phn CENTRAL AND EASTERN SYDNEY

An Australian Government Initiative

EXPRESSION OF INTEREST

Diabetes Care Clinic - General Practices

EOI release date	14 July 2026
Deadline for EOI application submission	3rd August 2026

EIS Health Ltd.

1. Overview

Central and Eastern Sydney Primary Health Network (CESPHN) welcomes small and solo general practices in the Inner West region to submit an Expression of Interest (EOI) to participate in the Diabetes Care Clinic program
This new program offers an innovative approach to multidisciplinary team-based care for people living with prediabetes and type 2 diabetes in the primary care setting. The program aims to improve integration of diabetes education and support in primary care, reduce or delay the progress of prediabetes to type 2 diabetes and reduce the risk of complications, hospitalisation and mortality for people living with type 2 diabetes.

Under the program, general practices will refer eligible patients to receive diabetes education and support from Diabetes Australia via defined clinical pathways. Clients participating in the program will receive a minimum of two consultations with a Credentialled Diabetes Educator (CDE), Accredited Practicing Dietician (APD) and/or Accredited Exercise Physiologist (AEP), depending on individual need. Consultations will be held in the participating general practice (diabetes education and support clinics), or virtually and will be provided free-of charge for eligible patients.

This program requires participating practices to work collaboratively with Diabetes Australia to facilitate a location in the practice where program consultations can occur, in addition to identifying patients for referral to the program and actively promoting the program to practice staff.
Financial support to the value of $5000 (excluding GST) will be offered to general practices to participate in the program. An initial payment of $1000 will be paid upon execution of the Services Agreement, followed by two instalments of $2000 until completion of the program in June 2027.

2. Information about Central and Eastern Sydney PHN

What are primary health networks?

Primary health networks (PHNs) have been established with the key objectives of increasing the efficiency and effectiveness of medical services for individuals, particularly those at risk of poor health outcomes. They also aim to improve coordination of care to ensure people receive the right care in the right place at the right time. PHNs are not for profit, regionally based organisations which aim to strengthen primary care by redirecting frontline health services to improve health outcomes of the community.

Our vision

Our vision is to achieve healthy and thriving communities and we do this by enabling high quality accessible health care. Our goals are to address community health and wellbeing needs, facilitate connected and quality care and partner to address regional challenges.

Our region, our community

The Central and Eastern Sydney catchment spans 587 square kilometres. Our region stretches from Strathfield to Sutherland, as far east as Bondi, and includes Lord Howe Island. We are the second largest of the 31 primary health networks across Australia by population, with over 1.5 million individuals residing in our region.
Our catchment population is characterised by cultural diversity, with an estimated 16,225 (1.05 per cent of total population) identifying as Aboriginal and/or Torres Strait Islander and forty percent of our community born outside Australia, and high population growth. Our boundaries align with those of South Eastern Sydney Local Health District and Sydney Local Health District. Refer to this template list of postcodes within the CESPHN catchment area.

For more information about our region visit the 'About CESPHN' page on our website at https://www.cesphn.org.au/

3. Program Activities

The program provides a structured multidisciplinary primary care model designed to provide timely, person-centred support for people with pre-diabetes and type 2 diabetes in their general practice or virtually.

Diabetes Australia will provide two pathways for patients at participating practices who are referred to the program. Following referral by the practice, Diabetes Australia will oversee intake into the program, assigning each patient to a clinical pathway based on diagnosis, risk profile, health literacy and goals.

Pre-Diabetes Pathway

- Diabetes Australia will provide patients with pre-diabetes with up to three individual consultations over 12 months. Consultations will be delivered by an Accredited Practising Dietitian (APD) and/or Accredited Exercise Physiologist (AEP).
- Visits will focus on lifestyle risk assessment and goal setting and progress reviews, diabetes-prevention education and referral to complementary services.

Type 2 Diabetes Pathway

- Diabetes Australia will provide clients with type 2 diabetes with a minimum of two consultations within six months, with flexibility for reviews where clinically indicated.
- Visits will be delivered by a Credentialled Diabetes Educator (CDE) and/or APD with AEP involvement as required, and focus on establishing a baseline assessment, individualised goal setting and progress reviews, and tailored diabetes education

This program requires participating practices to work collaboratively with Diabetes Australia. Program activities required by the practice are outlined in *Figure 1. Expectations of the participating practices.*

Key Service Principles for Participating GPs

GP-led care

The Diabetes Care Clinic model is designed to complement—not replace—existing general practice care. The GP remains the primary care provider and central coordinator of the patient's ongoing management.

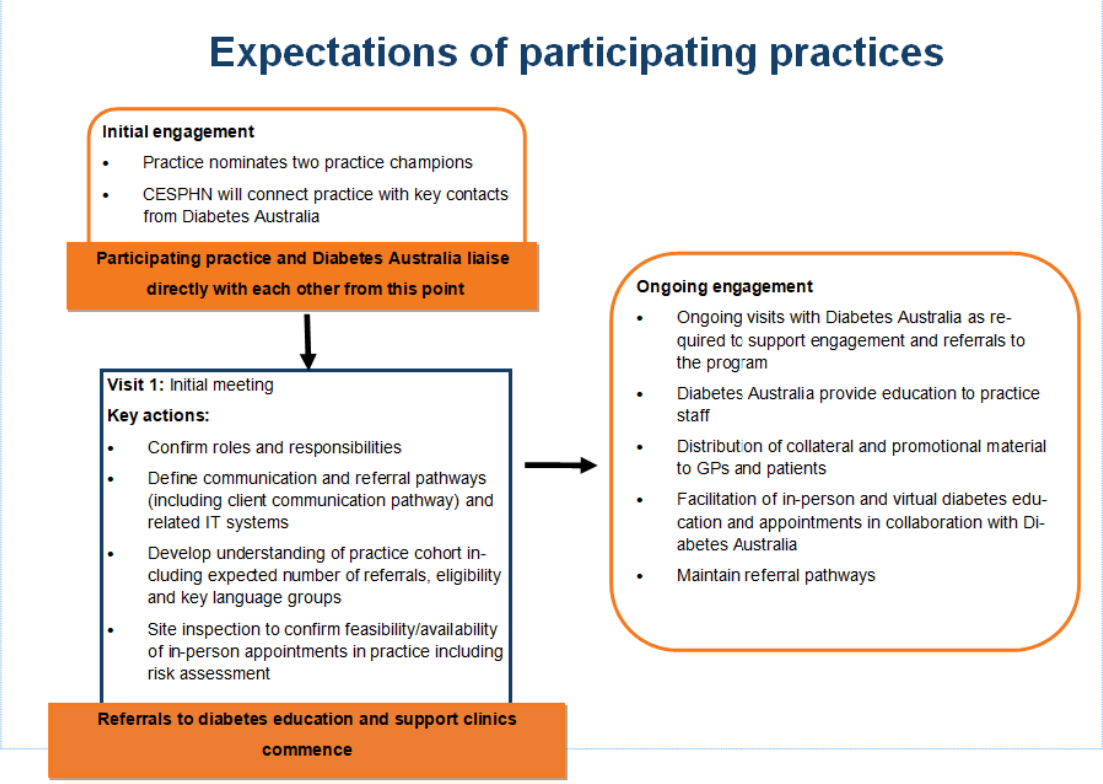
Advisory clinical support

The Diabetes Australia multidisciplinary team will provide evidence-based clinical recommendations to support patient care. Any treatment decisions, including medication changes, remain at the discretion of the referring GP.

Best-practice referral approach

Referrals into the service will align with established best-practice processes. The program will operate independently of individual practice clinical software systems, with clear and streamlined referral pathways and consultation outcomes provided.

Figure 1. Expectations of participating Practices



4. Eligibility criteria for general practices

To be eligible to participate in the Multidisciplinary care for prediabetes and type 2 diabetes program, the general practice must be a solo or smaller practice (1-5 GP FTE) located within areas in the Inner West region of Sydney (Canterbury SA3, Strathfield-Burwood-Ashfield SA3 and Marrickville-Sydenham-Petersham SA3). Practices require a data extraction tool (POLAR) to collect data relating to the project. Practices that do not have a data extraction tool installed will be assisted by CESPHN.

The eligibility criteria for Diabetes Care Clinic program are as follows:

- General practice located within the Inner West region identified by CESPHN for participation in the program
- Solo or smaller (1-5 GP FTE) general practice
- Available consulting room for at least one day per fortnight, with potential to increase depending on demand (to be negotiated with the Diabetes Australia)*
- Willingness to collaborate with Diabetes Australia staff prior to commencement of the service to determine scope of practice and establish systems required for successful implementation of the program as per *Figure 1. Expectations of participating practices.*

- Practices must be willing to facilitate practice visits with Diabetes Australia.
- Processes to ensure confidential information sharing, allowing Diabetes Australia to conduct comprehensive assessments for patients, including managing patient consent for referral to Diabetes Australia to participate in the program
- POLAR extraction tool, or willingness to install (through CESPHN)
- Onboarding of the Diabetes Australia staff with practice policies, processes and procedures
- Capacity to collect data and meet reporting requirements for patients referred to Diabetes Australia as part of the program
- Be connected to LUMOS or willing to connect to the LUMOS program.
- Be registered with Provider Connect Australia (PCA) or willing to connect to PCA.
- Capacity to establish and implement methods of communication, referral pathways and workflow plans for patients participating in the program
- Capacity to meet the program objectives and outcomes through the referral of eligible patients to the program
- Nominate lead GP (clinical champion) and practice manager/practice admin (administrative champion) at the general practice prior to commencement of service to guide the practice in program participation.
- Participating practices must attend the information session hosted by CESPHN once confirmed as successful.

Client eligibility criteria:

Eligible referrals include clients with pre-diabetes or type 2 diabetes who are not receiving duplicate care under another service and are referred from a participating practice.

As prediabetes and type 2 diabetes disproportionately impact certain populations, the following clients will be prioritised:

- Aboriginal and/or Torres Strait Islander clients and/or
- Clients from culturally and linguistically diverse backgrounds, particularly humanitarian entrants and/or
- Clients over the age of 60 years and/or
- Clients who are experiencing financial hardship (e.g. Hold a current Health Care Card, Low Income Health Care Card, Pension Card)
- Out-of-scope clients (e.g., with complex medical comorbidities or significant psychosocial barriers) will be redirected to specialist or tertiary care.

*Practices without an available consulting room may be able to access services via virtually held services. If room availability is a barrier, please specify your preference for offsite consultations in your application.

5. Reporting requirements

The general practice will be required to submit reports via completion of a survey submitted to CESPHN. The practice must also have appropriate procedures and processes in place for data collection to meet reporting obligations. This includes reporting against agreed milestones and outcomes.

Data collection specifications are clearly defined in the Memorandum of Agreement (MOA) and include:

Set up and baseline data

- Outline of roles and responsibilities and agreed communication channels including referral pathways
- Number of patients at the practice with type 2 diabetes/pre-diabetes
- Number of patients planned for recall and referral to the program
- Planned number of practice staff educations sessions
- Anticipated barriers/facilitators

Progress reporting

- Number of recalls made/number of patients successfully recalled
- Number of referrals made
- Number of practice staff education sessions
- Barriers/facilitators

6. Contract Term

Participating practices will enter into a MOA with CESPHN. The term of the contract is 1 August 2026 to 30 September 2027.

Attached to this EOI is a MOA which will form a legally binding agreement on signing by the parties. The general practice must retain all insurances outlined in the agreement.

7. Funding

A total sum of $5000 (excluding GST) will be provided as financial support for participating in the program and completing reporting requirements.

An initial payment of $1000 will be paid upon execution of the MOA, followed by two instalments of $2000 until 30 September 2027 to deliver the program.

8. Submitting your application

Please read this EOI guidance and the MOA prior to applying to participate in the Multidisciplinary care for prediabetes and type 2 diabetes program. Applications can be submitted through the CESPHN online application form which can be accessed via: Expression of Interest Application - Diabetes Care Clinic - General Practice

Applications will close 3rd August 2026.

9. Contact us

All questions related to this EOI are to be directed to mdtdiabetes@cesphn.com.au