Gold Coast - Aged Care
2022/23 - 2024/25
Activity Summary View

Contents

AC-EI - 1 - Commissioning early intervention initiatives to support healthy ageing

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-EI

Activity Number *

1

Activity Title *

Commissioning early intervention initiatives to support healthy ageing

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 *

Identified need:
• Recommendations from Royal Commission into Aged Care
• Some older Australians are entering aged care earlier than they may otherwise need to due to a lack of support for healthy ageing or ability to manage their chronic conditions in the community
• Locally, the burden of chronic disease is associated with significant health needs. Key local health needs and services issues formally identified in the 2022 GCPHN Needs Assessment submitted to the Department of Health (see section 3.8 Chronic Disease, page 1) include:
o Limited systems to support care coordination for people with a chronic condition.
o Minimal focus on prevention, early identification, and self-management of chronic disease.
o Rate of potentially preventable hospitalisations in the Gold Coast Primary Health Network region is above the national rate, top conditions included:
o Urinary tract infections
o Iron deficiency anemia
o Chronic obstructive pulmonary disease
o Cellulitis
o Vaccine preventable conditions

• Rate of people in the Gold Coast Primary Health Network region with chronic obstructive pulmonary disease and asthma above the national rate.

A particular sub-group of the senior population on the Gold Coast experience a greater burden of disease and higher premature entry into residential aged care homes. As identified in the 2022 GCPHN Needs Assessment submitted to the Department of Health and Aged Care (see section 3.11 Older People, page 1) the high prevalence of older people with frailty leads to many complex medical problems and is associated with an increased rate of future falls. Therefore, frailty has been identified as a key group to target for healthy ageing interventions because:
• Both frailty and prefrailty are significant predictors of nursing home placement among community-dwelling older adults.
• Frail older people are highly vulnerable to adverse health outcomes when exposed to an internal or external stressor.
• Many of the causes of frailty can be managed and, in some cases reversed to create better health outcomes and quality of life.
The importance of enabling people to play an active role in their health care was emphasised by the Productivity Commission in their report about Innovations in Care for Chronic Health Conditions. They found that better health outcomes are achieved when health care providers consider people's circumstances and preferences, and people are supported to self-manage their health. This requires delivery of advice and support in formats that are accessible and relevant to the consumer.

Aim:
• Implementation of targeted interventions to prevent, identify and reduce chronic disease and health issues, avoid inappropriate hospital admissions, reduce premature entry into residential aged care and improve health outcomes for the elderly.
• Supporting collaborative approaches between multidisciplinary teams and primary care providers.
• Expanding existing healthy ageing programs where relevant.
• Educating primary health care providers on how to connect senior Australians with necessary psychosocial, health, social and welfare supports.
• Educating family members or carers on how to manage an older person's health.

Description of Activity *

Quality improvement in general practice
• Continue to implement a new model of care with a pilot group of general practices with a focus on frailty screening, to support early intervention activities, increased ability to self-manage conditions, access to services at home
• Increase awareness in the local primary health care workforce of the needs of the local senior Australian population, the availability of healthy ageing programs and initiatives in the Gold Coast community and how to connect senior Australians to necessary psychosocial, health, social and welfare supports.
• Facilitate collaborative approach between multidisciplinary teams and primary care providers
• Implementation of a frailty quality improvement toolkit, action plan exemplar and RACGP approved clinical audit

Commissioning of Healthy Ageing program/s
• Commission new, or expand, existing Healthy ageing programs including consideration to upscale existing activities within the network and stimulate the market through a new provider/alternative model of service provision through supervised students.
• Implement monitoring and evaluation standards and capabilities to ensure that commissioned services are effective and efficient and meet the needs of the community using a patient centered outcomes assessment tool

Health promotion and resource development
• Development of referral pathway resources, and provide education and promotion for health professionals to support navigation and easier access to services available for older people
• Provide resources and education to support family members and carers to improve management of older person's health

Needs Assessment Priorities *

Needs Assessment

GCPHN Needs Assessment_2022

Priorities

Priority	Page reference
Chronic Disease	262
Older People	87

Activity Demographics

Target Population Cohort

Older People, primary health care providers, community based NGOs and healthy ageing program providers.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

• GCPHN committees:
o Community Advisory Council (Consumers)
o Primary Health Care Improvement Committee (general practitioners, practice managers, practice nurses, allied health provider)
o Aged and Palliative Care Leadership Group (consumers {including CALD community}, general practitioners, QLD Health and NGO representatives)

• Gold Coast Health – Aged Care Service providers, Health Pathways development team, Chronic Disease programs
• QLD Clinical Excellence Network: Older Persons Health
• Other PHNs
o QLD Aged Care Collaborative

• General practice teams
• GCPHN internal teams:
o Communications
o Events
o Data and reporting
o Digital Health
o Procurement
o Other project team/s interacting with RACHs

• Department of Health – Aged Care
o GC Aged Care Regional Stewardship team

• Community NGO aged care service providers

• Gold Coast City Council – Healthy ageing programs
• Consumer Peak Bodies

Collaboration

All of the above listed in stakeholder engagement consultation

---

Activity Milestone Details/Duration

Activity Start Date

30/11/2021

Activity End Date

29/06/2024

Service Delivery Start Date

July 2022

Service Delivery End Date

N/A

Other Relevant Milestones

Project monitoring and control - service/s establishment & contract management, monthly/quarterly reporting, participation in evaluation activities - July 2023 to June 2024

List of key project delivery milestone/s or decision gate/s - services established, evaluation tools developed and endorsed for service provider/s, referral pathway resources developed and endorsed (consumer and health professionals), education and training activities completed, RACGP audits completed (10 participating general practice), Quality Improvement action plans completed (15 participating general practice).

Project handover to Business-as-usual teams - integrate into primary health care improvement team activities for elements within scope for GCPHN as part of AWP for 2024/25 - June 2024

Project closure - Develop and submit project closure report, service decommissioning plan including maintenance strategy to support long term sustainability of project activities - May to June 2024

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

N/A

Summary of activity changes for Department

Activity Status
Returned

AC-EI - 2 - Operational - Commissioning early intervention initiatives to support healthy ageing

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-EI

Activity Number *

2

Activity Title *

Operational - Commissioning early intervention initiatives to support healthy ageing

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 *

Identified need:
• Recommendations from Royal Commission into Aged Care
• Some older Australians are entering aged care earlier than they may otherwise need to due to a lack of support for healthy ageing or ability to manage their chronic conditions in the community
• Locally, the burden of chronic disease is associated with significant health needs. Key local health needs and services issues formally identified in the 2022 GCPHN Needs Assessment submitted to the Department of Health (see section 3.8 Chronic Disease, page 1) include:
o Limited systems to support care coordination for people with a chronic condition.
o Minimal focus on prevention, early identification, and self-management of chronic disease.
o Rate of potentially preventable hospitalisations in the Gold Coast Primary Health Network region is

above the national rate, top conditions included:
o Urinary tract infections
o Iron deficiency anemia
o Chronic obstructive pulmonary disease
o Cellulitis
o Vaccine preventable conditions

• Rate of people in the Gold Coast Primary Health Network region with chronic obstructive pulmonary disease and asthma above the national rate.

A particular sub-group of the senior population on the Gold Coast experience a greater burden of disease and higher premature entry into residential aged care homes. As identified in the 2022 GCPHN Needs Assessment submitted to the Department of Health and Aged Care (see section 3.11 Older People, page 1) the high prevalence of older people with frailty leads to many complex medical problems and is associated with an increased rate of future falls. Therefore, frailty has been identified as a key group to target for healthy ageing interventions because:
• Both frailty and prefrailty are significant predictors of nursing home placement among community-dwelling older adults.
• Frail older people are highly vulnerable to adverse health outcomes when exposed to an internal or external stressor.
• Many of the causes of frailty can be managed and, in some cases reversed to create better health outcomes and quality of life.
The importance of enabling people to play an active role in their health care was emphasised by the Productivity Commission in their report about Innovations in Care for Chronic Health Conditions. They found that better health outcomes are achieved when health care providers consider people's circumstances and preferences, and people are supported to self-manage their health. This requires delivery of advice and support in formats that are accessible and relevant to the consumer.

Aim:
• Implementation of targeted interventions to prevent, identify and reduce chronic disease and health issues, avoid inappropriate hospital admissions, reduce premature entry into residential aged care and improve health outcomes for the elderly.
• Supporting collaborative approaches between multidisciplinary teams and primary care providers.
• Expanding existing healthy ageing programs where relevant.
• Educating primary health care providers on how to connect senior Australians with necessary psychosocial, health, social and welfare supports.
• Educating family members or carers on how to manage an older person's health.

Description of Activity *

Quality improvement in general practice
• Continue to implement a new model of care with a pilot group of general practices with a focus on frailty screening, to support early intervention activities, increased ability to self-manage conditions, access to services at home
• Increase awareness in the local primary health care workforce of the needs of the local senior Australian
population, the availability of healthy ageing programs and initiatives in the Gold Coast community and how to connect senior Australians to necessary psychosocial, health, social and welfare supports.
• Facilitate collaborative approach between multidisciplinary teams and primary care providers
• Implementation of a frailty quality improvement toolkit, action plan exemplar and RACGP approved clinical audit

Commissioning of Healthy Ageing program/s
• Commission new, or expand, existing Healthy ageing programs including consideration to upscale

existing activities within the network and stimulate the market through a new provider/alternative model of service provision through supervised students.
• Implement monitoring and evaluation standards and capabilities to ensure that commissioned services are
effective and efficient and meet the needs of the community using a patient centered outcomes assessment tool

Health promotion and resource development
• Development of referral pathway resources, and provide education and promotion for health professionals to support navigation and easier access to services available for older people
• Provide resources and education to support family members and carers to improve management of older person's health

Needs Assessment Priorities *

Needs Assessment

GCPHN Needs Assessment_2022

Priorities

Priority	Page reference
Chronic Disease	262
Older People	87

Activity Demographics

Target Population Cohort

Older People, primary health care providers, community based NGOs and healthy ageing program providers.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

• GCPHN committees:
o Community Advisory Council (Consumers)
o Primary Health Care Improvement Committee (general practitioners, practice managers, practice nurses, allied health provider)
o Aged and Palliative Care Leadership Group (consumers {including CALD community}, general practitioners, QLD Health and NGO representatives)

• Gold Coast Health – Aged Care Service providers, Health Pathways development team, Chronic Disease programs
• QLD Clinical Excellence Network: Older Persons Health
• Other PHNs
o QLD Aged Care Collaborative

• General practice teams
• GCPHN internal teams:
o Communications
o Events
o Data and reporting
o Digital Health
o Procurement
o Other project team/s interacting with RACHs

• Department of Health – Aged Care
o GC Aged Care Regional Stewardship team

• Community NGO aged care service providers
• Gold Coast City Council – Healthy ageing programs
• Consumer Peak Bodies

Collaboration

All of the above listed in stakeholder engagement consultation

---

Activity Milestone Details/Duration

Activity Start Date

30/11/2021

Activity End Date

29/06/2024

Service Delivery Start Date

July 2022

Service Delivery End Date

N/A

Other Relevant Milestones

Project monitoring and control - service/s establishment & contract management, monthly/quarterly reporting, participation in evaluation activities - July 2023 to June 2024

List of key project delivery milestone/s or decision gate/s - services established, evaluation tools developed and endorsed for service provider/s, referral pathway resources developed and endorsed (consumer and health professionals), education and training activities completed, RACGP audits completed (10 participating general practice), Quality Improvement action plans completed (15 participating general practice).

Project handover to Business-as-usual teams - integrate into primary health care improvement team activities for elements within scope for GCPHN as part of AWP for 2024/25 - June 2024

Project closure - Develop and submit project closure report, service decommissioning plan including maintenance strategy to support long term sustainability of project activities - May to June 2024

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

N/A

Summary of activity changes for Department

Activity Status

Returned

AC-VARACF - 1 - Support RACHs to increase availability and use of telehealth care for aged care residents

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-VARACF

Activity Number *

1

Activity Title *

Support RACHs to increase availability and use of telehealth care for aged care residents

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 *

Identified need:
• Timely access to primary health care professionals, whether through face-to-face consultation or telehealth, is recognised as an issue for many RACHs, that in some cases can lead to potentially preventable hospitalisations. RACHs require adequate telehealth facilities to support access to virtual consultations for their residents
• Recommendations from Royal Commission into Aged Care

Aim:
• Participating RACHs have access to appropriate telehealth facilities and equipment to enable their residents to virtually consult, when needed, with their primary health care professionals, specialists and other clinicians. The facilities and equipment provided should be compatible with most existing virtual consult technology used by providers in GCPHN region and complies with recognised telehealth standards.
• Participating RACH staff are appropriately trained to build their capability to enhance access to virtual consultations for their residents
• Primary care providers who service RACHs are provided education and training opportunities to ensure residents usual providers have knowledge and capabilities to support quality virtual care.
• RACHs are encouraged to increase their use of My Health Record, to improve the availability and secure transfer of resident's health care information between RACH, primary care and acute care settings.

Description of Activity *

Telehealth education and training – RACHs and Primary Care Providers who service RACHs
• Engagement and consulation with RACH staff and primary care providers who service residents in RACHs in the development of appropriate training and education solutions that will support high quality virtual care.
• Support the development, promotion and implementation of national standardised PHN telehealth online learning platform for residential aged care.
• Contract suitable provider to deliver/facilitate local education and training workshop events for RACH staff and primary care providers in clinical tools and skills required to support high quality virtual care in residential aged care setting.
• Promote learning opportunities for RACHs relating to My Health Record, and encourage use

Grant program – RACH telehealth equipment and technology
• Support and engage with RACHs to finalise grant acquittal requirements
• Evaluation of pre/post baseline surveys from RACH to assess change in use of technology and staff capabilities to support high quality virtual care

Broad stakeholder engagement with:
• GCPHN's key advisory groups (i.e. Consumer Advisory Council, Primary Health Care Improvement Committee, Clinical Council and Primary Care Partnership Council)
• RACHs (approach will be to engage executive level support where possible)
• General practice (in particular those that provide services to RACHs residents)
• PHNs in QLD and nationally where appropriate to ensure synergies of scale in shared learning and project development activities
• Relevant peak bodies (including consumer advocacy groups)
• Gold Coast Health
• Australian Digital Health Agency

Needs Assessment Priorities *

Needs Assessment

GCPHN Needs Assessment_2022

Priorities

Priority	Page reference
Older People	87

Activity Demographics

Target Population Cohort

Residents living in RACHs; staff working in RACHs; primary care providers who support residents in RACHs

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

• GCPHN committees:
o Community Advisory Council (Consumers)
o Primary Health Care Improvement Committee (general practitioners, practice managers, practice nurses, allied health provider)
o Aged and Palliative Care Leadership Group (consumers {including CALD community}, general practitioners, QLD Health and NGO representatives)

• Gold Coast Health – Aged Care Service providers, SPACE project team and Digital Health

transformation team
• Wound Management Pilot in RACHs - Service provider for project
• Australian Digital Health Agency
• Other PHNs
o QLD Aged Care Collaborative
• RACH executives and staff
• GCPHN internal teams:
o Communications
o Events
o Data and reporting
o Digital Health
o Procurement
o Other project team/s interacting with RACHs
• Department of Health – Aged Care
o GC Aged Care Regional Stewardship team
• Consumer Peak Bodies

Collaboration

All of the above listed in stakeholder engagement consultation

---

Activity Milestone Details/Duration

Activity Start Date

30/11/2021

Activity End Date

29/06/2024

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Project monitoring and control – Local education and training workshop, launch of national PHN online learning telehealth platform for RACHs, monthly and quarterly reports, participation in any evaluation activities – July 2023 to March 2024.

Project closure - Project completion report, policy and procedure manual for telehealth and MHR use in RACHs - April to June 2024

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

No

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

Yes

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

It is proposed that GCPHN will work collaboratively with QLD PHNs to design and commission identified requirements to support project implementation.
GCPHN will work with Tasmania and Victorian PHNs to develop and implement the National training platform for RACH staff.

Summary of activity changes for Department

Activity Status

Returned

AC-VARACF - 2 - Operational-Support RACHs to increase availability & use of telehealth care for aged care residents

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-VARACF

Activity Number *

2

Activity Title *

Operational-Support RACHs to increase availability & use of telehealth care for aged care residents

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 *

Identified need:
• Timely access to primary health care professionals, whether through face-to-face consultation or telehealth, is recognised as an issue for many RACHs, that in some cases can lead to potentially preventable hospitalisations. RACHs require adequate telehealth facilities to support access to virtual consultations for their residents
• Recommendations from Royal Commission into Aged Care

Aim:
• Participating RACHs have access to appropriate telehealth facilities and equipment to enable their residents to virtually consult, when needed, with their primary health care professionals, specialists

and other clinicians. The facilities and equipment provided should be compatible with most existing virtual consult technology used by providers in GCPHN region and complies with recognised telehealth standards.
• Participating RACH staff are appropriately trained to build their capability to enhance access to virtual consultations for their residents
• Primary care providers who service RACHs are provided education and training opportunities to ensure residents usual providers have knowledge and capabilities to support quality virtual care.
• RACHs are encouraged to increase their use of My Health Record, to improve the availability and secure transfer of resident's health care information between RACH, primary care and acute care settings.

Description of Activity *

Telehealth education and training – RACHs and Primary Care Providers who service RACHs
• Engagement and consulation with RACH staff and primary care providers who service residents in RACHs in the development of appropriate training and education solutions that will support high quality virtual care.
• Support the development, promotion and implementation of national standardised PHN telehealth online learning platform for residential aged care.
• Contract suitable provider to deliver/facilitate local education and training workshop events for RACH staff and primary care providers in clinical tools and skills required to support high quality virtual care in residential aged care setting.
• Promote learning opportunities for RACHs relating to My Health Record, and encourage use

Grant program – RACH telehealth equipment and technology
• Support and engage with RACHs to finalise grant acquittal requirements
• Evaluation of pre/post baseline surveys from RACH to assess change in use of technology and staff capabilities to support high quality virtual care

Broad stakeholder engagement with:
• GCPHN's key advisory groups (i.e. Consumer Advisory Council, Primary Health Care Improvement Committee, Clinical Council and Primary Care Partnership Council)
• RACHs (approach will be to engage executive level support where possible)
• General practice (in particular those that provide services to RACHs residents)
• PHNs in QLD and nationally where appropriate to ensure synergies of scale in shared learning and project development activities
• Relevant peak bodies (including consumer advocacy groups)
• Gold Coast Health
• Australian Digital Health Agency

Needs Assessment Priorities *

Needs Assessment

GCPHN Needs Assessment_2022

Priorities

Priority	Page reference
Older People	87

Activity Demographics

Target Population Cohort

Residents living in RACHs; staff working in RACHs; primary care providers who support residents in RACHs

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

• GCPHN committees:
o Community Advisory Council (Consumers)
o Primary Health Care Improvement Committee (general practitioners, practice managers, practice nurses, allied health provider)
o Aged and Palliative Care Leadership Group (consumers {including CALD community}, general practitioners, QLD Health and NGO representatives)

• Gold Coast Health – Aged Care Service providers, SPACE project team and Digital Health transformation team
• Wound Management Pilot in RACHs - Service provider for project
• Australian Digital Health Agency
• Other PHNs
o QLD Aged Care Collaborative
• RACH executives and staff
• GCPHN internal teams:
o Communications
o Events
o Data and reporting
o Digital Health
o Procurement

o Other project team/s interacting with RACHs
• Department of Health – Aged Care
o GC Aged Care Regional Stewardship team
• Consumer Peak Bodies

Collaboration

All of the above listed in stakeholder engagement consultation

---

Activity Milestone Details/Duration

Activity Start Date

30/11/2021

Activity End Date

29/06/2024

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Project monitoring and control – Local education and training workshop, launch of national PHN online learning telehealth platform for RACHs, monthly and quarterly reports, participation in any evaluation activities – July 2023 to March 2024.

Project closure - Project completion report, policy and procedure manual for telehealth and MHR use in RACHs - April to June 2024

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

No

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

Yes

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

It is proposed that GCPHN will work collaboratively with QLD PHNs to design and commission identified requirements to support project implementation.
GCPHN will work with Tasmania and Victorian PHNs to develop and implement the National training platform for RACH staff.

Summary of activity changes for Department

Activity Status

Returned

AC-AHARACF - 1 - Enhanced out of hours residential aged care

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-AHARACF

Activity Number *

1

Activity Title *

Enhanced out of hours residential aged care

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

Identified need:
• RACH residents can experience deterioration in their health during the after-hours period, but immediate transfer to hospital is not always clinically necessary. Lack of awareness and utilisation of out of hours services provided by GPs and other health professionals, including Gold Coast Health services, leads residents to unnecessary hospital presentations. RACH staff confidence and experience is often lower in after hours period.
• Recommendations from Royal Commission into Aged Care

Aim:
• Participating RACHs:
o will be able to develop, maintain and implement after-hours processes and management plans, in line with residents' wishes

o will be aware of after-hours health care options and referral pathways and utilise these when appropriate
o will develop and embed procedures to ensure residents' digital medical records are kept up to date, particularly where an after-hours episode of care occurs to support appropriate clinical handover and continuity of care
o will work collaboratively with their resident's GPs, and other health care professionals, to develop/review and update after-hours action plans as required

Description of Activity *

In partnership with Gold Coast Health Residential Aged Care Support Service
• Identify RACHs who have higher rates of ED transfer in after-hours space and engage with these facilities to encourage participation in activity
• Assess participating RACH staff baseline level of knowledge of after-hours care options and current management plan development status
• Engagement with participating RACHs, after hours service providers, and other key stakeholders to support project activities and enhance after hours processes
• Scope availability of appropriate after- hours management plan resources, templates and organisational procedures, to embed and sustain this process
• Identify enablers and barriers to develop after-hours management plans and potential solutions
• Provide education and training opportunities through one-on-one mentoring and/or group workshops to increase RACH capability in navigating after-hours care options and management.
• Support the development of best practice after-hours management plan/processes template as a legacy of this project
• Promote completion of Advance Care Plans for all residents of RACHs, and ensure they are uploaded and accessible via The Viewer.

Needs Assessment Priorities *

Needs Assessment

GCPHN Needs Assessment_2022

Priorities

Priority	Page reference
After hours	156
Older People	87

Activity Demographics

Target Population Cohort

Residents living in RACHs; staff working in RACHs, general practitioners, after hours service providers, Gold Coast Health, Queensland Ambulance Service

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

• GCPHN committees:
o Community Advisory Council (Consumers)
o Primary Health Care Improvement Committee (general practitioners, practice managers, practice nurses, allied health provider)
o Aged and Palliative Care Leadership Group (consumers {including CALD community}, general practitioners, QLD Health and NGO representatives)

• Gold Coast Health – Aged Care Service providers, SPACE project team and Digital Health transformation team
• Australian Digital Health Agency
• Other PHNs
o QLD Aged Care Collaborative

• RACH executives and staff
• GCPHN internal teams:
o Communications
o Events
o Data and reporting
o Digital Health
o Procurement
o Other project team/s interacting with RACHs

• Department of Health – Aged Care
o GC Aged Care Regional Stewardship team

• Consumers and relevant Peak Bodies
• General practices/practitioners that service RACH residents
• Queensland Ambulance
• After Hours medical service providers

Collaboration

All of the above listed in stakeholder engagement consultation

---

Activity Milestone Details/Duration

Activity Start Date

30/11/2021

Activity End Date

29/06/2024

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Monthly and quarterly reports, development of best practice after hours care plan template and resources, participation in any evaluation activities for RACH pre/post participation – July 2023 to June 2024

Project completion report on Enhance out of hours residential aged care - April to June 2024

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

N/A

Summary of activity changes for Department

Activity Status

Returned

AC-CF - 1 - Care Finder Program

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-CF

Activity Number *

1

Activity Title *

Care Finder Program

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 *

This activity forms part of the Australian Government's response to recommendations made by the Royal Commission into Aged Care Quality and Safety. Accessing and navigating the My Aged Care platform is complex for senior Australians, in particular those without appropriate support, impaired cognition, language barriers or fearful of government organisations. The Care Finder Program will provide intensive support, complementing other services being implemented in the Connecting senior Australians to aged care services measure.

Aims and outcomes:
• commission care finder services that provide specialist and intensive assistance to help people in the target population to understand and access aged care services and connect with other relevant supports in the community.
• The program will improve outcomes for people in the care finder target population including:
o improved coordination of support when seeking access to aged care

o improved understanding of aged care services and how to access them
o improved openness or willingness to engage with the aged care system
o increased rates of access to aged care services and connections to other relevant services
• Increased care finder workforce capability to meet client needs
• Improve integration between the health and aged care systems at the local level within the context of the care finder program

Overarching aim of GCPHN activities is to:
• Continue to gain a better understanding of the local needs in relation to care finder support by engagement with commissioned service providers and relevant stakeholders
• Support the commissioned care finder providers to provide specialist and intensive assistance in understanding and accessing aged care by promoting the service to local stakeholders
• Monitor implementation of the program and identification of opportunities for quality improvement
• Support the development, and maintenance of a community of practice with commissioned service providers to ensure local needs are met and emerging needs identified

Description of Activity *

• Monitor, support and manage the 3 care finder service providers contracted by GCPHN to ensure contractual obligations are met, including completion of required training and reporting
• Ensure care finder providers service delivery is available for the whole of the Gold Coast region as indicated in contracts
• Monitor target groups being serviced to ensure priority groups are being serviced
• Ensure providers complete extensive outreach activities to support identification of target population groups and monitor emerging needs of the region
• Work closely with other PHNs to identify where joint activities in the program will support efficiencies and collaboration and identification and monitoring of cross border referrals and impact on outcomes
• Participate in and monitor data collection by commissioned service providers to support national evaluation
• Support and promote continuous quality improvement of the care finder program
• Support improved integration of the care finder program between health, aged care and other systems by inclusion in locally developed Aged Care clinical referral pathways and establishment of a community of practice

Needs Assessment Priorities *

Needs Assessment

GCPHN Needs Assessment_2022

Priorities

Priority	Page reference
Chronic Disease	262
Mental health - underserviced population groups	425
Older People	87

Activity Demographics

Target Population Cohort

People who are eligible for aged care services and have one or more reasons for requiring intensive support to:
• interact with My Aged Care and access aged care services and/or
• access other relevant supports in the community

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

For the needs assessment stakeholders were identified and stratified. Key stakeholders were directly approached through meetings, video and telephone calls to inform target cohort, geographic areas of higher need, workforce and integration issues as part of the development of the needs assessment. These included:
• GCPHN committees:
o Community Advisory Council (Consumers)
o Primary Health Care Improvement Committee (members consist of general practitioners, practice managers, practice nurses, allied health provider)
o Aged and Palliative Care Leadership Group (consumers {including CALD community}, general practitioners, QLD Health and NGO representatives, Aboriginal and Torres Strait Islander organisation)
o Clinical Council
o Primary Care Partnership Council (primary health care organisations, Gold Coast Health)
o ACH providers
o First Nations and CALD service providers
o Housing and homelessness services
o Gold Coast Health
o City of Gold Coast

o Gold Coast Aged Care Regional Stewardship team (Michele McLauglin and team members)

In addition, a survey was distributed to stakeholders including other identified stakeholders such as:
• Community centers
• Community service providers
• Churches
• Peak bodies

Collaboration

All stakeholders in Collaboration section

GCPHN continues to participate in a NT/QLD PHN collaborative care finder working group to support information sharing to improve efficiency of the program delivery by sharing learnings, resources and strategies for quality improvement. These meetings also provided the opportunity for key stakeholders to engage efficiently with a group of PHNs, instead of individually.

Ongoing discussions with bordering PHNs (Brisbane South and North Coast) will be conducted to identify where cross-border referrals may occur and strategies to ensure client choice is respected irrespective of state, PHN or local government or other boundaries. These conversations will continue throughout implementation.

Ongoing collaboration with the three commissioned care finder organisations for the Gold Coast to refine service model and on-referring when appropriate.

Maintain and support a collaborative community of practice and effective engagement with potential referrers under the care finder implementation.

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/09/2025

Service Delivery Start Date

01/01/2023

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Quarterly providers meeting October, January, April and July each year
Quarterly Community of practice meetings – dates to be determined.

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

Summary of activity changes for Department

Activity Status

Returned

AC-AHARACF - 2 - Operational - Enhanced out of hours residential aged care

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-AHARACF

Activity Number *

2

Activity Title *

Operational - Enhanced out of hours residential aged care

Existing, Modified or New Activity *

Modified

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

Identified need:
• RACH residents can experience deterioration in their health during the after-hours period, but immediate transfer to hospital is not always clinically necessary. Lack of awareness and utilisation of out of hours services provided by GPs and other health professionals, including Gold Coast Health services, leads residents to unnecessary hospital presentations. RACH staff confidence and experience is often lower in after hours period.
• Recommendations from Royal Commission into Aged Care

Aim:
• Participating RACHs:
o will be able to develop, maintain and implement after-hours processes and management plans, in line with residents' wishes

o will be aware of after-hours health care options and referral pathways and utilise these when appropriate
o will develop and embed procedures to ensure residents' digital medical records are kept up to date, particularly where an after-hours episode of care occurs to support appropriate clinical handover and continuity of care
o will work collaboratively with their resident's GPs, and other health care professionals, to develop/review and update after-hours action plans as required

Description of Activity *

In partnership with Gold Coast Health Residential Aged Care Support Service
• Identify RACHs who have higher rates of ED transfer in after-hours space and engage with these facilities to encourage participation in activity
• Assess participating RACH staff baseline level of knowledge of after-hours care options and current management plan development status
• Engagement with participating RACHs, after hours service providers, and other key stakeholders to support project activities and enhance after hours processes
• Scope availability of appropriate after- hours management plan resources, templates and organisational procedures, to embed and sustain this process
• Identify enablers and barriers to develop after-hours management plans and potential solutions
• Provide education and training opportunities through one-on-one mentoring and/or group workshops to increase RACH capability in navigating after-hours care options and management.
• Support the development of best practice after-hours management plan/processes template as a legacy of this project
• Promote completion of Advance Care Plans for all residents of RACHs, and ensure they are uploaded and accessible via The Viewer.

Needs Assessment Priorities *

Needs Assessment

GCPHN Needs Assessment_2022

Priorities

Priority	Page reference
After hours	156
Older People	87

Activity Demographics

Target Population Cohort

Residents living in RACHs; staff working in RACHs, general practitioners, after hours service providers, Gold Coast Health, Queensland Ambulance Service

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

• GCPHN committees:
o Community Advisory Council (Consumers)
o Primary Health Care Improvement Committee (general practitioners, practice managers, practice nurses, allied health provider)
o Aged and Palliative Care Leadership Group (consumers {including CALD community}, general practitioners, QLD Health and NGO representatives)

• Gold Coast Health – Aged Care Service providers, SPACE project team and Digital Health transformation team
• Australian Digital Health Agency
• Other PHNs
o QLD Aged Care Collaborative

• RACH executives and staff
• GCPHN internal teams:
o Communications
o Events
o Data and reporting
o Digital Health
o Procurement
o Other project team/s interacting with RACHs

• Department of Health – Aged Care
o GC Aged Care Regional Stewardship team

• Consumers and relevant Peak Bodies
• General practices/practitioners that service RACH residents
• Queensland Ambulance
• After Hours medical service providers

Collaboration

All of the above listed in stakeholder engagement consultation

---

Activity Milestone Details/Duration

Activity Start Date

30/11/2021

Activity End Date

29/06/2024

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Monthly and quarterly reports, development of best practice after hours care plan template and resources, participation in any evaluation activities for RACH pre/post participation – July 2023 to June 2024

Project completion report on Enhance out of hours residential aged care - April to June 2024

Activity Commissioning

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

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

Is this activity being co-designed?

Yes

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

N/A

Co-design or co-commissioning comments

N/A

Summary of activity changes for Department

Activity Status

Returned

AC-CF - 2 - Care Finder ACH Transition

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-CF

Activity Number *

2

Activity Title *

Care Finder ACH Transition

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 *

This activity forms part of the Australian Government's response to recommendations made by the Royal Commission into Aged Care Quality and Safety. Accessing and navigating the My Aged Care platform is complex for senior Australians, in particular those without appropriate support, impaired cognition, language barriers or fearful of government organisations. The Care Finder Program will provide intensive support, complementing other services being implemented in the Connecting senior Australians to aged care services measure.

Aims and outcomes:
• commission care finder services that provide specialist and intensive assistance to help people in the target population to understand and access aged care services and connect with other relevant supports in the community.
• The program will improve outcomes for people in the care finder target population including:
o improved coordination of support when seeking access to aged care

o improved understanding of aged care services and how to access them
o improved openness or willingness to engage with the aged care system
o increased rates of access to aged care services and connections to other relevant services
• Increased care finder workforce capability to meet client needs
• Improve integration between the health and aged care systems at the local level within the context of the care finder program

Overarching aim of GCPHN activities is to:
• Continue to gain a better understanding of the local needs in relation to care finder support by engagement with commissioned service providers and relevant stakeholders
• Support the commissioned care finder providers to provide specialist and intensive assistance in understanding and accessing aged care by promoting the service to local stakeholders
• Monitor implementation of the program and identification of opportunities for quality improvement
• Support the development, and maintenance of a community of practice with commissioned service providers to ensure local needs are met and emerging needs identified

Description of Activity *

• Monitor, support and manage the 3 care finder service providers contracted by GCPHN to ensure contractual obligations are met, including completion of required training and reporting
• Ensure care finder providers service delivery is available for the whole of the Gold Coast region as indicated in contracts
• Monitor target groups being serviced to ensure priority groups are being serviced
• Ensure providers complete extensive outreach activities to support identification of target population groups and monitor emerging needs of the region
• Work closely with other PHNs to identify where joint activities in the program will support efficiencies and collaboration and identification and monitoring of cross border referrals and impact on outcomes
• Participate in and monitor data collection by commissioned service providers to support national evaluation
• Support and promote continuous quality improvement of the care finder program
• Support improved integration of the care finder program between health, aged care and other systems by inclusion in locally developed Aged Care clinical referral pathways and establishment of a community of practice

Needs Assessment Priorities *

Needs Assessment

GCPHN Needs Assessment_2022

Priorities

Priority	Page reference
Chronic Disease	262
Mental health - underserviced population groups	425
Older People	87

Activity Demographics

Target Population Cohort

People who are eligible for aged care services and have one or more reasons for requiring intensive support to:
• interact with My Aged Care and access aged care services and/or
• access other relevant supports in the community

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

For the needs assessment stakeholders were identified and stratified. Key stakeholders were directly approached through meetings, video and telephone calls to inform target cohort, geographic areas of higher need, workforce and integration issues as part of the development of the needs assessment. These included:
• GCPHN committees:
o Community Advisory Council (Consumers)
o Primary Health Care Improvement Committee (members consist of general practitioners, practice managers, practice nurses, allied health provider)
o Aged and Palliative Care Leadership Group (consumers {including CALD community}, general practitioners, QLD Health and NGO representatives, Aboriginal and Torres Strait Islander organisation)
o Clinical Council
o Primary Care Partnership Council (primary health care organisations, Gold Coast Health)
o ACH providers
o First Nations and CALD service providers
o Housing and homelessness services
o Gold Coast Health
o City of Gold Coast

o Gold Coast Aged Care Regional Stewardship team (Michele McLauglin and team members)

In addition, a survey was distributed to stakeholders including other identified stakeholders such as:
• Community centers
• Community service providers
• Churches
• Peak bodies

Collaboration

All stakeholders in Collaboration section

GCPHN continues to participate in a NT/QLD PHN collaborative care finder working group to support information sharing to improve efficiency of the program delivery by sharing learnings, resources and strategies for quality improvement. These meetings also provided the opportunity for key stakeholders to engage efficiently with a group of PHNs, instead of individually.

Ongoing discussions with bordering PHNs (Brisbane South and North Coast) will be conducted to identify where cross-border referrals may occur and strategies to ensure client choice is respected irrespective of state, PHN or local government or other boundaries. These conversations will continue throughout implementation.

Ongoing collaboration with the three commissioned care finder organisations for the Gold Coast to refine service model and on-referring when appropriate.

Maintain and support a collaborative community of practice and effective engagement with potential referrers under the care finder implementation.

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/09/2025

Service Delivery Start Date

01/01/2023

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Quarterly providers meeting October, January, April and July each year
Quarterly Community of practice meetings – dates to be determined.

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

Summary of activity changes for Department

Activity Status

Returned

AC-CF - 3 - Operational - Care Finder Program

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-CF

Activity Number *

3

Activity Title *

Operational - Care Finder Program

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 *

This activity forms part of the Australian Government's response to recommendations made by the Royal Commission into Aged Care Quality and Safety. Accessing and navigating the My Aged Care platform is complex for senior Australians, in particular those without appropriate support, impaired cognition, language barriers or fearful of government organisations. The Care Finder Program will provide intensive support, complementing other services being implemented in the Connecting senior Australians to aged care services measure.

Aims and outcomes:
• commission care finder services that provide specialist and intensive assistance to help people in the target population to understand and access aged care services and connect with other relevant supports in the community.
• The program will improve outcomes for people in the care finder target population including:
o improved coordination of support when seeking access to aged care

o improved understanding of aged care services and how to access them
o improved openness or willingness to engage with the aged care system
o increased rates of access to aged care services and connections to other relevant services
• Increased care finder workforce capability to meet client needs
• Improve integration between the health and aged care systems at the local level within the context of the care finder program

Overarching aim of GCPHN activities is to:
• Continue to gain a better understanding of the local needs in relation to care finder support by engagement with commissioned service providers and relevant stakeholders
• Support the commissioned care finder providers to provide specialist and intensive assistance in understanding and accessing aged care by promoting the service to local stakeholders
• Monitor implementation of the program and identification of opportunities for quality improvement
Support the development, and maintenance of a community of practice with commissioned service providers to ensure local needs are met and emerging needs identified

Description of Activity *

• Monitor, support and manage the 3 care finder service providers contracted by GCPHN to ensure contractual obligations are met, including completion of required training and reporting
Ensure care finder providers service delivery is available for the whole of the Gold Coast region as indicated in contracts
Monitor target groups being serviced to ensure priority groups are being serviced
Ensure providers complete extensive outreach activities to support identification of target population groups and monitor emerging needs of the region

• Work closely with other PHNs to identify where joint activities in the program will support efficiencies and collaboration and
identification and monitoring of cross border referrals and impact on outcomes
• Participate in and monitor data collection by commissioned service providers to support national evaluation
• Support and promote continuous quality improvement of the care finder program
• Support improved integration of the care finder program between health, aged care and other systems by inclusion in locally developed Aged Care clinical referral pathways and establishment of a community of practice

Needs Assessment Priorities *

Needs Assessment

GCPHN Needs Assessment_2022

Priorities

Priority	Page reference
Chronic Disease	262
Mental health - underserviced population groups	425
Older People	87

Activity Demographics

Target Population Cohort

People who are eligible for aged care services and have one or more reasons for requiring intensive support to:
• interact with My Aged Care and access aged care services and/or
• access other relevant supports in the community

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

For the needs assessment stakeholders were identified and stratified. Key stakeholders were directly approached through meetings, video and telephone calls to inform target cohort, geographic areas of higher need, workforce and integration issues as part of the development of the needs assessment. These included:
• GCPHN committees:
o Community Advisory Council (Consumers)
o Primary Health Care Improvement Committee (members consist of general practitioners, practice managers, practice nurses, allied health provider)
o Aged and Palliative Care Leadership Group (consumers {including CALD community}, general practitioners, QLD Health and NGO representatives, Aboriginal and Torres Strait Islander organisation)
o Clinical Council
o Primary Care Partnership Council (primary health care organisations, Gold Coast Health)
o ACH providers
o First Nations and CALD service providers
o Housing and homelessness services
o Gold Coast Health
o City of Gold Coast

o Gold Coast Aged Care Regional Stewardship team (Michele McLauglin and team members)

In addition, a survey was distributed to stakeholders including other identified stakeholders such as:
• Community centres
• Community service providers
• Churches
• Peak bodies

Collaboration

All stakeholders in Collaboration section

GCPHN continues to participates in a NT/Qld PHN collaborative care finder working group to support information sharing to improve efficiency of the program delivery by sharing learnings, resources and strategies for quality improvement. . These meetings also provided the opportunity for key stakeholders to engage efficiently with a group of PHNs, instead of individually.

Ongoing discussions with bordering PHNs (Brisbane South and North Coast) will be conducted to identify where cross-border referrals may occur and strategies to ensure client choice is respected irrespective of state, PHN or local government or other boundaries. These conversations will continue throughout implementation.

Ongoing collaboration with the three commissioned care finder organisations for the Gold Coast to refine service model and on-referring when appropriate.

Maintian and support a collaborative community of practice and effective engagement with potential referrers under the care finder implementation.

Activity Milestone Details/Duration

Activity Start Date

30/06/2022

Activity End Date

29/09/2025

Service Delivery Start Date

01/01/2023

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Quarterly providers meeting October, January, April and July each year
Quarterly Community of practice meetings – dates to be determined.

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

Summary of activity changes for Department

Activity Status

Returned