Western Queensland Primary Health Network

PHN Pilots and Targeted Programs

2025/26 – 2028/29 Activity Work Plan

phn WESTERN QUEENSLAND

An Australian Government Initiative

ACTIVITY: PP&TP-EPP - 1 - PP&TP-EPP-1 (26-27) PHN ENDOMETRIOSIS AND PELVIC PAIN CLINICS

Activity Priorities and Description

PROGRAM KEY PRIORITY AREA

Endometriosis & Pelvic Pain

AIM OF ACTIVITY

The Endometriosis and Pelvic Paim Clinic (EPPC) initiative aims to deliver multi-disciplinary, patient-centered care that addresses complex women's health needs. The primary objectives are. to improve timely access to multidisciplinary, patient centred care for women experiencing endometriosis, pelvic pain, perimenopause, and menopause symptoms across the Western Queensland PHN region through a hub and spoke model that supports early intervention and management. The clinic seeks to reduce diagnostic delays for patients with endometriosis, pelvic pain, perimenopause and menopause symptoms and to promote early access to intervention, treatment, and management for the Western Queensland PHN region. The EPPC will be delivered via an outreach model of care to maximise accessibility for patients across the WQPHN region, ensuring women can benefit from timely, high-quality care closer to home.

DESCRIPTION OF ACTIVITY

The Endometriosis and Pelvic Pain Clinic (EPPC) will deliver enhanced, multidisciplinary services for the assessment, treatment, and management of endometriosis and pelvic pain, as well as perimenopause and menopause symptoms, through an outreach based hub and spoke model of care. The activity is designed to improve access to timely, coordinated, and patient centred care for women living across multiple communities in the Western Queensland Primary Health Network (WQPHN) region.

The outreach service model will enable women to access care closer to home and will be supported by strong integration with primary care, allied health, and specialist services to ensure continuity of care, early intervention, and effective ongoing management.

This activity will be delivered through the following approaches, some of which have commenced:

- The first EPPC clinic appointments have been established within the Central West Hospital and Health Service (CWHHS) region. The outreach hub and spoke model has been developed with combination of telehealth and face to face. The initial EPPC consultation will be delivered via telehealth, enabling the clinician to undertake a comprehensive medical history and preliminary assessment to support effective care planning and optimise the use of subsequent face to face consultations. This approach will also support identification of the most appropriate outreach location for in person appointments. Following the initial consultation, patients will be scheduled for an in person appointment at the next available outreach clinic within their region. Outreach clinics will be conducted on a three monthly basis, with face to face appointments aligned to these scheduled visits. The EPPC outreach hub and spoke model will respond to the specific health needs of women in the Western Queensland PHN region, with a strong focus on improving access, enabling early intervention, and delivering culturally safe, inclusive, and appropriate care for Aboriginal and Torres Strait Islander women.
- WQPHN will continue to support the early establishment and ongoing implementation of the EPPC hub and spoke outreach model, using the Joint Health Regional Needs Assessment and other relevant data insights to guide the staged expansion of service locations based on population need, identified service gaps, established local relationships, and the specific needs of individual communities.
- Scoping and consultation with key stakeholders has commenced and will continue across the South West and North West Hospital and Health Service (HHS) regions to identify additional outreach locations and or utilise existing services that are already well established by the Commission Service Provider, this approach will complement and strengthen the EPPC hub and spoke model of care across the WQPHN region.
- Scoping work conducted to date has also identified that the EPPC hub and spoke model will include a telehealth component to support service delivery, particularly for women living in rural and remote communities. Telehealth will complement face to face outreach services by improving access, supporting continuity of care, and enabling timely specialist input where in person services are not immediately available.

- WQPHN will continue to work collaboratively with key stakeholders, including Hospital and Health Services (HHS), the Royal Flying Doctor Service (RFDS), general practice, allied health providers, and other relevant partners to support system integration, reduce duplication of services, and inform the ongoing planning and expansion of the EPPC hub and spoke outreach model.
- WQPHN will maintain regular engagement with the commissioned service provider and key stakeholders to support coordinated planning of EPPC outreach service locations and schedules, ensuring services are responsive to local needs and aligned with existing service arrangements.
- As the outreach model expands, WQPHN will continue to strengthen referral pathways between primary care, specialist services, and allied health providers to ensure seamless, coordinated care and continuity for women accessing the EPPC.
- WQPHN has commenced work with the commissioned service provider to develop and implement effective communication and promotion strategies that support coordination of the EPPC outreach model. This includes promoting awareness of the service among referring providers and stakeholders, and supporting clear, consistent messaging to communities regarding service availability, scope, and access pathways to support timely referrals and appropriate service utilisation.
- WQPHN will work with the commissioned service provider to confirm that any advanced training or upskilling required by clinicians and relevant staff aligns with current evidence based practice guidelines.
- Digital health technologies will be incorporated into the EPPC outreach model, supported by training and upskilling, to enhance access, care coordination, and continuity of care for women living across the Western Queensland PHN region.

Needs Assessment Priorities

NEEDS ASSESSMENT

WQPHN JRHNA 2025-2026

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Sexual Health	14
Primary Care	14
Aboriginal and Torres Strait Islander	10
Coordination, Integration and Continuity of Care	9
Young people	16

Activity Demographics

TARGET POPULATION COHORT

Women in the Western Queensland PHN region that experience pelvic pain, endometriosis and menopause and perimenopause symptoms.

Activity Consultation and Collaboration

CONSULTATION

This activity aims to consult with stakeholders including Royal Flying Doctors Service (RFDS), Hospital and Health Service (HHS), Allied Health and General Practice to ensure continuity of service delivery, to reduce duplication and expansion of service delivery.

COLLABORATION

True Relationships and Family Planning HHS, RFDS and General Practice.

Activity Milestone Details/Duration

ACTIVITY START DATE

01/01/2026

ACTIVITY END DATE

30/06/2028

ACTIVITY: PP&TP-EPP-AD - 1 - PP&TP-EPP-AD-1 (26-27) ADMIN SUPPORT FOR PHN ENDOMETRIOSIS AND PELVIC PAIN CLINICS

Activity Priorities and Description

PROGRAM KEY PRIORITY AREA

Endometriosis & Pelvic Pain

AIM OF ACTIVITY

To administer the WQPHN Endometriosis and Pelvic Pain Clinics activity in accordance with funding contract requirements and guidelines.

DESCRIPTION OF ACTIVITY

Western Queensland PHN (WQPHN) will provide administrative and coordination support to enable effective delivery of services across the region. This will include:

- supporting the commissioned service provider to establish and operationalise a hub and spoke outreach model of care, including engagement with participating primary care practices across the Western Queensland PHN region
- coordinating and maintaining clinical and service level data collection, including collation, quality assurance and monitoring, to support program oversight, Departmental reporting
- managing performance and activity reporting requirements as directed under the funding agreement, including timely submission of reports and documentation to the Department
- supporting review of service activity to inform ongoing refinement of the model of care

Needs Assessment Priorities

NEEDS ASSESSMENT

WQPHN JRHNA 2025-2026

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Activity Demographics

TARGET POPULATION COHORT

Women in the Western Queensland PHN region that experience pelvic pain, endometriosis and menopause and perimenopause symptoms.

Activity Consultation and Collaboration

CONSULTATION

This activity aims to consult with stakeholders including Royal Flying Doctors Service (RFDS), Hospital and Health Service (HHS), Allied Health and General Practice to ensure continuity of service delivery and expansion of service delivery.

COLLABORATION

True Relationships and Family Planning HHS, RFDS and General Practice.

Activity Milestone Details/Duration

ACTIVITY START DATE

01/01/2026

ACTIVITY END DATE

30/06/2028

ACTIVITY: PP&TP-DVP - 1 - PP&TP-DVP-1 (25-26 FOR 26-27) OUTREACH HEALTHCARE FOR VICTIM-SURVIVORS OF FD & SV PILOT

Activity Priorities and Description

PROGRAM KEY PRIORITY AREA

Domestic, Family and Sexual Violence Healthcare

AIM OF ACTIVITY

The overarching aim of the WQPHN Family, Domestic and Sexual Violence Pilot ("the Pilot") activity is to improve healthcare access, equity, and outcomes for victim-survivors of Family, Domestic, and Sexual Violence (FDSV) in remote and very remote communities across Western Queensland built on WQPHN's Connector Model (of place-based support).

DESCRIPTION OF ACTIVITY

The Pilot is continuing to implement a multidisciplinary wrap-around approach to enhance the provision of trauma-informed and integrated healthcare for victim-survivors of FDSV. The project focuses on increasing service availability in crisis accommodation settings, temporary shelters, designated safe spaces through a targeted outreach model.

Co-design is a core component of the Pilot, with WQPHN collaborating with local stakeholders in place-based workshops to design a model responsive to the needs of victim-survivors in rural and remote Western Queensland Through ongoing consultation with service providers, community leaders and organisations, the Pilot embeds a responsive, person-centered approach that prioritises victim-survivor safety, health and social support, accessibility, and long-term recovery outcomes. By integrating culturally safe, trauma-informed care with strengthened service coordination, the Pilot will play a vital role in improving health and wellbeing for FDSV victim-survivors.

Key Activities:

- engagement of Health Services - Multidisciplinary Services engaged to increase capacity of existing health service providers commissioned by WQPHN and enhance their skills in screening for and responding to presentations of FDSV. Health providers engaged for the Pilot include North-West Remote Health's (NWRH), General Practitioner and other specialists as required under the Stepped Care Model. The Pilot will also engage additional services through Women's Health Equity QLD via digital solutions and community visits, with mid-wife services and ongoing counselling services (for health workforce and victim-survivors) to increase reach across the region and to address community consult-feedback
- engagement of Specialist FDSV Services - Procurement of FDSV Health Linkers, to engage directly with victim-survivors navigating the health care and FDSV system- provisioned by Anglicare Central Queensland and 54Reasons Mount Isa. Statewide DFV peak body, DVConnect are co-designing the development of place-based training modules for the healthcare workforce and Pilot partners to increase capacity to identify and respond to the unique healthcare needs of victim-survivors in a trauma-informed approach. DVConnect, FDSV Health Linkers and WQPHN to establish a Community of Practice for the healthcare sectors to strengthen partnerships and to encourage collaboration and integration. These Pilot partners will collaborate with Aboriginal Community Controlled Health Organisations (ACCHOs), Multicultural Access Program initiatives, local primary health providers and community-based services (e.g. FDSV, housing/ homelessness sector, Multicultural supports) to deliver culturally responsive, trauma-informed and FDSV specialist care
- integration with current and future service system developments such as Mount Isa Medicare Mental Health Hub co-location with FDSV Health Linker, Medicare Mental Health Phone Service, referHEALTH e-referral system (RHealth) and all parts of the integrated system of care in the Stepped Care Model for Western Queensland

- in line with WQPHN Connector Model, place-based supports and services have been prioritised for engagement and co-design workshops/ongoing consultations. Engaging peak bodies and state based specialised FDSV services will increase coordination of services, partnership to localised specialised services and enhance resourcing and access for WQ rural and remote communities. Overcome geographic barriers by leveraging digital health, including telehealth as well as mobile outreach services to extend specialist healthcare services to remote and very remote communities, ensuring consistent and reliable access to care. Implementation of a tailored FDSV training program and digital learning models designed for rural and remote communities, addressing challenges such as large geographic areas, workforce retention, and limited access to specialist skills. Through pilot partnerships, the project will build capacity in local health and non-specialist services by adapting existing digital training resources for each community and priority group. Participants will also receive specialist FDSV supervision from Women's Health Equity Queensland to ensure safe, trauma-informed, and best-practice responses. Flexible brokerage funding model facilitated through partnership with referHEALTH, the FDSV Health Linker and other health pilot partners, to provide access to essential support relating to health needs, safety, material assistance to support recovery, transport and specialist services unique to victim-survivors of FDSV. Work with target groups disproportionately impacted through trauma and FDSV-informed tailored training program and co-design with service providers working with people from multicultural backgrounds, women and children, Aboriginal and Tores Strait Islander communities, LGBTIQA+ individuals, older persons, those experiencing issues such as homelessness, disability and chronic and/or complex health and mental health issues.
- evaluation through collaboration with Abt Global and other PHN's funded under the Pilot as well as co-design processes with WQPHN Pilot partners
- expected outcomes include improved access to primary healthcare and support services for higher risk populations living in rural and remote communities, increased integration between health and social services, equitably support victim-survivors during their recovery and healing journey to safely integrate back into their communities and enhanced capacity for support services to deliver specialised care in FDSV contexts. By engaging a multidisciplinary services approach, leveraging digital health solutions and engagement of place-based FDSV Health Linkers, WQPHN will adopt a strategic model that prioritises wrap around support, ensuring that services are accessible, culturally safe, and tailored to the needs of diverse communities

Needs Assessment Priorities

NEEDS ASSESSMENT

WQPHN JRHNA 2025-2026

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Systems Issues	15
Workforce	15
Young people	16

Activity Demographics

TARGET POPULATION COHORT

Victim-survivors of Family, Domestic, and Sexual Violence in the Western Queensland region and related networks.

Activity Consultation and Collaboration

CONSULTATION

Place-based Family, Domestic, and Sexual Violence Services- both Youth and Adult, as well as specialist Aboriginal and Torres Strait Islander providers.

Health and community services working with people impacted by FDSV.

People who identify as having a Lived Experience in relation to the target groups for this Project.

Other stakeholders, including key Family, Domestic, and Sexual Violence services and peak bodies, commissioned and non-commissioned services providers, relevant regional, state, and national networks, HHSs (including any targeted Family, Domestic, and Sexual Violence (Qld Police) positions and ACCHOs.

Place-based Allied Health and Mental Health Service providers and GP's.

COLLABORATION

Place-based Family, Domestic, and Sexual Violence Services- both Youth and Adult as well as specialist Aboriginal and Torres Strait Islander providers.

Health and community services working with people impacted by FDSV.

People who identify as having a Lived Experience in relation to the target groups for this Project.

Other stakeholders including key Family, Domestic, and Sexual Violence services and peak bodies, commissioned and non-commissioned services providers, relevant regional, state, and national networks, HHSs (including any targeted Family, Domestic, and Sexual Violence (Qld Police) positions) and ACCHOs.

Place-based Allied Health and Mental Health Service providers and GP's.

Activity Milestone Details/Duration

ACTIVITY START DATE

01/02/2025

ACTIVITY END DATE

30/06/2027

ACTIVITY: PP&TP-GCPC - 1 - PP&TP-GCPC-1 (26-27) GREATER CHOICES FOR AT HOME PALLIATIVE CARE

Activity Priorities and Description

PROGRAM KEY PRIORITY AREA

Palliative care

AIM OF ACTIVITY

The Greater Choices for At Home Palliative Care program activity aims to increase access to safe, quality palliative care, at the right time, in the right place for all Western Queenslanders. The activity and associated approaches aim to improve understanding of and capacity for (workforce and community) palliative care, end of life and advanced care planning concepts whilst encouraging use of continuous quality improvement and data collection mechanisms.

DESCRIPTION OF ACTIVITY

The WQPHN Palliative Care Health Needs Assessment 2025 identified five Tier 1a priority needs, reflecting areas of high need and strong potential for contribution through the Greater Choices for At Home Palliative Care (GCfAHPC) program. The GCfAHPC activity and associated approaches are aligned to these Tier 1a priorities, guiding program focus and delivery across the Western Queensland PHN region.

WQPHN will deliver coordinated approaches within the GCfAHPC program to improve equity, timeliness, and quality of access to palliative care across Western Queensland, with a focus on populations and settings experiencing the greatest need and barriers. The program will be centrally coordinated by a dedicated Senior Program Officer - Palliative Care (1.0 FTE), supported by a Program Support Officer, with governance provided through established WQPHN structures. Program staff will engage with subject matter experts, education and training resources available through National Palliative Care Projects, Palliative Care Queensland, Proveda and other external sources as required.

Approaches will be delivered in ways that recognise and respond to cultural safety, remoteness, and service access challenges. Where possible, consultation with local community and subject matter experts will promote use of place based, culturally safe language and ensure educational content is appropriate and relevant. [Priority: Aboriginal and Torres Strait Islander people experience additional cultural, geographic, and systemic barriers to accessing appropriate palliative care - WQPHN Palliative Care Health Needs Assessment p. 24].

To address low confidence and knowledge among some healthcare providers, which delays palliative care conversations and contributes to late referral, WQPHN will focus on targeted workforce capacity building including the promotion of existing education and training opportunities available within the region. This approach will encourage providers across general practice, Aboriginal and Torres Strait Islander health services, allied health, pharmacy, aged care, and community support sectors to participate through a mix of face to face and digital delivery. [Priority: The low confidence and knowledge of some healthcare providers delays conversations about palliative care and reduces early engagement - WQPHN Palliative Care Health Needs Assessment p.39].

Education and networking activities such as Last Aid, Dying to Know planning and more casual 'craft and conversation' sessions will strengthen understanding of palliative care, clarify its role earlier in the illness trajectory, and increase confidence to initiate timely conversations, including discussions about advance care planning. [Priority: Palliative care services are initiated too late in the course of illness, typically only towards the very end of life, impacting the patient's comfort and quality of life. WQPHN Palliative Care Health Needs Assessment - p.45] [Priority: Low awareness and health literacy about palliative care service options in the community - WQPHN Palliative Care Health Needs Assessment p.28]. Existing education and training opportunities available within the region and through National Palliative Care Projects will be actively promoted and facilitated, ensuring community members in rural and remote areas can access information and education through a variety of methods.

Improving service integration and referral pathways will be a key approach to address the current pattern of palliative care services being initiated too late in the course of illness, often only towards the end of life WQPHN will encourage collaboration and information sharing across primary care, palliative care services, aged care, and community based providers, supporting clearer, more consistent referral pathways. Review and promotion of palliative care pathways, including through platforms such as HealthPathways, will support earlier identification of need, reduce fragmentation, and improve navigation for both referrers and patients, particularly where services are dispersed or access is limited by geography. [Priority: Palliative care services are initiated too late in the course of illness, typically only towards the very end of life, impacting the patient's comfort and quality of life. WQPHN Palliative Care Health Needs Assessment - p.45].

Low community awareness and health literacy about palliative care service options remains a significant barrier to early access and engagement. WQPHN will implement community focused awareness, narrative, and communication approaches to improve understanding of palliative care, address misconceptions, and normalise conversations about death, dying, and supportive care. Existing palliative care information and resources will be promoted through websites, newsletters, digital platforms, and community engagement activities, using plain language and culturally appropriate messaging to reach diverse communities, including Aboriginal and Torres Strait Islander people and those living in rural and remote areas. [Priority: Low awareness and health literacy about palliative care service options in the community - WQPHN Palliative Care Health Needs Assessment p.28].

Insufficient support for family and informal caregivers, both before and after a person's death, will be addressed by strengthening awareness, referral pathways, and system responses to carer needs [Priority: Insufficient support for family caregivers – both before and after a person's death - WQPHN Palliative Care Health Needs Assessment p. 33]. WQPHN will identify gaps in caregiver support through community consultation. Where gaps are identified, targeted palliative care consultant expertise will be engaged to support improved service linkages, communication, and access to appropriate supports, helping to reduce caregiver burden and distress and improve sustainability of care.

WQPHN will ensure activity delivery is consistent across the region while remaining flexible to respond to local cultural, geographic, and service contexts. Ongoing monitoring, data collection, and evaluation will be undertaken to ensure activities remain aligned with identified priorities, deliver value, and support continuous improvement. Pre and post activity evaluation will aim to capture any increase in healthcare providers self reported confidence to initiate earlier palliative care conversations. Improved consistency and use of referral pathways will be measured by increased awareness and uptake of agreed palliative care pathways among referrers. Improved community understanding of palliative care and its role earlier in illness, will be measured through participant feedback and engagement with awareness activities. Improved awareness and navigation of carer support options will be measured through referrals; pathway use and qualitative feedback from carers and service providers. WQPHN will explore opportunities to address data constraints experienced by service providers to strengthen evidence based planning, reporting and use of available technology. Collectively, these activities will support earlier engagement with palliative care, improved provider confidence, increased community awareness, better support for caregivers, and improved comfort and quality of life for people with life limiting illness within Western Queensland.

Needs Assessment Priorities

NEEDS ASSESSMENT

WQPHN JRHNA 2025-2026

PRIORITIES

Priority	Page Reference
Palliative Care	12

Activity Demographics

TARGET POPULATION COHORT

Within the WQPHN:

- service providers including allied health, nursing and non-registered health care workers, including indigenous health workers and personal carers
- community members who are, have received or cared for someone living with a life-limited condition
- community members on a palliative care pathway

Activity Consultation and Collaboration

CONSULTATION

Consultation will be carried out across the WQPHN region – with current Palliative Care services, General Practices, community services, consumers and communities, ACCHO's, and visiting Specialist Palliative Care Providers & councils or other community groups.

COLLABORATION

All relevant Hospital and Health services (NW, CW, SW), NGO providers, Specialist Pall Care services, Allied Health Services, Commissioned Service providers, RACF's, ELDAC providers, General Practices, education and training providers and relevant community /consumer groups, internal WQPHN resources, other PHNS and peak bodies for palliative care.

Activity Milestone Details/Duration

ACTIVITY START DATE

10/11/2021

ACTIVITY END DATE

30/06/2029