North Western Melbourne - Aged Care
2023/24 - 2027/28
Activity Summary View

AC-OSP - 1 - Aged Care On-site Pharmacist Measure 25/26

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-OSP

Activity Number *

1

Activity Title *

Aged Care On-site Pharmacist Measure 25/26

Existing, Modified or New Activity *

New Activity

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

The ACOP Measure aims to:
• improve medication use and safety in RACHs, including safe and appropriate use of high-risk medications
• provide continuity in medication management, such as day-to-day reviews of medications and quick issue resolution
• provide easy access to pharmacist advice for residents and staff
• integrate on-site pharmacists with the health care team, including local general practitioners, nurses and the community pharmacy
• increase understanding of and response to individual resident needs.

Description of Activity *

NWMPHN will promote awareness and uptake of the ACOP measure by RACHs and credentialed pharmacists. Activities will include:
• Engage with stakeholders including residential aged care homes, pharmacy peak bodies, GPs, ACCHOs to understand the barriers and opportunities to inform program uptake.
• Run an environmental scan of eligible RACH investigating interest in participation of the ACOP measure
• Identify RACH requiring assistance to take up ACOP measure
• Coordinate information to RACHs in the PHN's region about the ACOP Measure
• Manage requests for support from RACHs seeking to engage eligible pharmacists to work on-site
• Identify eligible pharmacists who are available to work on-site in RACHs as part of the measure
• Assist RACH already participating in the ACOP measure with their understanding of the measure and avenues for further assistance
• Utilize the connections of the PHN to support engagement between RACHs, their pharmacists employed under the Measure, their residents' general practitioners and other relevant health professionals.

NWMPHN will continue to collect data to inform the local implementation and development of processes to facilitate uptake of the measure. We will monitor, evaluate and improve the resources following implementation to ensure ongoing effectiveness and impact. Where feasible we will collaborate with our Victorian PHN partners on this activity to enhance efficiency and promote consistency across the state.

Needs Assessment Priorities *

Needs Assessment

NWMPHN Needs Assessment 2024-2028

Priorities

Priority	Page reference
Health conditions-Increase access and coordinated care with culturally aware/diverse providers for people from diverse backgrounds with chronic conditions, while building GP capability and MDC (4.2.9)	186
Aged care - Change model of service delivery in light of primary care reforms to meet demand of older adults requiring health care (2.1.1)	184
Aged care - Improve integration of aged care services tailored to support physical emotional and social need (2.2.6)	184

Activity Demographics

Target Population Cohort

Residents living in Residential Aged Care Homes (RACHS)

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

North Western Melbourne Primary Health Network (NWMPHN) is committed to ensuring stakeholder engagement is embedded in our culture and core functions.

Stakeholder engagement occurs throughout all seven activities that comprise our commissioning approach:
- Assess and prioritise needs
- Review evidence to inform planning and design
- Design services to address need
- Prepare the system for delivery
- Support implementation
- Manage performance and drive continuous improvement
- Evaluate the impact

We use a range of mechanisms to engage with our communities. This includes working with our Community and Clinical Councils and Expert Advisory Groups (EAGs).

The Clinical and Community Councils provide advice to the Board about the unique needs of the region, and principles and mechanisms for engaging local stakeholders.

The Expert Advisory Groups provide subject matter expertise, insights, and advice to support operational model and service design, focusing on safety, quality, and integration. NWMPHN has EAGs for:
- General Practice
- Alcohol and Other Drugs
- Mental Health
- Aboriginal Health
- Older Adults

We continue to also consult and seek specific advice from relevant strategic and local organisations and other stakeholders, such as peak and professional bodies, governments, the primary health care sector and local hospital networks. Interviews and focus groups with community members (older adults) and key sector informants e.g. Council of The Aging (COTA) will continue to be undertaken.

This activity will also include meaningful key stakeholder input in the procurement and program development process. Commissioned provider(s) will also be expected to consult with community members when designing and implementing their activities.

Collaboration

NWMPHN's approach to collaboration and engagement is underpinned by the IAP2 model. Best practice in public engagement is influenced by the Spectrum of Public Participation developed by the International Association of Public Participation. This spectrum includes five levels of participation - Inform, Consult, Involve, Collaborate and Empower.

Collaboration will be utilised wherever possible throughout the commissioning cycle as NWMPHN recognises that working in this way adds value and strengthens our reach. Mutually meaningful collaboration is pursued and maintained in a systematic way across the organisation, which facilitates timely access to existing and new collaboration approaches. This is critical to driving a team-based and integrated approach to delivering person-centred primary care.

Collaboration with key stakeholders will occur throughout the commissioning process. Consequently, the following stakeholders may be involved in prioritisation, planning and design, implementation, monitoring and evaluation of activities:
• Community participants – consumers, patients, carers, other people with lived experience, priority populations, community leaders
• Peak and professional bodies
• Residential aged care homes
• Health care professionals
• General practice
• NWMPHN regional and strategic partnerships and collaboratives
• Community health services
• Local hospital networks
• Pharmacy
• Allied health
• Community-based organisations
• Other service providers with experience delivering within RACHs
• Research institutes
• Academic and training institutions
• Victorian Department of Health
• Local government.

Activity Milestone Details/Duration

Activity Start Date

31/12/2024

Activity End Date

30/12/2027

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

Not Yet Known: No
Continuing Service Provider / Contract Extension: No

Direct Engagement: No
Open Tender: No
Expression Of Interest (EOI): 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

AC-EI - 6 - Early intervention initiatives to support healthy ageing and chronic conditions - Operational 24/25

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-EI

Activity Number *

6

Activity Title *

Early intervention initiatives to support healthy ageing and chronic conditions - Operational 24/25

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

The aim of this activity is to support older Australians to live at home for as long as possible through commissioning early intervention activities and models of care for chronic disease management that support healthy ageing and reduce pressure on local health services. Informed by both the PHN strategic and care Finders needs assessments, the aim of this activity strategically aligns and is being will be delivered with NWMPHN's CF-1000 – Improve the physical and mental health and wellbeing of people with chronic conditions. This activity also aims to supports the empowering of GPs and other primary health care workers through training, tools and resources which contribute to improved health and care outcomes for older adults living in the community.

Description of Activity *

NWMPHN has:
• Commissioned 10 general practices to deliver early intervention initiatives to older people to promote healthy ageing and ongoing management of chronic conditions.
• Supported general practice to develop innovative models of care that examine how to establish and implement effective multidisciplinary approaches to the prevention and management of chronic conditions that consider the social determinants of health.
• Implemented monitoring and evaluation standards and capabilities that ensure that commissioned services are effective and meet the needs of the community.
• Commissioned and completed an evaluation of the program.

• Delivered communities of practice to support shared learnings, system integration opportunities, and drive quality improvement activities.

NWMPHN will:
• Deliver communities of practice to support shared learnings, system integration opportunities, and drive quality improvement activities.
• Complete an evaluation of the program, the findings of which will be used to support general practice to implement comprehensive chronic illness models of care that complement existing funding streams.
• Continue a revised program, incorporating learnings, recommendations and insights from both the program evaluation and previous contract management activities. These improvements will be monitored and evaluated via contract management processes.
• Ensure the refreshed program aligns with primary care broader allied health practice support multi-disciplinary team commissioning activities.
• Continue delivering communities of practice that support shared learnings, system integration opportunities and drive quality improvement activities.

The approaches or mechanisms, i.e. enablers, that may be used to support implementation of this activity include quality improvement, health literacy, workforce development, clinical and referral pathways for chronic disease management and older adults, and digital health.

Needs Assessment Priorities *

Needs Assessment

NWMPHN Needs Assessment 2024-2028

Priorities

Priority	Page reference
Health conditions - Focus on patient and carer education of conditions and improving health literacy of older adults regarding their health conditions (4.2.25)	187
Primary health care - Enhance primary care workforce capability to increase access to affordable primary care and allied health services to provide effective, person-centred care (6.2.1)	190
Primary health care - Improve health and system literacy among at-risk cohorts (6.1.12)	190
Primary health care - Improve health sector capability to implement data driven quality improvement to measure patient experience and health outcomes (6.3.9)	190
Primary health care - Increase access to flexible models of care to improve reach to at-risk cohorts (6.1.4)	190
Health conditions - Increase access to early intervention health programs to reduce the burden of chronic diseases and preventable deaths (4.2.1)	186
Health conditions-Increase access and coordinated care with culturally aware/diverse providers for people from diverse backgrounds with chronic conditions, while building GP capability and MDC (4.2.9)	186

Aged care - Change model of service delivery in light of primary care reforms to meet demand of older adults requiring health care (2.1.1)	184
Aged care - Improve integration of aged care services tailored to support physical emotional and social need (2.2.6)	184

Activity Demographics

Target Population Cohort

Older adults in the community

People aged at least 50 (or Aboriginal and Torres Strait Islander people aged at least 35) at risk of or with chronic conditions.

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Collaboration

Activity Milestone Details/Duration

Activity Start Date

13/02/2022

Activity End Date

29/06/2025

Service Delivery Start Date

13/02/2022

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

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

AC-VARACF - 7 - Support RACHs to increase availability and use of telehealth aged care residents - Operational 24/25

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-VARACF

Activity Number *

7

Activity Title *

Support RACHs to increase availability and use of telehealth aged care residents - Operational 24/25

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

Support participating Residential Aged Care Homes (RACHs) in our region to have appropriate virtual consultation facilities and technology so residents can access timely and clinically appropriate care with primary health care professionals, specialists and other clinicians.

Description of Activity *

NWMPHN offered RACHs grants to purchase or improve existing telehealth services and after engagement with 100% of RACHs in the region 77 (60% of the RACHs in the region) took up the grant opportunity.

To support equity and access, grants were prioritised based on whether the facility:
• Operates in a Local Government Area with lower SEIFA index ratings.
• Operates as a small, independently run and/or not for profit business model
• Operates to support priority populations such as caring for Aboriginal and Torres Strait Islander peoples, and or Culturally and Linguistically Diverse (CALD) backgrounds.

As part of the grant process, RACHs were required to:
• Deliver this activity in line with the Australian College of Rural and Remote Medicine's Telehealth Framework and Guidelines.
• Participate in telehealth training provided by NWMPHN.

• Actively participate in a community of practice where knowledge and lessons on implementation of telehealth will be shared.
• Provide an implementation plan, including details of current (baseline) usage of telehealth and how they will engage stakeholders to ensure successful implementation and sustainability of the activity.
• Complete an end-of-grant survey evidencing successful use of telehealth by the facility.

To implement the education component of this activity, Victorian & Tasmanian PHNs have collaborated to develop consistent, high-quality, tailored training for families, residents and clinical providers, to support adoption of telehealth within participating RACHs. These modules were launched in Q4 FY23/24. NWMPHN will support RACHs to access and use the models to underpin service delivery and support sustained integration of telehealth into workflows.

Needs Assessment Priorities *

Needs Assessment

NWMPHN Needs Assessment 2022-2025

Priorities

Priority	Page reference
Chronic conditions - range, higher rates, lower uptake of management plans	186
Preventative health checks - lower rates of screening	185
Comorbid conditions - complexity and demand	184

Activity Demographics

Target Population Cohort

Older Adults residing in RACHs

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Collaboration

Activity Milestone Details/Duration

Activity Start Date

13/02/2022

Activity End Date

28/06/2025

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

No

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

No

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

No

Decommissioning

No

Decommissioning details?

Co-design or co-commissioning comments

AC-CF - 3 - Care Finder Program ACH 24/25

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-CF

Activity Number *

3

Activity Title *

Care Finder Program ACH 24/25

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

North Western Melbourne PHN aims to establish and maintain a network of care finders in our region that provide specialist and intensive assistance to help older people within the care finder target population to understand and access aged care services, and connect with other relevant supports in our community.

Description of Activity *

NWMPHN utilised the care finder supplementary health needs assessment (SHNA) to identify the specific local needs of our region in relation to care finder supports and services, and to guide who we commission to deliver care finder services in our region. Key insights that emerged from the SHNA, which included analysis of data and synthesis of stakeholder and community consultations, were:

• People from culturally and linguistically diverse backgrounds and people living with a disability are the largest cohorts and are relatively evenly distributed across the NWM region, except for peri-urban areas.
• Older people with a disability who live alone, are on a low income and who rent are particularly vulnerable.
• Face-to-face communication and trust-building are very important for older people in our region.
• Staff recruitment and retention is difficult, particularly for diverse staff which reflects the care finder target population to achieve workforce mutuality and those that have the necessary cultural understanding and language skills.
• Trauma-informed care is critical given the historical experiences of many Aboriginal and Torres Strait Islander people, LGBTIQ+ people, Care Leavers, and Veterans.

• Cost of services (and of transportation) is a barrier for older people, many of whom live on low, fixed incomes.

From these insights, it was evident that there are many diverse population groups in our region that have specific needs that would need to be recognised and met by care finder providers. Therefore, NWMPHN commissioned providers that have demonstrated capability and capacity to deliver generalist or mainstream services as part of the care finder program, with commissioning intentions to take a robust quality/service improvement approach with a specific focus on:
• Improving access to care finder services for people from Culturally and Linguistically Diverse communities, Aboriginal and Torres Strait Islander communities (that choose to access care finder services rather than Trusted Indigenous Facilitators services), and people who live with a disability; and
• establishing/improving access to care finder services for people at risk of homelessness or homeless, through the transition of ACH providers in our region.

NWMPHN wworks with commissioned providers and other stakeholders to:
• Ensure care finder services are delivered in line with Care Finder Program policy guidance, and the terms and conditions and schedule of contracts.
• Support the evaluation, and promote continuous improvement, of the care finder program by utilising data and insights from the care finder minimum dataset and evaluation, and reporting streams to support care finder providers to understand:
o the population accessing their service
o the needs of their population
o referral pathways
o workforce and workforce training needs.
o identify and address opportunities to enhance integration between the health, aged care, and other systems at the local North Western Melbourne level.
• Maintain the integration of the care finder network into the local aged care and health system. This includes developing pathways between local care finder providers and providers of the Elder Care Support, program to ensure client choice and outcomes are achieved for Aboriginal and Torres Strait Islander communities, as well as with other relevant local services.
• Maintain processes to meet data collection and reporting requirements. This includes support with data quality and integrity and survey completion. Victorian PHNs are continuing to take a consistent approach to setting Key Performance Indicators to compare performance and support providers to engage in continuous quality improvement.

NWMPHN will continue to host regular communities for practice to highlight, discuss and share solutions for common issues or trends identified through the data and provider reporting and feedback. Other topics covered at the communities of practice will continue to include integration and workforce development.

Following the termination of contractual obligation to commission former ACH providers, NWMPHN is undertaking a review of commissioning processes and activities to ensure that we commission equitably, and to identify any unmet need that may have emerged since the inception of Care Finders. Informed by the findings of this review, planning activities will be undertaken in FY2025/26 and implementation of identified improvements scheduled for FY 2026/27.

Needs Assessment Priorities *

Needs Assessment

NWMPHN Needs Assessment 2022-2025

Priorities

Priority	Page reference
Chronic conditions - range, higher rates, lower uptake of management plans	186
Preventative health checks - lower rates of screening	185
Mental Health - demand, prevalence, complexity	183

Activity Demographics

Target Population Cohort

Older people across the north western Melbourne region 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.

More specifically, the following population groups have identified needs that emerged through the SHNA data analysis and consultations:
- Cultural and Linguistically Diverse
- Disability
- Aboriginal and/or Torres Strait Islander
- LGBTIQ+
- Care Leavers
- Veterans

Additionally, while this activity is broad reaching to all older people across our PHN region, there were identified needs specifically in the following geographic locations that will be prioritised for care finder support:
- Brimbank
- Darebin
- Moreland
- Hume
- Wyndham
- Melton

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

North Western Melbourne Primary Health Network (NWMPHN) is committed to ensuring stakeholder engagement is embedded in our culture and core functions.

NWMPHN's Health Needs Assessment 2022–25 provided a comprehensive compilation of health and wellbeing research and data, plus contextual information gathered through interviews, workshops and surveys of community members, general practices,

commissioned services, peak bodies, community health, acute health care and local government.

We use a range of mechanisms to engage with our communities. This includes working with our Community and Clinical Councils and Expert Advisory Groups (EAGs). NWMPHN's Older Adults EAG is consulted to provide subject matter expertise, insights, and advice on the current aged care system landscape and opportunities for better service integration, commissioning and delivery.

Our Older Adults EAG continues to be engaged to ensure effective governance and provide expert guidance to the program. NWMPHN works collaboratively with Care Finders providers and embeds feedback and learning into continuous improvement processes.

NWMPHN is a member of the Victorian and Tasmanian PHN Alliance (VTPHNA) and regularly attends meetings aimed at promoting standardisation and continuity of process where possible, and to share learnings and insights from other PHNs.

NWMPHN regularly consults Care Finder providers regarding areas for improvement through performance meetings and local communities of practice, and has developed strong relationships and feedback mechanisms with the DoHAC Care Finder team.

Collaboration

NWMPHN's approach to collaboration and engagement is underpinned by the IAP2 model. Best practice in public engagement is influenced by the Spectrum of Public Participation developed by the International Association of Public Participation. This spectrum includes five levels of participation - Inform, Consult, Involve, Collaborate and Empower.

NWMPHN drives a high uptake of consumer feedback about the Care Finder program through the use of contractual key performance indicators. The information is used by the program evaluator and NMWPHN (where possible while maintaining anonymity) to improve the program and ensure that it is person centered.

Broader collaboration with key stakeholders across the local aged care, health, and social care systems/services continues to occur throughout the commissioning life cycle. Consequently, the following stakeholders may be involved in prioritisation, planning and design, implementation, and monitoring and evaluation of the care finder commissioning activities:

- Community participants – consumers within the care finder target population, carers, other people with lived experience, priority populations, community leaders
- Organisations delivering other programs such as Access & Support services
- Community health services
- Community-based organisations
- Peak and professional bodies, including Council on the Ageing (FECCA, COTA)
- Local government and councils
- Residential aged care homes
- Community aged care providers
- Health care professionals
- General practice
- NWMPHN regional and strategic partnerships and collaboratives
- Local hospital networks
- Pharmacy
- Allied health
- Research institutes
- Academic and training institutions
- Victorian Department of Health
- AHA consulting, commissioned to evaluate the Care Finders program

NWMPHN is a member of the Victorian and Tasmanian PHN Alliance (VTPHNA) and regularly attends Care Finder specific meetings aimed at standardisation and continuity of process where possible, and to share learnings and insights from other PHNs. Additionally, NWMPHN attends state led community of practices attended by PHNs, Care Finder providers and the Department of Health and Aged Care, Care Finders program team. Finally, NWMPHN hosts regular local communities of practice to highlight, discuss and share solutions for common issues or trends identified through the data and provider reporting and feedback. Other topics covered at the communities of practice will continue to include integration and workforce development.

Activity Milestone Details/Duration

Activity Start Date

09/04/2022

Activity End Date

29/06/2025

Service Delivery Start Date

01/01/2023

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Establishment Period End Date for new provider - 30/4/2023

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

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

AC-EI - 5 - Early intervention initiatives to support healthy ageing and chronic conditions_AWP 24/25

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-EI

Activity Number *

5

Activity Title *

Early intervention initiatives to support healthy ageing and chronic conditions_AWP 24/25

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

The aim of this activity is to support older Australians to live at home for as long as possible through commissioning early intervention activities and models of care for chronic disease management that support healthy ageing and reduce pressure on local health services. Informed by both the PHN strategic and care Finders needs assessments, this activity strategically aligns and is being delivered with NWMPHN's CF-1000 – Improve the physical and mental health and wellbeing of people with chronic conditions. This activity also supports the empowering of GPs and other primary health care workers through training, tools and resources which contribute to improved health and care outcomes for older adults living in the community.

Description of Activity *

NWMPHN has:
• Commissioned 10 general practices to deliver early intervention initiatives to older people to promote healthy ageing and ongoing management of chronic conditions.
• Supported general practice to develop innovative models of care that examine how to establish and implement effective multidisciplinary approaches to the prevention and management of chronic conditions that consider the social determinants of health.
• Implemented monitoring and evaluation standards and capabilities that ensure that commissioned services are effective and meet the needs of the community.
• Commissioned and completed an evaluation of the program.

• Delivered communities of practice to support shared learnings, system integration opportunities, and drive quality improvement activities.

NWMPHN will:

• Deliver communities of practice to support shared learnings, system integration opportunities, and drive quality improvement activities
Complete an evaluation of the program, the findings of which will be used to support general practice to implement comprehensive chronic illness models of care that complement existing funding streams. The approaches or mechanisms, i.e. enablers, that may be used to support implementation of this activity include quality improvement, health literacy, workforce development, clinical and referral pathways for chronic disease management and older adults, and digital health.

Needs Assessment Priorities *

Needs Assessment

NWMPHN Needs Assessment 2024-2028

Priorities

Priority	Page reference
Health conditions - Focus on patient and carer education of conditions and improving health literacy of older adults regarding their health conditions (4.2.25)	187
Primary health care - Enhance primary care workforce capability to increase access to affordable primary care and allied health services to provide effective, person-centred care (6.2.1)	190
Primary health care - Improve health and system literacy among at-risk cohorts (6.1.12)	190
Primary health care - Improve health sector capability to implement data driven quality improvement to measure patient experience and health outcomes (6.3.9)	190
Primary health care - Increase access to flexible models of care to improve reach to at-risk cohorts (6.1.4)	190
Health conditions - Increase access to early intervention health programs to reduce the burden of chronic diseases and preventable deaths (4.2.1)	186
Health conditions-Increase access and coordinated care with culturally aware/diverse providers for people from diverse backgrounds with chronic conditions, while building GP capability and MDC (4.2.9)	186
Aged care - Change model of service delivery in light of primary care reforms to meet demand of older adults requiring health care (2.1.1)	184
Aged care - Improve integration of aged care services tailored to support physical emotional and social need (2.2.6)	184

Activity Demographics

Target Population Cohort

Older adults in the community

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

North Western Melbourne Primary Health Network (NWMPHN) is committed to ensuring stakeholder engagement is embedded in our culture and core functions.

Stakeholder engagement occurs throughout all seven activities that comprise our commissioning approach:
- Assess and prioritise needs
- Review evidence to inform planning and design
- Design services to address need
- Prepare the system for delivery
- Support implementation
- Manage performance and drive continuous improvement
- Evaluate the impact

We use a range of mechanisms to engage with our communities. This includes working with our Community and Clinical Councils, Expert Advisory Groups (EAGs), Primary Care Voices and People Bank members.

The Clinical and Community Councils provide advice to the Board about the unique needs of the region, and principles and mechanisms for engaging local stakeholders. The EAGs provide subject matter expertise, insights and advice to support operational model and service design, focusing on safety, quality, and integration. NWMPHN has EAGs for:
- General Practice
- Alcohol and Other Drugs
- Mental Health
- Aboriginal Health
- Older Adults

People Bank is a register of people who would like to participate in activities that help to improve the health of people in the region. Members participate in a range of different activities including workshops, governance groups, surveys, and tender evaluation panels.

We continue to also consult and seek specific advice from relevant strategic and local organisations and other stakeholders, such as peak and professional bodies, governments, the primary health care sector and local health services and hospital networks.

This activity will also include meaningful key stakeholder input in the procurement and program development process. Commissioned provider(s) will also be expected to consult with community members when designing and implementing their activities.

Collaboration

NWMPHN's approach to collaboration and engagement is underpinned by the IAP2 model. Best practice in public engagement is influenced by the Spectrum of Public Participation developed by the International Association of Public Participation. This spectrum includes five levels of participation, Inform, Consult, Involve, Collaborate and Empower.

Collaboration will be utilised wherever possible throughout the commissioning cycle as NWMPHN recognises that working in this way adds value and strengthens our reach. Mutually meaningful collaboration is pursued and maintained in a systematic way across the organisation, which facilitates timely access to existing and new collaboration approaches. This is critical to driving a team-based and integrated approach to delivering person-centred primary care.

Collaboration with key stakeholders will occur throughout the commissioning process. Consequently, the following stakeholders may be involved in prioritisation, planning and design, implementation, monitoring and evaluation of activities:
Community participants – consumers, patients, carers, and people with lived experience, priority populations, community leaders

- Health care professionals
- NWMPHN regional and strategic partnerships and collaboratives
- Local health services and hospital networks
- Community health services
- General practice
- Residential aged care facilities
- Pharmacy
- Allied health
- Community-based organisations
- Research institutes
- Academic and training institutions
- Peak and professional bodies
- Victorian Department of Health
- Local government
- Other PHNs

Activity Milestone Details/Duration

Activity Start Date

13/02/2022

Activity End Date

28/06/2025

Service Delivery Start Date

01/07/2023

Service Delivery End Date

30/06/2025

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

No

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

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?

na

Co-design or co-commissioning comments

AC-CF - 1 - Care Finder Program 25/26

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-CF

Activity Number *

1

Activity Title *

Care Finder Program 25/26

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 *

North Western Melbourne PHN has established and maintained a network of care finders in our region that provide specialist and intensive assistance to help older people within the care finder target population to understand and access aged care services, and connect with other relevant supports in our community.

Description of Activity *

NWMPHN will continue to work with commissioned providers and other stakeholders to:
• Ensure care finder services are delivered in line with Care Finder Program policy guidance, and the terms and conditions and schedule of contracts.
• Support the evaluation, and promote continuous improvement, of the care finder program by utilising data and insights from the care finder minimum dataset and evaluation, and reporting streams to support care finder providers to understand:
    • the population accessing their service
    • the needs of their population
    • referral pathways
    • workforce and workforce training needs.

• Identify and address opportunities to enhance integration between the health, aged care, and other systems at the local North Western Melbourne level.

• Maintain the integration of the care finder network into the local aged care and health system. This includes developing pathways between local care finder providers and providers of the Elder Care Support, program to ensure client choice and outcomes are achieved for Aboriginal and Torres Strait Islander communities, as well as with other relevant local services.
• Maintain processes to meet data collection and reporting requirements. This includes support with data quality and integrity and survey completion. Victorian PHNs are continuing to take a consistent approach to setting Key Performance Indicators to compare performance and support providers to engage in continuous quality improvement.

NWMPHN will continue to host regular communities of practice to highlight, discuss and share solutions for common issues or trends identified through the data and provider reporting and feedback. Other topics covered at the communities of practice will continue to include integration and workforce development.

Following the expiration of contractual obligation to commission former ACH providers, NWMPHN is undertaking a review of how providers are commissioned to ensure that it commissions equitably, and to identify any unmet need that may have emerged since the inception of Care Finders. Informed by the findings of this review, planning activities will be undertaken in FY2025/26 and implementation of identified improvements scheduled for FY 2026/27.

NWMPHN utilises the care finder supplementary health needs assessment (SHNA) to address regional needs in relation to care finder supports and services, and to guide commissioning to deliver care finder services in our region. Key insights from the SHNA, which include analysis of data and synthesis of stakeholder and community consultations, are:

• People from culturally and linguistically diverse backgrounds and people living with a disability are the largest cohorts and are relatively evenly distributed across the NWM region, except for peri-urban areas.
• Older people with a disability who live alone, are on a low income and who rent are particularly vulnerable.
• Face-to-face communication and trust-building are very important for older people in our region.
• Staff recruitment and retention is difficult, particularly for diverse staff which reflects the care finder target population to achieve workforce mutuality and those that have the necessary cultural understanding and language skills.
• Trauma-informed care is critical given the historical experiences of many Aboriginal and Torres Strait Islander people, LGBTIQ+ people, Care Leavers, and Veterans.
• Cost of services (and of transportation) is a barrier for older people, many of whom live on low, fixed incomes.

From these insights, it is evident that there are many diverse population groups in our region that have specific needs that need to be recognised and met by care finder providers. To address this, NWMPHN commissions providers that demonstrate capability and capacity to deliver generalist or mainstream services as part of the care finder program, with a robust quality/service improvement approach with a specific focus on:
• Improving access to care finder services for people from Culturally and Linguistically Diverse communities, Aboriginal and Torres Strait Islander communities (that choose to access care finder services rather than Trusted Indigenous Facilitators services), and people who live with a disability; and
• establishing/improving access to care finder services for people at risk of homelessness or homeless, through the transition of ACH providers in our region.

Needs Assessment Priorities *

Needs Assessment

NWMPHN Needs Assessment 2024-2028

Priorities

Priority	Page reference
Health conditions-Strengthen data collection processes to increase understanding and address the chronic health needs of LGBTIQ+ population/people experiencing homelessness/marginally housed (4.2.28)	187
Aged care - Improve capacity and support for family and carers of older people (2.1.6)	184

Aged care - Improve integration of aged care services tailored to support physical emotional and social need (2.2.6)	184

Activity Demographics

Target Population Cohort

Older people and those experiencing premature ageing across the north western Melbourne region 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.

More specifically, the following population groups have identified needs that emerged through the SHNA data analysis and consultations:
- Cultural and Linguistically Diverse
- Disability
- Aboriginal and/or Torres Strait Islander
- LGBTIQ+
- Care Leavers
- Veterans

Additionally, while this activity is intended to be broad reaching to all older people across our PHN region, there were identified needs specifically in the following geographic locations that will be prioritised for care finder support:
- Brimbank
- Darebin
- Moreland
- Hume
- Wyndham
- Melton

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

North Western Melbourne Primary Health Network (NWMPHN) is committed to ensuring stakeholder engagement is embedded in

Stakeholder engagement occurs throughout all seven activities that comprise our commissioning approach:
• Assess and prioritise needs
• Review evidence to inform planning and design
• Design services to address need
• Prepare the system for delivery
• Support implementation
• Manage performance and drive continuous improvement
• Evaluate the impact

We use a range of mechanisms to engage with our communities. This includes working with our Community and Clinical Councils, Expert Advisory Groups (EAGs), Primary Care Voices and People Bank members.

The Clinical and Community Councils provide advice to the Board about the unique needs of the region, and principles and mechanisms for engaging local stakeholders. The EAGs provide subject matter expertise, insights and advice to support operational model and service design, focusing on safety, quality, and integration. NWMPHN has EAGs for:
• General Practice
• Alcohol and Other Drugs
• Mental Health
• Aboriginal and Torres Strait Islander Health
• Older Adults

People Bank is a register of people who would like to participate in activities that help to improve the health of people in the region. Members participate in a range of different activities including workshops, governance groups, surveys, and tender evaluation panels.

We continue to also consult and seek specific advice from relevant strategic and local organisations and other stakeholders, such as peak and professional bodies, governments, the primary health care sector and local health services and hospital networks.

This activity will also include meaningful key stakeholder input in the procurement and program development process. Commissioned provider(s) will also be expected to consult with community members when designing and implementing their activities.

Collaboration

NWMPHN's approach to collaboration and engagement is underpinned by the IAP2 model. Best practice in public engagement is influenced by the Spectrum of Public Participation developed by the International Association of Public Participation. This spectrum includes five levels of participation, Inform, Consult, Involve, Collaborate and Empower.

Collaboration will be utilised wherever possible throughout the commissioning cycle as NWMPHN recognises that working in this way adds value and strengthens our reach. Mutually meaningful collaboration is pursued and maintained in a systematic way across the organisation, which facilitates timely access to existing and new collaboration approaches. This is critical to driving a team-based and integrated approach to delivering person-centred primary care.

Collaboration with key stakeholders will occur throughout the commissioning process. Consequently, the following stakeholders may be involved in prioritisation, planning and design, implementation, monitoring and evaluation of activities:
• Community participants – consumers, patients, carers, and people with lived experience, priority populations, community leaders
• Health care professionals
• NWMPHN regional and strategic partnerships and collaboratives
• Local health services and hospital networks
• Community health services
• General practice
• Residential aged care facilities

- Pharmacy
- Allied health
- Community-based organisations
- Research institutes
- Academic and training institutions
- Peak and professional bodies
- Victorian Department of Health
- Local government
- Other PHNs
- Media
- Other identified providers

Activity Milestone Details/Duration

Activity Start Date

08/04/2022

Activity End Date

29/06/2029

Service Delivery Start Date

01/01/2023

Service Delivery End Date

30/06/2029

Other Relevant Milestones

Establishment Period End Date for new provider - 30/4/2023

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: 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

AC-CF - 2 - Care Finder Program - Operational 25/26

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-CF

Activity Number *

2

Activity Title *

Care Finder Program - Operational 25/26

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

North Western Melbourne PHN has established and maintained a network of care finders in our region that provide specialist and intensive assistance to help older people within the care finder target population to understand and access aged care services, and connect with other relevant supports in our community.

Description of Activity *

NWMPHN utilises the care finder supplementary health needs assessment (SHNA) to address regional needs in relation to care finder supports and services, and to guide commissioning to deliver care finder services in our region. Key insights from the SHNA, which include analysis of data and synthesis of stakeholder and community consultations, are:

• People from culturally and linguistically diverse backgrounds and people living with a disability are the largest cohorts and are relatively evenly distributed across the NWM region, except for peri-urban areas.
• Older people with a disability who live alone, are on a low income and who rent are particularly vulnerable.
• Face-to-face communication and trust-building are very important for older people in our region.
• Staff recruitment and retention is difficult, particularly for diverse staff which reflects the care finder target population to achieve workforce mutuality and those that have the necessary cultural understanding and language skills.
• Trauma-informed care is critical given the historical experiences of many Aboriginal and Torres Strait Islander people, LGBTIQ+ people, Care Leavers, and Veterans.

• Cost of services (and of transportation) is a barrier for older people, many of whom live on low, fixed incomes.

From these insights, it is evident that there are many diverse population groups in our region that have specific needs that need to be recognised and met by care finder providers. to address this NWMPHN commissions providers that demonstrate capability and capacity to deliver generalist or mainstream services as part of the care finder program, with a robust quality/service improvement approach with a specific focus on:
• Improving access to care finder services for people from Culturally and Linguistically Diverse communities, Aboriginal and Torres Strait Islander communities (that choose to access care finder services rather than Trusted Indigenous Facilitators services), and people who live with a disability; and
• establishing/improving access to care finder services for people at risk of homelessness or homeless, through the transition of ACH providers in our region.

Needs Assessment Priorities *

Needs Assessment

NWMPHN Needs Assessment 2024-2028

Priorities

Priority	Page reference
Health conditions-Strengthen data collection processes to increase understanding and address the chronic health needs of LGBTIQ+ population/people experiencing homelessness/marginally housed (4.2.28)	187
Health conditions-Increase access and coordinated care with culturally aware/diverse providers for people from diverse backgrounds with chronic conditions, while building GP capability and MDC (4.2.9)	186
Aged care - Improve capacity and support for family and carers of older people (2.1.6)	184
Aged care - Improve integration of aged care services tailored to support physical emotional and social need (2.2.6)	184
Aboriginal and Torres Strait Islander Health - Improve integrated care pathways between mainstream mental health services, ACCHOs & ACCO services to provide an inclusive/safe/holistic approach(1.2.4)	183
Aboriginal and Torres Strait Islander Health - Mandate cultural safety training in mainstream services to understand historical and contemporary impacts of colonisation and racism (1.1.9)	183

Activity Demographics

Target Population Cohort

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

Collaboration

Activity Milestone Details/Duration

Activity Start Date

08/04/2022

Activity End Date

29/06/2029

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

Activity Commissioning

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

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

Is this activity being co-designed?

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

AC-AHARACF - 4 - Enhanced out of hours support for residential aged care 24/25

Activity Metadata

Applicable Schedule *

Aged Care

Activity Prefix *

AC-AHARACF

Activity Number *

4

Activity Title *

Enhanced out of hours support for residential aged care 24/25

Existing, Modified or New Activity *

Existing

Activity Priorities and Description

Program Key Priority Area *

Aged Care

Other Program Key Priority Area Description

Aim of Activity *

The aim of this activity is to build capability of Residential Aged Care Homes (RACHs) in the NWMPHN region to be able care for patients in the after hours period, be aware of the local after-hours services and care options. The intended outcome of this activity is to help reduce unnecessary hospital presentations among RACH residents and to increase the number of facilities with after-hours care plans.

Description of Activity *

NWMPHN will continue to support RACHs to develop and implement after hours care plans using the After Hours Tool kit that has been developed to support access to appropriate after hours care for their patients and to recognise patient deterioration within hours.

Activity: RACH consultation and engagement
• Continue to engage with RACHs to gain insight into after hours planning and processes including barriers and enablers for access to appropriate after hours care. Method of engagement include surveys and face to face or virtual consultations with facility staff.
• Engage with NWMPHN Older Adults Expert advisory Group.

Activity: Promotion of RACH After Hours Toolkit
Work with VTPHNA to implement the After Hours Toolkit. Toolkit contains the following resources:

• Communication tool – based on ISBAR Communications Tool
• Resident and family education fact sheet
• Service directory – to be localised with RACH to services available to their facility
• Person centred after hours action plan
• Preparedness self-assessment audit tool
• Collaborate with participating RACHs and other Victorian PHNs to refine and digitise RACH After Hours Toolkit

Activity: Implementation of RACH After Hours Toolkit
• Broad communication with RACHs in catchment to raise awareness of after hours support project and After Hours Toolkit
• Direct support and engagement with RACHs to implement After Hours Toolkit
• Guidance to assist RACHs to localise After Hours Toolkit and implement after-hours action plans
• Educate participating RACH staff on the after-hours health care options and processes for residents
• Encourage participating RACHs to implement procedures for updating residents' digital medical records
• Support engagement between RACHs and their residents' GPs (and other relevant health professionals), as part of after-hours action plan development.
• Broad education (via webinar) for participating RACHs on implementation of After Hours Toolkit and other general support
• Ongoing monitoring of toolkit implementation and support of RACHs
• Evaluation of uptake and revision of After Hours Toolkit resources as required
• Support the establishment of imprest medication systems in RACH to enable patients to be managed in the facility and reduce the need for ED admissionContinue establishing linkages with Residence in Reach, Virtual ED and Ambulance Victoria for support during the after hours period
• Ongoing monitoring of toolkit implementation and support of RACHs

Activity: Support RACH digital health initiatives
• This work will support implementation and meaningful use of telehealth as described in AC-VARACF - 3 - NWMPHN Support RACHs to increase availability and use of telehealth aged care residents_AWP 24/25- Support RACHs to utilise telehealth for after hours care where appropriate
• Promote the use of digital health enablers in RACHs, such as telehealth, My Health Record, PRODA and HPOS.
• Promote the use of electronic national residential medication charts (eNRMC)

The approaches or mechanisms, i.e. enablers, that may be used to support implementation of this activity include quality improvement, health literacy, workforce development, clinical and referral pathways for aged care, and digital health.

Needs Assessment Priorities *

Needs Assessment

NWMPHN Needs Assessment 2024-2028

Priorities

Priority	Page reference
Aged care - Enhance the competency of the workforce including nurses and case workers, to effectively manage complex aged care, including individuals with co-morbidities (2.1.3)	184
Aged care - Improve capacity and support for family and carers of older people (2.1.6)	184

Activity Demographics

Target Population Cohort

Residential aged care home residents

In Scope AOD Treatment Type *

Indigenous Specific *

No

Indigenous Specific Comments

Coverage

Whole Region

Yes

Activity Consultation and Collaboration

Consultation

North Western Melbourne Primary Health Network (NWMPHN) is committed to ensuring stakeholder engagement is embedded in our culture and core functions.

Stakeholder engagement occurs throughout all seven activities that comprise our commissioning approach:
- Assess and prioritise needs
- Review evidence to inform planning and design
- Design services to address need
- Prepare the system for delivery
- Support implementation
- Manage performance and drive continuous improvement
- Evaluate the impact

We use a range of mechanisms to engage with our communities. This includes working with our Community and Clinical Councils and Expert Advisory Groups (EAGs).

The Clinical and Community Councils provide advice to the Board about the unique needs of the region, and principles and mechanisms for engaging local stakeholders.

The Expert Advisory Groups provide subject matter expertise, insights, and advice to support operational model and service design, focusing on safety, quality, and integration. NWMPHN has EAGs for:
- General Practice
- Alcohol and Other Drugs
- Mental Health
- Aboriginal Health
- Older Adults

We continue to also consult and seek specific advice from relevant strategic and local organisations and other stakeholders, such as peak and professional bodies, governments, the primary health care sector and local hospital networks. Interviews and focus groups with community members (older adults) and key sector informants e.g. Council of The Aging (COTA) will continue to be undertaken.

This activity will also include meaningful key stakeholder input in the procurement and program development process. Commissioned provider(s) will also be expected to consult with community members when designing and implementing their activities.

Collaboration

NWMPHN's approach to collaboration and engagement is underpinned by the IAP2 model. Best practice in public engagement is influenced by the Spectrum of Public Participation developed by the International Association of Public Participation. This spectrum includes five levels of participation - Inform, Consult, Involve, Collaborate and Empower.

Collaboration will be utilised wherever possible throughout the commissioning cycle as NWMPHN recognises that working in this way adds value and strengthens our reach. Mutually meaningful collaboration is pursued and maintained in a systematic way across the organisation, which facilitates timely access to existing and new collaboration approaches. This is critical to driving a team-based and integrated approach to delivering person-centred primary care.

Collaboration with key stakeholders will occur throughout the commissioning process. Consequently, the following stakeholders may be involved in prioritisation, planning and design, implementation, monitoring and evaluation of activities:
• Community participants – consumers, patients, carers, other people with lived experience, priority populations, community leaders
• Peak and professional bodies
• Residential aged care homes
• Health care professionals
• General practice
• NWMPHN regional and strategic partnerships and collaboratives
• Community health services
• Local hospital networks
• Pharmacy
• Allied health
• Community-based organisations
• Other service providers with experience delivering within RACHs
• Research institutes
• Academic and training institutions
• Victorian Department of Health
• Local government.

Activity Milestone Details/Duration

Activity Start Date

13/02/2022

Activity End Date

29/06/2025

Service Delivery Start Date

Service Delivery End Date

Other Relevant Milestones

NA

Activity Commissioning

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

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

Is this activity being co-designed?

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?

na

Co-design or co-commissioning comments

na