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CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

CESPHN Strategy Workshop Report

Summary report to participants who attended CESPHN Strategy Workshop, held online 2 July 2025

Monday, 25 August 2025

Contents

Thank you for your input

Thank you for contributing to Central and Eastern Sydney Primary Health Network's (CESPHN) annual Strategy Workshop in 2025. We value your input. This brief report provides a summary of your contributions and next steps.

Background

One hundred stakeholders attended Central and Eastern Sydney Primary Health Network's annual strategy workshop on 2 July 2025. The theme of the workshop was the integration and coordination of care. The two key topics for discussion at the workshop were the NSW Single Front Door and Integrated Mental Health Hubs. Participants were sent briefing papers a week in advance of the workshop in order to gain an understanding of the topics and choose the workshop they wanted to contribute input to.

Due to severe weather conditions the workshop was held online rather than in-person as originally planned and participants were divided into seven breakout groups for discussions.

CESPHN CEO, Nathalie Hansen presented on the work CESPHN undertakes to improve the integration and coordination of care.

This was followed by the CEO of Brisbane North PHN, Libby Dunstan, discussing the PHN's experience of implementing integrated mental health hubs. Then Associate Professor Dr Amith Shetty, Clinical Director System Sustainability and Performance at NSW Health presented on the NSW Single Front Door.

The following summary captures key themes from the consultation sessions facilitated by CESPHN at the 2025 Strategy Workshop to inform the establishment of the service model for the Integrated Mental Health Hubs and CESPHN's role in relation to the single front door developments.

Single Front Door

Background

The NSW Single Front Door (SFD) is a state-wide 24/7 telephone and digital triage and navigation service designed to connect people with the right care at the right time, reduce unnecessary ED presentations, and improve integration between hospitals, primary care, and community services. Delivered by Healthdirect Australia, it links callers to GPs, urgent care clinics, virtual care, community health, and (in development) mental health pathways.

Single front door briefing paper was shared with participants prior to the workshop.

Input from stakeholders at the CESPHN Strategy Workshop reinforced the SFD's potential to improve access and efficiency but highlighted key challenges: low awareness in culturally and linguistically diverse communities; barriers for digitally excluded populations; risks of overburdening primary care without adequate funding, booking integration, and governance; and the need for seamless information sharing and clinical workflow integration. Stakeholders emphasized the role of PHNs in promoting the service, supporting primary care readiness, building cultural competence, and advocating for system interoperability.

There was support for the SFD's aims but stakeholders highlighted key risks for general practice. Without adequate preparation, the SFD could unintentionally shift demand onto already stretched GP teams, particularly for urgent, same-day appointments. Stakeholders called for:

- Integrated booking systems so referrals can be made directly into practice schedules without manual follow-up.
- Clear role definition to manage expectations on what care GPs can and should provide via SFD referrals.
- Timely clinical handover with secure messaging, triage notes, and discharge summaries to support continuity of care.
- Funding models that recognise the costs of urgent access, after-hours care, and short-notice consultations.
- Stronger communication so practices understand the SFD's pathways, referral rules, and integration with HealthPathways and UCCs.
- Continuous Feedback – Establish feedback loops with consumers, GPs, and allied health to monitor satisfaction, barriers, and outcomes, feeding into service improvement.
- Mental Health Integration – Align with development of the Mental Health SFD to ensure culturally safe, trauma-informed, and connected pathways in CESPHN's region.

Next steps

CESPHN will undertake the following:

- Advocate for GP Capacity and Funding – Engage NSW Health and Healthdirect to ensure MBS flexibility, after-hours support, and targeted investment in primary care to manage redirected demand.
- Promote system integration – Push for interoperability between SFD and GP clinical systems, including secure messaging, automatic transfer of triage notes, and integrated booking capabilities.
- Champion clear referral protocols – Advocate for agreed role definitions, clinical governance arrangements, and handover standards to protect continuity of care.
- Support GP and primary care awareness – Provide concise updates, briefings, and CPD opportunities so GPs and practice managers understand SFD processes and pathways.

- Collect and amplify GP and primary care feedback – Establish mechanisms to gather ongoing feedback from GPs and primary care providers and use this evidence to influence state-wide service design and improvement.
- Digital Integration – Push for real-time secure messaging, automatic triage data transfer, and interoperability with GP systems.
- Awareness and Communication – Launch tailored campaigns for GPs and practice managers explaining SFD workflows, benefits, and referral processes.

Summary of feedback from Single Front Door

1. *How can the Single Front Door be tailored to better meet the needs of culturally and linguistically diverse (CALD) communities?*

- **Multilingual support**: Interpreter services, multilingual staff, translated materials (All groups)
- **Cultural competency**: Training for staff, culturally appropriate messaging and service design (All groups)
- **Face-to-face options**: Preference for in-person support over digital-only access, especially for elderly and CALD communities (Groups 1 & 3)
- **Community engagement**: Use of community centres, libraries, and peer support workers to promote and explain SFD (Groups 1 & 3)
- **Marketing and awareness**: Lack of visibility of SFD; need for better branding, website and outreach (All groups)

2. *How can virtual care services be made more accessible and trusted by vulnerable or digitally excluded populations?*

- **Digital literacy support**: Workshops, guides, ambassadors, and training hubs (All groups)
- **Human connection**: Importance of face-to-face interaction, peer support, and trusted figures (All groups)
- **Multi-access**: Not just websites and apps – include texts, phone, kiosks, brochures, and community-based access points in libraries and community centres (All groups)
- **Stigma reduction**: Especially in mental health (Group 3)
- **Co-design and feedback**: Involving vulnerable groups in service design and evaluation (Groups 1 & 3)

3. *What changes are needed to ensure primary care is adequately supported to deliver urgent care at scale?*

- **Integrated booking systems**: Compatibility with GP systems like HotDocs, triage and direct booking (Groups 1 & 3)
- **Funding and billing models**: Expansion of MBS items, support for 7-day coverage, bulk billing expectations clearly explained (Groups 1 & 3)
- **Clear role definition**: Clarify what primary care is expected to deliver, avoid overburdening GPs (Group 1)
- **Allied health integration**: Better use of AHPs for chronic and preventative care (Group 1)
- **Clinical governance and continuity**: Establish who holds responsibility post-SFD referrals and follow up

4. *What are the critical factors to ensure the Single Front Door is user-friendly for primary care providers?*

- **Speed and efficiency**: Fast triage and low wait times, automation (Group 2)
- **Clinical workflow integration**: Seamless record sharing, secure messaging, real-time alerts (Groups 1 & 2)
- **Navigation tools and communication**: Clear messaging for providers, education on SFD and HealthDirect (Group 1)

- **Clarification of roles and services**: Ensuring clinicians have understanding of UCCs, HealthPathways, and state vs federal responsibilities (Group 1)

5. *What role should PHNs play in supporting general practices and commissioned mental health services to handle increased demand from SFD referrals?*

- **Education and training**: CPD, practice visits, support for digital integration, capacity building (All groups)
- **Improved communication**: Ensuring discharge summaries and referral info reach GPs (Groups 1 & 3)
- **Interoperability and data sharing**: Push for better systems integration and feedback loops (Groups 1 & 3)
- **Support for mental health services**: Training and coordination with community organisations (Group 3)

Detailed feedback from each group that discussed the Single Front Door is captured in Attachment 2.

Integrated Mental Health Hubs

Background

CESPHN commissions a range of mental health services across different levels of care. CESPHN's proposed future integrated care model will be delivered by a multi-disciplinary team of professionals addressing various mental health treatment needs and experiences. This new service model aims to streamline referral pathways and provide a more seamless care journey for individuals with complex or evolving care needs by offering a variety of care types within a single service.

CESPHN believes in designing solutions in collaboration with communities to ensure that commissioned services reflect the community's needs, goals, and aspirations. Beginning in 2022, CESPHN collaborated with Beacon Strategies to host co-design workshops, informing the initial development of the Integrated Mental Health Hub service model. Between May and June 2025, following the development of a draft service model, CESPHN hosted codesign workshops, invited written submissions, and offered 1:1 consultation sessions to validate and finalise the service model. The codesign workshops aimed to finalise the service model for the integrated mental health hubs to ensure the model is consistent with the community's needs and goals.

Before the Strategy Workshop participants were briefed with the Integrated Mental Health Hubs briefing paper.

Summary of feedback

1. Are there core components missing that should be included in the model?

- Physical health integration (All Groups)
- Support for children and young people (especially ages 10–17) (Groups 5, 6, 7)
- Cultural healing and safety, especially for Aboriginal communities (Groups 5, 6, 7)
- Peer-led support and workforce development (All groups)
- Flexible service hours (Groups 5, 7)
- Education, community integration, and outreach (Groups 5, 6)
- Continuous improvement and lived experience in design (Group 5)

2. What evidence would you want to see to know the model is working well?

- Client satisfaction and trust (Group 5)
- Community feedback loops and cultural relevance (Groups 5, 7)
- Reduction in acute service use (Groups 4, 5, 7)
- Improved quality of life of patients, and achievement of their goals (Groups 4, 5, 7)
- Workforce wellbeing and retention (Groups 4, 6)
- Use of diverse outcome measures (mentioned K10, RAS-DS, K5, functional recovery) (Group 5)
- Stigma reduction (perception) and community education (Group 5)

3. What partnerships are most important for the hubs to develop?

- ACCHOs and First Nations organisations (Groups 5, 6, 7)
- GPs and LHDs (All groups)
- Legal, housing, education, and justice services (All groups)
- Community-led and peer-based services (Groups 5, 6, 7)
- Shared care with existing providers (e.g., private psychologists) (Group 5)
- Use of hub space by community groups to reduce stigma (Group 5)

4. What types of services should be co-located at the hubs and how could this be facilitated?

- Legal, housing, employment, Centrelink, food pantries (All groups)
- NDIS and disability supports (Groups 6, 7)
- Peer support and recovery services (All groups)

- Culturally responsive design and welcoming spaces (Groups 5, 6, 7)
- Use of hub space by community groups for activities (Group 5)

5. What characteristics, capabilities, and experience should a provider demonstrate to deliver the service successfully?

- Trauma-informed, recovery-oriented, culturally safe practice (All groups)
- Diverse and representative workforce (All groups)
- Strong governance and clinical supervision (All groups)
- Experience with peer workforce and stepped care (Groups 4, 5, 7)
- Local knowledge and relationships with LHDs (Group 5)
- Innovative service delivery and continuous improvement culture (Group 5)

6. What should we call the hubs?

- Group 6: Kaleido Care, Comprehensive Health Care, Recovery Clinic/Space, Recover in Care
- Group 4: Suggested community consultation and traditional language naming
- Groups 5 & 7: No specific names suggested

Detailed feedback from each group that discussed Integrated Mental Health Hubs is captured in Attachment 2.

Next steps

CESPHN will:

- Finalise the service model guidelines to ensure the Hubs are delivered in accordance with consultation feedback.
- Prepare for the tender process to ensure that the most suitable provider(s) are selected to deliver the Hubs.
- The tender is due to be released in September 2025.
- Prepare for the process to ensure that the community's needs and goals are informing contracting and performance monitoring.
- The integrated mental health hubs are due to be established by 1 July 2026.