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CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

Strategy Day Workshop Report 2022

2 December 2022

Strategy Day 2022 Report

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Introduction

Central and Eastern Sydney Primary Health Network (CESPHN) held its annual strategic planning workshop on 15 October 2022 at their premises in Mascot. The goal of the day was to draw together diverse stakeholders who work in the region to discuss key issues and see how individual services when working together as regional partners might start to address key concerns for the health of the population. That is, the event was not to determine strategies for CESPHN's work necessarily, but priorities and strategies that could be implemented across the region by any service individually or in partnership.

Three topic areas were chosen as key focus areas:

- Mental Health and Wellbeing
- Healthy Ageing
- Primary Health Reform.

Prior to the workshop, invitees received detailed briefing papers that outlined the main issues for each topic. A total of 83 varied stakeholders attended (the attendance list is at the end of the document).

At the event, participants joined in two workshops of their choosing. In the workshops participants answered a series of questions and prioritised strategies they thought were important for each topic. Jenni Campbell facilitated the event and has summarised the discussions the questions prompted in this report, along with a summary of high priority solutions raised at each workshop.

Healthy Ageing

Question one: Do you support this assessment of healthy ageing as it currently is? Is there anything you would add or emphasise?

Participants added or emphasised the following points:

Social inclusion and connection

Participants expressed concern about older adults withdrawing socially and experiencing social isolation and loneliness. Participants were particularly concerned about:

- older adults who live alone
- older adults who live independently in the community that may not be aware of the services and supports available to them
- older adults who are not connected with general practice

Participants prioritised assertive home-based health services and social health initiatives that address health issues whilst addressing isolation and disconnection from the community. Participants highlighted simple strategies like dropping health information into letterboxes in communities with a high proportion of aged residents.

Addressing stigma and discrimination

Participants emphasised the importance of decreasing the stigma and discrimination experienced by older adults in various community settings by challenging and influencing the attitudes of the health workforce and the broader community, addressing the perception that older age is a period of inevitable decline.

Ageing well earlier

Participants highlighted the opportunities to start the healthy ageing journey early with proactive and preventative healthcare resources and services for people in their 40s, 50s and 60s.

Some participants suggested that healthy ageing information and education should begin during pregnancy and focus on the dynamic and preventable influences of healthy ageing, targeting mechanisms that influence age-related pathologies and disability.

Safe and appropriate resources and services

Participants reported that many resources and services are not designed for older adults and do not meet diversity and inclusion principles (see section four – Diversity and Inclusion).

Contribution

Participants would like stakeholder partners to focus on the strengths of older adults, including their knowledge, skills, and experiences. Stakeholders want to create opportunities in the health system for the contribution of older adults and elevate older adults beyond the status of passive recipients of services to active agents of change within the system and valuable contributors. As part of this aim, participants highlighted the importance of volunteering opportunities for older adults and formal consultancy/advisory roles and groups.

Question two: How can we work together to progress these solutions/strategies?

Participants recommended:

- An older adult consultative group for all local services to seek advice and support when designing resources or services.
- Collaborative effort to develop social prescribing resources or "Life scripts."
- Engage with stakeholders at the local government area (LGA) level and community level to progress place-based initiatives.
- Complete a stakeholder mapping activity by LGA and by diverse groups:
    - Identifying relevant groups, organisations, and people
    - Understanding how stakeholders would like to be involved
    - Mapping relationships to objectives and other stakeholders
    - Prioritising stakeholder relevance and identifying the resources required to optimise engagement with high-priority stakeholders
- Co-creation of a community-facing directory and Health Pathway resources for older adults, carers, and families with a commitment from local services to keep their own information up to date.
- Co-commissioning with other funding bodies to invest and co-design Primary Health Centres.

- Participants recommended improved opportunities for General Practice and Local Health Districts to communicate and work together
- Partnership with local businesses

Question three: What programs or partnerships have proven to be valuable for older adults in the past?

Participants noted the following examples of valuable programs or partnerships:

- Intergenerational exchange and interaction (young people and older adults)
- Partnerships with carers and families with a focus on education
- Partnerships with Elders and leaders and planning resources and services together
- Post-discharge support for older adults being discharged into the community
- Advanced care planning initiatives

Healthy Ageing

VERY HIGH PRIORITY SOLUTIONS

Innovative models

Participants discussed and referenced a range of models they would like introduced in Central and Eastern Sydney, with social prescribing projects generating the most enthusiasm.

Living longer in the community

Participants highlighted the importance of initiatives and activities being oriented around places in the community, designed with the community, and responsive to each community's unique needs.

Regional reform

Aged care reforms in Australia are underway, and participants identified solutions to progress reforms in a regionally meaningful way.

Excellence in General Practice

Participants articulated the critical role of general practice in supporting wellness in later life.

Innovative models

Participants discussed and referenced a range of models they would like introduced in Central and Eastern Sydney with social prescribing projects generating the most enthusiasm.

The following solutions were proposed by participants:

- Social prescribing, program/activity mapping, community health pathways (10)
- Peer support workers in the ageing model (9)
- One-stop shop for older adults (5)
- Front kiosk/resources for pharmacists (3)
- Volunteering programs focused on wellness (7)
- Last 1000 days. End-of-life planning and emotional support (5)
- Social Prescribing, including community engagement (11)
- Emergency hospital at home (2)
- Group work for older adults in community centres (4)
- Volunteers (particularly from among older people) to provide links to coordination (3)
- Doulas for older people (1)

Living longer in the community

Participants highlighted the importance of initiatives and activities being oriented around places in the community, designed with the community, and responsive to each community's unique needs

The following solutions were proposed by participants:

- Supporting local councils and groups (16)
- Appropriate supported housing (8)
- Location of care appropriate to services community and individual needs (4)
- Evidence-based community development models e.g., old people's homes for teenagers (4)
- Healthy neighborhoods - environments in local community town planning (1)
- Pharmacies as a resource (3)
- Empowering each community to identify the priorities for programs and projects (4)
- Greater support for carers and families (7)

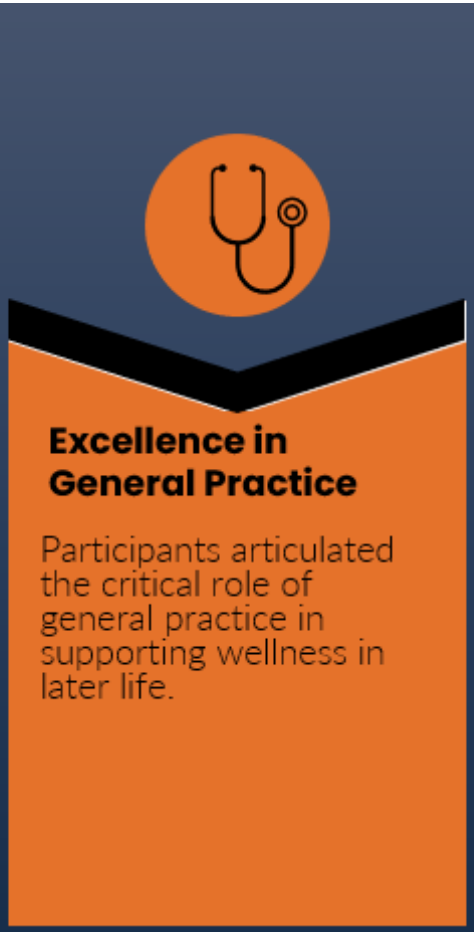
Regional reform

Aged care reforms in Australia are underway and participants identified solutions to progress reforms in a regionally meaningful way.

The aged care reforms will put senior Australians first, improving quality, safety and choice in aged care to create a sector that is simpler to navigate, empowers senior Australians to make informed choices, is strongly regulated, is more transparent, makes sure providers are accountable, and values and grows the aged care workforce.

Participants proposed the following solutions to progress reforms in a regionally meaningful way:

- Communicate about and contribute to reform in aged care activities (12)
- Link in with reform initiatives (e.g., community and workforce training in preventing elder abuse).
- Medicare reform for longer consults for GPs and allied health (4)



Participants proposed the following solutions:

- PHN to profile what patients want from their GP and raise awareness of their profile with GPs (2)
- Patient registration to enable better preventative care and engagement (4)
- Concierge service from the PHN to connect potential patients and GPs with services (6)
- Extended GP consultations (1)
- Brief, accessible strategies with evidence in a culturally accessible format (2)
- Taking GP/Allied services to the home (4)
- Program for people without GPs and assistance (3)

ENABLER

REFERRAL PATHWAYS

- Head start for ageing referrals (6)
- Mapping of Gap and community services (8)
- Navigator for healthy and unhealthy (9)
- Improve accessibility to service (2)
- Health pathways for services in the community for older people - preventative or early intervention (2)

ENABLER

WORKFORCE

- Ongoing education and resources from early intervention to late stages of life (4)
- Types of workforce (8)
- Workforce pathways from university placements (2)
- Health promotions to the potential workforce to ensure workforce capacities are maintained and increased overtime (1)
- Build awareness (incentives support, languages, cultural messages, destigmatises support (2)
- Culturally appropriate communication (3)
- Cultural safety training (3)
- Aboriginal cultural needs to be addressed (this is a must) (3)
- Education about systems and programs for culturally diverse and aboriginal communities (3)

Mental Health and Wellbeing

Question one: Do you support this assessment of the primary mental health sector as it currently is? Is there anything you would add or emphasise?

Participants added or emphasised the following points:

Physical healthcare needs

Participants at all tables highlighted concerns about the gap in physical healthcare status and outcomes for people who experience mental health issues. Participants reflected on the little progress made to bridge this gap. Consumers, carers, and services continue to report a siloed experience of a disjointed system.

Participants identified several opportunities:

- Improve health literacy of consumers, carers, and families
- Improve the mental health literacy of primary health and allied health providers
- Commissioning with clear expectations and specifications relating to physical healthcare and outcomes.
- Lobby for a Medicare item that covers physical health and mental health together

- Create an integrated service model that includes primary health and allied health resources and services

Partnered needs assessment, planning, mapping, and co-commissioning
Acting with a one-health system mindset resonated with participants. Participants expressed a desire for the PHN, LHDs and SHNs to undertake joint needs assessments, planning, mapping, and co-commissioning.

Neurodiversity and health system responses

Participants identified significant challenges in finding resources and services for people with Attention Deficit Disorder (ADD), autism, intellectual disability, developmental delay and co-occurring mental health issues. This is compounded if the person requires access to specialist support (e.g., psychiatry). Participants acknowledged that the responsibility for this problem and potential solutions is not the PHNs alone but emphasised the importance of sector leadership to address this issue.

Primary care and allied health representatives emphasised the challenges experienced when attempting to locate assessment and treatment options for patients and the clinical isolation experienced when a multi-disciplinary response is indicated but unavailable.

Participants also suggested advocating for an increased prescribing role for GPs with psychiatry consultation liaison if needed and education programs for GPs.

Supporting Stolen Generations

A lack of social and emotional well-being supports focused on Stolen Generations, and healing from trauma was noted. There has been considerable progress in other states (e.g., QLD Healing Strategy) but limited visible support in NSW. Support to access the National Redress Scheme was also noted – how might stakeholders communicate with people about the National Redress Scheme? Participants indicated a desire to engage in a dialogue and co-design process with stakeholders to address this need at the regional level.

Question two: How can we work together to progress these solutions/strategies?

Participants recommended:

- Linking services with like-minded priorities around a particular demographic or issue
- Increasing opportunities for psychiatrists, GPs and mental health services to network and get to know each other's roles.
- Co-design and co-develop with all stakeholders for all commissioning activities
- Virtual café series promoting new resources and services in the region (monthly or quarterly process) with an open invitation to interested stakeholders (including GPs).
- Deconstruct the predominant isolated service models and create co-location, place-based and flexible service offerings.

Question three: What programs or partnerships have proven to be valuable for target populations in the past?

Participants reflected on positive previous experiences with the following programs and partnerships:

- Partners in Recovery, where people were supported to access resources and services relevant to their biopsychosocial needs and goals
- Peer-led models (e.g., GROW is written by people with lived experience)
- Cross-agency training and networking events
- headspace Bondi Junction (LHD partnership and co-located services)
- Redlink Integrated Service Hub, which offers free daily services with legal, health and financial needs to social housing residents in the area.
- Head to Health – with a recommendation to build on the model by including assisted self-management, social prescribing, and low-intensity options.
- St Vincent's Hospital Homeless Health Program
- The Village Medical Practice at Summer Hill

Question four: How can existing and emerging workforces assist in addressing these issues?

Participants recommended:

- Grow and develop the consumer and carer Peer Workforce
- Grow and develop health navigators
- Practice nurse involvement in supporting mental health and physical healthcare

MENTAL HEALTH AND WELLBEING

VERY HIGH PRIORITY SOLUTIONS

PEER WORKERS

Participants reinforced a desire for increased investment in and support for consumer and carer Peer Workers, First Nations Peer Workers, lived experience leaders and educators.

TRAUMA

Participants highlighted the importance of service models being trauma-informed and responsive. Participants expressed interest in developing a trauma-informed workforce plan with training, supervision, mentoring, and experiential learning.

NAVIGATION

Participants celebrated the recent investments in digital navigational support. Participants are seeking in-person navigation support across primary care and community services.

SAFE AND APPROPRIATE CARE

Participants highlighted the importance of local services and providers delivering safe and appropriate care for First Nations Peoples, CALD people, LGBTIQ+ people, children, young people and older adults.

PEER WORKERS

Participants reinforced a desire for increased investment in and support for consumer and carer Peer Workers, First Nations Peer Workers, lived experience leaders and educators.

Participants proposed the following solutions:

- Strategies that help **grow** the peer workforce in mental health and alcohol and other drugs (6)
- Strategies that help **support** the peer workforce (6)
- Strategies that build the capabilities of the peer workforce to deliver evidence-based intentional peer support and carer perspective peer support (6)
- Peer Workers available to provide practical assistance for self-management (4)
- Development of a First Nations Peer Worker Strategy for the region (4)
- Mobile peer workforce in primary care (4)
- Greater promotion of the evidence and value of the peer workforce (4)
- A lived experience recognition program (celebrating the impact of consumer peer workers, carer peer workers, lived experience leaders and lived experience educators (4)

TRAUMA

Participants highlighted the importance of service models being trauma-informed and responsive. Participants expressed interest in developing a trauma-informed workforce plan with training, supervision, mentoring, and experiential learning.

Participants proposed the following solutions:

- Fund a Train the Trainer program or training placements in CALM https://calmtraining.co.uk/programmes/trauma-informed-practice/ (10)
- Training in addressing trauma within the body through sensory interventions (9)
- All new models of care must be trauma-informed and responsive (6)
- Specifications of new models of care should be reviewed against trauma-informed principles/standards (5)
- Models of Care that are trauma-informed (e.g., Dialectical Behavioural Therapy) (4)

NAVIGATION

Participants celebrated the recent investments in digital navigational support. Participants are seeking in-person navigation support across primary care and community services.

The following solutions were proposed by participants:

- Peer Workers in navigation roles (10)
- Peer navigation to support social referral, e.g., a program to reach out to hardly-reached people (8)
- Navigators (peers + bilingual + First Nations) between GPs, mental health, and other services (5)
- Peer Workers / lived experience navigators to demystify the services available, optimise informed decision-making and facilitate warm introductions to services (4)
- Navigation roles embedded in community organisations (3)
- Increase support for GPs to help navigate services/social groups and technology (3)
- Service mapping (8)

SAFE AND APPROPRIATE CARE

Participants highlighted the importance of local services and providers delivering safe and appropriate care for First Nations Peoples, CALD people, LGBTIQ+ people, children, young people and older adults.

The participants proposed the following solutions.

- Invest in programs that are evidence-based and address stigma and discrimination in the health workforce towards First Nations people, LGBTIQA+, and CALD people (7)
  - An annual stakeholder program of cultural awareness, education and cultural immersion activities (4)
  - Culturally appropriate/healthy living/wellbeing education videos. Culturally appropriate/healthy living/wellbeing education videos (4)
  - Placement of service providers in Aboriginal communities (5)
  - Create opportunities for workforce and consumers - sharing stories with purpose and intent in many forms, meetings and ways
- Develop a 'culture in CES' video (First Nations, CALD, lived experience, LGTBTIQA+) and play at all training and events and host on the website (3)
- GPs are often willing to address MH issues (due to so much effort in the past 30 years in training GPs around MH and efforts to reduce the stigma of MH) but reluctant to address AOD issues (limited training of GPs and still so much stigma remains around substance use).

INTEGRATED MENTAL HEALTH SERVICE MODELS

COMPONENTS

- Service navigation
- Intentional Peer Support
- Carer Perspective Peer Support
- Assisted self-management
- Psycho-education groups
- Evidence-based psychological interventions
- Support Coordination
- Secondary consultation
- Specialist support (e.g., Dokotela)
- Across the continuum of stepped care (levels 1 – 5)

TARGET GROUP

People experiencing mental health issues, co-occurring issues and their family, carers, kin and supporters

LOCATION

Operational hub with place-based spokes.

OUTCOMES

- Improved quality of life
- Improved psychological wellbeing
- Increased social connection
- Improved overall wellness
- Identified service and support needs met
- Increased knowledge and skills associated with self-management
- Increased knowledge and skills for pre-crisis, crisis, and post-crisis

ACCESS

No formal referral required but a strong focus on connecting all consumers and carers with general practice

PARTNERS

- Aboriginal Community Controlled Organisations
- Mental Health and AOD services
- Primary care

VALUES

Welcoming
Inclusive
Safe
Appropriate
Respectful
Responsive
Connected
Accessible
Integrated
Hopeful
Person-centred
Family-oriented
Relational
Accountable
Transparent

COST STRUCTURE

- Co-commissioning by PHN and LHDs and drawing in funding from other sources (NDIS, Medicare, etc.).
- One lead agency responsible for the hub function
- Multiple providers commissioned to deliver a service component based on organisational expertise

OTHER

ENABLER

COLLABORATION

- Regular interagency roundtables, both ADO and MH. (NGO, Primary care, LHD, PHN)
- CESPHN and partner working group to start progressing today's ideas.
- Thought leadership on the impacts of climate change on MH and resources to address this
- Re-energise strategies that lead to better integration between the hospital, community and primary health
- All partners pool a proportion of their training budgets to invest in high-priority shared capability development (e.g., trauma-informed and responsive care)

ENABLER

LIVED EXPERIENCE LEADERSHIP

Develop a Lived Experience Health Workforce Education Strategy

- Education to medical students from peer workers and lived experience leaders on how best to work with the cohort
- Co-facilitated education (consumers, peer workers, primary care) around physical and mental healthcare.
- AOD training co-facilitated by AOD educators

ENABLER

WORKFORCE

- Work together to develop an interagency mechanism for working with universities, RTOs and colleges to plan training, placements, and opportunities for the emerging health workforces in mental healthcare and AOD settings
- All partners pool a proportion of their training budgets to invest in high-priority shared capability development (e.g., trauma-informed and responsive care)
- Help GPs to understand all roles in MH and support wellbeing
- Train GPs in brief psychological interventions (mindfulness minute)
- Offer help, support and opportunities for allied health workers to practice in mental health and AOD settings
- Mastery of risk management training (rather than risk avoidance)
- Advanced skills in mental health training for all GPs
- Advanced skills in AOD assessment and interventions for all GPs

ENABLER

COMMUNICATION

- Better promotion of new psychological services (email, education, newsletters).
- Add head start on the landing page of the CESPHN website
- Informing GPs about existing community services and how to access
- Change of focus on people's experiences rather than diagnosis/labels
- Social view of health and medical, e.g., social prescribing and social view of health

ENABLER

REFERRAL PATHWAYS

- Alternate pathways to care, e.g., peer referrals (2)
- Targeting Youth (12-24 years) - Gap service 16–18-year-olds within hospitals
- Include social prescribing in health pathways (5)
- Health pathways as an option supports GPs with no wrong door (9)

Primary Health Reform

Primary Health Reform

Question one: Do you support this assessment of primary health reform as it currently is? Is there anything you would add or emphasise?

There was support for the content of the Primary Health Reform Topic Guide. In addition, participants added or emphasised the following points:

Under-utilisation of practice nurses

Participants acknowledged that when practice nurses work at the top of their scope, they may experience increased role satisfaction. Some participants suggested that practice nurses not working to the top of their scope is correlated with GPs not working to the top of their scope. Advocacy for the nurse practitioner role was also highlighted as an important addition to the paper. Participants suggested an enhanced partnership between local stakeholders and the Australian Primary Health Nurses Association (APNA).

Under-utilisation of allied health professionals

Participants reinforced that the MBS does not adequately fund the care provided to allied health professionals, and subsequently, patients experience difficulties accessing and funding allied health services. Again, reform of Medicare billing was identified as the primary solution. In the absence of Medicare reform, participants recommended innovative funding models for high-priority population groups (e.g., older adults) and supplemental funding (e.g., through vouchers).

The future of General Practice

Strategies outlined in the Topic Guide garnered considerable support from participants. These include:

- Pressure and advocacy around Medicare reform
- Voluntary patient registration
- Refocusing workforce incentive payments

Importantly, participants discussed the lack of respect and appreciation for General Practice. The consequence is turnover in the workforce, GPs reducing their clinical hours (and taking on other roles in the health system), and declining interest from medical students to become a GP.

Other disciplines and community members may not appreciate the complexity of general practice. As 'general medical specialists' GPs transverse the spectrum of wellness and illness and provide services across the lifespan – with a vast variety of skills, knowledge and training required to do so.

Participants discussed how the PHN and stakeholders might work together to address this issue. One stakeholder wrote: "the good GP is invisible. How do we change that together?"

General Practice pipeline

Participants spent much time at the tables talking about the General Practice pipeline and the importance of addressing the decline of medical students choosing to participate in a GP Training Program.

Participants identified several ideas:

- PHNs and general practice should work together to create positive learning experiences for students
- Exposure to General Practice – opportunities to work with universities to showcase general practice.
- Opportunities to work with universities and leaders to 'reframe' the conversation around General Practice (e.g., culture and attitude of educators).
- With the 2023 changes to GP education, participants wondered if the PHN can be part of the student training and promote the best primary care experience.
- Promote General Practice as an existing, clinically diverse and rewarding profession (local collaborative marketing campaign).
- Participants suggested that any strategies are best explored and implemented collaboratively (e.g., PHN, GPs, universities, peak bodies, and colleges).

Diversity and Inclusion

Diversity and inclusion were strong themes during the CESPHN Strategy Day. Diversity is about recognising, respecting, and valuing differences. Diversity includes the following identities:

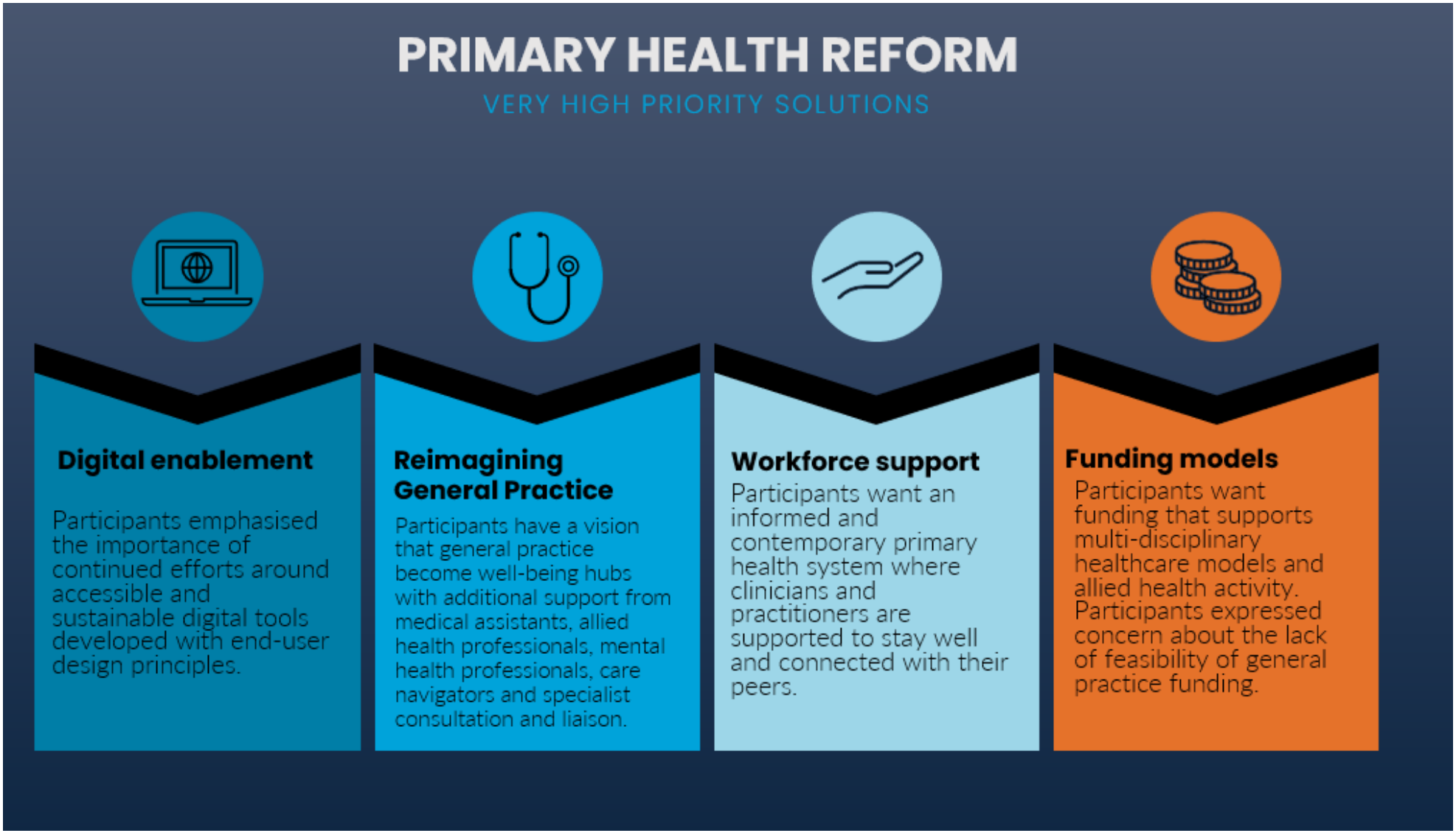
- First Nation Australians
- Age
- Cultural background
- Caring responsibilities
- Disability status
- Gender
- Religious affirmation
- Sexual orientation
- Gender identity
- Socio-economic background.

A range of strategies relevant to diversity and inclusion emerged from the CESPHN Strategy Workshop. Participants across all topics highlighted the importance of health information and health service improvements regarding diversity and inclusion.

These strategies include:

- An expectation that providers recruit a diverse workforce of employees and volunteers.
- Actively recruiting members from diverse backgrounds and across the lifespan to participate in committees and councils.
- Include people from diverse backgrounds and across the lifespan in the development, planning and evaluation of services.
- Being visible and vocal in our work with diverse communities (e.g., displaying the rainbow flag accreditation, promotional material in languages other than English, First Nations Art, and images of older adults in promotional materials).
- Being overt about our commitment to diversity and inclusivity in promotional materials and communications.
- Being mindful of and adjusting our language to ensure the terms used when discussing health and mental health aren't offensive or alienating.

- That communications avoid the use of nuclear-normative language when referring to families.
- Stakeholders partner with communities in hosting ceremonies, events, and activities (e.g., Mardi Gras, Aged Care Exhibitions).
- Stakeholders formalise partnerships with organisations serving diverse communities. Work with community leaders to build relationships, address challenges, and make the most of opportunities.
- An investment in policies that promote service partnerships and referral networks specific to the needs and goals of diverse communities and across the lifespan.
- That service providers offer assessment, resources and services that are appropriate, safe, and responsive to people from diverse backgrounds and deepen our understanding of the unique needs, beliefs, understandings, and preferences of each person.
- Enable and support expressions of culture and identity and the sharing of culture and identity with others.
- That service providers co-locate with a diverse range of services (e.g., multicultural mental health services, disability support services, aged care services) where appropriate.
- With informed consent, involve and welcome family, kin, and significant people (e.g., disability support workers, spiritual leaders) to be involved in decision-making.
- Communicate in ways that are accessible and appropriate, including through the use of interpreters, Easy English, accessible documents, and multiple languages.

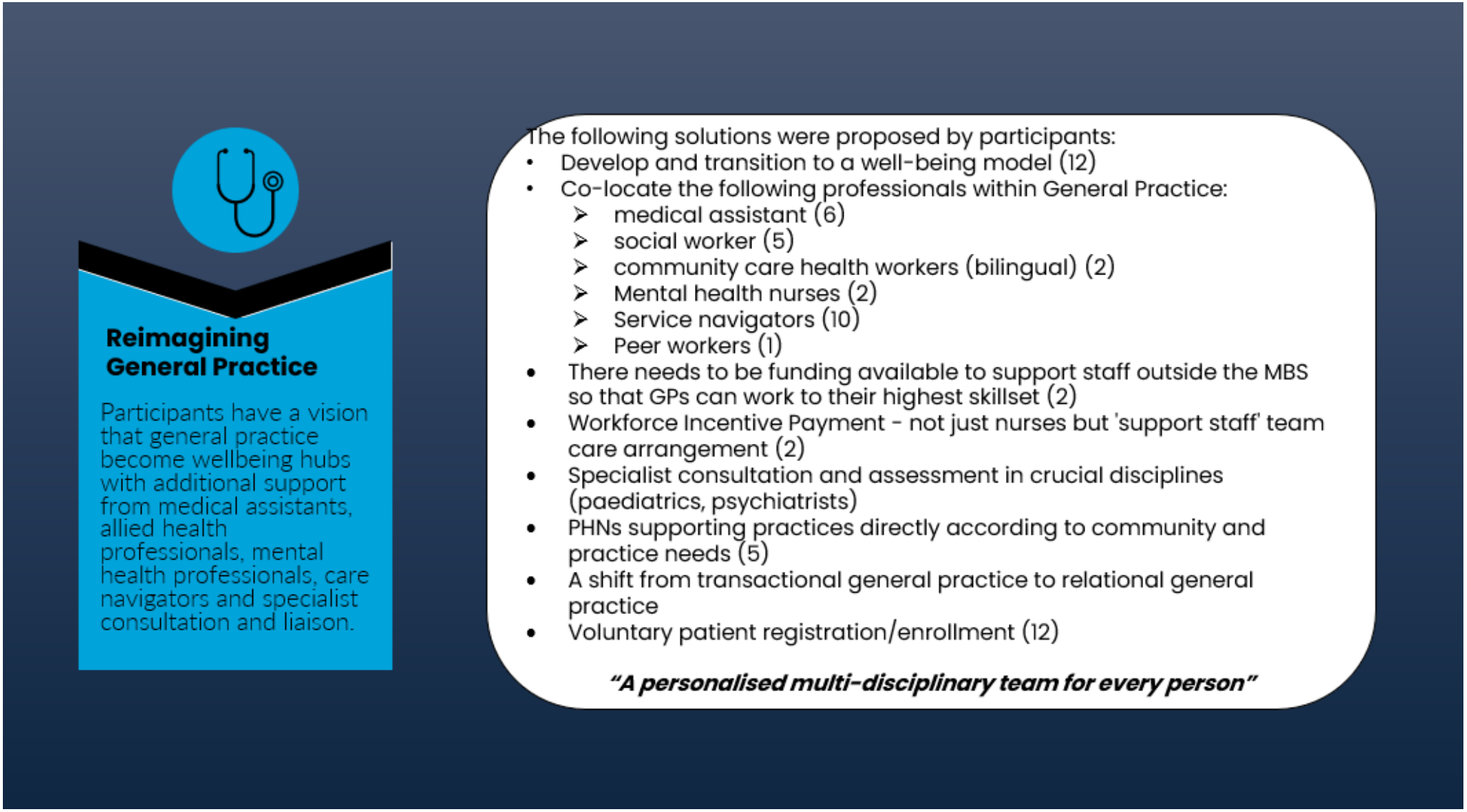

PRIMARY HEALTH REFORM
VERY HIGH PRIORITY SOLUTIONS
Digital enablement
Participants emphasised the importance of continued efforts around accessible and sustainable digital tools developed with end-user design principles.
Reimagining General Practice
Participants have a vision that general practice become well-being hubs with additional support from medical assistants, allied health professionals, mental health professionals, care navigators and specialist consultation and liaison.
Workforce support
Participants want an informed and contemporary primary health system where clinicians and practitioners are supported to stay well and connected with their peers.
Funding models
Participants want funding that supports multi-disciplinary healthcare models and allied health activity. Participants expressed concern about the lack of feasibility of general practice funding.

Digital enablement

Participants emphasised the importance of continued efforts around accessible and sustainable digital tools developed with end-user design principles.

Participants endorsed the "greater focus on digital health" solution proposed in the briefing paper and added the following:

- Focus on establishing an integrated digital health system (18)
  - Training in digital health literacy and security for providers
  - Secure messaging and e-referrals
  - Connect and improve interoperability of digital health systems across providers
  - Electronic discharge summaries
- Upgraded telehealth in primary care payment models for video/phone/email consults in all practices (2)
- Influence the development and use of patient-friendly booking systems (where patients can book, reschedule, pay a deposit if needed, arrange a long appointment, and fill in pre-appointment paperwork) (5)


Reimagining General Practice
Participants have a vision that general practice become wellbeing hubs with additional support from medical assistants, allied health professionals, mental health professionals, care navigators and specialist consultation and liaison.
The following solutions were proposed by participants:
• Develop and transition to a well-being model (12)
• Co-locate the following professionals within General Practice:
➢ medical assistant (6)
➢ social worker (5)
➢ community care health workers (bilingual) (2)
➢ Mental health nurses (2)
➢ Service navigators (10)
➢ Peer workers (1)
• There needs to be funding available to support staff outside the MBS so that GPs can work to their highest skillset (2)
• Workforce Incentive Payment - not just nurses but 'support staff' team care arrangement (2)
• Specialist consultation and assessment in crucial disciplines (paediatrics, psychiatrists)
• PHNs supporting practices directly according to community and practice needs (5)
• A shift from transactional general practice to relational general practice
• Voluntary patient registration/enrollment (12)
"A personalised multi-disciplinary team for every person"

Workforce support

Participants want an informed and contemporary primary health system where clinicians and practitioners are supported to stay well and connected with their peers.

Participants proposed the following solutions:

- Primary care leadership program (focus on management, governance, quality improvement, and research) (6)
- Funded GP placements in various settings (e.g., mental health, alcohol and other drugs, disability) (4)
- Activities that support the mental health and well-being of the workforce (mentoring, lunch and learn sessions, peer group education and support) (4)
- Promotion of resources designed to support the mental health of professionals (e.g., Doctors 4 Doctors https://www.drs4drs.com.au/resource-hub/) and the Black Dog Institute Essential Network (TEN) or Health Professionals Burnout Program https://burnout.blackdoginstitute.org.au/#/ (4)

Many participants expressed concern about the future of general practice, with fewer students (proportionately) participating in a general practice training program. Participants want to work with the PHN to offer programs to prepare and motivate students for work as general practitioners. Promoting General Practice to student and junior doctors and creating positive primary care placement experiences was seen as key.


Funding models
Participants want funding that supports multi-disciplinary healthcare models and allied health activity. Participants expressed concern about the lack of feasibility of general practice funding.
The following solutions were proposed by participants:
• Funding structures that support multi-disciplinary care in primary practice (6)
• Funding or vouchers for allied health services in general practice (13)
• Continued pressure on Government to improve the funding model for General Practice (11)
• Longer funding contracts
• Funding for allied health professionals (AHPs) and vouchers for allied healthcare services (9)
• Funding structures that support multi-disciplinary care in primary practice – general practitioners and allied health professionals (9)
• Maintain efforts in lobbying for improved Medicare funding and arrangements for GPs and AHPs and better remuneration for GP practices (8)
• Change funding model - no one-year projects (2)
• Practice nurse funding must change – presently focused on maximising the billing of the practice, rather than holistic patient care.

ENABLER

DATA AND RESEARCH

- Data and research to show outcomes of primary care work
- Collaborative research between partners, e.g., discharge summary audit
- Tying accreditation to outcomes
- Partnerships with local universities and opportunities for GPs and health professionals to participate in research teams

Attendee list

First Name	Last Name	Organisation
Alessandra	Doolan	HTAG - The Health and Technology Advisory Group, Clinical Council
Alex	Zaia	CESPHN staff
Alex	Dolezal	CESPHN staff
Andrew	Anderson	Windgap Foundation, Community Council
Ann-Marie	Crozier	Sydney Local Health District, Clinical Council
Anton	Mayne	Mental Health Consumer Advocate, Community Council
Barbara	Kallinosis	Lifestyle Enhancers Physiotherapy, Clinical Council
Barbara	Simms Keeley	Community Elder, Aboriginal Advisory Committee
Belinda	Ivanovski	CESPHN staff
Ben	Steele	South Eastern Sydney Local Health District, Community Council
Bertha	Harvey	CESPHN staff
Brendan	Goodger	CESPHN staff
Caroline	Tumeth	3 Bridges Community - Penshurst Community Centre
Catherine	Goodwin	CESPHN staff
Charlotte	Hespe	GP Glebe Family Medical Practice, Chair RACGP NSW
Cherie	Bennett	Australasian Society for HIV Medicine (ASHM), Clinical Council
Cheryl	Brady	South Eastern Sydney Local Health District, Community Council
Christine	Lau	Sydney Children's Hospital, Randwick
David	Kelly	Odyssey House Redfern
Dominic	Le Lievre	St Vincent's Health Network Sydney
Gabrielle	Kay	One Door Mental Health
Gary	Nicholls	CESPHN Board Director
Hanna	Pak	CESPHN staff
Jackie	Curtis	Mindgardens
Jacky	Peile	Early Links, Clinical Council
Jan	Sadler	CESPHN staff

Jane	Miller	CESPHN staff
Janet	Green	The Junction Neighbourhood Centre, Chair Community Council and Chair Sydney Health Community Network
Jenifer	Diekman	Fresh Therapeutics Compounding Pharmacy Broadway
Jenny	Smith	Consumer advocate, Community Council
Jessica	Nicholls	CESPHN staff
John	Petrozzi	Body Mind Central, Central and Eastern Sydney Allied Health Network Chair, Clinical Council
Jonathan	Harms	Mental Health Carers ARAFMI NSW Inc
Julie	McCarthy	Move Well Physiotherapy and Exercise, Community Council
Julie	Millard	JM Consulting, Community Council
Karen	Rosier	CESPHN staff
Kathryn	Refshauge	The University of Sydney - Sydney School of Health Sciences, Clinical Council
Kay	Wilhelm	St Vincent's Hospital
Kira	Wright	CESPHN staff
Kylie	Woolcock	Australian Healthcare & Hospitals Association
Laurence	Gagnon	Flourish Australia
Lesley	Pullen	CESPHN staff
Lidia	Konik	CESPHN staff
Lilon	Bandler	Wayside Chapel Kings Cross
Lisa	Altman	South Eastern Sydney Local Health District
Lisa	Gamer	Stride Mental Health
Lisa	Merrison	CESPHN staff
Lisa	Parcsi	Sydney Local Health District
Lou-Anne	Blunden	Sydney Local Health District, Clinical Council
Lynn	Garlick	CESPHN staff
Margot	Woods	GP Rozelle Total Health, Clinical Council
Mariam	Faraj	CESPHN staff
Marianne	Gale	South Eastern Sydney Local Health District
Mark	Harris	CESPHN Board Director

Martina	Gleeson	GP Caringbah Family Practice, Clinical Leaders Network Chair
Nadia	Clifton	GP Ultimo Medical Practice, Clinical Council Chair
Nadine	Rose	CESPHN staff
Nathalie	Hansen	CESPHN staff
Nicky	Beckett	One Door Mental Health
Owen	Brookes	GP Engadine West Family Medical Practice, Chair Sutherland Division of General Practice
Pamela	Garrett	Sydney Local Health District
Paul	Bennett	Sydney Local Health District
Paul	Hardy	CESPHN staff
Peggy	Huang	CESPHN Board Director
Peter	Gonski	South Eastern Sydney Local Health District
Phoebe	Molesworth	CESPHN staff
Rachel	Turner	Lived Experience Representative
Rene	Pennock	CESPHN Board Director
Rob	Ramjan AM	CESPHN Board Director
Sanjay	Zanak	GP Medfirst Medical Centre, St George Division of General Practice
Sara	Whimster	GP Life Medical Clinic Bexley, St George Division of General Practice
Sharlene	McKenzie OAM	CESPHN Board Director
Sharon	Carey	South Eastern Sydney Local Health District
Sharon	Lee	Stride Mental Health
Sharon	Friel	GROW Australia
Shaylee	Matthews	Department of Communities and Justice, member Aboriginal Advisory Committee
Steven	Jreige	Albemarle Medical Practice, Clinical Council
Suzi	Petrozzi	Body Mind Central, Clinical Council
Tobi	Wilson	South Eastern Sydney Local Health District, CESPHN Board Director
Trent	Carruthers	Activ8 Health Club, CESAHN, Clinical Council
Vicki	Johnston	Leopard Consulting, Community Council
Wei-May	Su	GP East Sydney Doctors

Wendy	French	Kurranulla Aboriginal Corporation, Community Council
William	Ramage	Community Advocate, member Aboriginal Advisory Committee
Yvonne	Cheong Costa	CESPHN staff