablement.
• A pilot project is currently underway (led by Brisbane South PHN) for providing PHNs with access to Copilot for GitHub, which will enable them to use the full generative AI capabilities of OpenAI to analyse, document, understand and modify software and analytics code faster and at a higher level of quality. This will also significantly improve collaboration and re-use of processes and code across PHNs, enabling staff to incorporate and even modify code shared by other PHNs without requiring the same level of skill or experience in the language used.
• The Microsoft Fabric readiness assessment has been completed, providing the foundational architecture and governance required to support AI-driven transformations.
• Additional work will occur only if carryover of funds are approved for FY26, otherwise any ongoing support or deployment of these capabilities will be subject to PHNs' capacity to fund within existing budgets.

Change Management (Completed)

This project stream aims to ensure that adoption of new technologies, methods, agreements, policies and procedures in a risk adverse environment include appropriate resources to educate, train, test and improve the views and attitudes of various participants in the primary care health system including PHNs, GPs, allied health providers, commission service providers and the community. Moving to a more digital and virtual world is a difficult process and its usually faced with initial resistance before even testing the options. People work in different ways and the community have high expectations when dealing with their digital data. Building confidence takes time and investment to ensure that what is implemented (namely those items listed above) is undertaken robustly building confidence in the health system. A detailed and comprehensive change management and support plan will be developed for each of the initiatives listed above.

Status:

• A comprehensive Change Support Framework has been established, supported by regular communication with PHNs through a variety of channels (dedicated PHI intranet, regular newsletters, targeted emails, surveys, and explanatory videos).
• Change support staff are engaging directly with PHNs adopting or exploring new services to identify and adjust to barriers. Training materials have been developed and hosted within the PHI LMS.
• Each initiative completed or in progress is supported by a Change Management Plan and Change Analysts.

Needs Assessment Priorities

Needs Assessment

WAPHA Needs Assessment 2025-2027

Priorities

Priority	Page reference
Support primary health care providers to implement effective health interventions for those living with overweight and obesity (Metro).	10
Support primary health care providers in managing complex care cases for patients with mental and physical comorbidities (Metro)	10
Support primary health care providers to refer to appropriate mental health services, including telehealth-enabled services (Metro).	9
Enable access to integrated and coordinated care for clients with a mental health condition and harmful alcohol and other drug use (Metro)	36
Support primary health care providers to provide culturally appropriate chronic disease management for Aboriginal people living with chronic disease and build capacity for patient self-mgmt (Metro).	44

Activity Demographics

Target Population Cohort

Australia wide in collaboration with participating PHNs.

Indigenous Specific

No

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

WAPHA & other PHNs will consult with the following in developing and delivering the work plans under this Activity:
• General Practices, through GP Champions, the GP Advisory Panel, and GP users of existing and new digital services
• Commissioned Service Providers
• Professional bodies such as the RACGP
• State Health agencies
• Commonwealth health agencies, including Department of Health and Aged Care, Australian Institute of Health and Welfare and Australian digital Health Agency
• Other PHNs across Australia

Collaboration

WAPHA intends to deliver the outputs and outcomes of this Activity in collaboration with the providers of other systems being integrated with (such as State Health Agencies) as well as with other PHNs (where appropriate).

Activity Milestone Details/Duration

Activity Start Date

06/12/2023

Activity End Date

29/06/2025

Service Delivery Start Date

07/12/2023

Service Delivery End Date

30/06/2025

Other Relevant Milestones

- Clinical Health Pathways feasibility assessment complete by June 2024, with prototype implemented for at least one PHN by June 2025
- Primary Care Portals piloted with at least one PHN (outside of WAPHA) by June 2025
- Data Linkage pilot project commenced by December 2023 and completed by March 2025.
- PHOCUS full adoption and implementation completed by June 2024
- Activity Work Plans Due 30/04/2025
- Twelve Month Performance Report Due 30/09/2025
- Financial Acquittal Reports Due 30/09/2025

Activity Commissioning

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

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

Activity Planned Expenditure

Funding Stream	FY 23 24	FY 24 25	FY 25 26	FY 26 27	FY 27 28	Total
PHN Shared Data Warehouse Primary Health Insights	$4,470,000.00	$2,973,216.01	$0.00	$0.00	$0.00	$7,443,216.01
Total	**$4,470,000.00**	**$2,973,216.01**	**$0.00**	**$0.00**	**$0.00**	**$7,443,216.01**