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NORTHERN SYDNEY
An Australian Government Initiative

SYDNEY NORTH
Primary Health Network

2016/17

SYDNEY NORTH PRIMARY HEALTH NETWORK

ANNUAL REPORT

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ACKNOWLEDGEMENT OF COUNTRY

The Sydney North Primary Health Network wishes to acknowledge Australia's Aboriginal people as the Custodians of this land. We pay our respect and recognise their unique cultures and customs and honour their Elders past, present and future.

Artist Acknowledgement: Jessica Birk

01

SNAP SHOT

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SYDNEY NORTH
Primary Health Network

SYDNEY NORTH PRIMARY HEALTH NETWORK
HEALTH PROFILE

Sydney North Primary Health Network (SNPHN) is one of 31 Primary Health Networks (PHNs) in Australia covering 9 Local Government Areas (LGAs) in the Northern Sydney region.

Key Areas: Childhood immunisation rates, ageing population, alcohol attributable hospitalisations and large culturally and linguistically diverse population (CALD).

HEALTH DRIVERS

SNPHN is ranked the least socio-economically disadvantaged PHN in Australia. However, there are pockets of high disadvantage within Hornsby, Hunters Hill, North Sydney, Ryde, Warringah and Willoughby LGAs.

1.7% of people aged 16-64 years receive unemployment benefits
NSW: 5.2%

46.1% of people aged 17 years participate in tertiary education
NSW: 29.9%

33.6% of low-income families experience financial stress from mortgage or rent
NSW: 32.9%

VULNERABLE GROUPS

Children

7.2% (12,291)
of children in low-income, welfare-recipient families
NSW: 24%

Older People

15.5% (140,498)
of the total population aged 65+ years
NSW: 15.7%

Between 2016-2031, there will be an increase of **43.3%** in the 65+ years population
NSW: 50.3%

Disability

3.4% of the population have a severe or profound disability
NSW: 4.9%

HEALTH RISK FACTORS

Obesity

17.7 per 100
(18+ years) obese
NSW: 26.4

Alcohol

759 per 100,000
alcohol attributable hospitalisations, higher than the **NSW rate (672 per 100,000)**

Smoking

10.2 per 100
(18+ years) current smokers
NSW: 16.2

CHILDHOOD IMMUNISATION

IMMUNISATION RATES LOWER THAN THE NATIONAL ASPIRATIONAL TARGET OF 95%

1-year-old
90%
fully immunised
NSW: 90.1%

2-years-old
89%
fully immunised
NSW: 90.7%

5-years-old
90%
fully immunised
NSW: 92.5%

CANCER SCREENING

Bowel cancer screening participation rates among people aged **50-74 years in SNPHN (37.1%)** higher than the NSW rate (35.1%).

Cervical cancer screening participation rates among women aged **20-69 years (62.7%)** higher than the NSW rate (56%).

Breast cancer screening participation rates among women aged **50-69 years (52.5%)** higher than the NSW rate (51.6%).

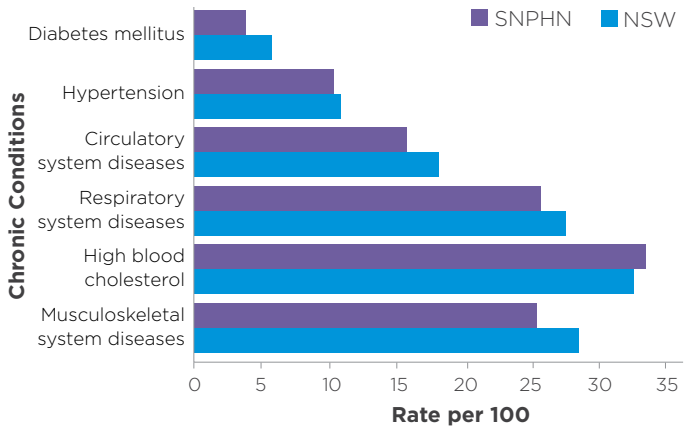
MENTAL HEALTH

12.1 per 100
(15+ years) report mental and behavioural problems
NSW: 13.1

8.5 per 100
(18+ years) report high or very high psychological distress
NSW: 10.5

6,271 per 100,000
with a Mental Health Treatment Plan created by a GP
NSW: 8,222

CHRONIC CONDITIONS



POTENTIALLY PREVENTABLE HOSPITALISATIONS

1599 per 100,000
NSW: 2,113 per 100,000
Cellulitis, kidney and urinary tract infections, and dental conditions accounted for 38.7% of potentially preventable hospitalisations.

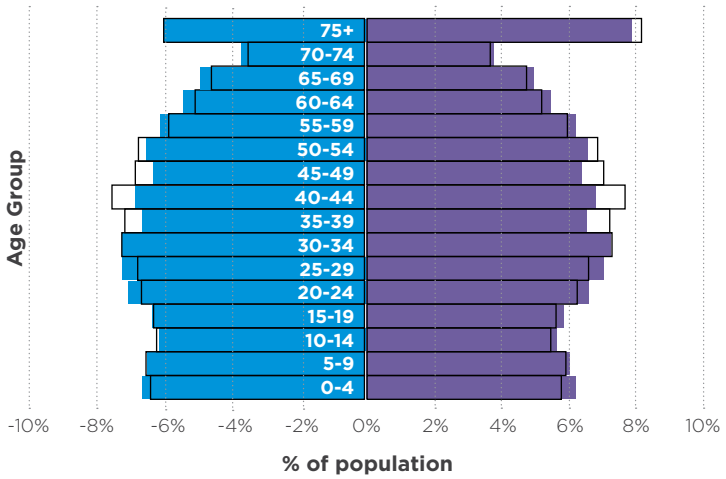
PRIMARY HEALTHCARE

291 GP practices in the SNPHN region

128 GPs per 100,000 people **NSW: 118 per 100,000 people**

DEMOGRAPHY

Age structure comparison by sex for SNPHN and NSW



Total population 907,008. Between 2016-2031, the total population will increase by 20.3% to 1,090,550
NSW: 19.7%

CALD

SNPHN has a higher proportion of people culturally and linguistically diverse (22.1%) compared to NSW (18.6%).
Chinese and Indian largest culturally and linguistically diverse groups.

2.8% of people born overseas report poor proficiency in English
NSW: 3.4%

Aboriginal

0.4% (3,182) of the population identify as Aboriginal and Torres Strait Islander
NSW: 3%

Sources

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- Australian Government - Department of Health 2016, Immunisation Coverage Data, Department of Health, Canberra, viewed 17 August 2016, www.immunise.health.gov.au.
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CHAIR'S REPORT

Dr Magdalen Campbell
SNPHN Chair

The delivery of healthcare in Australia is changing fast.

In its second year of operation, the Sydney North Primary Health Network has engaged and supported primary care to be at the forefront of these changes to influence and design the future of healthcare within Northern Sydney. This has brought about numerous transformations in the delivery of primary care and a range of community services within the Northern Sydney region. It has been achieved by proactively engaging with general practice, allied health, patients, and community service groups to plan and implement these changes - to improve coordination of patient care within our community as well as supporting innovation within our primary health services.

At the core of our strategic plan has always been the **Person Centred Medical Home** (PCMH) model. Through our Primary Care Advancement Team and the innovative PCMH program, our PHN will aim to strengthen primary care to provide the quadruple aim in healthcare – enhance the patient experience; improve systems and efficiencies; optimise population health and wellbeing; and improve the work life of clinicians.

Through the strong and exemplary SNPHN Commissioning Framework we have commissioned a unique suite of new Mental Health and Alcohol and Other Drug services aimed at building on existing services and addressing areas of need. SNPHN has consulted widely with the community as well as existing services and experts in the Northern Sydney region to identify and then design our flexible and responsive model of care. Within the **Stepped Care** approach, SNPHN has commissioned new Mental Health and Alcohol and Other Drug services to address the needs of vulnerable populations and streamline appropriate referral to these services.

Throughout this second year SNPHN has listened to and engaged our community on all levels. The Board would like to thank the **Community Council** for their dedication and commitment to shaping the future of healthcare in Northern Sydney. Our Community Engagement Team have worked with the Community Council to improve health literacy, and provide information and resources to the appropriate available healthcare services to the Northern Sydney community. The Council input has been integral to developing **HealthPathways** for the Community and key to bringing issues on public health to the fore within the Northern Sydney region.

Our other key arm is the enthusiastic and experienced **Clinical Council** who have also been a fundamental source of experience and knowledge in the building of SNPHNs HealthPathways - an online local health information portal providing service navigation and condition management for General Practice and health services. They have also been an essential partner alongside the **Sydney North Mental Health Advisory Committee** in the development of our commissioned services. Their valuable input, insight and experience has led the way in primary healthcare reform. Thank you all for your commitment.

The Board would also like to thank our dynamic CEO Lynelle Hales, the innovative Executive Team of Cynthia Stanton, David Grant and Ramon del Carmen and the amazing team at the Sydney North Primary Health Network who have strengthened primary care with their hard work and dedication. They are responsive to the community and primary care services needs and always looking beyond the horizon to assist in shaping and improving primary care within our region.

Dr Magdalen Campbell - SNPHN Chair

CHIEF EXECUTIVE OFFICER'S REPORT

Lynelle Hales
SNPHN CEO

It has been another successful year for the Sydney North Primary Health Network (SNPHN), with significant progress made in delivery against our Strategic Plan priority areas and building our reputation in the community.

The first two years of operation initially focused on the development of solid foundations across all four strategic priority areas, followed by rapid growth and delivery.

Key achievements over this last 12 months include:

- **BUILDING PRIMARY HEALTHCARE CAPACITY**
  Remaining a key area of focus for the PHN, this year SNPHN has established the **Person Centred Medical Home** program to support development of clinical leadership, along with introducing partnership opportunities through the establishment of **Local Coordinated Networks** and commissioned services. SNPHN has supported quality improvement programs, including the **WellNet** chronic disease management program, the **iSOLVE** falls prevention program, and data quality improvement. There has been a significant growth and improvement in the uptake and use of clinical data in general practices in 2016/17 including a **45%** increase in GPs uploading Shared Health Summaries to the My Health Record.

- **COMMISSIONING**
  Our PHN has built our competencies in commissioning through establishing a strong governance structure, reviewing local needs, building partnerships, and co-designing solutions through multiple commissioning processes. This has resulted in over **60** recipients of grants and contracts in the program areas of **After Hours, Mental Health, Alcohol and Other Drugs, Aboriginal Health, Innovation,** and **Vulnerable Populations.** We have built a commissioning evaluation framework to focus both commissioners and providers on continuous improvement, and utilised the quadruple aim (improved population health, improved patient experience, better value for the system, and greater clinical workforce satisfaction and sustainability) as a framework for measuring impact and outcomes of services commissioned.

- **SERVICE TRANSFORMATION**
  In its first year, the **HealthPathways** clinical decision support tool has rapidly grown, with **83 pathways** live at end of June 2017. There are currently **365** users of HealthPathways since its launch in May 2017. SNPHN has also established

> “These achievements are only possible through the hard work of staff, the Board, our Clinical and Community Councils and our partners, to help us strengthen our local primary healthcare system.”

a community activation program, including a community health literacy website, called **Community HealthPathways**, and established the **SNAPO** (Smoking, Nutrition, Alcohol, Physical activity, and Obesity) program for implementation during 2017/18. Integrated care has led our partnership discussions this year, with a joint integrated care strategy under development with the Northern Sydney Local Health District, and digital health integration opportunities being explored.

◆ ORGANISATIONAL EXCELLENCE

The rollout of a **new finance, human resources,** and **payroll system**, has enabled a robust financial management and reporting system. The addition of a **staff intranet** has improved document, email, and workflow management. Utilisation of our **website** and **social media channels** has gone from strength to strength, with a **268%** growth in website page views and **89%** increase in social media engagement since 2015/16. In addition, the Executive Team has continued to build a strong, positive, and productive culture across the organisation, through training and support. This resulted in the recording of a **90.4%** ‘culture of engagement’ in the staff PHN benchmarking survey in early 2017.

Our key focus this year has been to raise the profile of our PHN with our partners and within the community. It has been an enormous year, commissioning a range of new services and establishing key tools and resources to further support coordination of care. It has also been a year of great achievements, which you will read about in this report. These achievements are only possible through the hard work of staff, the Board, our Clinical and Community Councils and our partners, to help us strengthen our local primary healthcare system to better support our community. I would like to extend my thanks to staff for their continuous enthusiasm and contributions this year. The focused support received from our Chair and Board has also been instrumental in ensuring the SNPHN remains focused on delivering its strategic vision.

I look forward to building continued regional confidence in our organisation’s ability to meet the challenges of delivering a world-class primary healthcare system in the Sydney North region.

Lynelle Hales
SNPHN Chief Executive Officer

WHO'S WHO?

THE BOARD

DR MAGDALEN CAMPBELL
Chair

Qualifications: M.B.B.S, FRACGP, MAICD

Experience:
- Inaugural SNPHN Board Member.
- GP and principal of own practice.
- Training and experience in corporate governance and strategic planning.
- Former Board Member of General Practice Network Northside from 1992 to 2012, holding positions of Chair, Treasurer, and Secretary.
- Board Member of Northern Sydney Medicare Local from 2012 to 2015.
- Elected to the Board of Networking Health NSW in November 2014.
- Member of ACI Chronic Disease Mgmt Committee.
- Member of the ACI Chronic Disease Mgmt Committee.

DR HARRY NESPOLON
Deputy Chair

Qualifications: BM BS, DipRACOG, FRACGP, BEc, LLB (Hons), GCLP, FACLM, MBA, FAICD, MHL

Experience:
- Chair of GP Synergy.
- Board Member of Northern Sydney Local Health District.
- Former Chair of Sydney North Shore and Beaches Medicare Local.
- Former Chair of Northern Sydney Division of General Practice.
- Principal of two General Practices.

DR STEPHEN GINSBORG

Qualifications: MB BCh, MA, MAICD

Experience:
- Board Member of Manly Warringah Division of General Practice.
- Former Deputy Chair of Sydney North Shore and Beaches Medicare Local.
- Chair of SNPHN Clinical Governance Committee.
- Board Member of Council on the Ageing (NSW).
- Board Member of CCNB (formerly Community Care Northern Beaches).

BRYNNIE GOODWILL

Qualifications: JD International and Corporate Law. AB, GAICD

Experience:
- Strategy and Partnerships Director of SharingStories Foundation.
- Chair of SNPHN Community Council.
- Former CEO of LifeCircle Australia.
- Former CEO of Jubilee Australia.
- Former Health Consumer Director of Sydney North Shore and Beaches Medicare Local.

CAROLYNN HODGES

Qualifications: BA (Hons), MPsych (Clin), BPsych (Hon), DipClinHyp, MAPS, MCCLP, MASH, CEAP, MAICD

Experience:

- Principal of a Clinical Psychology private practice.
- Previous mental health delivery experience in both public and private sectors.
- Member of SNPHN Clinical Governance Committee, SNPHN Clinical Council and SNPHN Mental Health and Alcohol & Other Drugs Advisory Committee.
- Board Member of Primary and Community Care Services.
- Member of Primary and Community Care Services Clinical Governance Committee.

KATHRYN LOXTON

Qualifications: BA AppSc (Occupational Therapy), GAICD

Experience:

- Founder of Caswell Health Care, a multidisciplinary private practice working in primary health throughout Sydney.
- Former Board Member of Sydney North Shore and Beaches Medicare Local.
- Former Board Member of Independent Living Centre NSW.
- Former Board Member of NSW Brain Injury Association.

PROF. SIMON WILLCOCK

Qualifications: MBBS (Hons 1), PhD, FRACGP, Dip Obs, GAICD

Experience:

- Director of Primary Care Services at MQ Health.
- Board Chairman of Avant Mutual Group.
- Board Member of Avant Insurance Limited.
- Board Member of Doctors Health Fund.
- Chair of SNPHN Clinical Council.
- Clinician and academic with extensive experience in medical education and workforce development.

SAMANTHA CHALLINOR

Qualifications: BBus (Accounting), FCPA, JP, GAICD

Experience:

- Director Corporate Services at Agency for Clinical Innovation (NSW Health).
- Member of SNPHN Finance, Audit, and Risk Management Committee.
- Senior financial management, audit, risk, information technology and governance experience.

WHO'S WHO
THE EXECUTIVE

LYNELLE HALES Chief Executive Officer

Lynelle Hales is an accomplished health executive who brings over 20 years' experience in executive health and social care leadership roles at local, state, and national levels across the Australian and UK health systems. Lynelle has led the design and delivery of innovative approaches to healthcare, including strategic planning, service redesign, integrated commissioning, and working in partnership to deliver transformational change.

As CEO of Sydney North Primary Health Network, Lynelle is advancing strong strategic alliances to lead localised and responsive health commissioning that result in holistic care for the community, wrap-around services, and system integration with primary healthcare as the foundation.

Lynelle Hales is a Registered Nurse, and holds a Bachelor of Health Education, Masters in Health Planning, and is currently completing a Doctorate in Applied Public Health. Lynelle is also a graduate of the Australian Institute of Company Directors.

CYNTHIA STANTON General Manager, Primary Care Advancement & Integration

Cynthia Stanton is a healthcare professional with over 12 years' experience developing and implementing primary care programs to support healthcare professionals and integrating health services to improve the patient journey. Her extensive knowledge of the Northern Sydney region comes from experience working previously in both the Division of General Practice and Medicare Local.

Cynthia has led successful primary care and integrated care programs including Sydney North's Person Centred Medical Home program, Primary Care Nurse Transition program and Primary Care Education program, which has supported growth and development for local health professionals and strengthened the delivery of local primary care to patients.

At Sydney North Primary Health Network, Cynthia leads the Primary Care Advancement and Integration team, who are focused on building primary care capacity through quality improvement, development of local health pathways and connecting health providers through digital health to support smoother transitions of care and the delivery of a simplified healthcare system for our community.

Cynthia's knowledge of the primary care sector and understanding of the importance of integrated care in the patient's healthcare journey is backed by a Bachelor of Science, Pharmacology.

DAVID GRANT General Manager, Commissioning & Partnerships

David Grant is a senior healthcare leader who has led and developed multi-professional teams and services in the public and not-for-profit sectors to improve health outcomes and patient experience.

Qualified with a Master of Science, Public Health and Bachelor of Science in Physiotherapy, and with expert knowledge and a system wide view of healthcare provision in the UK and Australia, David is a passionate advocate for health system reform and sustainability. David also has extensive experience in strategic healthcare planning in response to population health needs and has experience of outcomes based commissioning within the United Kingdom primary care setting. More recently David has been responsible for developing and implementing the integrated commissioning strategy for Sydney North Primary Health Network which has focussed on delivering new and innovative mental health and alcohol and other drug primary care services in the region.

RAMON DEL CARMEN
Chief Financial Officer

Ramon del Carmen is a senior organisational leader with extensive experience in highly competitive and heavily regulated environments including commercial banking and telecommunications as well as the not-for-profit health sector. He combines innovation and strategic thinking with strong leadership to deliver results in challenging environments that are undergoing significant and time-critical change.

Prior to joining Sydney North Primary Health Network, Ramon was the CEO of Primary and Community Care Services Limited (PCCS), Northern Sydney Medicare Local and St John of God Health Care's two private psychiatric hospitals in NSW.

Ramon holds a Bachelor of Economics degree from the University of Sydney and an MBA and Master of Arts (Business Research) from Macquarie Graduate School of Management (MGSM). He is a Chartered Accountant and a Graduate of the Australian Institute of Company Directors (AICD).

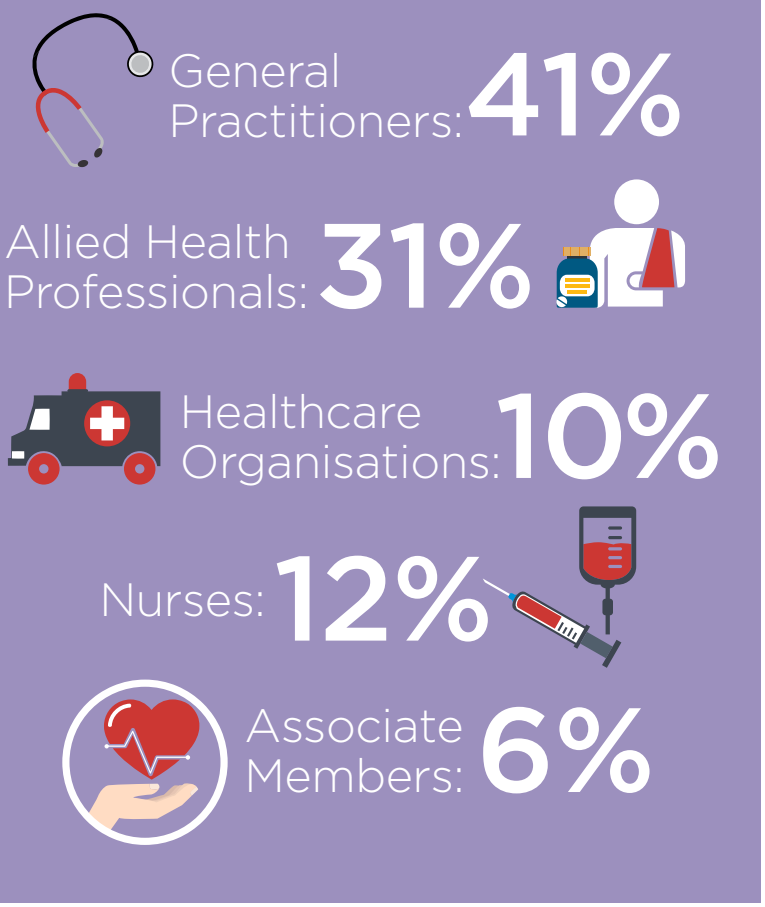
MEMBERSHIP

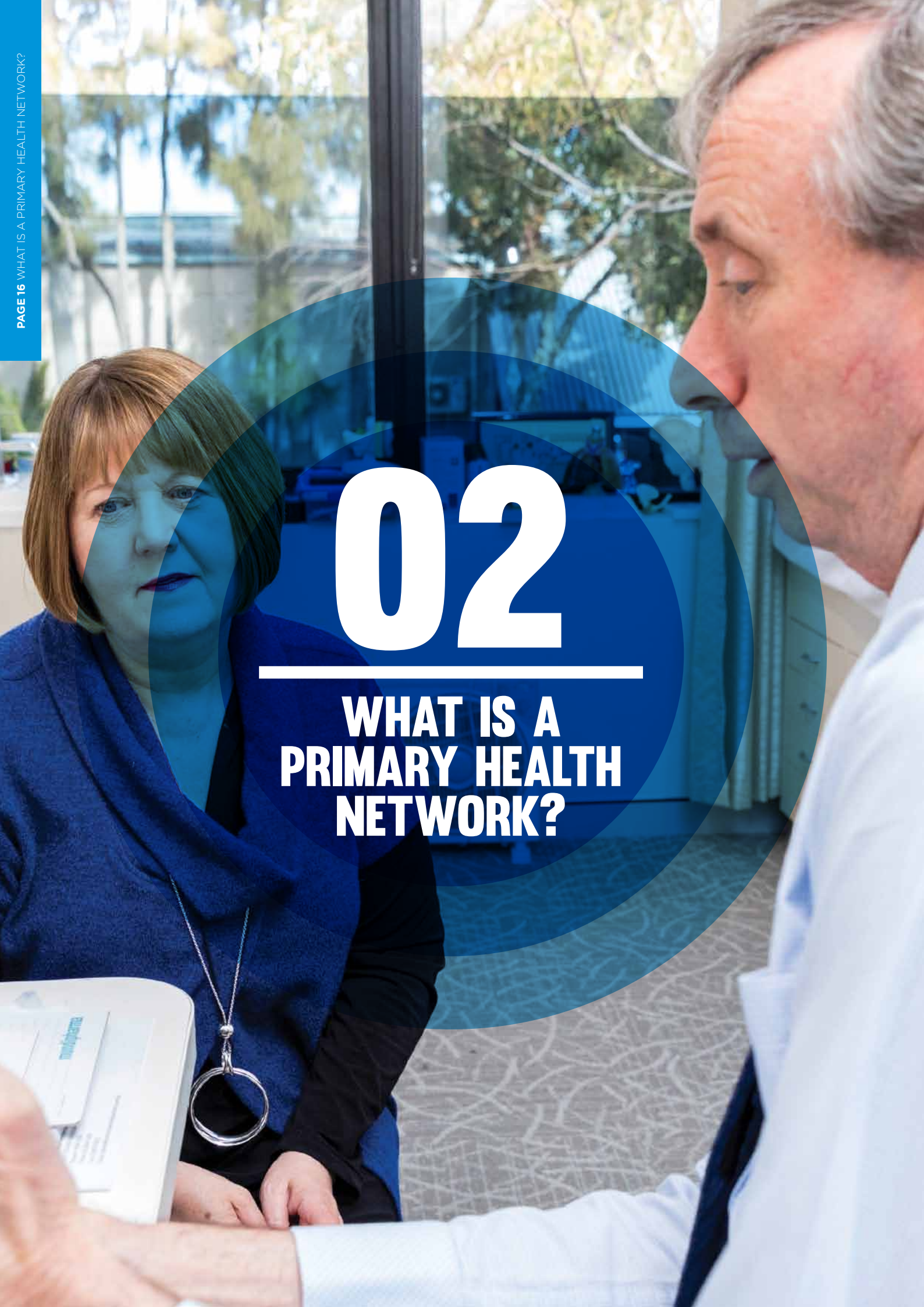
SNPHN has a growing and dynamic membership base. At the close of the financial year, SNPHN had 906 Individual members, 114 Organisational members and 69 Associate members. This is an increase of 334% over membership numbers at the end of 2015/16.

Memberships are an important way for SNPHN to engage with general practitioners, community organisations and allied health professionals across the region.

SNPHN offers annual membership to Individuals, Organisations, and Associates, with **1089** members registered as of 30 June 2017. Membership with SNPHN provides the opportunity to present views on primary healthcare, priority access to continuing professional education events, networking opportunities with other health professionals, the right to be nominated, to nominate and to vote at Board Elections, and attend the Annual General Meeting. Membership also delivers the opportunity to drive improvements in primary healthcare, ensuring that services are better aligned with the needs of the local community.

SNPHN MEMBERSHIP BREAKDOWN





02

WHAT IS A PRIMARY HEALTH NETWORK?

WHAT IS A PRIMARY HEALTH NETWORK?

On 1 July 2015, the Australian Government established 31 new Primary Health Networks (PHNs), following a review by its former Chief Medical Officer, John Horvath.

The Horvath review recommended that new, larger primary health organisations be established to reduce fragmentation of care by **integrating and coordinating** health services, **supporting the role** of general practice, and **leveraging and administering** health program funding.

PHNs have been established with key policy objectives of increasing the efficiency and effectiveness of medical services for patients, and improving coordination of care. The Northern Sydney PHN is operated by the Sydney North Primary Health Network (SNPHN) and is focused on enabling the 907,008 people in the Sydney North region to care for their own health and effectively navigate a complex healthcare system. This is achieved by providing better information, education, and networking opportunities for health professionals, establishing connections across the health system, and working with partners to deliver a better experience for health providers and better healthcare to the community.

PHNs provide an unprecedented opportunity to focus efforts at a regional level to achieve better **whole of system** care. They engage and coordinate across the care continuum to support services to do the right things (improve effectiveness) and to do things right (improve efficiency) to best meet the individual needs of health consumers in their local area and provide better value for money.

Sydney North Primary Health Network recognises that with change comes opportunity. The PHN has an important role to drive, support, and strengthen primary healthcare in the Northern Sydney region. SNPHN is completely focussed on striving towards achieving the quadruple aim – better health, better care, better value, and a sustainable workforce.

SNPHN plays an important role in leading strategic, regional level commissioning to drive service improvement and achieve system change. This involves understanding the health status of our local population, the services available within the region, identifying where the gaps are and working with services to ensure they meet the needs of the community. SNPHN does this by working together with a network of health professionals including general practitioners, primary care nurses, allied health providers, the Northern Sydney Local Health District (NSLHD), private hospitals, private health insurers and other health and social care service providers. This partnership approach and community focus is reflected in our vision:

Achieving together - better health, better care.

HOW DO WE HELP OUR COMMUNITY?

Internationally, the ageing population and increasing prevalence of chronic disease, combined with improvements in technologies and treatment, has resulted in significant changes in the way healthcare is delivered.

As the focus shifts towards provision of more care in the community, outside of hospital settings, the role of Primary Health Networks in driving high quality, integrated care becomes increasingly important.

Primary healthcare is the first point of contact for most people within the health system. This can occur through general practice, allied health services, community health organisations, or local pharmacies to help ensure the most efficient use of the health system to achieve the best patient outcomes.

The Primary Health Network name reflects the critical role that PHNs play in **networking health services** across local communities so that patients, particularly those needing coordinated care, have the best access to a range of healthcare providers.

SNPHN has implemented a range of new initiatives and introduced new tools and programs to build capacity in primary healthcare to manage the increasing complexity that comes with providing care closer to home. As a Primary Health Network, a strong focus is also placed on developing strategic partnerships to support hospital avoidance. This report highlights SNPHNs successes to date through the commissioning of services in response to the unique health needs of the Sydney North community. Over the next year we will continue to work closely with our providers to maximise the impact of these services and expand our role to build and improve the health literacy of our community.

LOCAL COORDINATED NETWORKS

With the growing burden of chronic disease, multiple co-morbidities and an ageing population in Northern Sydney, there is a need to further support the primary care workforce to be organised to effectively meet these challenges and to continue to deliver high quality, safe, best practice care.

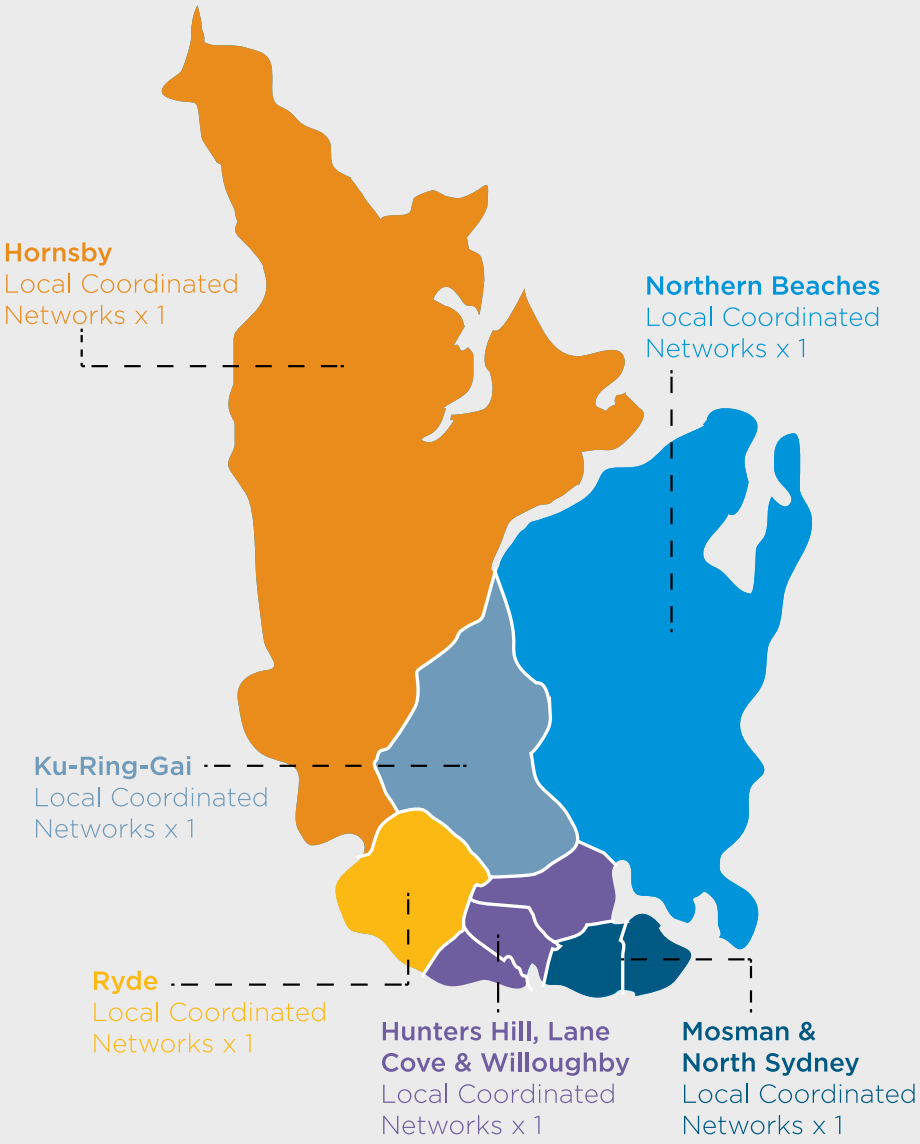
Examining a range of models in Australia, New Zealand, US and the UK, the Sydney North Primary Health Network developed an innovative framework for strengthening the role of primary healthcare providers in supporting the patient journey through the complex health system, whilst bringing services closer to patient's homes.

SNPHN worked closely with general practices and wider primary care to establish **Local Coordinated Networks** (LCNs) in the Northern Sydney region.

Reflecting a 'Medical Neighbourhood' model, an LCN is a grouping of general practices within a locality. Multidisciplinary teams and services work in collaboration with general practice so together they can provide services which best meet the needs of their local population. The establishment of LCNs provides a significant opportunity for SNPHN to work in partnership with the Northern Sydney Local Health District, private hospitals, private health insurers and local government councils to align services and co-design and co-commission local solutions relevant to each Local Coordinated Network.

THERE ARE SIX GEOGRAPHICALLY LOCATED LCNS IN THE SNPHN REGION, AS OUTLINED BELOW:

- Hornsby
- Ku-ring-gai
- Ryde
- Hunters Hill, Lane Cove & Willoughby
- Mosman & North Sydney
- Northern Beaches



During the last 12 months, SNPHN have worked closely with general practices from each Local Coordinated Network as well as consumers and other stakeholders to better understand the needs of consumers as well as the needs of service providers to enable them to drive service improvements. This resulted in identification of areas that could be addressed in enabling a more accessible primary care system to positively impact patient experience of care, improve patient outcomes and ultimately improve population health.

Based on key issues pertinent to individual LCNs, as identified through co-design sessions and needs assessment data, the Sydney North Primary Health Network has provided funding to support and enhance local service delivery and commission services in the following areas:

- Aged care social work services.
- Aged care services for people with dementia.
- Chronic and complex care coordination.
- Falls prevention.
- Support for members of the community experiencing severe and complex mental illness.

ADDITIONAL BENEFITS OF THE LOCAL COORDINATED NETWORK MODEL INCLUDE:

- Primary healthcare services commissioned to address local need for greater impact.
- Reaffirming general practice as having a key role within the health system.
- Better understanding of local population health needs and priorities.
- Care provided closer to the patient's medical home.
- Improved use of data to measure the impact on patients including health outcomes.

FURTHER OPPORTUNITIES FOR LOCAL COORDINATED NETWORK ACTIVITY INCLUDES:

- Opportunities to test new ways of working.
- Networking with general practice, community providers and the Northern Sydney Local Health District.
- GP involvement in commissioning of community based services based on identified needs within their network e.g. social work, allied health, and mental health.
- Closer working relationships with acute services to agree on priority areas and investment, providing specialist outreach support services, care coordination, and co-commissioning.
- Further development of localised care pathways – simplifying access to and navigation of the local system (including HealthPathways).
- Working with local government councils to explore opportunities for collaboration, co-commissioning, and a systems approach to meeting local needs.
- Alignment of commissioning funds to LCNs to ensure best use of resources for local needs.

As a first step SNPHN is working with the NSW Health Agency of Clinical Innovation (ACI) and the Northern Sydney Local Health District as a pilot site for Healthcare Neighbourhood, utilising our Local Coordinated Networks. The Healthcare Neighbourhood is a localised health system that adopts the vision, and supports the implementation of the person centred medical home. It aims to form a single cohesive system to enable a person centred approach to care.

SNPHN will continue to work closely with general practice in the development of the LCN framework to promote GP ownership and support of enhanced integrated services in Northern Sydney.

03

BUILDING PRIMARY HEALTHCARE CAPACITY

Strengthening the Healthcare System

CLINICAL ENGAGEMENT

PRIMARY CARE SUPPORT

A core part of SNPHN's role is to build capacity within primary care.

As a Primary Health Network, one of the ways we achieve this is through the development and implementation of quality improvement programs for general practice, using the concept of clinical data audit and review. To support this, Sydney North Primary Health Network offers general practices in the region access to data extraction tools that facilitate efficient management of the practice's patient population. Practice staff can easily identify and target populations, such as those with multiple chronic diseases, for review and proactive management to support the health of the community. Practices can collect and view their own data to identify areas for improvement, that can impact on patient health outcomes. This also provides practices with assistance in meeting Royal Australian College of General Practitioners (RACGP) 4th Edition accreditation standards.

Data driven improvement is a key foundation of high performing primary care systems. Engaging in activities such as data cleaning, performance measurement, and benchmarking is a marker of commitment to the provision of quality and safe care. SNPHN uses the "Model for Improvement" as the framework to facilitate small, but rapid changes that are pragmatic, achievable, and measurable.

Since the launch of this program, 137 (47%) general practices in the SNPHN region have agreed to participate in data collection and provision of de-identified data to the Primary Health Network. As of 30th of June 2017, SNPHN had received de-identified data from 119 (41%) practices, which when aggregated, provides a rich source of information to inform our population health needs assessment and commissioning activity.

The Primary Care Advancement Team creates quarterly reports based on the de-identified data received to provide meaningful, practical feedback to practices for initiating quality improvement activities. Practices have completed a number of these activities by implementing rapid Plan, Do, Study, Act (PDSA) cycles. This year, the team has produced 340 data feedback reports and actively engaged 63 practices to accomplish their goals through this process. Practices have been free to choose their own focus areas for improvement as this inspires greater motivation to persist through challenges! Some examples include data cleaning and coding, creating registers to assist with proactively managing patients with chronic disease, and identifying patients that could benefit from a health assessment or "check-up".

The regular submission of de-identified clinical data and activities based on PDSAs has supported local general practices to develop a culture of data driven improvement – which is a key ingredient in high-performing, quality primary healthcare systems.

Supporting and engaging general practice in Sydney's North:

20

77

136

58

TIER 1:
Advanced quality improvement skills and frequent input into health system design and planning.

TIER 1

TIER 2:
Intermediate quality improvement capability and regular participation in SNPHN programs and initiatives.

TIER 2

TIER 3:
Basic quality improvement capability and occasional participation in SNPHN programs and initiatives.

TIER 3

TIER 4:
Participants who only receive communications and information from SNPHN.

TIER 4

TOTAL PRACTICES: 291

QUALITY IMPROVEMENT IN ACTION

Quality improvement in action is about enhancing patient healthcare.

The Quality Improvement Coach (qiCoach) program is an initiative of the Improvement Foundation, which helps equip general practices with the knowledge and skills to identify strengths and opportunities for improving patient health outcomes, staff engagement, and day to day business and financial processes. Aligning closely with the SNPHNs focus on building the capacity of general practices through quality improvement, the qiCoach program has been the perfect fit!

Members of the Primary Care Advancement Team were trained and supported as Practice Coaches by the Improvement Foundation. Eight practices in the Sydney North region expressed interest in participating in the program. These practices were provided with a detailed assessment of their clinical and business practices, through a process of data extraction and analysis. Each practice selected their highest priorities from these tailored diagnostic reports. Led by their coach, practices were then guided through each step of the quality improvement planning and implementation process and introduced to a comprehensive suite of online quality improvement tools and resources.

Areas for quality improvement included clinical measures, such as chronic disease management, preventive health assessments, cervical screening, and the recording of clinical information; team health, such as professional development or communication; day to day business processes, such as recall and reminder or appointment systems; or a combination of these key areas.

A practice, who had been using agency nurses previously, decided to focus on building the capacity of the team. This included supporting the retraining of an existing staff member in the completion of a diploma of enrolled nursing, and employing a registered nurse at the practice. This will allow greater flexibility and utilisation of valuable staff resources and will enable the practice to establish nurse led clinics in the future.

One practice has gradually transitioned from being paper based to implementing a clinical software system. The qiCoach program has presented an easy and convenient methodology for the practice manager to cleanse their data and develop a process for archiving paper files. This same practice has adopted a new recall and reminder system, resulting in improved access to cervical screening and follow-up care, and increased efficiencies for clinical staff. The recording of cervical screens in the clinical software has also increased.

A third practice has increased their knowledge and use of certain Medicare Benefits Scheme (MBS) billing items. Subsequently, they ran a database search and developed a register of eligible patients. This practice has implemented an effective system for recalling these patients and utilising the appropriate MBS item for the service provided. Being involved in the qiCoach program has helped build the confidence of practice staff in completing quality improvement cycles and implementing change. Their patients will continue to benefit from even better access to the care and services they need.

> “It was a very worthwhile project to be part of, with great support and advice. It provided the practice with coaching and tools, that encouraged more open communication and brainstorming between doctors, nurses, and administrative staff. The program proved how valuable a data tool is within general practice. It encouraged team engagement and allowed for all ideas to be explored. It has opened the door for further improvements, which will benefit both the patients and practice.”
>
> Gabrielle Clancy, Practice Manager – Pennant Hills Medical Centre

> “Overall, I think being part of the qiCoach program has made me stop and reflect on the jobs my team does every day in a different way and how we measure any success. I really do appreciate all the help the Sydney North Primary Health Network has given me and wonderful support offered.”
>
> Patricia Rigg, Practice Manager - Lindfield Medical Practice

DIGITAL HEALTH

Secure and timely exchange of health information is a core foundation of Australia's expanding digital health program and one that is being widely promoted by the Sydney North Primary Health Network across the region's primary care sector.

Tools such as the My Health Record, shared care platforms and secure messaging have the potential to draw together patient information stored in disparate information systems to improve patient safety and provide more comprehensive, integrated care for our community.

Providers in the Northern Sydney area have been increasingly interested to learn more about the benefits of implementing digital health technologies within their practices and in the last year alone SNPHN have provided education events around:

- My Health Record – Privacy and Consent
- Digital Health Initiatives for Aged Care
- Shared Care Planning Platforms (Multi-vendor demonstrations)
- My Health Record for Pharmacy

> "The SNPHN region now has approximately 157,000 consumers with a My Health Record – **an increase of almost 50%** since this time last year and one set to increase significantly with the introduction of the national My Health Record expansion program in 2018."

The SNPHN region now has approximately 157,000 consumers with a My Health Record – **an increase of almost 50%** since this time last year and one set to increase significantly with the introduction of the national My Health Record expansion program in 2018.

Digital health engagement is now firmly embedded amongst our local GP population with 226 practices registered in the My Health Record system. Between these practices more than 26,000 Shared Health Summaries have been uploaded since July 2016.

In addition, over 42,000 discharge summaries from local public and private hospitals were uploaded to the My Health Record for consumers within the SNPHN region. In early 2017, the Primary Health Network also commenced working closely with clinicians at Royal North Shore, Mona Vale, and Ryde hospitals to raise awareness of the availability of primary healthcare patient data accessible via the NSW Health clinical portal. In the year ahead SNPHN hope to extend these information sessions to other hospitals and facilities within the region.

During the last year SNPHN have also expanded engagement within the aged care sector, recognising the value to these patients of being able to share their information across a range of healthcare providers. We now have 28 residential aged care facilities (RACFs) registered for the My Health Record system, with six of these participating in a pilot to explore ways in which secure messaging and the My Health Record can improve clinical handover and therefore patient safety for residents moving between the primary, acute and community care sectors.

> “Statistics show that when you move to an electronic platform the error rate is greatly reduced – I think that our families and our residents will be greatly comforted by that.”
>
> Jennifer Stuart Smith - CEO, James Milson Village Hostel

> The My Health Record system has been a very welcome addition to our pharmacy. It has enabled streamlined communication with other health professionals and our patients, and has thoroughly enhanced our quality of care.
>
> Dominica Hooper - Pharmacist, Plunkett's Pharmacy Mona Vale

Increasing engagement with the local pharmacy community has also been an integral part of SNPHNs digital health strategy for the region and a vital connector for the work we are doing in the aged care setting. Following a pharmacy education event held in June 2017, there was an immediate 25% spike in the number of pharmacies registering for the My Health Record system. This sector has also been particularly enthusiastic about the uptake of secure messaging, with pharmacists quick to grasp how risks to patient safety can be mitigated through greater sharing of medication data.

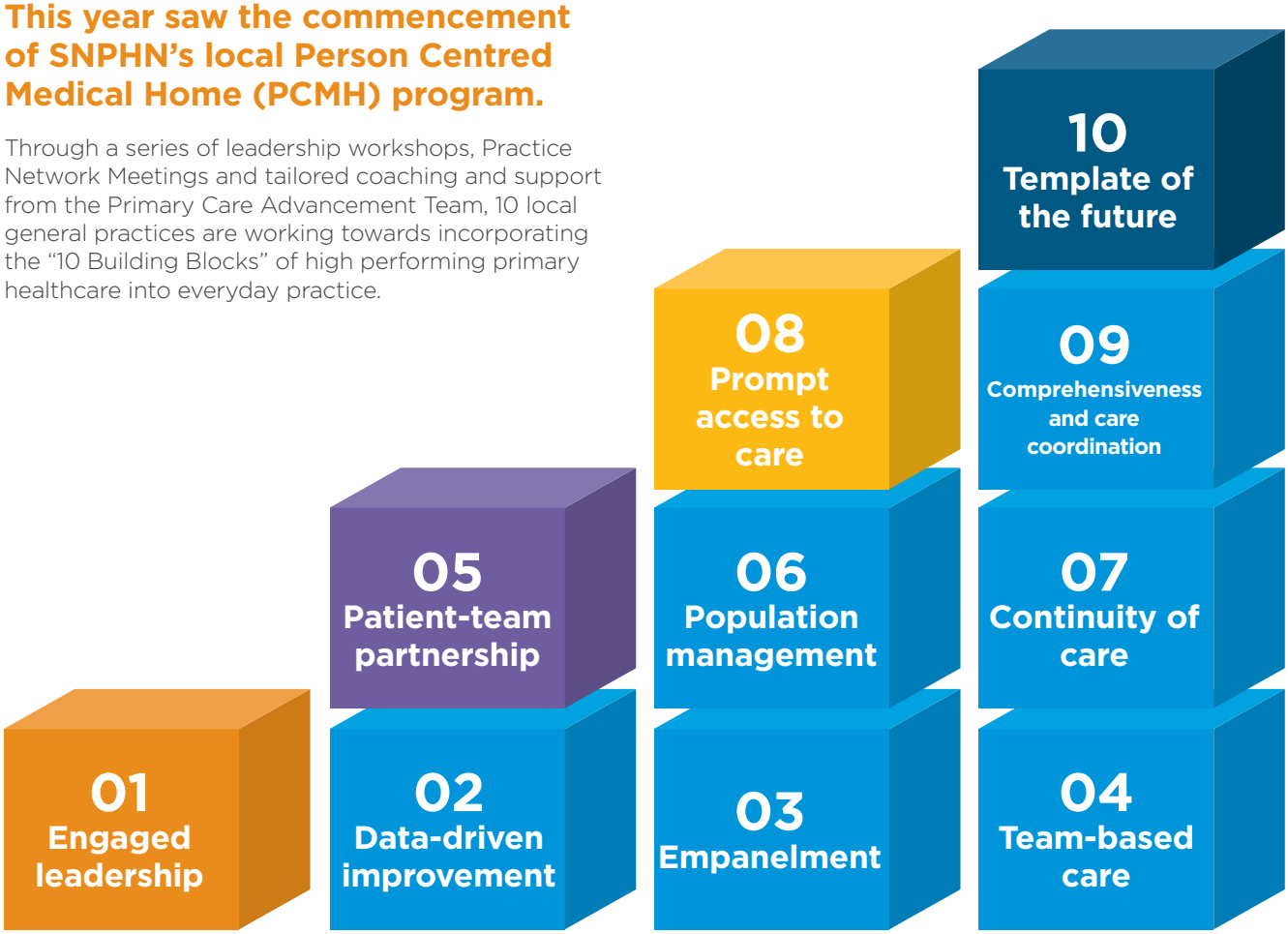
During this past year SNPHN has continued to collaborate very closely with the Northern Sydney Local Health District (NSLHD) and other external agencies (such as the Family Referral Service and Breast Screen NSW) to develop and promote the use of eReferral templates by GPs. In January 2017 SNPHN commenced a year-long pilot with the NSW Ambulance Extended Care Paramedics to trial sending of follow-up letters to GPs via secure messaging. Whilst this pilot is still in progress it has already resulted in significantly less time spent chasing 'lost' information and in scanning hardcopy information into the patient's record.

Over the coming year digital health enablers such as the My Health Record, secure messaging, and shared care planning platforms will be critical to the provision of integrated, coordinated care as part of our Person Centred Medical Home program. This program will provide great opportunity for SNPHN to expand digital health engagement to specialists and allied health providers, and to further explore innovative ways to enhance the patient journey through a myriad of healthcare settings.

PERSON CENTRED MEDICAL HOME

This year saw the commencement of SNPHN's local Person Centred Medical Home (PCMH) program.

Through a series of leadership workshops, Practice Network Meetings and tailored coaching and support from the Primary Care Advancement Team, 10 local general practices are working towards incorporating the "10 Building Blocks" of high performing primary healthcare into everyday practice.



© 2012: UCSF Center for Excellence in Primary Care

> This medical practice is different to all the others I've ever been to... it feels like it has a soul!
>
> Patient from a PCMH practice

The goal and framework for PCMH is to achieve the quadruple aim, this being:

- Improved population health.
- Improved cost efficiency.
- Improved patient experience of care.
- Improved provider wellbeing.

The key principles of the PCMH model are to provide care that is based on an ongoing relationship between a person and their primary healthcare team. These principles are:

- Patient centred;
- Coordinated;
- Comprehensive;
- Accessible;
- Continuous; and
- Committed to quality and safety.

The PCMH model was developed in the USA in response to the growing need for primary care to manage the challenges inherent in changing population health needs, including increased numbers of people with multiple chronic diseases and an ageing population. These challenges are being faced by healthcare systems across the world, including Australia.

A key highlight for practices has been participation in an intensive **Business and Clinical Leadership program** that is supporting the development of strong multidisciplinary practice teams, including GPs, practice managers, staff, and nurses. The program includes tailored one-on-one coaching, in between workshops, to ensure improvement efforts are sustained and staff get protected time to work on planning, implementing, and measuring change.

Data driven improvement is an essential part of the PCMH journey. The practices involved in the program are encouraged to analyse their own data to better understand their patient population and then take the necessary steps to target patients with chronic disease, to be proactive in facilitating better patient outcomes, and to enable patients to better manage their conditions. Practices are encouraged to take a whole of practice team approach so each team member works to the full scope of their practice; this includes reception staff through to healthcare clinicians.

> An excellent program with many practical applications. The system changes address multiple issues.
>
> GP from a PCMH practice

BUILDING WORKFORCE CAPACITY

NURSE TRANSITION PROGRAM

Building on the success and learnings of the 2014/15 Nurse Transition Program Pilot, this year SNPHN collaborated with Primary Community Care Services (PCCS) and local general practices to launch the Sydney North Primary Care Nurse Transition Program.

Nursing graduates in this program are supported by an experienced Primary Care Nurse Coordinator to advance knowledge and skills acquisition, through two rotational general practice placements over one year.

The program facilitates the transition of new graduate nurses to advance their career in primary care general practice. This program contributes to the development of a primary care workforce that has the capacity to support the health needs of the local community, offers wider patient choice for clinician engagement, and increases access to a wider range of practice services. Enrolment in the SNPHN Primary Care Nurse Transition Program offers graduate nurses a structured program of study days, access to SNPHN's General Practice Education Program, and an opportunity to build relationships with the Primary Care Advancement Team for ongoing support beyond the one-year Nurse Transition Program. In addition, graduates have the opportunity to learn about SNPHN's Primary Care Advancement Initiatives including Person Centred Medical Home and Local Coordinated Networks. They are also provided with tools to support quality improvement, and equipped with access to navigate the local health system through the Sydney North HealthPathways website.

Bianca Cantarella is a graduate nurse enrolled in the SNPHN Nurse Transition Program and she said, "Before I started I didn't know much about primary care, but as the demands of healthcare are changing I realised it is an important aspect of healthcare in the future. When I started the program, I was greatly supported by the Program Coordinator who introduced me to the role of a practice nurse and all that it entails. The program has been an amazing opportunity to refine and develop my skills as a nurse while having the support of the Sydney North Primary Health Network and senior nurses with a wealth of knowledge. The practice I am working in has provided me with fantastic mentors who allow me to learn and grow as a registered nurse, as well as providing me with seminars and education related to my work to develop professionally. I recommend this program to anyone who is interested in being on the front line of healthcare for the future and refining their skills with a great support network – it has been a fantastic opportunity!"

Graduates of the 2016/17 Primary Care Nurse Transition Program will celebrate at the graduation ceremony in December 2017. SNPHN is now recruiting practices for the next Graduate Program commencing in January 2018.

Other areas in which practice nurses have been shown to be effective include counselling patients with health problems related to their lifestyle, including smoking, hazardous drinking, nutrition, immunisation, and chronic disease including cardiovascular, asthma and diabetes.

> "This is the second Graduate Nurse Program we have been involved with. We have been extremely happy with our new graduate nurse. The registered nurses enjoy teaching and passing on their knowledge in all aspects of primary healthcare, including wound care, immunisation, chronic disease management, triage, and health assessments. We are looking forward to our next graduate nurse placement, and have confirmed an expression of interest to participate in the program for 2018/19."
>
> Deirdre Stacey, Senior Registered Nurse

Starting a nursing career in general practice can be a confronting experience for new nurses, and the benefits of mentorship have been recognised in the testimonials of nurses both participating in the program and those receiving support outside the program.

> "Since I joined the GP Nursing Program in February, I have learnt a lot. I have been introduced to health assessments relevant to primary healthcare, and provided with guidance on documentation with reference to wound management. This has accelerated my skills allowing me to adapt better to this new role. Having a mentor has also been invaluable. On a personal level being able to speak with someone who has well-travelled a path on the professional journey that I am about to embark on has been amazing."
>
> Pooja Shankar, Practice Nurse

EDUCATION

In 2016/17 SNPHN remained committed to providing a high quality and evidence based Education Program for general practice and health professionals in the Sydney North region.

The Continued Professional Development calendar facilitates education that supports general practice and primary care providers and builds capacity for a high performing local primary healthcare system.

SNPHN is a Royal Australian College of General Practice (RACGP) accredited provider with four RACGP endorsed providers on staff. SNPHN understands the importance of delivering a program that encompasses adult learning principles and provides participants with locally relevant education.

The Education Program is governed by a multidisciplinary **Education Advisory Committee** (EAC) who focus on providing education that:

- Promotes person centred healthcare to improve the overall health of our population and reduce avoidable hospital presentations.
- Strengthens multidisciplinary team based care.
- Aligns with local and national health priorities as well as Northern Sydney health indicators and priority areas identified by SNPHNs needs assessment.
- Promotes the use of HealthPathways to facilitate right care, in the right place at the right time.
- Aligns with the quadruple aim – better population health, better patient experience of care, better value for the system and greater clinical workforce satisfaction and sustainability.

Education highlights for 2016/17 included **3,568** general practitioners and health professionals attending **80 education events** hosted by SNPHN.

Education opportunities have included:

- Evening Workshops
- Network Meetings
- Online Learning
- Clinical Audits
- Plan Do Study Act (PDSA) Cycles
- Active Learning Modules (ALM's)
- Hospital Updates
- Emergency Medicine Series
- GP Shared Antenatal Care Updates
- Business and Clinical Leadership Coaching
- Quality Improvement Coaching

This year has also seen the growth of our Education Program microsite (www.snhn.org.au/education) on the SNPHN website, which includes an online calendar of events with online registrations, links to videos of events held by SNPHN, online learning opportunities, and events hosted by other healthcare providers.

There is a strong emphasis on collaboration at Sydney North Primary Health Network. As such, the PHN has co-hosted several events in partnership with:

- Sonic Health Services
- Northern Sydney Local Health District
- Manly Warringah Division of General Practice
- University of Sydney
- HammondCare
- Sydney Adventist Hospital
- Australian Digital Health Agency
- Black Dog Institute
- RACGP

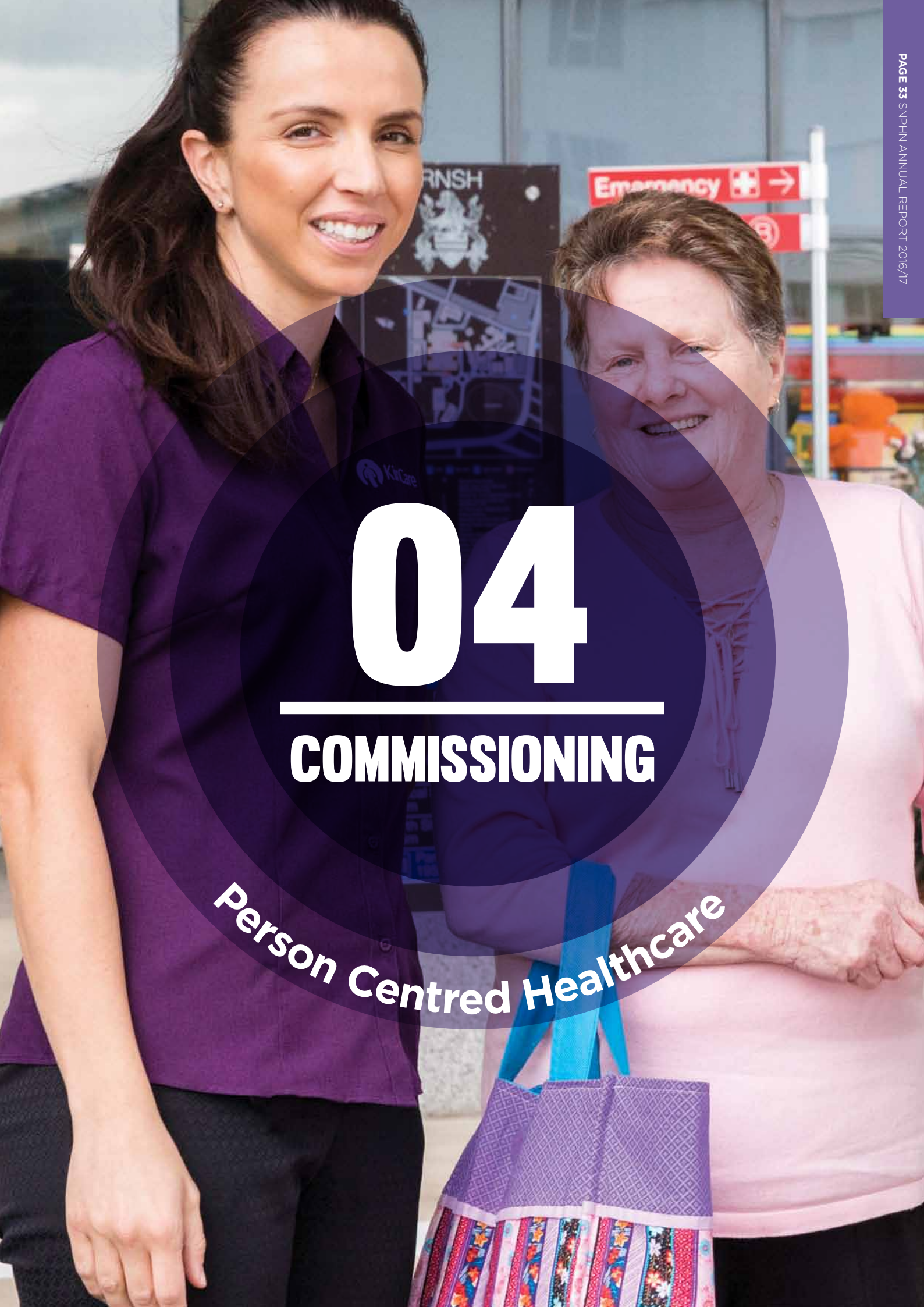
Moving forward our education calendar for 2018 will incorporate priority areas identified by GPs and health professionals in our region, as well as identified local and national health priorities. At the Sydney North Primary Health Network, we remain dedicated to offering education that is relevant, dynamic, and focused on patient-centred care.

SHARED ANTENATAL CARE

The Shared Antenatal Care Advisory group has been in operation since 2015. It consists of general practitioners from across the Primary Health Network and obstetricians and GP liaison midwives from the Northern Sydney Local Health District. Their role has included establishing a Shared Antenatal Care webpage on the SNPHN website, providing online access to the list of shared antenatal care GPs in the Northern Sydney region, designing, and providing information brochures on models of care, and delivering three antenatal education events in 2016/17.

The shared antenatal care GP education events are always at capacity and have received very positive feedback from the participants. The presentations have been filmed and are available on SNPHNs website.

The advisory group also guided a review of the program, which included interviews with mums who participated in Shared Antenatal Care, GPs, hospital doctors, midwives, and clinic staff. The review has identified a number of areas for improvement and the results will be used to form the basis of an activity plan for 2017/18.



04

COMMISSIONING

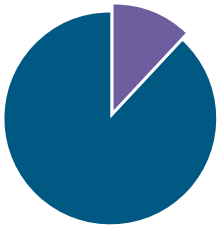
Person Centred Healthcare

MENTAL HEALTH

SNPHN received $22.5 million over 3 years to redesign and deliver effective and responsive mental health services in the Sydney North area.

As a Primary Health Network, there are 6 key areas for primary mental healthcare commissioning including:

1. Low intensity mental health services;
2. Child and youth mental health;
3. Psychological therapies for underserviced, at risk and hard-to-reach groups;
4. Aboriginal and Torres Strait Islander mental health;
5. Clinical care packages for people with severe and complex mental illness; and
6. Community based suicide prevention services.



12 in 100 people in the Northern Sydney region report mental and behavioural problems with depression and anxiety being the most commonly diagnosed mental health disorders.

Certain population groups in the Northern Sydney region are at **higher risk of suicide and self-harm,** including humanitarian entrants, men aged 75+ years, lesbian, gay, bisexual, transgender and intersex community members and young people.

In Northern Sydney, there is a **higher rate of hospitalisations for mental disorders** (2,686 per 100,000) among Aboriginal people compared to non-Aboriginal people (1,860 per 100,000).

Youth mental health remains a significant issue for Northern Sydney with Emergency Department (ED) presentations relating to self-harm or suicidal behaviour particularly prominent in young people aged 15-19 years, averaging over one presentation to EDs per day in the SNPHN region.

Intentional self-harm is the leading cause of death in 15 -24 year old's in Northern Sydney.

It is in response to the above statistics and from our 2016 needs assessment, the Sydney North Primary Health Network launched six new mental health and suicide prevention services in 2016/17.

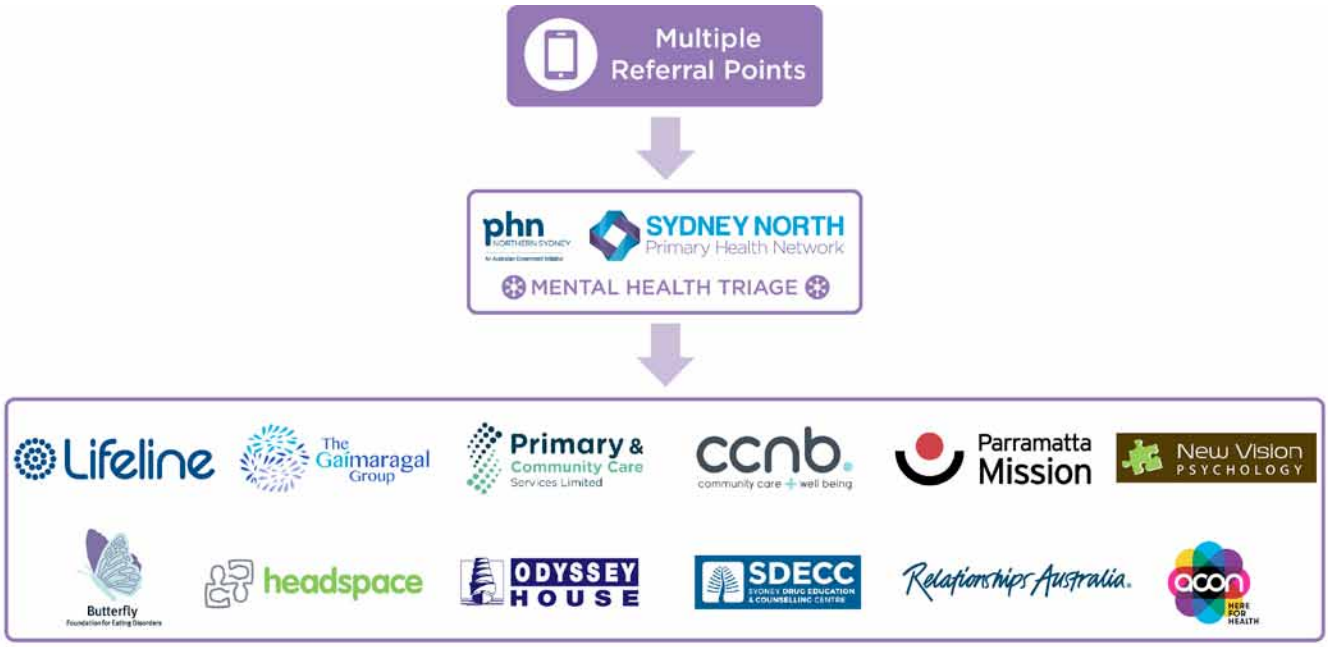
SNPHN consulted extensively with the mental health sector, GPs, Clinical and Community Councils, the SNPHN Mental Health Advisory Committee, the Northern Sydney Local Health District, mental health providers, and the wider community to design the mental health services that would have the most impact and support those of greatest need across the region.

Using a **co-design approach**, the key needs identified for the local region included:

- Increased support for GPs, service users and their families to navigate the local mental health service system.
- Improved access to primary mental health services that are flexible and responsive to the needs of service users, including access to psychological therapies via telephone or video.
- More group-based psychological therapies.
- Services for adults and young people with, or at risk of, severe and complex mental illness receiving treatment in primary care.
- Community-based support services for people following a suicide attempt.
- A greater range of services, including low-intensity mental health services, to support those at risk of developing more severe illness.
- Holistic support services for Aboriginal and Torres Strait Islander people.

SNPHN has commissioned a range of innovative mental health services, providing care across the spectrum of needs for people receiving their support in the primary care sector.

To assist navigation for GPs and service users, SNPHN has established a **Primary Mental Health Triage** to direct patients to the most appropriate mental health service. This clinical triage replaces the administrative intake function of the Access to Allied Psychological Services (ATAPS) program and offers a central point of access for SNPHN commissioned mental health services.



SNPHN has commissioned a range of mental health services across the stepped care continuum, ensuring that service users who receive their support in primary care can access the most appropriate level of care according to their mental health needs. These services are:

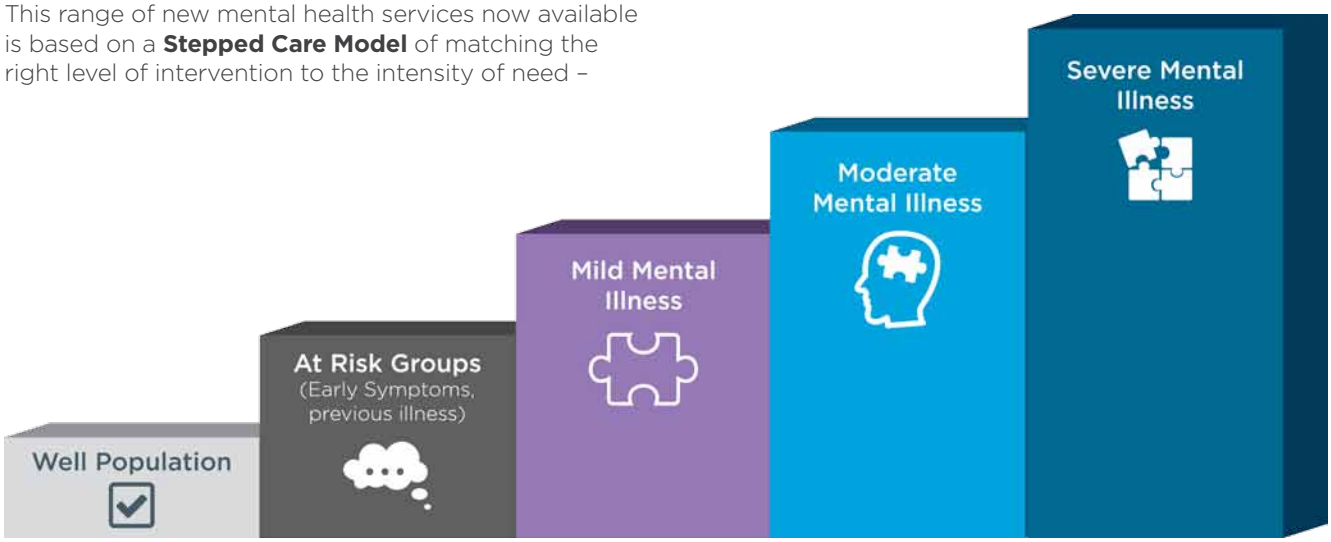
- **Lifeline Harbour to Hawkesbury -** providing low intensity telephone-based support, coaching and call back services for people with mild mental health issues or at risk of developing mental illness. Lifeline also provides group psychological therapies, including groups for women experiencing perinatal anxiety or depression and psychological skills groups for adults and adolescents. **www.way2wellness.org.au www.lifelineh2h.org.au**
- **Primary & Community Care Services -** providing short-term psychological therapies delivered by mental health clinicians for people experiencing mild to moderate mental illness from identified underserviced groups. **www.pccs.org.au**
- **New Vision Psychology -** providing short-term psychological therapies and group programs for people of Chinese cultural background. **www.newvisionpsychology.org.au**
- **Relationships Australia and Gaimaragal Group -** providing care coordination, advocacy, and culturally appropriate support for Aboriginal and Torres Strait Islander people. **www.relationshipsnsw.org.au**
- **CCNB -** providing community-based suicide prevention services for people who have accessed hospital services following a suicide attempt. **www.ccnb.com.au**

- **headspace -** services providing early intervention mental health, drug and alcohol, sexual health, and employment services for young people with or at risk of mild to moderate mental illness. **www.headspace.org.au**
- **Parramatta Mission -** providing clinical case management, care coordination and psychological treatment services for young people and adults with or at risk of severe mental illness. **www.parramattamission.org.au**
- **Butterfly Foundation -** providing intensive outpatient support services for young people experiencing an eating disorder. **www.thebutterflyfoundation.org.au**

This range of new mental health services now available is based on a **Stepped Care Model** of matching the right level of intervention to the intensity of need – ranging from low intensity mental health services through to severe and complex mental health service clinical management.

These services build on the previous Access to Applied Psychological Services (ATAPS) model, a one size fits all approach, now with greater flexibility, access, and choice for those impacted by mental health illness.

In the year ahead, SNPHN will work with commissioned providers to deliver high quality, connected and clinically sound mental health services to residents of the Sydney North region and continue to work with general practice to enhance access and awareness.



ALCOHOL AND OTHER DRUGS

The Sydney North Primary Health Network received $3.58 million of federal funding over three years for local drug and alcohol rehabilitation services.

Dependency on other drugs is a widespread community concern in the region that knows no geographical boundaries and, like alcohol, is often part of a more complex adjunct to mental illness.

SNPHN acknowledge that alcohol and other drugs are both a health and social issue, and treatment needs to be supported at a community level. Through extensive consultation and co-design with the alcohol and other drug sector, including service users and peak bodies, the PHN has identified opportunities to provide new services that will complement existing drug and alcohol rehabilitation services within the region.

In 2016 SNPHN undertook an initial Alcohol and Other Drugs (AOD) Needs Assessment which identified vulnerable populations and AOD priority needs within the region, including Aboriginal and Torres Strait Islander people, lesbian, gay, bisexual, transgender, queer or questioning, and intersex (LGBTQI) people, culturally and linguistically diverse (CALD) communities, young people, and women.

The population health data SNPHN have gathered in Northern Sydney uncovered:

- Increasing rates of methamphetamine use across the region;
- Higher rates of alcohol and other drug misuse of people with mental health illness;
- Risky drinking in young males across the region; and
- Increasing hospitalisations due to alcohol in females.

Following the needs assessment, the PHN developed an Integrated Commissioning Framework embedded with the principles of co-design and engaged stakeholders extensively in the consultation to identify gaps in current AOD service delivery. The SNPHN AOD and Mental Health Advisory Committee, is well represented from the across region, including general practice, consumers, and the Northern Sydney Local Health District, who supported the development of a shared vision for the region and the future of primary care based AOD services.

Community based treatment that supports adults and youth was identified as an area requiring new investment within the Northern Sydney region, specifically in the form of non-residential day programs that complement existing and established services, but crucially, meet an identified gap in the current management of alcohol and drug rehabilitation within the region.

ALCOHOL AND OTHER DRUGS COMMISSIONED SERVICES

The first commissioned service - a partnership between **Odyssey House McGrath Foundation and New Horizons** - delivers a drug and alcohol rehabilitation day program for up to 400 adults a year from across the region.

This **adult non-residential day program** provides intensive rehabilitation and relapse prevention with additional provision for women, who have been identified as being a vulnerable population within the region. Odyssey House and New Horizons have also developed, with the local Aboriginal community, a specific AOD program that includes Aboriginal appropriate workforce competency education and the hiring of an Aboriginal liaison worker.

In addition, and as part of a range of drug and alcohol rehabilitation programs, the SNPHN have also commissioned a **youth specialist day rehabilitation program** to be operated by the **Sydney Drug Education and Counselling Centre**. This much-needed service will provide a support program for young people aged 14-25 years across the region who are experiencing moderate to severe drug and alcohol addiction, including ice addiction.

Finally, **ACON** will deliver alcohol and other drug treatment services to LGBTQI community members residing in the region.

SNPHN has also developed an **AOD Shared Care Model** for the region. This project, once fully operational, will build capacity in general practice to manage and support people with drug and alcohol issues in the community. The project involves:

- Providing specialist outreach services directly to general practice in the Northern Sydney region.
- Developing an AOD Active Learning Module and AOD HealthPathways (a clinical referral tool for GPs, nurses, and allied health professionals).
- Creating an information and resource pack for GPs including promotional materials to reduce stigma and encourage patient identification, screening and assessment tools, information about local AOD services and referral/intake processes, template treatment and management plans.

These AOD treatment pathways will enhance access to much needed primary care based AOD rehabilitation services across the region and improve the coordination and efficiencies between AOD, mental health and other health services. Collectively this will better enable those people affected by AOD to remain healthier in the community with greater support.

VULNERABLE POPULATIONS

Following the 2016 needs assessment results the SNPHN has confronted, and is working to address, the gaps to increase the capacity and capability of health, social and education providers to vulnerable populations.

This included better primary healthcare management for the Aboriginal and Torres Strait Islander population, people with an intellectual disability, and people under mental or social distress. Improving access to appropriate services for youth, as well as the socially and financially disadvantaged, were also targets identified and addressed.

NEW PROGRAMS

Over the last 12 months SNPHN has funded numerous new programs designed to:

- Enhance health outcomes of vulnerable populations living within our region;
- Improve access to health services; and
- Support the local primary care workforce to build capacity to better support those identified vulnerable populations.

These programs have delivered:

- Education to 20 mental health clinicians to enhance their skills and capability to provide psychotherapy/counselling to adults with mild to moderate intellectual disability who are experiencing mild to moderate mental illness. The education consisted of 4 one-day workshops, with each participant receiving four mentoring sessions. **The Centre for Disability Studies** conducted the intellectual disability and mental health training.
- Increased capacity of experienced shift supervisors to support and build the volunteer workforce capability attending to the **Lifeline Telephone Crisis Line**. Improvement in volunteer engagement and satisfaction were reported, as well as increased retention and quality of service.

ENHANCING PROGRAMS

Some of the existing programs that SNPHN has supported this year aimed to improve the experience of our vulnerable populations when accessing health services. These people include the socially and financially disadvantaged, youth, those from a culturally or linguistically diverse background, Aboriginal and Torres Strait Islander community members, older people, and people with poor mental health.

> Greenway

Greenway at Kirribilli continues to be focus of access improvement. During the last twelve months, the Greenway Community have been involved in fundraising efforts to assist in the purchase of a community bus as well as the installation of a new lift from the grounds to the train station. A car has been donated to the community which is now used to assist residents to attend medical appointments, with many residents now reporting regular GP visits instead of going to hospital emergency departments.

In collaboration with Community Care Northern Beaches, a social work program called **Greenway Connect**, has been established to assist with the identification of mental and social issues, and coordination of referrals. This program has managed 23 long-term clients and 73 short-term clients, working with them to assess their needs and link in with appropriate services. The diversity of services referred to included: Centrelink, Community Mental Health, ATAPS via GP referral, Alcohol and Other Drug support, Housing NSW, Sydney Home Nursing, My Aged Care, various local health district medical specialists and allied health clinics, Dementia Advisory, Carer Respite, and Legal Aid.

Work has commenced on converting a ground floor unit into a clinic and educating area. Outside the building, the gardens and grounds have been landscaped.

"I used to be scared and ashamed to live here. Now I am so happy and healthy and it feels like home."
Greenway Resident

> Aboriginal Health

During the year SNPHN successfully commissioned the **Integrated Team Care (ITC)** program, a chronic disease management program designed to support and improve health outcomes for Aboriginal and Torres Strait Islander people in the region.

SNPHN held a consultation workshop in October 2016 to work with the local community, including many local Aboriginal Groups, and local health providers to co-design the most appropriate service for the region that would enhance access to healthcare and improve health outcomes for Aboriginal people. After evaluation by an independent panel, the tender was awarded to the Northern Sydney Local Health District in partnership with The Gaimaragal Group and the program is now fully operational. Clients experienced

very little disruption to their ongoing care coordination and the ITC program has continued to grow, receiving more referrals from a variety of health stakeholders across the region.

In addition, SNPHN has partnered with key agencies, including the Northern Sydney Local Health District to deliver Aboriginal health events across the region including: women's health check days, chronic disease management, and mental health addressing youth and trauma management. SNPHN is actively engaged in the regional Aboriginal Health Advisory Committee and has funded 28 Group Hydrotherapy sessions and six regional 'Yarning Circles' for the local community.

SNPHN has worked closely with the community to review the Aboriginal Cultural Training program for the region, which has resulted in a new partnership with TAFE Gawura Brookvale. The Aboriginal Cultural Education program has been enhanced and adapted to meet the needs of general practice clinical and non-clinical staff, to assist with further development of skills and knowledge to create culturally safe practices in which to provide holistic care for their Indigenous patients. SNPHN staff have also undertaken Cultural Awareness Training from the local TAFE unit.

The **BEE Program**, conducted by The Gaimaragal Group, targeted teachers, principals, local Aboriginal and Torres Strait Islander Community members, local Aboriginal education and health services and local professionals to provide health, social and emotional support to Aboriginal and Torres Strait Islander peoples. The aim was to improve their capability to provide trauma informed care to the Aboriginal and Torres Strait Islander youth residing or attending school within the region. This two-day workshop was attended by over 70 professionals from general practice, the Northern Sydney Local Health District, not-for-profit organisations, private health providers, public and private schools, TAFE, justice health and Taronga Zoo.

> Mental Health Support

SNPHN funded **Lifeline Harbour to the Hawkesbury** to deliver two full treatment courses for people that experience Hoarding Disorder. This disorder can have devastating effects on individuals, their families, and communities. Over the past year, 24 individuals have participated in the program, with most graduates continuing to attend the support group.

> Youth Health

In 2016/17 a comprehensive review of the **GPs in Schools** and **uConnect Health** programs were undertaken. In consultation with local stakeholders, the GPs in Schools program is being redesigned and expanded across the region to meet the changing needs of youth, engaging, and encouraging them to access health and associated services. Redesign of the facilitators' course is underway, along with a recruitment drive to establish a larger team of facilitators. This increase in capacity will enable further expansion of the program across the region.

THE AGEING POPULATION

AGED CARE

There are approximately 140,000 people aged 65 and over residing in Northern Sydney, equating to 15.5% of the total population. This is expected to grow by 43% between 2016 - 2031, the largest increase of any age group. As they age, many will experience chronic illnesses, disability, and/or physical or cognitive decline. To ensure they can remain independent and in their own homes for as long as possible, they will need a range of health and social care services, which will be delivered by a mix of public, private, and not-for-profit organisations. A large proportion of their care will be delivered informally by family and friends.

Sydney North Primary Health Network has established a solid and supportive network for people working across the aged care sector. **The Ageing Strategy Network** facilitates sharing of local knowledge between a variety of health and community care providers, carers, and consumers. Members are invited to come together on a regular basis for formal meetings, education events and other activities aligned with aged care, providing an opportunity to discuss issues and share ideas and solutions on how to better deliver services to this patient population across the SNPHN region.

During the year, the SNPHN Aged Care Team set out to gain a better understanding of the challenges faced specifically by general practice and staff within Residential Aged Care Facilities (RACFs), in providing high quality care. Our survey highlighted the main areas of support needed by RACFs included Palliative and End of Life Care (EoLC), Wound Care and Dementia Care. Other areas identified were the ability of staff to recognise a patient whose health was declining, mental health challenges and improved access to general practitioners.

General practice, on the other hand, identified communication as being the key challenge, including sharing of patient information, accurate medication lists and efficient access to residents during GP visits.

In response, SNPHN invited GP's and RACF managers to join a round table discussion to develop possible solutions to these challenges. The following initiatives have now commenced as a result:

- Improved flow and efficiency of clinical information transfer between RACFs, GPs and pharmacies, through a trial of secure messaging. This includes training by SNPHN staff on set-up, use, and connectivity to the national My Health Record.
- Development of an online education module, in collaboration with the Northern Sydney Local Health District, to support roll out of a tool to help staff identify residents with declining health. The tool also supports staff to triage appropriately, so residents receive the right care, at the right time, in the right place, whether that be within the facility, by the GP, or when to call an ambulance.

This year, SNPHN also conducted extensive consultation to establish how Palliative and End of Life Care services were delivered in Northern Sydney as key issues in the after hours environment. This mapping exercise identified three key areas for improvement:

- Provision of high quality End of Life Care through primary care.
- People who want to die at home dying in hospital.
- Quality End of Life Care in Residential Aged Care Facilities.

As a result, SNPHN have commissioned HammondCare to provide specialised training via a "Link Nurse" to dedicated, palliative care champions within 20-30 local RACFs and build "communities of practice", including local GPs, to facilitate education and networks for staff members.

SNPHN is also a key driver of the Northern Sydney Dementia Collaborative. This partnership consists of representatives from the NSLHD, general practitioners, CCNB's Northern Sydney Regional Dementia Advisor, Alzheimer's Australia, and a carer. The collaborative continues to implement the **Better Journey's for People with Dementia** in Northern Sydney implementation plan.

Outcomes to date have included:

- Creation and extensive distribution of the "Memory Problems" brochure which provides both consumers and health professionals with essential local service information.
- Development of a cognitive impairment pathway - one of Northern Sydney's first HealthPathways.
- Co-design of a discharge follow-up service to support transition from hospital to home for people at high risk of readmission.
- Development of national quality improvement indicators for dementia care in general practice, which will be the basis of a quality improvement collaborative in 2017/18.
- Education events for health professionals, carers and consumers.

SNPHN is leading the way in collaborating to ensure services are integrated, effective and accessible to the older residents of Northern Sydney. Our Aged Care Team have also actively taken part in discussions at a national level, influencing improvements on access and referral processes for primary healthcare professionals to the My Aged Care portal. They have also initiated a New South Wales state network for Primary Health Network staff across Australia working on aged care initiatives.

"There are approximately 140,000 people aged 65 and over residing in Northern Sydney, equating to 15.5% of the total population."

iSOLVE

The iSOLVE project - a partnership between the University of Sydney, the NSW Clinical Excellence Commission, and the Sydney North Primary Health Network (SNPHN) - aims to establish integrated processes and pathways between general practice, allied health services, and programs to identify older people at risk of falls and engage a whole of primary care approach to falls prevention.

Since 2015, 27 general practices and 560 patients have participated (or are currently participating) in a controlled trial conducted as part of the iSOLVE project. General practices in the trial are equipped with a falls prevention clinical decision tool and resources (e.g. - guidelines, case studies, patient education flyers) to help them identify people at risk of falling and provide tailored management options. Practices are also offered in-practice educational sessions and a list of trained falls prevention service providers in the local area. Data collection on practice change (GPs, nurses, allied health) and number of falls (patients) is ongoing and expected to be completed early 2018.

At the end of June 2017, 55 in-practice falls prevention educational sessions have been conducted with 48 GPs and 20 practice nurses. Based on 50 returned evaluation forms, most participants have found their learning objectives were completely met in the following areas:

- 88% in identifying risk factors for falls in older people.
- 86% in understanding evidence-based management options to risk factors.
- 94% in understanding the iSOLVE algorithm in screening, assessing, managing, and referring for falls prevention.

Feedback from participants:

"Information regarding local resources and programs, and appropriate allied health services was especially helpful."

General Practitioner

"Excellent session. Very useful resources and extremely informative. Going through case studies also helped a lot."

Practice Nurse

Workshops

Twelve workshops training allied health professionals in falls prevention topics relevant to their practice, have been conducted since the program commenced in 2015. 251 health professionals attended one of the workshops and another 59 attended more than one workshop. After consolidating information, 123 service providers (physiotherapists, exercise physiologists, occupational therapists, pharmacists, podiatrists, and other falls prevention groups) were mapped to their local areas of service and listed on a directory provided to general practices in the iSOLVE trial to facilitate patient referral to falls prevention services in the local community.

Based on returned evaluation forms, many participants have found their learning objectives were completely met in the following workshops:

- **Three Exercise Intervention workshops:** 90% in understanding the components of balance, 87% in applying evidence to design an exercise program to improve balance, and 86% in understanding how to progress the exercise program over time.
- **Two Lifestyle-Integrated Functional Exercise (LiFE) workshops:** 86% in understanding the concepts for the LiFE program, 91% in embedding exercise into daily life routines, and 71% in implementing the LiFE program.
- **Three Home Environment Intervention workshops:** 92% in understanding the foundations of Westmead home safety intervention, 52% in using validated assessment tools, and 78% in understanding how to engage the older person to implement home environment interventions.
- **Two Medication Management workshops:** 83% in understanding fall risk factors, 85% in identifying medications that increase the risk of falling in older patients, and 73% in understanding medication management strategies.
- **Two Foot and Ankle Intervention workshops:** 96% in understanding the contribution of foot problems and footwear to falls, 91% in understanding foot and ankle interventions, and 81% in tailoring those interventions in older people.

Feedback from the workshops included:

"I have gathered some very useful ideas for my practice and implementing exercises as a habit."

Physiotherapist

"Straight forward approach. Very relevant to my practice and looking forward to starting to implement."

Occupational Therapist

"Gave me a complete picture of the project and method of applying a systematic screening approach to falls prevention."

General Practitioner

"I'm very keen to establish a falls prevention program from our two clinics, so great timing with these informative workshops."

Podiatrist

URGENT CARE

AFTER HOURS

The After Hours program aims to prevent the need for members of the community to present at local hospital emergency departments and, instead, utilise one of the many options available to receive appropriate after hours healthcare.

Evidence suggests that people with chronic illness, who are well managed within primary care, are less likely to present to the hospital emergency department after hours. Part of the strategy at the Sydney North Primary Health Network has been to commission services seeking to improve access to, and coordination of, community based care.

These include:

- A **hospital discharge follow-up service** to facilitate transfer of patient care back to the community and ensure appropriate services are sourced. To reduce the risk of re-admissions and impact on after hours presentations.
- Commissioning a **community-based social work service** that works collaboratively with general practice to address the social determinants of health and reduce the risk of unplanned hospital presentations.

Both **Just Better Care** and **KinCare** have been working collaboratively with SNPHN over the previous year to ensure their services are patient-focussed and provide the support required to make a successful transition back "home" after a stay in hospital. This can include liaising with and coordinating multiple service providers, including on weekends, to ensure people get the support they need, minimising the chance of returning to hospital unexpectedly.

These services have also identified vulnerable groups which would benefit from extra support and better coordination of care to keep them out of hospital in the first instance. As a result, the services have been expanded to include these functions.

Over 100 general practitioners in Northern Sydney have referred patients to the new **GP Social Work Connect Program** since it began in 2016. This program is delivered by **Community Care Northern Beaches (CCNB)** - servicing the lower North Shore and Northern Beaches areas - and **Primary and Community Care Services (PCCS)** – covering Hornsby, Ku-ring-gai, and Ryde.

> **91** patients have been supported from hospital to home by KinCare and Just Better Care this year as part of their discharge follow-up services commissioned by SNPHN. **No unplanned re-admissions to hospital have occurred since these services began.**

These organisations have filled a significant gap in community based service delivery as described by a local practice nurse:

"We have some very complex patients with chronic diseases and, consequently, socio-economically disadvantaged patients. We have been struggling for the last few years with these patients as we do not have any community social workers to assist us with their challenges. The new GP Social Work Connect Program provided by PCCS has had a profound effect on the lives and health of three of our most complex patients in the short time since the program started."

A gentleman talking about one of the social workers visiting his neighbour from the CCNB Social Work Service said:

"She has been tireless in her efforts to assist our neighbour who has early onset dementia. She has gone beyond her call of duty to take him to medical appointments and arranged his affairs to be managed by the NSW Public Trustee and the Guardianship Board. She is also well on the way to having him registered for the NDIS and therefore appropriate accommodation."

SNPHN has taken a more targeted approach to the after hours advertising and health promotion campaign this year, to inform and engage specific population groups who most frequently present to the emergency department in the after hours period. Of particular focus has been parents and carers with young children and elderly populations.

The campaign featured on several high-profile parenting websites and electronic direct mail in Northern Sydney. The campaign was also featured in major print such as the Manly Daily, North Shore Times, Hornsby Advocate, Mosman Daily, Hills Shire Times, Rouse Hill Times, and online publications such as Active Living Magazine, Sydney's Child, North Shore Mums, and Ryde District Mums to cover the holiday periods throughout the year.

Furthermore, attendance at several community events, expos and activities aimed specifically at these population groups, meant the After Hours Team could directly engage with consumers and improve community awareness about after hours healthcare options.

Over the past six months SNPHN has also been able to direct and track the number of people who have called the HealthDirect Helpline for advice on accessing the right healthcare. **The PHN has directed over 1,147 phone calls in that time.**

The after hours program has successfully commissioned additional services and worked with other health providers to ensure awareness that alternative options to the emergency department are available, so that the community have more informed choices about access to the right care, in the right place at the right time.

END OF LIFE CARE

Another key priority area for SNPHN is End of Life Care (EoLC). With an ageing population in Northern Sydney, improvements in EoLC have been recognised as an opportunity to strengthen community based care, improve coordination of care between existing services, improve access to and delivery of supportive resources and reduce unplanned hospitalisations, especially after hours.

Therefore, SNPHN has commissioned **HammondCare** to build capacity and increase the skills of health professionals working within Residential Aged Care Facilities. This is to ensure increased choice and control for the patient and their families and to have a better End of Life experience. The University of Technology Sydney will independently evaluate the initiative, under the experience of Professor Deborah Parker.

ylaxis - Paediatric
SYDNEY NORTH

CHRONIC AND COMPLEX HEALTH CONDITIONS

DIABETES

There are an estimated 32,000 people in Northern Sydney living with diabetes. The condition is often managed in collaboration with GPs and other primary care allied health professionals. However, as the condition progresses or complications arise, the involvement of specialists (such as endocrinologists) is usually required.

The Sydney North Primary Care Diabetes Steering Group is working to improve how services from primary care and the Northern Sydney Local Health District can work together to strengthen the management of diabetes in Northern Sydney. The group includes endocrinologists, general practitioners, practice nurses, and a representative from Diabetes Australia.

Some of the achievements of this group in 2016/17 include:

- Offering GPs prompt access to specialist endocrinologist advice via a diabetes emergency hotline, available 24 hours a day.
- Training for 12 general practice nurses in screening for diabetes complications, with another 6 booked in for the remainder of 2017.
- Case conferencing by a specialist endocrinologist via clinics held within general practice. Six practices have trialed this, with another 4 booked over the coming months.
- Two education events held over the last year. The first event attracted over 80 local health professionals.

WELLNET

It is well known that an ageing population and growing incidence of chronic and complex disease is placing increased demands on the health system. For patients living with one or more chronic diseases, care is often fragmented with poor linkages between primary, secondary, and tertiary care, making it difficult for patients to confidently engage in their own care. It is also recognised that general practice plays a critical role in the management of patients living with long term conditions, however to address these challenges models of care must change and adapt.

The WellNet Integrated Care Program (WellNet) is a comprehensive suite of GP led, integrated care programs for patients with one or more chronic diseases. It is built on, and is consistent with, the

Commonwealth Governments proposed approach to managing chronic diseases in the primary care setting and was trialled for the first time in Northern Sydney in partnership with Sonic Clinical Services and 4 private health insurers – BUPA, HCF, NIB, and Teacher's Health Fund.

The WellNet trial presents general practices, private and public funders, and healthcare providers the unique opportunity to test and refine a new approach to managing patients with chronic diseases. It has been designed to meet the needs of individuals, clinicians, and care providers. It enables collaboration across all sectors of the health system and ensures that the patient is at the centre of the care.

The core principle behind WellNet is using the patient's general practice as their healthcare home. It works with patients to establish a baseline measure of health, set clear goals and work with them to achieve these goals. WellNet programs are carefully designed to offer the right amount of care with support being stepped up and down according to the needs and response of the patient. At SNPHN it is recognised patients are not all the same; their care needs depend on personal, psycho-social, and clinical factors. Therefore, data and analytics are used to stratify patients based on their individual needs. Efficient coordination of services across primary, acute, and allied settings makes access simple, streamlined and effective, making it easier for patients to get the care they need.

The aim is to support a proactive, yet targeted approach to delivering care and includes risk stratification of patients, care planning, care coordination, electronic health records, after hours support and patient centred care.

Six general practices are currently participating with over 340 patients enrolled at the end of June 2017. Over the next 3 years, the clinical outcomes and hospital service usage will be monitored by the SNPHN, as well as the ability of the program to support general practice to transform care delivery and the patient's aptitude to proactively engage in their own care.

IMMUNISATION

SNPHN's focus on immunisation for this year has been supporting data quality and the delivery of up-to-date evidence based information for general practice who, in turn, are ideally placed to educate the community about the benefits of vaccination.

This has been achieved through an increase in the information provided on the SNPHN website around immunisation. Information includes resources to enhance the use of the Australian Immunisation Register (AIR) - including "how to" guides for registering for access, ordering reports, and adding and updating encounters.

Through distribution of our "Hot Topics" publication, the Primary Care Advancement Team offer practice visits on familiarisation with AIR, to support practices to order reports of overdue children, with a view of sending recalls to increase vaccination rates in targeted areas as well as in targeted age groups.

91.4% of children aged five years are fully immunised in the SNPHN region, compared to the National rate of 89.3% and 93.1% for NSW. Mosman (87.4%) and Manly (88.3%) have the lowest immunisation rates, with Hunters Hill the highest at 94.7%.

SNPHN will continue to collaborate closely with the Public Health Unit and other PHNs to improve immunisation rates. The Immunisation Road Shows (a collaboration between the Sydney North Primary Health Network and the Northern Sydney Local Health District) covered the Northern Beaches, Lower North Shore, and Ryde areas, and saw an attendance of 60 GPs and practice nurses. In addition, two immunisation update events were delivered with a total of 126 health professionals attending.

"91.4% of children aged five years are fully immunised in the SNPHN region, compared to the National rate of 89.3% and 93.1% for NSW. Mosman (87.4%) and Manly (88.3%) have the lowest immunisation rates, with Hunters Hill the highest at 94.7%."

INNOVATION GRANTS

SNPHN awarded Innovation Grant funding to six organisations to implement innovative primary healthcare projects.

The six projects and the work that they do are:

> A Men's Health Clinic

An initiative of MQ Health (Macquarie University Health Sciences Centre), the Men's Health Clinic provides a male friendly whole-of-health and wellbeing service with access to general practitioners, allied health professionals, specialists, as well as imaging and pathology services all in the one place. The service aims to improve health outcomes in men.

> Consumer Peer Worker Interagency Forum

An initiative of the Northern Sydney Local Health District and partners, this project provides forums whereby consumers and peers working, volunteering, or aspiring to work in mental health services and with a lived experience of mental health illness, come together to share their experiences, provide support, and receive training and mentorship to improve their professional development.

> Integrated Care Program

The 'Wellnet' integrated care program, an initiative led by Sonic Clinical Services Pty Ltd, provides enhanced GP led integrated care services to patients with chronic disease.

The program offers a proactive approach to delivering care and includes risk stratification of patients along with care planning, care coordination, after hours support, and targeted patient centric care with a view to creating a sustainable model that both public and private healthcare partners can support.

> A Patient Centred Approach to the Transfer of Care

The Hornsby Hospital and Hornsby GP Unit are developing a patient centred transfer of care model between the hospital and general practice to enhance the older and complex patient's journey between leaving hospital and returning to the community.

> A Practice Approach to Managing Chronic Care

A Pennant Hills general practice, MC Family Medical Practice, is adapting the Agency for Clinical Innovation Chronic Disease Management Model to meet the needs of its at risk patient populations. This project includes identification of the cohort of patients at risk and of chronic disease, stratifying their risk, and targeting care appropriately. The practice is employing innovative approaches including the use of exercise tracking devises and health coaching from local allied health providers.

> Northern Beaches GP Education

A membership based network of GPs, the Manly Warringah Divisions of Practice, have benefitted from new educational opportunities because of the SNPHN innovation grant. These education events aim to broaden GPs knowledge of services available in the Northern Sydney region and provide continuing professional development (CPD) opportunities for the group to improve health outcomes for the Northern Beaches community.

SNPHN look forward to publishing the findings and learning from these innovative initiatives on completion of these projects.

05

SERVICE TRANSFORMATION

Care Coordination

CLINICAL COUNCIL

The role of the Clinical Council is to assist and advise the Sydney North Primary Health Network to develop local strategies to improve the operation of the healthcare system for people in the Sydney North region.

The Clinical Council focuses on providing expert advice to the PHN facilitating an effective, person centred approach in the design and delivery of PHN activities.

Clinical and Community Councils were assigned as fundamental and vital components of the new Primary Health Network structure at the time of their establishment and the SNPHN Clinical Council has now been operational for the last two years. In that time, it has:

- Contributed to the SNPHN Population Needs Assessment process and provided input to assist in determining local health priorities.
- Contributed to the development of a regional health strategy.
- Provided advice on local strategies to address national health priorities.
- Identified strengths, weaknesses, opportunities, and areas for improvement within the current primary healthcare landscape and advise on local strategies to improve integrated care.
- Overseen the development of local clinical pathways.
- Advised on the data sharing requirements between primary care and other sectors to improve the quality, efficiency, and continuity of care.
- Advised on the development of innovative services and implementation of new models of care.
- Supported the development of approaches to build capacity, capability, quality, and safety in primary care.
- Advised on strategies to maintain engagement with local primary care providers.
- Identified and advised on opportunities for relevant research partnerships.

The twelve Clinical Council members are all community based health providers from diverse backgrounds who have brought a wealth of experience and ideas to the Primary Health Network. This has provided an important source of clinician input and direction for the SNPHN staff when designing and implementing commissioned primary healthcare services.

Moving into 2017/18 the Clinical Council will be refocussing their efforts to achieve more active engagement and maximise their value and contribution to the Sydney North Primary Health Network. This will include having Council members themselves presenting at meetings.

COMMUNITY COUNCIL

The SNPHN Community Council has played a significant role in 2016/17 in guiding the Primary Health Network regarding its strategic programs and initiatives.

Comprising of ten members representing diverse communities, health priorities and perspectives, the Council has provided consultation and feedback on:

- The PHNs Activity Plan.
- HealthPathways and Community HealthPathways.
- Digital self-management tools.
- The Mental Health Review.
- The After Hours marketing strategy to reach culturally and linguistically diverse as well as mainstream communities.
- Local Coordinated Networks.

The Council is a highly engaged, inspired group of people committed to ensuring that appropriate healthcare services are provided where needed to achieve the best outcomes for people and their families in the region.

Community Council members represent numerous community groups, raise public concerns in response to primary care, are healthcare advocates and champions, and provide vital information and resources back into the local community.

SNPHN Community Council representatives have participated on panels co-designing the following care and service areas:

- Mental Health
- Aged Care
- Aboriginal Health
- Alcohol and Other Drugs

Information has been shared across communities and with the PHN for further dissemination to our constituency regarding screening programs (breast screening, prostate, early childhood checks); services available to support vulnerable populations; home care packages; peer mentoring; disability services and the next steps to address NDIS changes; anxiety disorders; homelessness programs and services; LGBTQI community needs; and the engagement of culturally diverse populations.

The Community Council has also engaged in new initiatives to build health literacy, improve community health outcomes and wellbeing, and deliver evidence based early intervention strategies that address risk factors from SNAPO (Smoking, Nutrition, Alcohol, Physical Activity, and Obesity). This initiative was catalysed by a discussion at the Community Council on the impact of sugar on chronic illness, mental illness, diabetes, obesity, pregnancy and family health and wellbeing.

The Community and Clinical Councils have meet jointly this year and will continue to work collaboratively to support proactive engagement concerning critical issues impacting on Northern Sydney communities in the Primary Health Network, and alignment regarding SNPHN priorities and activities.

The enduring driver of the Community Council is to ensure that the Sydney North Primary Health Network comprehensively address the diverse population health needs of Northern Sydney.

HEALTHPATHWAYS

May 2017 marked the start of a new chapter for the Northern Sydney health sector with the launch of the HealthPathways live site.

At its simplest, HealthPathways is a web-based clinical 'filing cabinet' that allows GPs to assess and manage patient conditions with greater efficiency and integration of care.

Specifically, HealthPathways supports clinicians with:

- Condition management
- Service navigation
- Referral to specialists when appropriate
- Access to reference materials
- Access to patient educational resources

At its core, HealthPathways is much more sophisticated as its true strength lies in its ability to build relationships between hospitals, community, management, and funders, so that they work together to enable collective decision making, leading to better health outcomes.

The long-term goals of the HealthPathways program are to improve patient access to the right care, at the right time, in the right place and to better integrate primary and specialist systems of care.

HEALTHPATHWAYS BENEFITS

For Patients:

- Reduces waiting times to see a specialist;
- Receive the right care, in the right place, at the right time;
- Supports patients to look after themselves; and
- Supports better health outcomes.

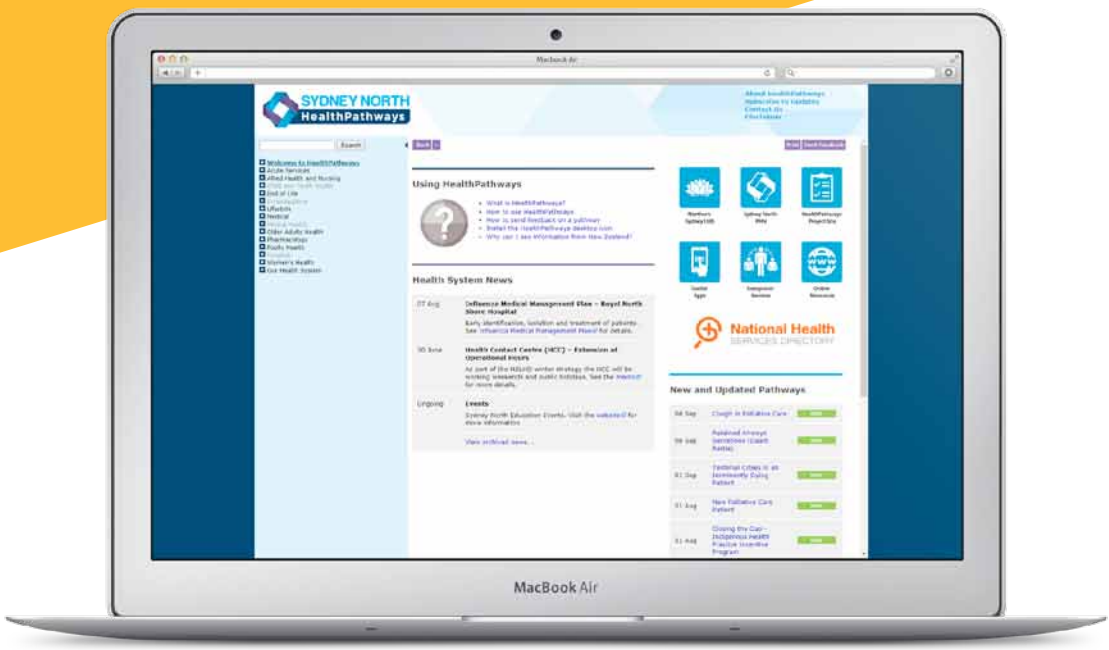
For Clinicians:

- Builds relationships between general practitioners, hospital specialists and allied health services;
- Enables comprehensive assessment and management of patients; and
- Facilitates navigation through local services.

For the Local Health System:

- Facilitates integrated patient care;
- Less demand on acute and hospital based services as patients are better managed in the community;
- System redesign and localisation of services to reflect individual and community need; and
- Enhances current workforce capacity through better use of primary care resources including practice nurses, allied health providers and non-government organisations.

“It currently takes a lot of time and effort to navigate the system to direct patient care appropriately. HealthPathways will reduce the waste of time and resources across general practice, acute care, community and for patients. HealthPathways is a tool to enable better use and design of our local health system.”



Key achievements of the HealthPathways program to date include:

- HealthPathways was launched in May 2017 to 168 local health professionals, with 35 service providers involved in a demonstration ‘expo’.
- 156 Pathways are in development and 83 were completed and live at the end of June 2017 including:
  - Aboriginal Health
  - Acute Home Care
  - Aged Care
  - Dementia / Cognitive Impairment
  - Diabetes
  - Palliative Care
  - Pregnancy / Shared Antenatal Care
  - Sexual Health
- 365 unique users have accessed HealthPathways as of end June 2017.
- 5 HealthPathways Clinical Work Groups were held involving over 60 participants to support development of pathways and identify opportunities for health system improvement (Dementia, Domestic Violence, Palliative Care, Musculoskeletal and Diabetes).

WHERE TO FROM HERE?

Dr Fiona Robinson, Clinical Lead for Sydney North HealthPathways, will be working with her team of GP Editors, the Northern Sydney Local Health District, and our local community providers to continue the development of local pathways and broaden the range of services included to better reflect the range of options available in Northern Sydney.

In addition, a key focus will be to encourage local health professionals to utilise the website during their day to day consultations through practice visits and inclusion of relevant pathways in all SNPHN education and networking events.

A key area of focus for the Sydney North Primary Health Network in the coming year will also be to utilise the HealthPathways collaborative development process to explore opportunities for health system change that leads to service transformation.

“The number of people attending from both the Sydney North Primary Health Network and the Northern Sydney Local Health District, made it one of the best attended symposiums we have seen to date (well done!). It is also great to see the partnership led by the executive team is already getting people excited and thinking differently.”

Matthew Sinclair, Service Delivery Manager – Streamliners

COMMUNITY HEALTHPATHWAYS

The Community HealthPathways website is the community facing information portal that is equivalent to the clinical facing portal known as HealthPathways.

Community HealthPathways is a hub for health information, resources and topics based on the needs identified by the Northern Sydney community. Areas of focus include Aboriginal and Torres Strait Islander Health; Aged Care; Alcohol and Other Drugs; Cancer; Carers Information; Chronic and Complex Conditions; Domestic Violence; End of Life Care; Family Services; Health and Wellbeing; Housing, Transport and Disability Services; Mental Health; Pregnancy and Childbirth; Sexual Health; Urgent Care; and Youth Health.

If you click on a health topic then information and services local to Northern Sydney in these health and wellbeing areas is displayed – such as locations, phone numbers, websites, emails of specific services, and if a GP referral is required.

This interactive website also has video tips on getting the best from your GP, highlights specific community health news and campaigns, and is the home of our PeopleBank.

The **PeopleBank** is Sydney North Primary Health Network's commitment to include the Northern Sydney community in the conversation about improving local health services and solutions.

As well as being a community based interface from the clinical HealthPathways platform it includes features such as:

- Health topics and local services;
- Getting the best from your GP;
- Links and resources to health news and local health campaigns;
- Information on health topics from A-Z by interfacing with the HealthDirect website;
- Access via widgets to the National Health Services Directory and Symptom Checker;
- An invitation to join our PeopleBank to take part in health mapping and surveying; and
- Top tips from local GPs via short video instalments.

You can access the website via **www.communityhealthpathways.com.au**

HEALTH LITERACY

Health Literacy helps to address how people access, understand, and apply health information to themselves.

SNPHN understands that health literacy is about tapping into the needs of the community and then providing sustainable, peer led programs for these populations.

The PHNs approach to community activation is:

- Building health literacy and individual engagement in proactive health self-management;
- Improving community health outcomes and wellbeing; and
- Delivering evidenced based early intervention strategies that address risk factors.

SNPHNs approach to improving health literacy includes ensuring members of the community have access to information and resources on health topics and available services to enable them to make informed decisions and better manage their health.

A key element of health literacy is collaboration with a range of organisations and stakeholders to ensure a coordinated approach. This includes working with the Northern Sydney Local Health District Community Engagement Team to share information and resources, working with local councils on the development of health resources and navigation tools, and engagement with community development officers to ensure accurate and relevant health information is provided to our communities.

SNPHN directly engage a range of community members to gain insight into the needs of our population so that we can develop a targeted approach to health literacy.

Over the past year we have developed and supported numerous initiatives and events aimed at improving health literacy, including:

- Working with Breast Screen NSW to reach vulnerable and culturally and linguistically diverse communities to encourage and facilitate access to screening.
- Working with the Manly Community Centre to reach out to members of our community who are homeless.
- An Aboriginal Women's Health Check and Expo.
- A Multicultural Disability Services Expo representing the Korean, Mandarin, Cantonese, Japanese, Farsi and Dari communities.
- A Tibetan Women's Health Forum.
- Working with the Northern Beaches Council on Inclusive Communities.
- The development of a health literacy and information check list.

SNPHN has also continued collaboration with the Northern Sydney Institute of TAFE and the Adult Migrant English Program (AMEP) to improve the health literacy of newly arrived migrants and refugees. This program brings local GPs together with the students to increase awareness around accessing a GP and how to effectively navigate the Australian health system. In addition, this program provides information about accessing after hours medical services, helping new migrants in the Northern Sydney area to get the right care, in the right place at the right time. SNPHN has successfully engaged over 500 newly arrived migrants and refugees over the last 12 months.

SNPHN will also be focussing community activations moving forward on SNAPO (Smoking, Nutrition, Alcohol, Physical Activity, and Obesity) interventions targeting vulnerable populations and looking towards programs covering areas such as nutrition and smoking cessation programs.

The PHN will also continue to link in with key health promotions such as National Mental Health Week, Cancer Screening, and Palliative Care Week and continue to collaborate with the Northern Sydney Local Health District delivering Health Expos.

2017/18 also looks to deliver an exciting chronic disease self-management tool that will allow the Northern Sydney population health coaching that links in with their GP. This digital health coaching system will then work alongside clinicians who will be alerted when health issues arise.

Moving further into 2017/18, SNPHN will continue to support and empower individuals and communities to make decisions about managing their own health and care. We will also continue to liaise with other Primary Health Networks to identify opportunities to collaborate on health literacy projects and initiatives.

PARTNERSHIPS

Partnerships are vital to SNPHN and this is reflected in our vision of "Achieving together – better health, better care".

2016/17 saw existing partnerships advance and mature and numerous new partnerships blossom and develop with private health insurers, corporate health organisations, universities, non-government organisations, and the Northern Sydney Local Health District.

EXISTING PARTNERSHIPS

> WellNet

The 'WellNet' integrated care program was jointly funded by SNPHN and Sonic Clinical Services and has since expanded to involve four major private health insurers – BUPA, HCF, NIB, and Teachers Health Fund. It is built on an evidence based framework of delivering a GP led, patient centred healthcare home. The program provides a suite of targeted healthcare interventions for patients with complex conditions in a stepped approach, providing care through the patients regular GP.

The aim is to support a proactive, yet targeted approach to delivering care and includes risk stratification of patients, care planning, care coordination, electronic health records, after hours support and patient-centred care.

Six general practices are currently participating with over 340 patients enrolled at the end of June 2017. Over the next 3 years, the clinical outcomes and hospital service usage will be monitored by the SNPHN, as well as the ability of the program to support general practice to transform care delivery and the patient's aptitude to proactively engage in their own care.

> Northern Sydney Dementia Collaborative

The Northern Sydney Dementia Collaborative was established with assistance from the NSW Agency for Clinical Innovation's "Building Partnerships" program, which aims to form collaborations that work together to integrate care for older people with complex health needs. Nowhere is this more needed than in patients with dementia. It is estimated that over 4,000 people in Northern Sydney are living with dementia and this figure will continue to grow as the population ages. There are a range of services available in Northern Sydney for people with dementia and their carers. However, information about these services and how to access them is not well understood by the people who need them the most or by general practitioners. The group includes SNPHN, Northern Sydney Local Health District, Alzheimer's Australia NSW and CCNB - a local organisation funded to provide local dementia advisory services. This collaborative aims to improve the healthcare journey for people with dementia and their carers by supporting healthcare professionals through education and tools such as HealthPathways, to make services more transparent and accessible.

> iSOLVE

The iSOLVE project, a partnership between the University of Sydney, the NSW Clinical Excellence Commission and SNPHN, is leading the way in establishing integrated, user-friendly screening processes and referral pathways between general practice, allied health services and other programs, to identify older people at risk of falls and engage a whole of primary care approach to falls prevention.

General practices in the trial are offered a falls prevention clinical screening tool and resources (e.g. guidelines, case studies, patient education flyers) to help GPs and practice nurses identify people at risk of falling and provide tailored management options. Practices are also offered in-practice educational visiting sessions and a list of trained falls prevention service providers in the local area.

Throughout 2016/17 the research project recruited 27 local general practices involving 560 patients and trained an additional 150 local allied health providers, taking the total number of allied health professionals trained to 276 since the program started in 2015. Early results indicate improved recognition and assessment of falls risk by GPs and practice nurses and referral to a wider number of allied health professionals that can support evidence-based care.

> TAFE

SNPHN continues to provide education sessions to new migrants enrolled in Northern Sydney TAFE's Adult Migrant Education Program. These sessions are delivered by local GPs and aim to provide new migrants with practical information about the Australian Health System, including Medicare, general practice, after hours services and when it's appropriate to visit the emergency department. TAFE sites within Northern Sydney participating include Meadowbank, Brookvale, and St Leonards. In 2016/17 a total of 18 sessions were held involving 422 participants.

NEW PARTNERSHIPS

> Mental Health, Alcohol and Other Drugs

During 2016/17 SNPHN has continued to build on partnerships with a range of organisations and stakeholders. The Mental Health Alcohol & Other Drugs (MHAOD) Advisory Committee consisting of SNPHN Board members, Community and Clinical Council members, clinicians, service providers, consumers, and carers, has provided information and guidance to SNPHN on issues relevant to mental health and alcohol and other drug care. This has included supporting the co-design of mental health and alcohol and other drugs services, and providing feedback on key features to inform service delivery and ensure services are designed to meet identified need.

> Ambulance NSW (Digital Health)

Extended Care Paramedics (ECPs) is a program delivered by Ambulance NSW that increases the clinical role of a small group of selected paramedics who have received additional training in:

- Patient assessment.
- Recognition and management of minor illness and minor injury presentations.
- The provision of definitive care.
- Referral to community based health services for a range of presentations.

The aim of the ECP program is to provide paramedics with greater choice about treatment options for patients with non-life-threatening illnesses. This includes treating on the spot and referral to a GP for follow-up care.

ECPs have successfully reduced the number of patients being unnecessarily transported to emergency departments by 60% compared to usual care.

SNPHN is working with Ambulance NSW to implement a trial of secure messaging to facilitate communication between Extended Care Paramedics and local GPs.

ECPs have been set-up with a laptop, WiFi, small portable printer and a secure messaging licence by SNPHN so that referrals and treatment summaries can be sent to a patient's GP securely and electronically, improving patient safety and minimising the chance of paper based information getting "lost".

"ECPs have successfully reduced the number of patients being unnecessarily transported to emergency departments by 60% compared to usual care."

06

ORGANISATIONAL EXCELLENCE

Support Services

MARKETING AND COMMUNICATIONS

The primary role of the Marketing and Communications Team is to support all departments across the SNPHN to achieve their organisational targets, build the PHN brand and promote the benefits of primary healthcare.

This team are responsible for managing the brand and reputation of the organisation through the strategic use of SNPHN's internal and external communications channels. As a team, they seek to strengthen stakeholder relationships, foster staff engagement and, above all, keep target audiences informed, engaged and up-to-date about the work the PHN is doing delivering on our vision of:

Achieving together – better health, better care.

PUBLICATIONS AND COLLATERAL

In 2016/17 the Marketing and Communications Team have worked closely with SNPHN stakeholders to produce a suite of resources designed to educate and support healthcare professionals as well as improve community access to clear and relevant health information necessary to make appropriate decisions about their wellbeing.

Materials produced have ranged from brochures, fact sheets and posters to videos, presentations, banners, magnets, and whiteboards. SNPHNs marketing materials to improve health literacy are produced in a range of different languages including Simplified Chinese, Traditional Chinese, Korean, Japanese, Italian, Tibetan, and Farsi. These marketing tools and materials also play an important role in reinforcing the SNPHN brand and the integral role the PHN performs in providing services and improving healthcare experiences throughout the Northern Sydney region through various programs and healthcare partnerships.

In the online space, the team have delivered numerous regular publications (including a monthly eNewsletter and event updates) supported by bespoke communications including health news and alerts, event information, primary healthcare commissioning opportunities and community updates. These are distributed to more than 5,100 general practitioners, allied health professionals, and community organisations with publication click through rates significantly higher than industry benchmarks.

DIGITAL

The SNPHN has continued to expand our presence in the online space as a cost effective and rapidly growing tool to engage with health stakeholders and members of the Sydney North community.

www.snhn.org.au

The website is the linchpin of our online activity featuring detailed content that supports both health professionals and the community in improving healthcare in the region.

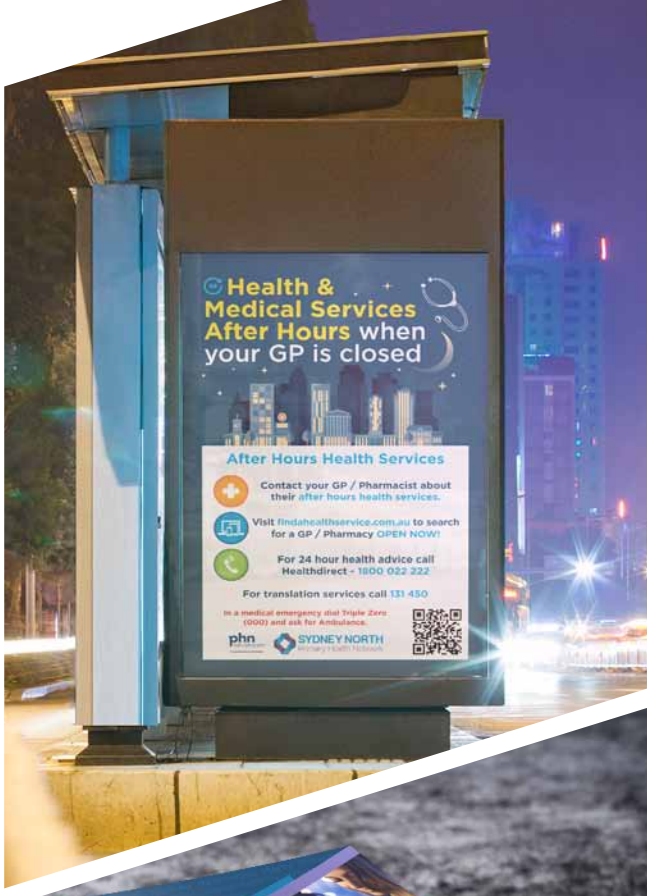
From a clinical perspective, the site provides a hub of information and practice support materials to assist health professionals to provide or refer patients to the most appropriate care, and improve their navigation experience of healthcare system. The comprehensive education event listings and registration system also provides a streamlined way for health practitioners to attend learning and education events that improve their skills and provide them with professional development experience.

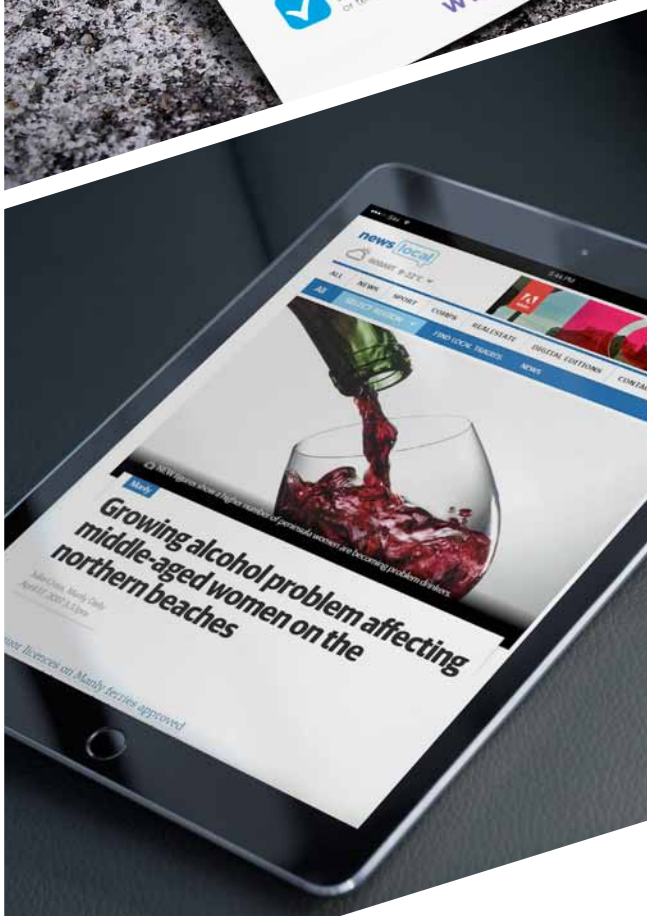
Our community resources and recently launched Community HealthPathways website (**www.communityhealthpathways.com.au**) work to address the underlying health literacy gap in our society by assisting people to obtain, process and understand health information relevant to their situation or condition.

The SNPHN website receives between 25,000 - 30,000 page views per month and continues to grow.

SOCIAL MEDIA

SNPHN have built on established social media channels to assist the network in delivering a strong messaging strategy. The social channels engage the Sydney North community with regular content to raise awareness of local health issues, act as a two-way communication network to connect with stakeholders, and raise the profile of the work SNPHN undertakes improving the healthcare experience. The PHN currently has an online social media community of over 800 people involved on Twitter, Facebook, Instagram, and LinkedIn. The ever evolving and engaging YouTube channel features education, patient centred, after hours, My Health Record, digital health, and carer videos.





KEY PROJECTS AND INITIATIVES

Marketing and Communications work closely with teams across the SNPHN to provide the communication support required to implement key organisational enterprises. Over the past year the PHN has developed several integrated marketing and communications campaigns to support specific strategic initiatives.

These undergo a rigorous planning and messaging process and have been implemented across a range of mediums including external events, display advertising, video loops in medical centres and cafes, print advertising, online and social media, and a range of comprehensive multi-lingual collateral.

Some of these initiatives and campaigns include:

- After Hours / Emergency Avoidance
- Aged, Palliative and End of Life Care
- Alcohol and Other Drugs
- Commissioning and Co-design
- Community Engagement
- Digital Health
- HealthPathways
- Local Coordinated Networks
- Mental Health
- Person Centred Medical Home
- Population Health
- Primary Care Nurse Transition
- Primary Care Support
- Youth Health

MEDIA AND PUBLIC RELATIONS

Over the past year the Marketing and Communications Team have worked with all forms of media not only to create awareness about the Primary Health Network and its brand, but also to improve population health by building an understanding around key public health issues and highlighting programs and services that address community health needs and improve overall patient experience.

The work in this area has resulted in media coverage about commissioned services in Mental Health, Alcohol and Other Drugs, After Hours and End of Life Care. SNPHNs Population Health Data and Needs Assessment has also attracted keen media interest over the last 12 months. The PHN has received a wide range of coverage in publications including Australian Doctor, PHC News, Australian Ageing Agenda, Palliative Matters, the Manly Daily, North Shore Times, Peninsula and North Shore Living, and online media such as The Zine and The Wrap.

HUMAN RESOURCES AND ADMINISTRATION

Human Resources (HR) at Sydney North Primary Health Network provide expert support to all employees in the areas of recruitment, professional development, career management, performance management, industrial relations, and work, health, and safety.

A comprehensive induction program welcomes new employees to the organisation.

Our Administration Team are our **Ambassadors of First Impressions**. They welcome visitors to our organisation and quietly and efficiently manage the various meetings and events held on site.

2016/17 has seen the organisation move from establishment to operational phase. HR have collaborated with our People Managers to support our employees to deliver to the organisations strategic priorities and funding commitments through individual skills training and coaching.

In February 2017, SNPHN participated in an Employee Engagement Survey along with other Primary Health Networks. Our results were gratifying with a **96%** participation rate and an overall engagement score of **90.4%**, the highest of all participating PHN's in Australia.

SNPHN is an equal opportunity employer, with a varied workforce where diversity is celebrated. The SNPHN workforce is made up of 78% females and 22% males across both full time and part time roles. All employees are required to undergo a National Police Check as part of their appointment, and Working with Children Check where required.

The SNPHN People Strategy is underpinned by the **iCARE** organisational values below.

The HR strategic areas are:

TALENT

LEADERSHIP AND CAPABILITY

ENGAGEMENT AND CULTURE

REWARD AND RECOGNITION

Our Performance Management Framework was transitioned to an online portal in early 2017. This allowed our People Managers and employees to more efficiently review and give feedback on individual key performance indicators, ensuring we continually focus our whole team on alignment with, and delivery of, SNPHN's vision and strategic priorities.

SNPHN has undertaken numerous learning and development initiatives during this year including:

- Professional business writing skills program;
- Working with personalities workshop;
- The introduction of online eLearning compliance modules for all employees;
- Partnering with Sydney TAFE to deliver a Project Management Skills Development program; and
- Partnering with Ignite Purpose to support People Managers with regular performance coaching.

At SNPHN we constantly strive to make our team feel valued and appreciated for their contribution to the organisation through a formal quarterly recognition program called **'Let's Celebrate Living the Values'**.

Other people management initiatives at SNPHN include:

- Cultural competency training;
- Monthly team meetings;
- Weekly 15minute executive updates; and
- Monthly staff surveys to ensure continuous improvement.

These communication initiatives help keep our team informed, engaged, and across all activities, projects, and workflow in a dynamic organisation.

Moving into our third year, the Human Resources and Administration Team will continue to promote the vision and values of SNPHN and support our People Managers to motivate, develop and retain our **Innovative, Collaborative, Accountable, Respectful, and Excellent SNPHN workforce!**

SYSTEMS IMPROVEMENTS

During the year, SNPHN implemented new general ledger, payroll, and human resources systems to build on its ongoing commitment to operate in an environment of continuous quality improvement and systematic risk management and to strengthen the organisation's governance processes through effective decision making and accurate reporting.

The PHN also implemented an intranet to improve information flow, record data, utilise version control, reduce email traffic, deliver 'shared' documentation, control brand and templating, share calendars and digitally record the delivery and understanding of policies and procedures.

07

FINANCIALS

SNPHN LTD ABN 38 605 353 884

DIRECTORS' REPORT
30 June 2017

The Directors present their report on SNPHN Ltd for the financial year ended 30 June 2017.

1. General information

Directors
The names of the directors in office at any time during, or since the end of, the year are:

Names	Appointed/Resigned
Dr Magdalen Campbell	
Dr Harry Nespolon	
Dr Stephen Ginsborg	
Brynnie Goodwill	
Carolynn Hodges	
Kathryn Loxton	
Prof. Simon Willcock	
Janet Grant	Resigned 10 November 2016
Samantha Challinor	Appointed 31 December 2016

Directors have been in office since incorporation unless otherwise stated.

Economic Dependence
SNPHN Ltd is dependent on the Department of Health for almost all of its revenue. At the date of this report the Directors have no reason to believe the Department of Health will not continue to support SNPHN Ltd. SNPHN Ltd's core funding contract is scheduled to end on 30 June 2018. The Department of Health has agreed in-principle to extend the core funding arrangements for Primary Health Networks for an additional two years, to 30 June 2020. The Company also has funding contracts in place which extend to 30 June 2019.

Company Secretary
The following person held the position of Company Secretary at the end of the financial year:

Lynelle Hales (AICD Company Director Graduate (2013), Governance Institute of Australia's Accidental Company Secretary course (2016)) has been the Company Secretary since 10 August 2015. Lynelle has four years' experience as a voting Executive Director on NHS Boards (UK). In addition, Lynelle has worked with Boards for over 12 years in Executive roles.

Members guarantee

SNPHN Ltd is a Company limited by guarantee. In the event of and for the purpose of winding up of the Company, the amount capable of being called up from each member and any person or association who ceased to be a member in the year prior to the winding up, is limited to $10, subject to the provisions of the Company's constitution.

At 30 June 2017 the collective liability of members was $ 10,760 (2016: $ 5,340).

Principal activities

The principal activities of SNPHN LTD during the financial year were;

(a) identifying the health needs of the community, developing locally focused and responsive services and addressing service delivery gaps;

(b) strengthening the effectiveness, vitality and responsiveness and performance of the Primary Health Care sector through support to Primary Health Care organisations and entities (including without limitation to Members);

(c) advocating and representing Primary Health Care organisations and entities to the Australian public to improve the provision of health care;

(d) improving the patient journey and outcomes through the development, integration and coordination of an equitable Primary Health Care sector;

DIRECTORS' REPORT
30 June 2017

(e) promoting quality in Primary Health Care and improving patient care by providing support to clinicians and Service Providers;

(f) improving consumer access to health services by working to coordinate and integrate care within the Primary Health Care system and across other sectors of the health system;

(g) collaborating with consumer and community groups to ensure consumer engagement and representation in the provision of Primary Health Care;

(h) identifying health needs of the community and developing locally focussed and responsive health services to improve local patient care, including:

(i) analysing and reporting on the Primary Health Care service gaps; and

(ii) identifying strategies to improve health outcomes and quality of services including for disadvantaged or under serviced groups;

(i) promoting quality and evidence based leading practice;

(j) contributing to development, regional leadership, innovation and research on Primary Health Care methods, technology, teaching, skills and practice;

(k) promoting cooperation, collaboration and communication with other regional organisations with an interest or impact in health and social care;

(l) facilitating the implementation of successful Primary Health Care and preventive health initiatives and programs;

(m) initiating and promoting policy and other matters related to the Primary Health Care sector and activities of Members; and

(n) doing all such other things as are conducive or incidental to the attainment of the objects and aims of any or all of the above.

Operating results

The surplus / (deficit) from ordinary activities amounted to $139,836. (2016: $0).

2. Other items

After balance date events
No matters or circumstances have arisen since the end of the financial year which significantly affected or may significantly affect the operations of the Company, the results of those operations or the state of affairs of the Company in future financial years.

Auditors independence declaration
The lead auditor's independence declaration in accordance with subdivision 60-C of the *Australian Charities and Not for profits Commission Act 2012* for the year ended 30 June 2017 has been received.

SNPHN LTD ABN 38 605 353 884

DIRECTORS' REPORT
30 June 2017

3. Director Information

Dr Magdalen Campbell	**Chair**
Qualifications	M.B.B.S, FRACGP, MAICD
Experience	Inaugural SNPHN Board Member. GP and Principal of own practice. Training and experience in Corporate Governance and Strategic Planning. Previously on the General Practice Network Northside Board from 1992 to 2012, holding positions of Chair, Treasurer and Secretary. Board member for Northern Sydney Medicare Local from 2012 to 2015. Elected to the Board of Networking Health NSW in November 2014. Member of the ACI Chronic Disease Management Committee.
Dr Harry Nespolon	**Deputy Chair, Chair of SNPHN Finance, Audit and Risk Management Committee**
Qualification	BM BS, DipRACOG, FRACGP, BEc, LLB (Hons), GCLP, FACLM, MBA,FAICD, MHL
Experience	Chair of GP Synergy. Former Chair, Sydney North Shore and Beaches Medicare Local. Former Chair, Northern Sydney Division of General Practice.
Dr Stephen Ginsborg	**Member**
Qualifications	MB BCh, MA, MAICD
Experience	Director of the Manly Warringah Division of General Practice. Former Deputy Chair of the Sydney North Shore and Beaches Medicare Local. Chair of the SNPHN Clinical Governance Committee. Medical Director of the National Home Doctor Service. Board member Council on the Ageing (NSW). Board member of Community Care (Northern Beaches) Limited.
Brynnie Goodwill	**Member**
Qualifications	JD International and Corporate Law. AB, GAICD
Experience	Strategy and Partnerships Director at SharingStories Foundation. Director of Earth Trust and BKG Group. Former CEO of Jubilee Australia and LifeCircle Australia. Chair of the SNPHN Community Council and of the SNPHN Remunerations and Nomination Committee. Former Health Consumer Director of Sydney North Shore and Beaches Medicare Local.
Carolynn Hodges	**Member**
Qualifications	BA (Hons). MPsych(Clin). BPsych(Hon). DipClinHyp. MAPS MASH. CEAP. MAICD.
Experience	Principal of a Clinical Psychology private practice. Previous mental health delivery experience in both public and private sectors. Member of SNPHN Clinical Governance Committee and SNPHN Clinical Council. Board member of Primary & Community Care Services, member of Primary & Community Care Services Clinical Governance Committee.
Kathryn Loxton	**Member**
Qualifications	BaAppSc (Occupational Therapy), GAICD
Experience	Founder of Caswell Health Care, a multidisciplinary private practice working in primary health throughout Sydney. Former Board Member of the Sydney North Shore and Beaches Medicare Local. Former Board member of Independent Living Centre NSW. Former Board Member of NSW Brain Injury Association.
Prof. Simon Willcock	**Member**
Qualifications	MBBS (Hons 1), PhD, FRACGP, Dip Obs, GAICD
Experience	Director of Primary Care Services at MQ Health. Board Chairman - Avant Mutual Group. Board member - Avant Insurance Limited. Board member - Doctors Health Fund. Clinician and academic with extensive experience in medical education and workforce development.

SNPHN LTD ABN 38 605 353 884

DIRECTORS' REPORT
30 June 2017

Janet Grant Qualifications	**Resigned 10 November 2016** CA, MCom, BAcc
Experience	Chair of SNPHN Finance, Audit and Risk Management Committee. Board member, NSW Government Audit and Risk Committees. Financial management and accounting, risk management and governance experience.
Samantha Challinor Qualifications	**Appointed 31 December 2016** BBus (Accounting), CPA, JP, GAICD
Experience	An accomplished Executive Manager, Samantha is adept at bringing financial oversight and process to organisations through experience gained in the government, non-government and multi-national corporate sectors. Samantha is currently the Corporate Services Director at the Agency for Clinical Innovation, NSW Ministry for Health. Prior to this appointment she was the Deputy Chief Executive Officer at Sydney North Shore and Beaches Medicare Local.

Meetings of directors

During the financial year, 28 meetings of Directors (including committees of Directors) were held. Attendances by each Director during the year were as follows:

	Directors' Meetings		Audit & Risk Management		Remuneration & Nominations		Clinical Governance	
	Number eligible to attend	Number attended	Number eligible to attend	Number attended	Number eligible to attend	Number attended	Number eligible to attend	Number attended
Dr Magdalen Campbell	8	8	11	11	4	3	-	-
Dr Harry Nespolon	8	8	11	10	-	-	-	-
Dr Stephen Ginsborg	8	8	-	-	4	4	5	4
Brynnie Goodwill	8	8	7	7	4	4	-	-
Carolynn Hodges	8	7	-	-	-	-	5	5
Kathryn Loxton	8	6	-	-	2	2	5	4
Prof. Simon Willcock	8	5	-	-	2	2	2	2
Janet Grant	4	4	4	4	-	-	-	-
Samantha Challinor	3	3	6	6	-	-	-	-

Indemnification and insurance of officers

The Company has paid premiums to insure each of the Directors against liabilities for costs and expenses incurred by them in defending any legal proceedings arising out of their conduct while acting in the capacity of Director of the Company other than conduct involving a willful breach of duty in relation to the Company. The amount of the premium is not disclosed due to the terms of the insurance contracts and to protect commercially sensitive information of the Company.

Signed in accordance with a resolution of the Board of Directors:

Director: M. Campbell Director: A.M. Nespolon

Dated 6 September 2017

SNPHN LTD ABN 38 605 353 884

AUDITOR'S INDEPENDENCE DECLARATION

I declare, that to the best of my knowledge and belief, during the year ended 30 June 2017 there have been no contraventions of;

(i) the auditor independence requirements as set out in the *Australian Charities and Not-for-profits Commission Act 2012* in relation to the audit; and

(ii) any applicable code of professional conduct in relation to the audit.

Cutcher & Neale Assurance Pty Ltd
(An authorised audit company)

M.J. O'Connor
Director

21 August 2017
NEWCASTLE

SNPHN LTD ABN 38 605 353 884

INDEPENDENT AUDIT REPORT TO THE MEMBERS OF SNPHN LTD

Report of the Independent Auditor on the Summary Financial Statements

Opinion

The summary financial statements, which comprise the summary statement of financial position as at 30 June 2017, the summary statement of comprehensive income, summary statement of changes in equity and summary cash flow statement for the year then ended, and related notes, are derived from the audited financial report of SNPHN LTD for the year ended 30 June 2017. In our opinion, the accompanying summary financial statements are consistent, in all material respects, with (or a fair summary of) the audited financial report, on the basis described in Note 1.

Summary Financial Statements

The summary financial statements do not contain all the disclosures required by Australian Accounting Standards - Reduced Disclosure Requirements. Reading the summary financial statements and the auditor's report thereon, therefore, is not a substitute for reading the audited financial report and the auditor's report thereon.

Management's Responsibility for the Summary Financial Statements

Management is responsible for the preparation of the summary financial statements on the basis described in Note 1.

Auditor's Responsibility

Our responsibility is to express an opinion on whether the summary financial statements are consistent, in all material respects, with (or are a fair summary of) the audited financial report based on our procedures, which were conducted in accordance with Auditing Standard ASA 810: *Engagements to Report on Summary Financial Statements.*

Cutcher & Neale Assurance Pty Ltd
(An authorised audit company)

M.J. O'Connor
Director

7 September 2017
NEWCASTLE

SNPHN LTD ABN 38 605 353 884

DIRECTORS' DECLARATION

The Directors of the Company declare that the summary financial statements of SNPHN Ltd for the year ended 30 June 2017:

a) comply with the accounting policies described in Note 1; and

b) have been derived from and are consistent with the full financial statements of SNPHN LTD.

This declaration is made in accordance with a resolution of the Board of Directors.

Director: ..... Director: .....

Dated 6 September 2017

SNPHN LTD ABN 38 605 353 884

SUMMARY STATEMENT OF SURPLUS OR DEFICIT AND OTHER COMPREHENSIVE INCOME

For the Year Ended 30 June 2017

	Note	2017 $	2016 $
Operating revenue	2	**17,114,085**	10,020,504
Other income	2	**324,153**	303,375
Program expenses		**(9,846,462)**	(4,509,788)
Employee benefits expense		**(5,676,884)**	(4,395,149)
Equipment and IT expense		**(140,615)**	(261,591)
Depreciation and amortisation expense		**-**	(205,953)
Marketing and communication expense		**(292,945)**	(343,798)
Management and administration expenses		**(1,341,495)**	(607,600)
Surplus / (deficit) before income tax		**139,836**	-
Income tax expense		**-**	-
Surplus / (deficit) after income tax		**139,836**	-
Other comprehensive income for the year		**-**	-
Total comprehensive income for the year		**139,836**	-

The accompanying notes form part of these financial statements.

SNPHN LTD ABN 38 605 353 884

SUMMARY STATEMENT OF FINANCIAL POSITION

For the Year Ended 30 June 2017

	2017 $	2016 $
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	**6,081,881**	3,911,738
Trade and other receivables	**353,692**	100,267
Prepayments	**82,269**	194,439
TOTAL CURRENT ASSETS	**6,517,842**	4,206,444
NONCURRENT ASSETS		
Property, plant and equipment	**-**	-
TOTAL ASSETS	**6,517,842**	4,206,444
LIABILITIES		
CURRENT LIABILITIES		
Trade and other payables	**3,193,638**	397,631
Other liabilities	**2,059,086**	3,120,700
Provision for ATAPS referrals	**462,240**	479,082
Employee benefits	**274,215**	111,055
TOTAL CURRENT LIABILITIES	**5,989,179**	4,108,468
NON-CURRENT LIABILITIES		
Employee benefits	**96,160**	28,376
Provision for make good of premises	**69,600**	69,600
Other liabilities	**223,067**	-
TOTAL NON-CURRENT LIABILITIES	**388,827**	97,976
TOTAL LIABILITIES	**6,378,006**	4,206,444
NET ASSETS	**139,836**	-
FUNDS		
Accumulated Surplus	**139,836**	-
TOTAL FUNDS	**139,836**	-

The accompanying notes form part of these financial statements.

SNPHN LTD ABN 38 605 353 884

SUMMARY STATEMENT OF CHANGES IN FUNDS

For the Year Ended 30 June 2017

	Accumulated Surplus $
Balance at 1 July 2016	**-**
Total comprehensive income	**139,836**
Balance at 30 June 2017	**139,836**

	Accumulated Surplus $
Balance at 1 July 2015	-
Total comprehensive income	-
Balance at 30 June 2016	-

The accompanying notes form part of these financial statements.

SNPHN LTD ABN 38 605 353 884

SUMMARY STATEMENT OF CASH FLOWS

For the Year Ended 30 June 2017

	2017 $	2016 $
CASH FLOWS FROM OPERATING ACTIVITIES:		
Receipts from government grants and services	**17,730,487**	14,197,728
Payments to suppliers and employees	**(15,744,661)**	(10,364,015)
Interest received	**184,317**	78,025
Net cash provided by (used in) operating activities	**2,170,143**	3,911,738
Net increase (decrease) in cash and cash equivalents held	**2,170,143**	3,911,738
Cash and cash equivalents at beginning of year	**3,911,738**	-
Cash and cash equivalents at end of financial year	**6,081,881**	3,911,738

SNPHN LTD ABN 38 605 353 884

NOTES TO THE SUMMARY FINANCIAL STATEMENTS

For the Year Ended 30 June 2017

1. Accounting Policies

The summary financial statements have been prepared from the audited financial report of SNPHN LTD for the year ended 30 June 2017. The audited report for the year ended 30 June 2017 is available at request from SNPHN LTD.

The financial statements, specific disclosures and the other information included in the summary financial statements are derived from and are consistent with the full financial statements of SNPHN LTD. The summary financial statements cannot be expected to provide as detailed an understanding of the financial performance, financial position and financing and investing activities of SNPHN LTD as the full financial statements.

The accounting policies have been consistently applied to SNPHN LTD and are consistent with those of the financial year for their entirety.

SNPHN Ltd is dependent on the Department of Health for almost all of its revenue. At the date of this report the Directors have no reason to believe the Department of Health will not continue to support SNPHN Ltd. SNPHN Ltd's core funding contract is scheduled to end on 30 June 2018. The Department of Health has agreed in-principle to extend the core funding arrangements for Primary Health Networks for an additional two years, to 30 June 2020. The Company also has funding contracts in place which extend to 30 June 2019.

The presentation currency used in the financial report is Australian dollars.

2. Revenue and Other Income

	2017 $	2016 $
Revenue from ordinary operations		
- Operating grants	**17,114,085**	10,020,504
	17,114,085	10,020,504
Other income		
- Interest revenue	**184,317**	78,025
- Sundry income	**139,836**	19,397
- Donated assets	**-**	205,953
	324,153	303,375
Total revenue & other income	**17,438,238**	10,323,879

SNPHN LTD ABN 38 605 353 884

SUMMARY AND ANALYSIS
For the Year Ended 30 June 2017

Statement of Surplus or Deficit and Other Comprehensive Income

The surplus from ordinary activities for the year was $139,836 (2016: $Nil).

This year has been the second year of operations subsequent to incorporation of the Company on 23 April 2015.

The Company was established following the successful joint bid submitted to the Australian Government by Northern Sydney Medicare Local and Sydney North Shore and Beaches Medicare Local to establish and operate the Northern Sydney PHN. Northern Sydney PHN is one of 31 Primary Health Networks established nationally to increase the efficiency and effectiveness of medical services for the community.

From July 1, 2016 the Company began commissioning local health services on behalf of the Australian Government. These newly commissioned services have been designed to improve the efficiency and effectiveness of health services and improve health outcomes for people with priority needs. The services and programs include Alcohol and Other Drug Services, Mental Health Services, Aboriginal Health Services, Hospital Discharge Program for People with Dementia, and Social Worker GP Support.

Revenue

Operating revenue for the year was $17,114,085 (2016: $10,020,504). Almost all of this revenue was derived from delivering outcomes in accordance with Commonwealth Department of Health funding contracts.

Operating grant income increased as a result of continued growth of the Company's grant funded activities with notable increases in recognised income for; Operational and Flexible Funding, Innovation Funding, Mental Health Funding and Drug and Alcohol Funding.

Expenditure

Total expenses incurred for the year were $17,298,402 (2016: $10,323,879).

Employment costs amounted to $5,676,884 (2016: $4,395,149) and the number of employees at balance date was 59 (2016: 51 employees at balance date).

Program costs amounted to $9,846,462 (2016: $4,509,788). These costs represent the cost of allied health professionals and similar direct costs incurred for planning, developing, promoting and delivery of primary health care services. The increase in program expenses is due mainly to the commencement of commission of services resulting in more payments to 3rd parties for service delivery.

Statement of Financial Position

The Company's statement of financial position discloses net assets of $139,836 as at 30 June 2017. The net asset position is consistent with the requirements of the Company's reciprocal funding arrangements with the Commonwealth Department of Health. Unspent grant funds are recorded as liabilities and represent amounts carried forward to be applied in future periods in accordance with plans and strategies approved by the Department of Health.

The Company has reported current assets of $6,517,842 (2016: $4,206,444) and current liabilities of $5,989,179 (2016: $4,108,468). Assets consist mainly of cash of $6,081,881 (2016: $3,911,738) which is of similar value to the sum of unspent current year funding $603,302 (2016: $1,804,578), grant funding received in advance of $1,455,784 (2016: $1,316,122) and trade and other payables of $3,655,878 (2016: $876,713).

Statement of Cash Flows

Operating Activities

Cash inflows from operating activities were $17,914,804 (2016: $14,275,753). Almost all of the cash receipts represented funding received from the Department of Health. Cash payments to suppliers and employees amounted to $15,744,661 (2016: $10,364,015).

Thank you to the wonderful SNPHN staff for their wonderful work and contribution to this Annual Report.

Achieving together - *better health, better care*.

ACKNOWLEDGEMENTS

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DISTRIBUTION

This Annual Report is available on Sydney North Primary Health Network's website (www.snhn.org.au) and directly from the SNPHN offices.

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Special note: The majority of the photos in this Annual Report are of actual Northern Sydney healthcare professionals, members of the Northern Sydney community, and SNPHN commissioned organisations.

Published in October 2017.

Australian Government

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An Australian Government Initiative

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SNPHN LTD (ABN 38 605 353 884), trading
as Sydney North Primary Health Network.