2015-2016

Central and Eastern Sydney PHN

Annual Report

phn
CENTRAL AND
EASTERN SYDNEY

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Supporting, strengthening and shaping
a world class, person centred
primary health care system

We are delighted to publish our first annual report, and to showcase what has been accomplished in our first year of operations.

On 1 July 2015, Central and Eastern Sydney PHN was established as the second largest primary health network, by population, of the 31 PHNs nationwide. In forming this new entity, we brought together the collective strengths of our three founding Medicare Locals, with the vision of 'supporting, strengthening and shaping a world class, person centred primary health care system'. Maintaining and strengthening relationships with our stakeholders remained front and centre during this transition, with there being minimal impact on the delivery of programs.

Supporting our workforce

Our continuing professional development (CPD) program has expanded alongside our growing workforce, with 145 events delivered over the course of the year. Our CPD Team has worked hard to ensure events are accessible throughout our larger region, and relevant to the diverse learning needs of our health professionals. In addition to education and upskilling our clinicians, we implemented quarterly practice nurse and practice manager network meetings to build support networks and strengthen relationships within each profession.

Our Practice Support Team also hit the ground running, working with our local general practices and allied health practices to prepare for accreditation, meet eligibility requirements for practice incentive payments, provide support around digital health, improve data quality, immunisation recall and reminder systems, support GP registrars, link practices with a practice nurse and much more.

Building on our strengths

We have worked hard to ensure that many programs successfully run by our founding Medicare Locals, have continued to grow through our primary health network. For example, our Antenatal Shared Care Program allows women with uncomplicated pregnancies to share their care with their local GP and hospital services. Run in partnership with the maternity units in South Eastern Sydney Local Health District, and Sydney Local Health District, this model of care is used by up to 30% of pregnant women across our region, which accounts for up to 60% of all low risk pregnancies.

Quality improvement

While we've built upon what we know works well, a commitment to continuous improvement helps drive positive change in primary care. This is evident in our three quality improvement initiatives – Q Pulse, the Putting Data into Practice Program and the Diabetes Breakthrough Series Collaborative – which have engaged 157 general practices to date. These initiatives have yielded great results over the past year for both participants and practices involved. We look forward to collaborating with our stakeholders on future quality improvement initiatives that address identified needs in our communities.

Meeting our community's needs

Our programs and services have produced a multitude of positive health outcomes over the past year, however we recognise that the health needs and health service needs of our growing population are not static. The completion of our first baseline needs assessment ensures that our activities are locally responsive and tailored to the current and emerging needs of our local community. This is an iterative process, with our next needs assessment already underway.

Expert guidance

Our activities are guided by our allied health, community and general practice member companies, who provide strong and independent perspectives to improve the health and wellbeing of the central and eastern Sydney community. In addition, our first year of operation saw us establish a Foundation Community Council and Foundation Clinical Council who provide strategic advice to our Board.

The coming year presents exciting new challenges which will see preparations commence for Health Care Homes, and all of our clinical services transition to a commissioning model. The health sector is perpetually changing and as an organisation we must adapt accordingly. We must pursue innovation to ensure changes reflect the identified needs of our community and adhere to current best practice.

Finally, we would like to express our sincere gratitude to the Board, our member companies and staff without whom we could not have had such a successful first year.

Dr Charlotte Hespe, *Chair EIS Health Ltd*

Dr Michael Moore, *Chief Executive Officer Central and Eastern Sydney PHN*

Meet our Board

Dr Teresa Anderson
B.App Science (Speech Pathology) PhD

Ms Trisha Cashmere
BAppSc (Phty)(Hons), LLB, GAICD

Dr Wayne Cooper
BMedSc, MBBS(Hons), MAICD

Professor Mark Harris
MBBS, MD, FRACGP, FAAHMS

Dr Charlotte Hespe, (Chair)
MBBS(Hons), FRACGP, DCH, FAICD, GCUT

Mr Steven Kouris
BEc, LLB, LLM

Mr Gerry Marr
RN, PhD, OBE

Dr Gary Nicholls
MBBS, FRACGP, MRCGP, MRCP, MA, BA(Hons)

Mr Robert Ramjan
AM, BA, BSocStuds

Assoc. Prof. Anthony Schembri
BSocStud(Hons), GDPA, MPP, FCHSM

Dr Tim Smyth
MBBS, LLB, MBA, FCHSM

Mr Chris Tzarimas (Tzar)
MSc(Ex. Rehab.), BSc(HMS), FAAESS, MBA

A Snapshot of Central ar

CURRENT POPULATION

TOTAL POPULATION
1,497,186

49.8%
50.2%

LIFE EXPECTANCY

♂ **82.0**
♀ **86.7**

ABORIGINAL

PHN 0.8%
NSW 2.5%

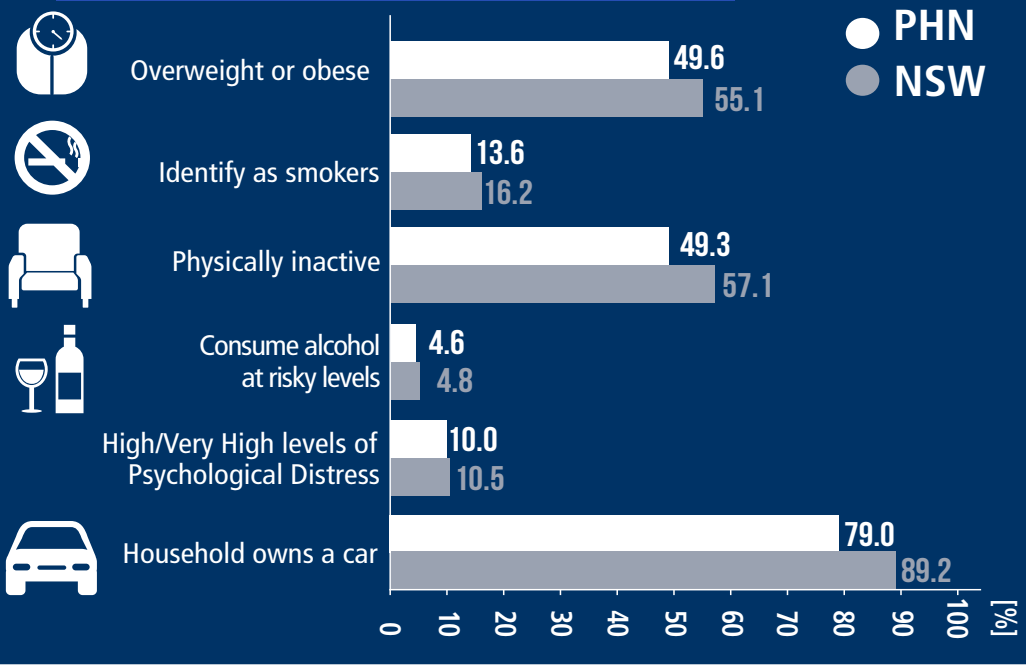
BORN OUTSIDE AUSTRALIA

PHN 35%
NSW 26%

SPEAK LANGUAGE OTHER THAN ENGLISH AT HOME

PHN 35.2%
NSW 22%

HEALTH AND LIFESTYLE INFORMATION



87%
Rate their health POSITIVELY

84%
Saw a GP in the PAST YEAR

1,474
Hospital admissions PER DAY

1,932 PER 100,000 POPULATION
Avoidable hospital admissions PER YEAR

PROJECTED CHANGE IN POPULATION

2011

0-14 YEARS	15.7%
15-64 YEARS	70.9%
65+ YEARS	13.4%

2031

0-14 YEARS	16.3%
15-64 YEARS	66.9%
65+ YEARS	16.8%

2031 TOTAL POPULATION
1,851,500

AREA PROFILE

18	Public Hospitals
2	Local Health Districts
2	Hospital Networks
667 KM²	Land Area
5	headspace Sites
1	Aboriginal Medical Service
↑2,400	General Practitioners
↑4,500	Allied Health Professionals
↑480	Practice Nurses

nd Eastern Sydney PHN

PRIORITIES AND OBJECTIVES

PHN OBJECTIVES

- Increase in the efficiency and effectiveness of health services for individuals, particularly those people at risk of poor health outcomes
- Improve coordination of care to ensure people receive the right care in the right place at the right time.

PHN PRIORITIES

- Reduce avoidable hospitalisations and emergency department presentations
- Improve health outcomes for people with complex chronic conditions.

NATIONAL HEALTH PRIORITIES FOR PHNS

- Aboriginal health
- Aged care
- Digital health
- Health workforce
- Mental health
- Population health

FUNDING PRIORITIES INCLUDING COMMISSIONING ACTIVITIES

- After Hours
- Innovation
- Mental Health and Suicide Prevention
- Alcohol and Other Drugs Treatment
- Partners in Recovery
- Integrated Team Care (Aboriginal Health)
- Norfolk Island

IDENTIFIED LOCAL PRIORITIES AND GOALS

STRATEGIC GOALS

- Improve health outcomes and address health needs
- Support our primary health care professionals and services
- Work in partnership to facilitate person centred seamless care

LOCAL PRIORITIES IDENTIFIED THROUGH NEEDS ASSESSMENT

- Aboriginal and Torres Strait Islander Health
- Addressing service gaps
- Aged care
- Alcohol and other drugs
- Areas with poor health status
- Care coordination
- Child and maternal health
- Digital health
- Early intervention and prevention
- Health literacy
- Integrated care
- Mental health
- Population health
- Service navigation
- Workforce

HOW WILL SUCCESS BE MEASURED?

NATIONAL HEADLINE INDICATORS

- Potentially preventable hospitalisations
- Childhood immunisation rates
- Cancer screening rates (cervical, breast, bowel)
- Mental health treatment rates (including for children and adolescents)

ORGANISATIONAL INDICATORS

- Governance
- Financial management
- Stakeholder management
- Delivery of contracted services and any direct services

Community Council

Membership of the Foundation Community Council comprises about 20 individuals representing the diversity of central and eastern Sydney. We are particularly fortunate to have younger voices, as well as lived experience of mental health and physical disability, and representation from Aboriginal people and lesbian, gay, bisexual, transgender, intersex, and questioning (LGBTIQ) groups. Each member has a passion for improving the wellbeing of every person in the community.

As with the Foundation Clinical Council we have been tasked with providing advice to the EIS Health Board to assist in identifying opportunities to improve access to health services, and to provide advice about population health planning and commissioning of services.

Our initial meeting in November was very much about getting to know each other, and understanding our mandate. We gelled quickly and in the three subsequent meetings have managed very spirited conversations and I believe good advice to the Board. Our only limitation seems to be the length of the meeting! At the first meeting we decided that quarterly meetings would not do justice to our mission and we now meet bi-monthly.

We have a representative of the Board at each meeting, who provides an update to the Council and also listens to our advice and questions. Furthermore, to ensure clear communication lines, the chairs of both councils meet regularly with the EIS Health Chair.

Members have been initially appointed for 12 months. It's a real privilege to chair this passionate group of people who want the best for our community. After four meetings we are well and truly established, and I believe that we are in a position to provide sound advice to the EIS Health Board, and really make a positive difference to the health outcomes of every resident of our community.

Peter Kennedy
Chair Foundation Community Council

Clinical Council

The members of the CESPHN Foundation Clinical Council were appointed after an open selection process in mid 2015, and the Council has met four times since being appointed.

We are a large group (fluctuating between 18 and 25 members) of health professionals working within the CESPHN catchment area; a combination of those working within primary care (such as GPs, practice nurses, and multiple allied health professionals) and others with strong interactions or important interfaces with primary care (such as representatives from our multiple local health districts and mental health services).

The Foundation Clinical Council has been tasked with providing advice to the Board about clinical issues within the region, to assist in identifying opportunities to improve health services, and provide advice about population health planning and commissioning of services.

After a brief period of getting to know each other, we have clarified our broad role and gotten down to work. We have had discussions assisting the development of the CESPHN needs assessment and some of the Board's strategic priorities.

Our advice has focused on areas with strong clinical context, and the Council has provided practical advice on how the Board's strategies might be more successfully or more easily implemented. We have a Board representative at each meeting, which allows the Council to clarify any concerns it may have, and allows the Board to feedback on our early direction.

The Clinical Council Chair has also met with the Community Council Chair and the EIS Heath Chair, Dr Charlotte Hespe, to identify synergies or overlapping areas of concern. We have also been well supported by CESPHN staff to ensure we do not duplicate existing work.

This Foundation Clinical Council has only been appointed for a year, and we are tasked with determining the best structure of the Clinical Council of the future. Determining one's future is never an easy task, but one which we will debate at our forthcoming meetings.

These are early days for the Clinical Council (as they are for the broader PHN). As Chair of the Council, it has been inspiring to meet so many motivated health professionals working within the PHN, who are keen to support the Board in its decision making. We hope that the future Clinical Council can harness this good will.

Dr Michael Wright
Chair Foundation Clinical Council

Needs Assessment

Commencing in late 2015, we carried out a needs assessment in partnership with the local health districts (Sydney and South Eastern Sydney), speciality health networks (St Vincent's and Sydney Children's Hospital), representatives of our member networks, Family and Community Services and local government. The objective of the needs assessment is to inform the strategic planning phase of the commissioning cycle, enabling the PHN to plan and commission health services based on the assessment, understanding and prioritisation of local needs.

The needs assessment has built upon previous knowledge and intelligence gathered and prioritised by the former Medicare Locals and current plans produced by our local health districts. We complemented this with local level data collection, health service mapping, assessment of service utilisation and stakeholder and community feedback.

To better understand the health needs and service needs of the diverse population living within the CESPHN region, we analysed information at the local government level and suburb level (when available). Comparison and trends were drawn with state and national data sets to better understand where the areas of focus should be.

Stakeholder consultations were a fundamental element of the needs assessment process providing the opportunity to build an in-depth understanding of the issues and needs at the community level.

Community members and key stakeholders were engaged through a variety of approaches, including: surveys of health care professionals and community and carers (116 and 345 responses respectively), six community forums held throughout the region and in partnership with the local health districts (225 attendees), stakeholder meetings and one-to-one interviews with key agencies on areas of specific need such as health of people who are homeless, veteran's health and prisoner health.

The key needs and issues identified were shared at community forums, discussed with the Foundation Clinical Council and Foundation Community Council, the member network chairs and with our staff.

In February 2016, we held a strategic planning workshop with the Board, Foundation Clinical Council and Foundation Community Council to further prioritise and identify possible options for implementation. Our intention for 2016-17 is to focus on the following priority areas:

Areas with poor health status
Population health
Workforce
Aged care
Care coordination
Mental health
Early intervention and prevention
Addressing service gaps
Aboriginal health
Alcohol and other drugs
Health literacy
Child and maternal health
Integrated care
Service navigation
Digital health

The priority areas will form the basis of our activity work plans for 2016-17 in addition to the portfolios of suicide prevention, drug and alcohol and after hours primary care. We will continue to update our needs assessment as new information becomes available. This will be undertaken annually in partnership with key stakeholders.

Sector Reform

Health Care Homes

In March 2016, the Australian Government announced that it will support the establishment of 'Health Care Homes' in general practices or primary health care services. These services are designed to improve the delivery of care for people with chronic conditions.

Health Care Homes will design tailored care plans (in consultation with patients) that outline the health services they need, and coordinate them.

This means people with chronic conditions will be supported with access to coordinated medical, allied health and out-of-hospital services, regardless of whether they are provided by Medicare, state and local governments, the community sector or the multitude of other sources currently fragmenting the system.

NDIS

Implementation of the National Disability Insurance Scheme (NDIS) will commence in our region on 1 July 2017. It will mean a significant increase in funding for disability support and a change of funding model from one where service providers receive block funding to one whereby people with a disability will have choice and control over the support they need.

The need to prepare for NDIS was flagged as a major issue at our community consultations in February 2016 and this will be a key activity for us over the coming year.

Aged care

This year saw a number of significant changes to the aged care system including establishment of the Commonwealth Home Support Programme, the implementation of a Regional Assessment Service, and expansion of the My Aged Care website including making this the main referral pathway to services.

From February 2017, funding for Home Care Packages (government-subsidised home care services) will follow the consumer. This means that a consumer will be able to choose a home care provider that suits their needs and direct their package funding to that provider.

From July 2018 the Home Care Packages Programme and the Commonwealth Home Support Programme will be integrated into one single home care program.

Local government amalgamations

In April 2016, the NSW government announced a number of local government amalgamations. In our region four new councils have been created – the Inner West Council (Ashfield, Leichhardt, Marrickville), the Georges River Council (Hurstville and Kogarah), the Bayside Council (Botany Bay and Rockdale) and the Canterbury Bankstown Council.

Two other potential council mergers have been flagged – Randwick, Waverley and Woollahra; and Burwood, Canada Bay and Strathfield. City of Sydney and the Sutherland Shire remain unchanged.

Mental Health Reform

PHNs play a key role in the architecture of the mental health system, leading the planning and purchasing of mental health programs, services and integrated care pathways at a regional level.

The Department of Health has identified six key objectives for PHNs in commissioning mental health services and supports

1. Improve targeting of psychological interventions via commissioning of low intensity mental health services
2. Support region-specific, cross sectoral approaches to early intervention for children and young people with, or at risk of mental illness
3. Address service gaps in the provision of psychological therapies for people in rural and remote areas and other under-serviced and/or hard-to-reach populations
4. Commission primary mental health care services for people with severe mental illness being supported in primary care
5. Encourage and promote a regional approach to suicide prevention
6. Enhance and better integrate Aboriginal and Torres Strait Islander mental health services at a local level facilitating a joined up approach with other closely connected services including social and emotional wellbeing, suicide prevention and alcohol and other drug services.

In response to these new objectives, we have developed evidenced based regional mental health plans and suicide prevention plans. These plans are underpinned by regional consultation on the health and service needs of local communities in relation to mental health and include input from consumers, carers, practitioners, service providers and community members.

What we heard from local communities was a call for a more flexible, joined up system that is easy to navigate and provides support based on an individual's needs. We've identified several key concerns around mental health and mental health services which our operational plans will respond to.

Potentially preventable hospitalisations

Higher rates of psychological distress and or mental health problems

Poor health outcomes for vulnerable groups

Service distribution

Service coordination, integration and navigation

Stigma and discrimination

Drug and Alcohol Reform

In line with the commissioning model, PHNs will also assist in growing the capacity of the drug and alcohol treatment sector, to ensure adequate and effective delivery of treatment services at a local level. We will commission more drug and alcohol treatment services, including Indigenous-specific services, based on the needs of local communities.

In order to develop an evidenced based drug and alcohol operational plan, we conducted a range of consultations with the government and non-government service sector to develop a comprehensive needs assessment.

With the operational plans complete, we will work with consumers, carers, service users, practitioners and service providers via a co-design process to develop and shape service specifications to meet the needs of local communities.

Targeting

Population

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n Health Needs

Working with primary health care providers to strengthen health care services in the region and ensure a seamless journey for consumers

Population Health

The past year has seen the transition and consolidation of a number of projects from our foundation Medicare Locals, and the expansion of our scope to meet the new objectives of primary health networks. We are involved in a variety of quality improvement and service redesign projects and initiatives that will ultimately improve the consumer experience and increase the efficiency and effectiveness of the health system.

We are currently involved in more than 30 initiatives across various populations which target a range of audiences including GPs, nurses, allied health professionals and the general public. Our work is enhanced by collaborations within and outside the organisation including SESLHD, SLHD, Sydney Children's Hospital Network, educational institutes and other key stakeholders.

National Health Priorities Project Officers are committed to reducing the burden of chronic disease. They work closely with primary care providers to improve quality of health care and enhance access to and delivery of services whilst also addressing the health needs of the local community.

We facilitate integrated care for people with long term and complex conditions through our strategic partnerships and initiatives such as our Allied Health Access projects and the SESLHD Integrated Care Strategy.

We currently offer three quality improvement programs for general practices to improve data quality, and the identification and management of long term conditions.

We promote chronic disease prevention and management in line with evidence based best practice and support the community to adopt healthy lifestyles through programs such as ComDiab, which provides diabetes education.

Our involvement in cancer control includes running the Rockdale Women's Health Clinic to increase cervical cancer screening rates for eligible women, increasing breast cancer screening rates and improving the management of skin cancer and chronic wounds in the primary health care setting.

Our diverse team works across multiple national health priority areas including asthma, cancer control, cardiovascular disease, diabetes and obesity as well as child and maternal health and immunisation.

Our work around maternal and child health includes a range of initiatives that support coordinated care and optimal health outcomes for women and families, such as the Antenatal Shared Care Program, Healthy Homes and Neighbourhoods and Kids Guided Personalised Services (GPS) Integrated Care Projects.

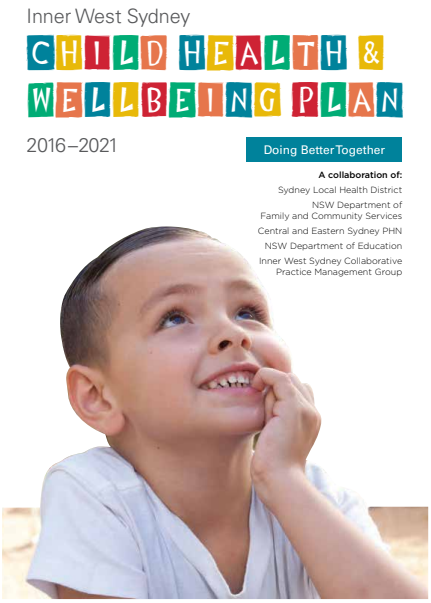
Our immunisation portfolio addresses coverage rates, cold chain management and public health updates to promote the uptake of vaccines within target populations. We work to enhance best practice storage and management of vaccines and to identify, treat and contain the spread of communicable diseases.

These programs demonstrate the significant role the Population Health Team plays in supporting our goals to improve health outcomes and address the health needs of the local population, as well as in providing ongoing support to our primary health care professionals and services.

Child Health

Inner West Sydney Child Health and Wellbeing Plan

In November 2015 we were proud to launch the Inner West Sydney Child Health and Wellbeing Plan, a historic partnership bringing together Central and Eastern Sydney PHN, Sydney Local Health District (SLHD), NSW Family and Community Services and NSW Education and Communities in a collaborative effort to improve outcomes for children, particularly amongst those who are most vulnerable. Since then we have been working in collaboration with key stakeholders to scope, plan and deliver the activities as outlined in the Plan.



The Healthy Homes and Neighbourhoods Integrated Care Initiative

The Healthy Homes and Neighbourhoods (HHAN) Initiative aims to ensure vulnerable families have their complex health and social needs met; keep themselves and their children safe; and keep families connected to society.

We are participating in the project to improve the overall health of vulnerable families within Sydney Local Health District, with a particular focus on general practice engagement and building the capacity of general practice to care and coordinate health services for family members over the long-term.

To date, the team have progressed the following:

Promotion

Commenced dissemination of HHAN information and updates to GPs and practice staff.

Engagement

Individual practice HHAN recruitment visits commenced in November 2015, starting with areas of significant disadvantage (Riverwood and Redfern). 34 practices are now familiar with the program and 22 GPs are engaged to work with HHAN clients.

Education

The HHAN Team presented at CESPHN's Paediatric Update CPD event in February 2016.

Communication

A practice information pack has been developed and delivered during visits to individual GPs including information about the project.

Collaboration

Consumer and community consultation has commenced and we will continue to develop collaborative, local approaches to meeting the needs of vulnerable families. Healthy Homes and Neighbourhoods staff will be based at 'hubs' within these areas to ensure key services are integrated and support local collaboration.

Quality improvement

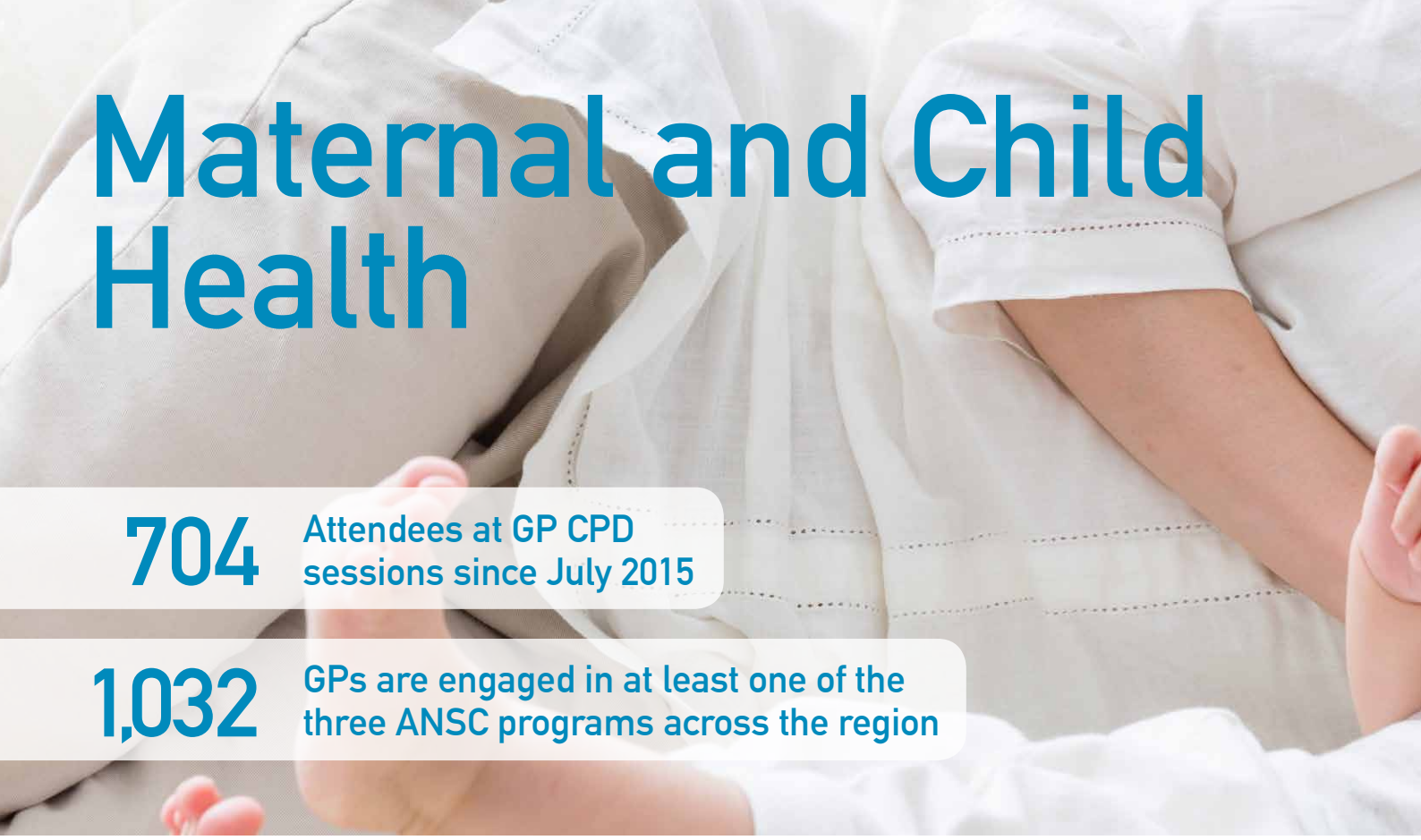
- GP and Practice Nurse Survey administration – The View from General Practice: Working with Vulnerable Children and their Families in the SLHD which aims to identify barriers and facilitators to working well with vulnerable children and their families in SLHD.
- eLearning Pilot Child Health and Developmental Surveillance Module for GPs and PNs – developed by Dr Nathalie Ong.

Kids GPS Integrated Care Initiative

The Sydney Children's Hospital (SCH) Network is working with CESPHN and SESLHD to build repeatable and sustainable integrated care practices that will result in the improved health and wellbeing of children with chronic conditions. Over the course of the three year project it is anticipated there will be a range of new models of care introduced across the region.

CESPHN is currently working with the QI Implementation Team on a model of care which aims to have paediatric feeding tubes for children managed locally under a shared care plan with SCH. A survey has been created and will be disseminated in the near future to explore enablers and barriers of managing nasogastric tube feeding in the community.

Maternal and Child Health



704 Attendees at GP CPD sessions since July 2015

1,032 GPs are engaged in at least one of the three ANSC programs across the region

We have maintained a collaborative partnership with both our local health districts and general practitioners to support and enhance patient outcomes and improve quality standards in relation to maternal and child health.

The major focus of the Maternal Health Program is the GP Antenatal Shared Care (ANSC) Program. We support three ANSC programs across our region's five public maternity hospitals: Canterbury Hospital, RPA Women and Babies, the Royal Hospital for Women, St George Hospital and Sutherland Hospital.

Approximately 30% of pregnant women across the central and eastern Sydney region are managed under this model of care which accounts for up to 60% of all low risk pregnancies. Since July 2015, 151 GPs have been newly affiliated with the ANSC programs, with a total of 1,032 GPs engaged in at least one of the three ANSC programs across the region.

We support the ANSC program by providing the interface between GPs and the hospital, developing and distributing program resources (including a new electronic bimonthly newsletter), coordinating orientation sessions for GPs new to the program and on-going education events.

Each ANSC program is overseen by an advisory committee consisting of key ANSC program stakeholders that provide support in developing ANSC program standards, education priorities, ongoing evaluation and clinical governance.

GPs are engaged in advisory roles to ensure there is appropriate and relevant representation at all levels of program planning, delivery and evaluation.

Results of a GP ANSC patient satisfaction survey (RPA Women and Babies and Canterbury) revealed a high level of satisfaction with the overall level of care provided under the GP ANSC program by both the woman's recognised ANSC GP and the hospital delivering care.

Patient responses were extremely favourable in regards to:

- provision of information
- opportunities for discussion
- involvement in their care decisions
- respect for their privacy and confidentiality
- level of communication between care providers.

Women were primarily attracted to the program because of the convenience, flexibility and the continuity of care throughout their pregnancy.

In the past year, we have delivered specific ANSC continuing professional development events, ensuring that GPs maintain and improve their knowledge of obstetrics and gynaecology, and stay abreast of the latest evidence based practice. We have supported a total of 704 attendees at 13 GP CPD sessions since July 2015. The GP ANSC Resouce Manual (RPA/Canterbury) was revised to incorporate close links with the HealthPathways Sydney online clinical support tool.

Approximately 30% of pregnant women across our region are managed under the ANSC program

Gestational diabetes is increasing in prevalence and is becoming a significant concern for both the community and service providers. We have partnered on two initiatives that aim to address this:

- The SugaMama App for mobile devices supports monitoring and self-management for women diagnosed with gestational diabetes. We supported the Royal Hospital for Women to trial the app with a small number of women and GPs.
- In collaboration with Canterbury Hospital the "Too Long to Wait" clinical redesign project is improving the quality and continuity of care for pregnant women diagnosed with gestational diabetes or type 2 diabetes in the antenatal clinic and primary care setting. Already we have made improvements in both clinic waiting times, timely referral of high risk women and improvements in post-natal follow-up.

Domestic and Family Violence

Domestic violence is often the reason people seek assistance from a health service with more than one in five women making their first disclosure of domestic violence to a health professional. GPs and allied health professionals are well placed to identify those at risk of domestic violence and to take action to intervene early.

We have established partnerships with key stakeholders within both SESLHD and SLHD in regards to matters relating to domestic violence and child protection. This includes membership of the SLHD Domestic Violence Committee, attendance at relevant network meetings, development of health professional educational activities and communication updates to GPs and allied health professionals to emphasise and raise important messages.

Over the past year, we have delivered two educational activities with 49 GPs and allied health professional attendees. We have disseminated four articles through our hardcopy and electronic newsletters, providing information to health professionals to assist them to identify and respond to domestic and family violence.

SUPPORT, EDUCATE, COMMUNICATE, INNOVATE

CENTRAL AND EASTERN SYDNEY PHN IMMUNISATION PROGRAM

LAUREN DALTON, NINA NI, KIRA WRIGHT

OUR GOAL

To support best practice relating to the delivery of the National Immunisation Program by working with immunisation providers and the community

OBJECTIVES

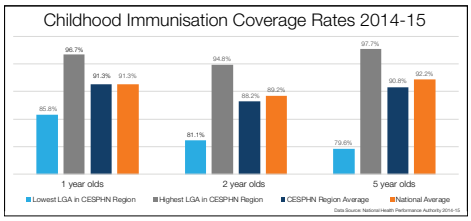
- ↓ incidence of vaccine preventable diseases
- ↓ avoidable hospital admissions
- ↓ vaccine wastage
- ↑ childhood immunisation rates above the national goal of 90% across the region

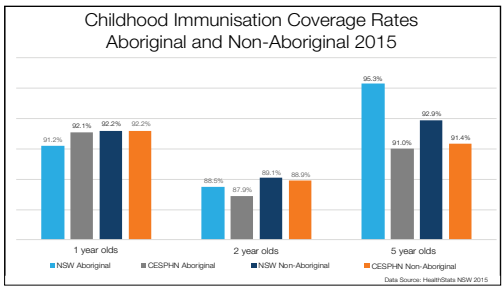
INPUTS
Time
Staff
Knowledge
Experience
Stakeholder expertise
Technical expertise

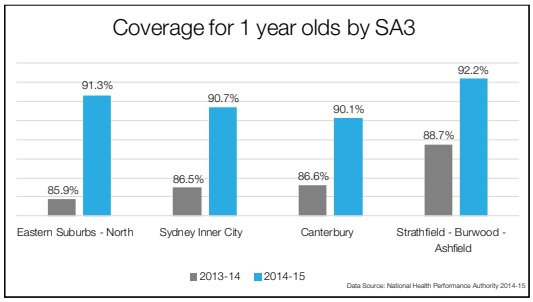
OUTPUTS
Education
Resources
Communication
Support

EXPECTED OUTCOMES
Growth of immunisation awareness in the community
Increase in childhood coverage rates
Improvement in immunisation knowledge of providers
Decrease in vaccine wastage
Improvements in practice systems and procedures for recording immunisations

INTERIM RESULTS
Growth in coverage rates







FOUR SA3 AREAS IN CESPHN REGION WERE AMONG THE TOP TEN NATIONALLY WITH SIGNIFICANT IMPROVEMENT IN IMMUNISATION RATES FOR CHILDREN AGED ONE YEAR

SUPPORT

Practice visits
Cold chain training
ACIR transmissions
Overdue children follow-up
Schedule information
New vaccines
New recommendations
Resources
ACIR online and accessing overdue reports
Quality improvement in practice systems

EDUCATE

General practice
- Annual Immunisation Update
- Annual cold chain training
- Practice-based education
- Nurse network meetings

Community
- Community talks
- Child care centres
- Play groups

COMMUNICATE

Alerts and notices
Website
Bi-monthly Immunisation eNewsletter
Resources
Weekly eNews update

INNOVATE

Research projects
Pilot studies
Surveillance studies

CENTRAL AND EASTERN SYDNEY PHN AT A GLANCE

1.5 MILLION PEOPLE
2ND LARGEST POPULATION
2 LOCAL HEALTH DISTRICTS
2 SPECIALTY HEALTH NETWORKS

CESPHN IMMUNISATION RATES

91.3% 1 YEAR OLDS
88.2% 2 YEAR OLDS
90.8% 5 YEAR OLDS
Data Source: HealthStats NSW 2013-14

0.8% IDENTIFY AS ABORIGINAL NSW 2.5%
45% BORN OVERSEAS NSW 31%
35% SPEAK A LANGUAGE OTHER THAN ENGLISH AT HOME NSW 21%
Data Source: 2011 Census

718 GENERAL PRACTICES
2151 GENERAL PRACTITIONERS
467 PRACTICE NURSES

1474 DAILY HOSPITAL ADMISSIONS
6.1% POTENTIALLY VACCINE PREVENTABLE
Data Source: HealthStats NSW 2013-14

POPULATION DENSITY
2263 PEOPLE/KM²
NSW 9 PEOPLE/KM²
Data Source: 2011 Census

Our vision is ***supporting, strengthening and shaping a world class, person centred primary health care system.***
We work to achieve this by working directly with all key players including general practitioners, allied health, nurses, secondary care providers, local health districts and hospital networks, local communities and non-government organisations to ensure improved health outcomes for people living and working in our region.

www.cesphn.org.au @cesphn /cesphn immunisation@cesphn.com.au

phn CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative

Immunisation

Our Immunisation Program reduces the incidence of vaccine preventable diseases in the community by providing appropriate and timely information about vaccine preventable diseases and the National Immunisation Schedule to immunisation providers and the community.

The Immunisation Team has formed strong partnerships with the SESLHD Public Health Unit (PHU) and SLHD PHU to work towards achieving the objectives of the program.

In the past 12 months, the PHUs and our team have identified a number of geographic areas with low childhood immunisation coverage rates and we have worked closely with practices in those areas to improve reporting, recalls and follow-up of children.

Overall our region has achieved childhood immunisation coverage rates above the national goal of 90%. There are small geographic areas in which coverage rates are lower than the goal, however we continue to prioritise these areas and work with providers and the community in improving these rates.

The Immunisation Team also provides ongoing support to practices regarding vaccine management and cold chain support.

Six education events were held focussing on the latest immunisation news, cold chain training and travel vaccinations. Community groups have also been engaged, with education programs being delivered to two community groups in our region.

The Immunisation Team presented a poster (see adjacent) at the 15th National Immunisation Conference hosted by the Public Health Association of Australia in which we showcased the work of the PHN in achieving increased childhood immunisation coverage rates and improved vaccine storage.

In 2016, we have participated in the AusVaxSafety Surveillance Project which is an initiative led by the National Centre for Immunisation, Research and Surveillance. This program collects information regarding influenza associated vaccine reactions. Currently seven practices are participating to provide real-time reporting to ensure the safety of influenza vaccines.

We strive to provide timely information regarding the latest immunisation news and alerts to all stakeholders through our website and bimonthly electronic newsletters.

> **The South Eastern Sydney Public Health Unit and Central and Eastern Sydney PHN have continued to build an excellent working relationship to achieve common goals including increasing childhood immunisation coverage rates, decreasing vaccine wastage and decreasing avoidable hospital admissions. The two organisations complement each other in providing support to immunisation providers and parents across the region.**
>
> *Professor Mark Ferson, Director, Public Health Unit, South Eastern Sydney Local Health District*

> **The Sydney Local Health District Public Health Unit works closely with Central and Eastern Sydney PHN to support immunisation providers to deliver quality vaccination services, with the overall goal of improving immunisation coverage rates and timeliness of vaccinations for our residents.**
>
> *Dr Leena Gupta, Director, Public Health Unit, Sydney Local Health District*

329 *practice visits*

number of practices we've provided with cold chain support **265**

Access to Allied Health Services

Since becoming a primary health network, we have taken many steps towards providing greater access to allied health services and lifestyle modification programs. These steps have been important in the prevention and management of increasingly prevalent chronic diseases.

Translating and Interpreting Service

We have continued to provide free access to Translating and Interpreting Services (TIS) National for all registered Allied Health Professionals working in private practice.

The initial research highlighted that 88% of AHPs in our catchment communicated with patients who speak limited English. Providing free interpreting services has increased the access to allied health services for the non-English speaking population within our region.

The program has experienced a 96% increase in usage in the second half of the financial year, when compared to the first half of the financial year. The program will continue to be funded in the 2016/2017 financial year.

All registered AHPs working in private practice within our region are eligible to take advantage of this service.

Lifestyle Modification Programs

Having mapped the lifestyle modification programs (LMPs) in the region, we have improved our knowledge and understanding of which former local government areas (LGAs) offer a variety of LMPs catering to a large proportion of the areas' needs versus the areas underserviced.

The LGAs of Botany Bay, Canterbury, Kogarah and Marrickville were highlighted by the mapping report as underserviced in regards to the LMPs offered. In response to this, we researched potential LMPs to enhance access to preventive health, particularly focusing on SNAP (smoking, nutrition, alcohol and physical activity). This has led to the first stages of the expansion of the General Practitioner Exercise Referral Scheme (GPERS) into the Canterbury area.

The GPERS program, providing group exercise therapy from an exercise physiologist, operates in the Hurstville and Sutherland Shire areas. The program started more than 12 years ago, and now treats and assesses more than 300 new individuals annually. The program focuses on individuals with risk factors and diagnoses of lifestyle diseases.

Findings from the LMP mapping report showed that the Burwood, Randwick, Strathfield, Sutherland Shire, Sydney, Waverly and Woollahra LGAs cater well for a large section of their population. The LMPs in the Ashfield, Canada Bay, Hurstville, Kogarah and Leichhardt LGAs focus heavily toward the elderly population. Over the coming year we will continue to identify and expand appropriate and evidence based preventive health programs to support the needs of our communities across the region.

Public to Private Program

We have also sustained our work with the Allied Health Public to Private (P2P) program in partnership with SLHD. The program has created links between the AHPs in public hospitals and in private practices to establish referral pathways that aim to reduce the waiting list for the public system by referring eligible and suitable patients to private AHPs for treatment.

The P2P program has assisted structural changes within the allied health services offered at RPA hospital. Patient induction now includes questioning about private health insurance to increase knowledge of appropriateness of referral to a local, private AHP.

Diabetes

While diabetes rates in our region are similar to NSW as a whole, prevalence of diabetes is higher in Aboriginal, Torres Strait Islander, culturally and linguistically diverse populations and areas with higher levels of social disadvantage.

We work closely with multiple partners on a wide range of strategies that address the identification and management of diabetes across the area. Examples of these partnerships include working with HealthOne Sutherland on the Diabetes Breakthrough Series Collaborative and delivery of community diabetes education sessions in collaboration with LHD community health services and local practice nurses.

In November 2015 we presented the results of a research study undertaken in collaboration with Royal Prince Alfred Hospital Diabetes Centre at the National Primary Care Conference in Brisbane. This study highlighted the significant need to improve management and explore effective models of care for people under the age of 40 who are diagnosed with type 2 diabetes.

ComDiab

We also promote community based diabetes education sessions to GPs working in the region. ComDiab is a free, interactive, patient-focused type 2 diabetes introductory group education program led by nurses that are registered with Diabetes NSW. ComDiab improves patient self-management and care to reduce their risk of developing type 2 diabetes related complications.

Through a partnership with SESLHD, four ComDiab trained nurses were hired to deliver monthly sessions for the St George area. Sutherland and Hillsdale also have monthly sessions scheduled for the second half of 2016 and SLHD has bimonthly sessions scheduled. Since July of last year, approximately 200 participants have attended ComDiab sessions held in our region.

Diabetes education for health professionals

Over the last 12 months we held three diabetes education events with participation from 105 health professionals, including dietitians, exercise physiologists, GPs, practice nurses and podiatrists.

We recognise that primary care nurses are ideally placed to provide education and self-management support to people with diabetes. By offering professional development we have enabled practice nurses to increase their knowledge and confidence in managing people with type 2 diabetes. This year we sponsored five practice nurses to take part in a face-to-face 'Diabetes study day for nurses' and eleven practice nurses completed the 'Diabetes essentials for health professionals' online course. Feedback from course participants was overwhelmingly positive with one nurse stating that after the study day she was "more aware of issues and able to better give overarching education to patients".

Diabetes annual cycle of care and continuous quality improvement

The diabetes annual cycle of care can help achieve better outcomes for people with diabetes and is recommended by Diabetes Australia and RACGP guidelines. Further it has been demonstrated that people with diabetes who have completed the diabetes annual cycle of care and have regular HbA1c recordings have a reduced likelihood of hospitalisation[1]. Completing the diabetes annual cycle of care has been promoted to general practices through practice visits and diabetes related educational courses.

Of the 76 practices currently participating in our quality improvement programs, 39 have selected diabetes as their priority area and focus on improving clinical coding, data entry and completing the cycle of care items. Practices are encouraged to identify and recall high risk individuals for targeted care such as referral to allied health, care coordination or support with self-management.

Our Quality Improvement Project Officers support practices by providing regular progress reports and onsite assistance to enable them to better manage their patients with type 2 diabetes.

Already we have seen some fantastic results with significant improvement in the number of patients with HbA1c recordings in the target range and increased compliance with evidence based best practice.

1.http://www.nps.org.au/conditions/hormones-metabolism-and-nutritional-problems/diabetes-type-2/for-health-professionals/annual-cycle-of-care

Quality Improvement

The effective use of clinical data and a culture of quality improvement (QI) has been shown to improve patient care through better prevention and management of chronic disease. Improvement in quality of care and patient safety is dependent on a general practice's understanding of their patient population, setting achievable targets for improved outcomes and designing tasks to achieve change. Decisions on areas for improvement need to be determined and measured based on evidence produced by the practice's own data.

Since July 2015, our Quality Improvement programs have successfully engaged 157 general practices, with 76 practices currently active in one or more of three QI programs to improve practice data collection, support chronic disease prevention and management and provide regular progress feedback.

1 **Q Pulse** is an innovative cardiovascular disease research project that assists GPs with the identification and management of high risk patients. It utilises an electronic decision support tool, HealthTracker, which is designed to assess cardiovascular risk and provide tailored management advice specific to the patient's circumstances. Project partners include the George Institute, University of Notre Dame and the Improvement Foundation.

44 practices participating

2 The **Diabetes Breakthrough Series Collaborative** is a 15-month project run in partnership with SESLHD that aims to improve delivery of diabetes care through greater adherence to best practice guidelines and clinical service redesign.

12 practices participating

3 The **Putting Data into Practice (PDIP)** program is tailored to priorities identified by each practice and enhances data quality by highlighting high risk patients, such as patients who are overdue for screening and pathology measures.

41 practices participating

Improvements at the PHN level include

- an overall increase in blood pressure recordings of 2.6%
- 2.4% rise in the population with a blood pressure recording in the target range (<130/80)
- allergy status recorded was in line with accreditation standards (90% of active patients) and also experienced a 1.5% increase
- recording of smoking status has increased by 3%
- improvements in cervical screening for targeted practices were achieved

> "...seeing the data broken down into achievable steps has been valuable, improving the quality of our data and our patient care"
>
> Life Medical Clinic Bexley's Practice Manager and PDIP participant, Sneha Naicker

QI Project Officers provide regular onsite and remote assistance and feedback to clinicians and practice staff, offering motivation and education, and informing them of their progress. QI is an increasingly important aspect of practice management processes, and GPs, practice nurses and practice staff need to be familiar with the key principles of quality improvement and its implementation.

The support provided through the QI programs allows identification of high risk patients and those overdue for recalls in accordance with evidence based best practice guidelines. The support also allows for a smoother transition through RACGP accreditation, and assists with an increased uptake of relevant MBS initiatives, leading to increased practice income.

Research and Innovation

We are committed to supporting research and innovation to improve health, facilitate seamless care and address the local health needs for the people in our region. A key role of our research support is to enhance the evidence base, and promote the application of proven interventions and translation of evidence into practice.

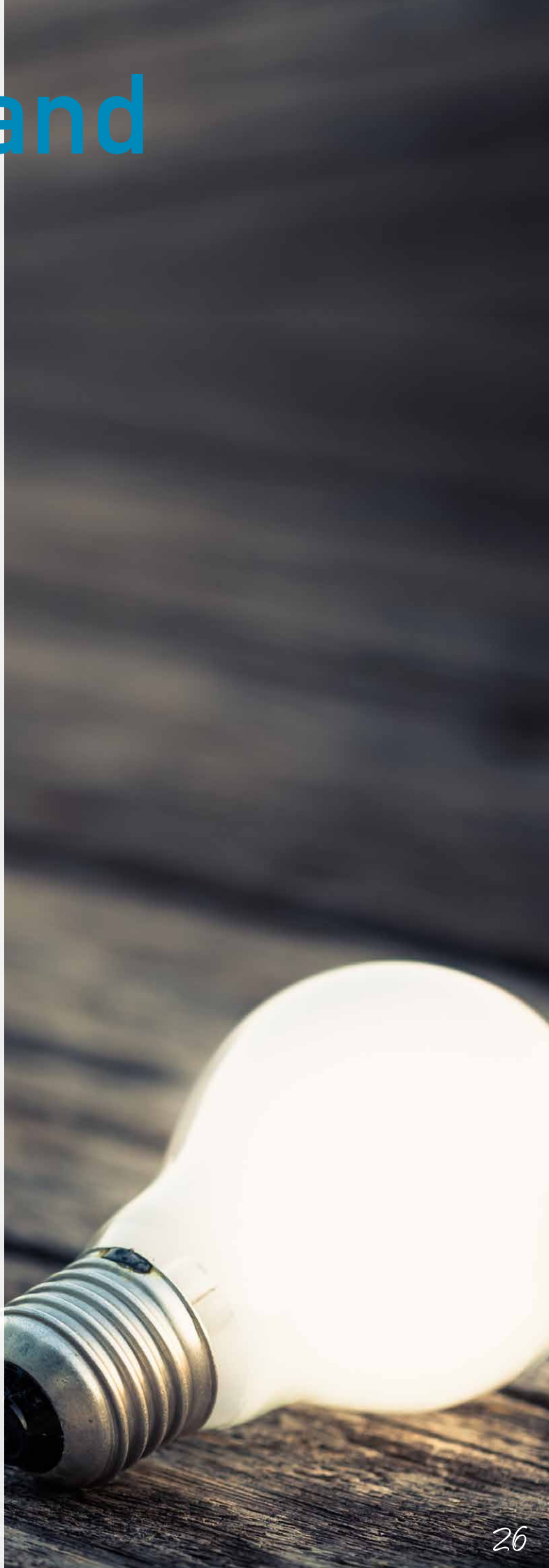
Since July 2015, we have supported more than 30 primary care research projects, including clinician surveys, program evaluations, clinical trials, qualitative interviews and focus groups, novel interventions, clinical audits, randomised controlled trials, case-control and cohort studies.

We are supporting projects that explore health technology, service navigation and patient pathways, patient support, quality improvement, health literacy, novel treatments, clinical pathways, clinical education, and behaviour change interventions.

Our partners' projects cover a broad scope of health issues including Aboriginal health issues, ageing, asthma, cancer, cardiovascular diseases, dementia, diabetes and lifestyle modification, drug and alcohol, immunisation, mental health and comorbidities, motor vehicle accidents, pregnancy and preconception transport, vulnerable families and wound care. We have been invited as key research partners and investigators, to contribute our advice and support on 11 research grant applications for assessment in 2017 funding rounds.

In our first year of operations, we have identified and built key research partnerships with local and national universities and research organisations, our regions' hospitals networks and local health districts. We proudly partnered with SLHD to host the 'Good Health - The New Thinking Practical Innovations in Primary Health Care' education symposium; and have developed key strategic partnerships by becoming a member of the Sydney Research Council, and the Health Science Alliance.

We are involved in various research committees and advisory groups, including the SLHD Patient and Family Centred Care Research Working Group; HealthPathways Sydney Research and Evaluation Committee, and Halting Antipsychotics in Long Term Care – Dementia Collaborative Research Centres.



Cancer Screening and Prevention

Rockdale Women's Health Clinic

Since 2009, Rockdale Women's Health Clinic has been providing cervical cancer screening to more than 300 women each year who choose not to be screened by their GP. The clinic also serves as a valuable referral pathway for local male GPs who prefer not to offer cervical screening themselves. Over the past year, our women's health nurses have delivered 52 clinic sessions and screened more than 350 women for cervical cancer.

As we move towards a commissioning model, we have consulted with consumers and GPs to ensure women continue to receive the right care in the right place at the right time. With clear evidence for the service to continue, in May 2016 we invited external organisations to apply to deliver the clinic on our behalf.

Following a competitive tender process, we were pleased to award Family Planning NSW the contract to deliver the clinic from 1 July 2016. Since then, the two organisations have worked together to successfully transition the service without disruption to referring GPs or their patients.

We are delighted to report that today the clinic continues to provide the valuable, high quality women's health services that our GPs and patients have come to expect.

Cancer screening

Increasing participation in bowel, breast and cervical cancer screening programs has been a key focus across our region with a number of areas demonstrating low screening rates compared to the NSW average. We have built strong relationships with our key stakeholders, including Cancer Institute NSW, both BreastScreen services and LHD women's health teams, so we can work collaboratively to increase screening participation.

As part of the broader quality improvement program, practices that have chosen to focus on cervical cancer screening as their priority area for improvement have collectively shown a 2.2% increase in women who have had a pap test in the last two years.

We have been active in encouraging practices to implement systematic recall and reminder systems to increase cancer screening participation rates. As well as using their own clinical systems GPs are particularly encouraged to access the following new initiatives introduced by the cervical cancer and bowel cancer screening programs.

In October 2015 the NSW Pap Test Register implemented a new initiative allowing GPs to identify their female patients who are overdue for cervical cancer screening via HealthLink secure messaging. 123 general practices have registered to receive their overdue lists via HealthLink.

In May 2016 , the National Bowel Cancer Screening Program introduced a system whereby general practices can now electronically receive FOBT test results by registering with the Program's pathology partner.

MultiLevel Innovators Integrated Care Project

We have played a key role in supporting the MultiLevel Innovators Project, delivered in partnership with SESLHD and Integrated Specialist HealthCare Miranda. The project aims to establish a new model of multi-level integrated care for skin cancer and chronic wounds within the Sutherland Shire. The project will also enable better patient access to services through pathways to screening and prevention of wounds and skin cancers in high-risk patients.

21 GPs practising in the St George and Sutherland Shire regions have been awarded the first MultiLevel Skin Cancer Fellowship, with another seven due to complete the program by the end of 2016. Delivered in partnership with SESLHD and Integrated Specialist Healthcare Miranda, the six-month fellowship program provides weekly hands-on training supervised by a plastic surgeon and/or dermatologist, allowing GPs to develop their scope of practice in the detection and treatment of skin cancer. Practical skills are underpinned by theoretical learning delivered via lectures throughout the program.

Dr Leanne Corbett from Miranda Central General Practice (pictured below) completed the first fellowship round in 2015 and shares her experience:

> *"I have worked in general practice for over twenty years, and this is the most valuable course I have ever attended ..I feel privileged to have been a part of this program and highly recommend it to others"*

Left to right: Greg Stewart (Director Primary and Integrated Health SESLHD), A/Prof Anand Deva (Integrated Specialist Healthcare Miranda), Dr Leanne Corbett, Gerry Marr (Chief Executive SESLHD) , Lee Evans MP
(Photo by SESLHD) MultiLevel Innovators Project Launch 6 May 2016 at HealthOne Sutherland.

The team looks forward to working in partnership with our key stakeholders and general practices in the coming period to continue to improve cancer screening across the region with a focus on groups that have particularly low participation rates. Additionally, we will be supporting general practice and the community to prepare for the imminent changes to the cervical and bowel screening programs.

Building the capa

Primary

acity

Care

of our workforce

Improving the quality, efficacy and efficiency
of health care delivery in our region

Digital Health

Digital health is the electronic management of health information to deliver safer, more efficient, better quality health care. The Commonwealth Government's digital health initiatives include My Health Record, Telehealth and the Healthcare Identifiers Service.

Digital health is a part of our core business and we have taken long strides in our first year of operation. Our founding Medicare Locals had a strong commitment to digital health and had worked together on the program since 2013 under the hub and spoke model. Despite funding for eHealth ceasing in June 2014, work has continued with stakeholders in our area. In the coming year we are planning to extend our digital health activities to other service providers and to embed digital health in all of our program areas.

Achievements

- Recruitment of a very dedicated team with collective strength in technical and clinical fields and data quality
- 457 general practices, 81 pharmacies, 20 specialists and 26 hospitals connected to the My Health Record system and communicating with it on a regular basis
- Successful upgrade of the systems for most of our general practices for ePIP
- Delivery of monthly education events along with individual and group training on the use of My Health Record
- Approximately 156,000 people registered for My Health Record and that number is steadily growing
- Roll out of CAT4 (formerly Pen Clinical Audit Tool): a software for training practices to regularly ensure data quality
- Facilitating adoption of eDischarge summary from SESLHD and SLHD
- Secure messaging delivery including current drive to actively engage with specialists.

Challenges

Our challenges have been mirrored by other PHNs and are comparable to any other new initiative in the early phases of implementation.

- As decisions are made across multiple levels starting from Commonwealth Government to individuals sometimes multiple consultations have been required to resolve technical issues
- System competencies have sometimes affected adoption by general practice
- Cultural shifts are required to speed up the adoption process. For example, from seeing digital health as a supplementary aid that improves efficiency, to digital health technology is necessary for best practice care and public health.

HealthPathways

400 Pathways launched

making Sydney the lead Australian HealthPathways region

This year we held pathway development workgroups on

- Adolescent Mental Health
- Chronic Pain Management
- Closed Head Injury
- Gastroenterology / Colorectal Surgery
- Nutrition and Dietetics
- Osteoporosis
- Paediatric Surgery
- TIA / Stroke Management

This workgroup identified a further 150 pathways which are currently under development

Workshop attendees

- 25 GPs
- 24 Hospital Clinicians
- 12 Allied Health
- 10 Nursing
- 10 NGO and other

71 GP practice visits

undertaken between July 2015 and June 2016

We have also commenced pathway development for

- Child Protection
- ENT
- Obesity
- Ophthalmology
- Physical Activity Assessment

Top viewed pathways

1. Antenatal – First Consult
2. Chronic Hepatitis C
3. Chronic Hepatitis B
4. New Palliative Care Patient
5. Iron Deficiency Anaemia
6. Heart Failure
7. Hypertension
8. Miscarriage and Ectopic Pregnancy
9. Preconception Assessment
10. Thyroid Disease in Pregnancy

Top search terms

1. Developmental Milestones
2. Diabetes
3. Hypertension
4. Hepatitis C
5. Antenatal
6. Pertussis
7. Pregnancy
8. Antenatal – First Consult
9. Osteoporosis
10. Sinusitis

Website usage

This year we've seen a 96% increase in the number of users

Return visitors

New visitors

131,712 Page views

4,089 Users

Continuing Professional Development

During the 2015/2016 financial year we hosted a wide range of continuing professional development (CPD) activities for primary health care providers across the region. Sessions have focused on relevant clinical and practice support areas in primary health care. Many events have also been delivered with a specific focus for practice nurses, practice staff and allied health professionals. All CPD sessions contribute to the vital role that primary health care providers play in providing high quality health care outcomes for their patients and ensure that practices are meeting best practice guidelines.

In our inaugural year, we hosted 145 events attended by 4,237 people. Furthermore, a CPD advisory committee was established to help plan, guide and facilitate events across the region. This ensures that topics are relevant to providers within the local context.

Education topics have been diverse, such as antenatal updates, paediatrics, endocrinology, respiratory, dementia, domestic violence, wound management, chronic kidney disease and mental health.

We also recognise the importance of educating all members of the practice in a whole-of-practice team approach. As a result, specific practice management topics have been covered including infection control, practice billing, triage, digital health, clinical software management, work, health and safety, dealing with difficult patients and CPR.

Events are hosted at venues spread across the region and we have collaborated with a number of partners to host events, including Prince of Wales Private Hospital, Chris O'Brien Lifehouse, St Vincent's Private Hospital and St Vincent's Clinic, St Luke's Care Darlinghurst and Sydney Private Hospital.

Moving forward we plan to enhance our partnerships and continue to link in with local stakeholders to ensure that primary health care providers have access to a wide and varied range of educational opportunities.

We pride ourselves on hosting a robust and up-to-date CPD program which meets the learning needs of local primary health care professionals. We will continue to provide a range of high quality CPD events to assist primary health care professionals and their practice staff to constantly improve their knowledge, attitudes and practical skills, enhance referral pathways across health disciplines and encourage peer-to-peer interaction.

Practice Support

Supporting primary health care providers and practices to deliver safe, high quality services to consumers continues to be a key priority. Our Practice Support Program assists both general practice and allied health practices, and focuses on three main areas:

Workforce support

We are committed to supporting the primary care workforce across the region. Being such a large geographical area, with a number of programs, we endeavour to promote and educate primary health care professionals within our region on the programs we have to offer them.

This includes support for:

- newly opened practices within the region as well as GPs new to the area
- GP registrars on rotation within the region as well as medical students on placements
- allied health professionals and their practices, and
- orientation and mentoring to practice nurses and student nurses.

Accreditation

We promote and support practices and health professionals undergoing the accreditation process.

This is achieved by:

- providing advice and support on meeting the RACGP accreditation standards
- provision of templates for policies and procedures, computer security guidelines and many other resources
- advising on key aspects of accreditation including infection control, sterilisation and cold chain management
- delivering mock accreditation visits prior to a practice's survey visit including interview rehearsals and advice
- facilitating onsite training sessions for health professionals and administration staff.

Practice management

Support regarding practice management issues includes:

- practice incentive and service incentive payments (PIPs and SIPs)
- practice management support for allied health professionals
- MBS item numbers including chronic disease management items and health assessments
- cold chain management support around accreditation processes
- CAT4 (PenCAT) enquiries and licence set up, including troubleshooting
- support regarding Closing the Gap program and cultural awareness training.
- recall and reminder system information and assistance
- targeted CPD events including triage, dealing with difficult patients, CPR, PIPs and practice billing, infection control, data quality and management and work health and safety
- practice nurse-specific clinical education sessions
- quarterly practice managers and practice nurse network meetings.

Primary health care support will continue to be at the cornerstone of services that we provide. We aim to continue delivering a high level of support to our stakeholders to ensure that they are equipped with the right knowledge and resources to provide optimal patient care.

13 practice management specific CPD events | 404 attendees

Support provided to 15 **new practices across our region**

High general practice accreditation rate

341 practices accredited

21 are currently registered for the first time

619 practice visits undertaken

110 visits to GP registrars on rotation within the region

Our Pro

and

grams

the community

We deliver a range of programs including Aboriginal Health, Aged Care, Mental Health and Sexual Health. We have also been involved in direct service delivery through headspace and Partners in Recovery, and care coordination programs

Aboriginal Health

Throughout 2015/2016 the Aboriginal health team have worked in many diverse ways to meet the needs of local Aboriginal and Torres Strait Islander communities. A core component of the program is assisting our Aboriginal community members to connect with accessible, available, culturally appropriate and affordable health care to best meet their needs.

We have worked in conjunction with the Practice Support Team to offer visits directly to health services to assist with the provision of information, education and provision of templates for practice use.

In collaboration with the CPD Team, we delivered two RACGP accredited cultural awareness programs to multidisciplinary health care professionals and practice staff during Close the Gap month and Reconciliation week this year. Both events received positive comments and feedback.

In addition, we have provided presentations to approximately 140 GP Synergy registrars during events in July 2015 and May 2016 to promote the various initiatives available for Indigenous people in the general practice setting and to promote the Closing the Gap program.

Our Aboriginal Outreach Workers have worked across the district linking in with our local health districts' and hospital networks' staff, Aboriginal community controlled organisations, other non-government organisations and government agencies to provide holistic services to assist the community to improve their health and break down any identifiable barriers in accessing services. We have also collaborated to support community members in making positive choices towards a healthy life and linking up with relevant local services to assist them.

Where have we visited this year?

attendance and support of NAIDOC events across the region

This year our team of four Clinical Care Coordinators have provided

16,000 occasions of service | 6,000 of which were direct clinical services including care planning

184 individual GPs have referred clients to the program

care coordination for 670 clients in the program | Including 155 first time clients

Consumer evaluation surveys have confirmed that our clients have benefited greatly from the care provided by our team of coordinators. All surveys received have reported the highest level of professionalism demonstrated by and satisfaction with care provided by the staff. Some people have even gone as far to say coordinators have been 'angels' for them.

Both Aboriginal Outreach Workers have been supported by CESPHN to undertake studies in Cert III Primary Health Care for Aboriginal and Torres Strait Islanders and Cert IV in Mental Health (Aboriginal Studies), with the objective of contributing to the support of workforce and personal development.

Two Aboriginal community representatives have joined the CESPHN Foundation Community and Clinical Councils and provide valuable input and perspective for our organisation.

Community input has remained paramount to the planning and development of programs and work plans. Collaboration with other program teams within CESPHN has further strengthened the positive impact of the Aboriginal health program, particularly within the mental health and Access to Allied Psychological Services programs.

We now look forward to continuing the professionalism and competency of our robust and efficient Aboriginal Health Team in the coming year where some changes will be applied to the way in which the program will be delivered. A commissioned service model will be introduced in the new year financial year, in line with Department of Health requirements, with a rebranded 'Integrated Team Care' program.

a health assessment and promotion day held at Endeavour Sports High School
to promote health initiatives for pupils and staff

a health promotion program at Matraville Sports High School
linking a group of young male students with a local GP for health assessments and a follow up healthy lifestyle program

a health promotion program at Kirinari Aboriginal Youth Hostel
to improve knowledge and understanding of healthy food and dietary choices, combined with developing individual life skills in preparing healthy meals

Aged Care

supporting health professionals navigate health care reforms

assisting older people remain well and living in the community

Falls Prevention | Medication Management | Mental Health

The Aged Care Team has had a busy first 12 months successfully settling into the new organisational structure and providing support to GPs and allied health professionals as they navigate the Commonwealth Government's Aged Care Reforms.

This includes the introduction of a new referral system, My Aged Care. The new system had a notable impact on primary health providers so the Team hosted three CPD events, to assist them to make the transition in addition to ongoing communications. The high number of attendees at CPD events demonstrated the level of support that GPs and allied health professionals required around the introduction of My Aged Care.

The Team have also been busy addressing other government priorities in dementia, advanced care planning and assisting older people remain well and living in the community. The Team hosted a CPD event on dementia management, presented by a leading dementia researcher.

Additionally they have delivered four falls prevention programs in-language to older Arabic, Cantonese, Greek and Italian speaking people. The falls prevention program's success has been evidenced by the demand for additional programs from the participating groups.

To promote advanced care planning (ACP) the Team organised a Decision Assist workshop for 30 GPs and practice nurses from New South Wales' primary health networks. Attending participants can now offer training to other colleagues. The team also presented ACP at a CESPHN practice nurse meeting and delivered more than 100 information packages to residential aged care facilities (RACFs) in the SESLHD region to encourage them to initiate ACP with their residents and carers.

In response to challenging behaviours by some residents of RACF's, the Team hosted six education sessions about anxiety and depression in the aged population for RACF staff, which were well received.

Being transferred to hospital as an elderly person is a daunting experience, especially in the after-hours period. The Aged Care Team worked with RACFs, SESLHD staff and GPs to investigate the current challenges in accessing health care services during the after-hours period. The results will inform RACFs of options available to help them decrease the need for hospital transfers.

A dedicated Medication Management Project Officer was able to promote the quality use of medicines and medication reviews to primary health care providers, hospitals, community and RACFs. The Project Officer participated in two Agency for Clinical Innovation projects at War Memorial Hospital and Royal Prince Alfred Hospital, assisting to integrate Home Medicine Reviews (HMR) into the projects, sourcing a pharmacist to undertake medication talks and providing electronic GP referral templates.

In addition, the Medication Management Project Officer provided HMR information at CPD events, attended community service provider forums and consumer events including giving talks to Greek, Indonesian, Italian, Russian and Vietnamese community groups. GPs, pharmacists, hospitals and RACFs have been educated about Residential Medication Management Reviews (RMMRs) at professional development events and meetings. It was pleasing to see an increase in both HMRs and RMMRs in the April 2015/March 2016 year compared to the previous year (Medicare Statistic Reports).

ATAPS

Access to Allied Psychological Services

ATAPS providers are spread across the region and provide short term psychological interventions to people who have difficulty in accessing psychological services for a variety of reasons. Some of our providers are located in headspace centres, community services and in their own practices

The ATAPS Team has had a very productive 12 months, successfully transitioning into one centralised intake model for delivering the ATAPS program across the region. The central intake and triage model has been implemented across most of the region, with many GPs now receiving additional support in accessing appropriate services for their clients by utilising the expertise and knowledge of our triaging clinicians.

Allied health providers delivering ATAPS services across the region, are all now using our Client Information Management System which assists us to track and manage referrals more effectively. The ATAPS Team have assisted approximately 140 providers across the region to transition to this system along with supporting headspace sites to also utilise the system.

Another important aspect of the work that is carried out by staff is in the area of community engagement. This is especially important for stakeholders in the community who are able to send provisional referrals for clients who may not initially seek the support from a GP but who would benefit from ATAPS. Meetings and events have been attended across the region.

The ATAPS team also understands the importance of supporting GPs and held two CPD events. The first was a Category 1 mental health skills training event through Black Dog Institute, which was very well attended with participants reporting a high level of satisfaction. The second of these events was a youth mental health event which was conducted at headspace Ashfield and again resulted in a high level of satisfaction from participants.

We look forward to continuing to provide access to psychological services to our communities who are under serviced and hard to reach.

1,900 people have accessed the service

11,000 sessions have been delivered

Who has accessed the service?

72.3% People with low incomes

15.8% People from culturally and linguistically diverse communities

9.6% Children and families

5.8% Aboriginal and Torres Strait Islander people

Partners in Recovery

Eastern Sydney Partners in Recovery

Consortium partners

- Aftercare
- Anglicare Sydney
- CESPHN
- Eastern Suburbs Mental Health Service (SESLHD)
- Jewish Care
- Lou's Place (The Marmalade Foundation Ltd)
- Mission Australia
- Neami National
- New Horizons Enterprises Ltd
- Richmond PRA
- St Vincent's Hospital-Inner City Health Programme
- The Benevolent Society

Eastern Sydney Partners in Recovery (ESPIR) has successfully completed three years of our original contract and are now entering into a further three years in the client transitioning phase to the NDIS.

The full complement of Support Facilitators (17) and Team Leaders (3) have been recruited as planned. The two host agencies (Aftercare and Neami National) along with the Lead Team are working together effectively, with collaboration and joint meetings across all functions.The program succeeded in a seamless transition from Medicare Local to PHN with minimal impact on consumers and staff.

The ESPIR consortium has continued to effectively collaborate through quarterly meetings and a majority of the consortium stakeholders have partnered in capacity building initiatives.

The awareness and success of PIR across eastern Sydney has increased dramatically, demonstrated by the number of referrals, enquiries, joint meetings, capacity building initiatives and feedback received. More than 400 affiliate organisations and professionals across eastern Sydney have been communicated to or networked with, and now have awareness of or involvement with services of ESPIR. Multiple contacts with these bodies through our Support Facilitators reached approximately 7,000 meetings or events for the program to date, with a 50% increase in organisational contact activity this reporting period.

Our success has had a compensating effect where the demand increase has stretched the capacity of our resources. Demand management strategies have been implemented and a waitlist is now being effectively managed.

A key component of the ESPIR model is our ability to successfully outreach and engage consumers in the target group. Along with joint patrols and in-services, integral to success was the setup of co-locations and outreach at seven sites in eastern Sydney.

Homelessness is a major issue across the region. ESPIR has co-locations with Housing NSW in their local offices to assist with homelessness issues for consumers with mental health concerns. ESPIR is also a key member of the South Eastern Sydney Homelessness Action group. A key initiative was Registry Week for the Waverley area, where 40 volunteers spent three days surveying homeless people across the area. This initiative gained interest and support from a number of organisations who are now working in partnership to advocate strongly for housing and support for some of the most vulnerable people in our community. The event was also reported on by local media.

Anglicare were funded to run the independent living skills pilot project, developed by ESPIR. The pilot was proven a success and Anglicare has continued with the program as part of their ongoing service delivery – which is positive in terms of sustainable change and capacity building.

The ESPIR Manager is a key member of the Eastern Sydney Housing and Mental Health Agreement District Implementation and Coordinating Committee along with senior representatives from Housing and Health, chairs the sub-committee and has developed a mental health strategic paper to drive the Committee.

The University of NSW has assisted with the evaluation of the One Wave project and has been re-engaged to evaluate and provide a qualitative analysis report on ESPIR registered consumers and Support Facilitators.

South Eastern Sydney Partners in Recovery

South Eastern Sydney Partners In Recovery (SESPIR) had a really exciting year. SESPIR had many successes that resulted in both increased access to services and supports for those experiencing mental illness in the region, and a more collaborative and innovative mental health sector. The achievements of SESPIR came about from real partnerships, strong values around working from a recovery oriented perspective and a determination from everyone involved to make things work in a complex and changing sector. The success of the program is demonstrated in the real difference it makes in the lives of consumers.

This year we have delivered a reengagement project, implemented by a Peer Support Facilitator, to provide another opportunity to consumers who had exited the program early or with unmet needs to access further support. Additionally, we have provided specialist cultural support to Aboriginal and Torres Strait Islander consumers as well as training opportunities for Aboriginal and Torres Strait Islander people working in the mental health sector. Training for their managers has also been offered in order to increase cultural competency in the workplace.

SESPIR has facilitated strong partnerships by attending regular co-locations with St George and Sutherland Community Mental Health Teams and Mental Health Inpatient Units, HNSW, and with a number of local NGOs. Co-location has several purposes and benefits. But, essentially it enables us to outreach to services that are utilised by the SESPIR target group so that we are better placed to engage them, and assists with the coordination of supports to people in the region via increased collaborative work, increase in communication between services and better responsiveness to consumer needs.

One of our key events for this year was Registry Week, which surveyed people sleeping rough in the Sutherland Shire. This developed strong partnerships with other agencies and an integrated approach in supporting those experiencing homelessness. We commenced the Sutherland Street to Home Project. Utilising an evidence based housing first model, the program aim is to rapidly house vulnerable individuals experiencing primary homelessness utilising head leasing arrangements. The project provides housing and support for seven of the most vulnerable people sleeping rough in the Sutherland Shire LGA.

We also deliver Assertive Street Outreach support to vulnerable rough sleepers. Outreach street patrols are conducted twice weekly to rough sleeper hotspots in Sutherland Shire LGA. This combined with our attendance at local service hubs supports the engagement of vulnerable rough sleepers into supports in the region.

We also delivered the Rethinking Mental Health 2.0 community forum, which had more than 100 attendees. The aim of the forum was to explore new innovations and best practice approaches through application of the recovery model to mental health practice.

Our Innovation Grants Program achieved success this year resulting in seven new programs that address service gaps in the region including two squalor and hoarding programs, an individual placement and support employment program, two projects targeting increased social inclusion and one to increase access to GPs.

Partnering with ESPIR and the University of Sydney, SESPIR has been involved in the development of a regional Mental Health Atlas. The atlas maps services for people experiencing mental illness and is available for service providers and planners to achieve improved planning of services.

> working with my Support Facilitator from PIR and other services has been like a working alliance and it feels like everyone believed in me and that it was possible for me to achieve my dreams of recovery
>
> -PIR consumer

Consortium partners

- Advance Diversity Services
- Aftercare
- CESPHN
- Kurranulla Aboriginal Corporation
- Neami National
- Peer Work Matters
- South Eastern Sydney Local Health District
- St George Community Housing
- The Benevolent Society
- The Friendship Foundation
- University of NSW

Sexual Health

Central and Eastern Sydney PHN's dedicated Sexual Health Program was established in response to our region having some of the highest rates of sexually transmitted infections (STIs), HIV and blood borne viruses (BBVs) in NSW.

The Program covers a wide range of health issues and responds to a diverse population including the LGBTIQ community, young people, people with chronic conditions, newly released prisoners as well as intravenous drug users. With the introduction of new treatments for hepatitis C and a new trial for HIV prevention, the Program has had a dynamic first year.

Our Program Officers have worked with key stakeholders - the Public Health, Sexual Health and HIV Harm Reduction (HARP) units in our two LHDs, key peak bodies such as the Australasian Society of HIV Medicine (ASHM), AIDS Council of NSW (ACON), Hepatitis NSW, NSW Users and AIDS Association (NUAA) and Positive Life, as well as other, diverse community organisations - to build strategic relationships, and facilitate better strategies to address sexual health priorities for our region.

We are a member of STIGMA, an action group addressing the rising incidence of STIs among gay men and men who have sex with men (MSM). We are also linked into the work of our LHDs in responding to the NSW Hepatitis B, Hepatitis C, STI and HIV Strategies and are integral to communicating education and information about the new hepatitis C treatment to GPs, practice nurses and pharmacists.

Our work has contributed to increasing the access to, and capacity of, primary health services to undertake more screening and treatment of STIs, HIV and BBVs to reduce the burden on public health services. This has included promoting the first gay-friendly online learning module and gay-friendly GP list to GPs and practice nurses, facilitating clinical placements at sexual health clinics and encouraging GPs to become S100 prescribers.

In response to viral hepatitis, we have worked to increase access to screening by conducting CPD events and, in partnership with the LHDs, promoted fibroscan testing and management in GP practices and community settings.

Other hepatitis C projects included working to design and implement PRISM (patient refererral intelligent service matching), the new electronic referral and matching platform in SESLHD. We have also continued to participate in the 'going viral' project encouraging community gyms to provide clean injecting equipment to young men who inject steroids.

Our Sexual Health Project Officers also participated in 'HIV testing week', a campaign that is part of the wider Ending HIV Strategy. Our team was out and about in the community having meaningful discussions on HIV awareness and health promotion. We have also provided seven education events on BBVs including the update on the new hepatitis C treatments, three events on HIV and two on STIs.

Can Get Health

Promoting healthy lifestyle and diabetes prevention

The promotion of healthy lifestyles to combat increasing rates of type 2 diabetes in the Arabic community of Canterbury has been a continuing priority of Can Get Health in Canterbury (CGHIC). From November 2015 – May 2016, four Healthy Eating, Physical Activity programs were successfully delivered to 48 participants in different areas of Canterbury.

Promoting child health and injury prevention

The Health Equity and Research Development Unit of the SLHD, delivers the Learning by Doing program in order to train and support health professionals to improve access and quality of care to marginalised social groups.

The Canterbury Hospital health equity Learn by Doing team is one of four teams within SLHD working to support Rohingya people to access and benefit from health services in the Canterbury area, with a particular focus upon emergency department presentations.

There has been a large increase in paediatric presentations at Canterbury Hospital Emergency Department between 2013 and 2015, especially in children aged 0-4 years. In order to encourage parents to manage common child health conditions at home, CGHIC facilitated two CPR Kids first aid courses which were delivered by expert paediatric nurses.

The Kids Don't Fly program is a partnership between CGHIC and the Canterbury Bengali community to help parents living in apartments, and strata managers, to ensure window locks are installed in all apartments to prevent children from falling out. CGHIC has employed a Bengali community leader to ensure a community-based response takes place, in preparation for the 2018 legislation for window safety devices.

The growing concerns in the Bangladeshi community about domestic violence, and the need for culturally appropriate information, has led to the development of a domestic violence awareness video in Bangla.

Increasing awareness of mental health

In an effort to continue the work of the SLHD, Chinese Australian Services Society and CGHIC in raising mental health awareness in the Chinese community, we held a Body and Mind Wellbeing workshop in October 2015.

Mental health events have been supported by social media campaigns and posters, with posters being available in both English and traditional Chinese language. Mental health continues to be a priority area for CGHIC.

Promoting refugee health

CGHIC has focussed on building connections with local Rohingya communities to address important health priorities such as women's and oral health. During November 2015 educational courses in both of these subjects were held with support from Family Planning NSW, NSW Refugee Health Service, bilingual community educators and local allied health professionals.

The refugee health event held in May was targeted specifically at GPs in order to prepare them for commonly seen physical and mental health issues in general practice, referral pathways and resources available to support refugee patients.

Presentations from NSW Refugee Health Service, Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), HealthPathways Sydney and a case study with support from Settlement Services International (SSI) were featured as part of this event.

headspace

> I have learnt lots of new skills that I can use to help cope with anxiety, so I can say that headspace has put me in a better place than I had been before
>
> -client at **headspace** Hurstville

The most important measure of success is that young people are getting positive outcomes and therefore feedback from young people is important for us to ensure that we are meeting their needs.

With their consortium of partners and private practitioners **headspace** Hurstville and Miranda have had a busy year supporting young people and their families. Of particular vulnerabilities are those young people from Aboriginal and Torres Strait Islander, culturally and linguistically diverse backgrounds and those young people that identify as lesbian, bisexual, gay, transgender, intersex and questioning, and we are happy to see that they are accessing our services.

In accordance with the Australian Government's Mental Health Reforms from 1 July 2016 Central and Eastern PHN are now the fund holders for the five **headspace** centres, (Ashfield, Bondi Junction, Camperdown, Hurstville and Miranda) in our region. As fund holders we can no longer be a lead agency and it is therefore with sadness that we say goodbye to **headspace** Hurstville and Miranda and deliver them into the safe hands of one of our partners, Aftercare.

We would like to thank all of our partners in **headspace** Hurstville and Miranda service provision, South Eastern Sydney Local Health District, including St George and Sutherland Mental Health Services, St George and Sutherland Drug and Alcohol Services, Kirketon Road Centre and Mindset; Aftercare; 3Bridges Community and The Bridge Youth Service and congratulate Aftercare in being the successful lead agency.

> headspace helped me in even more ways I can imagine. The thing I like most about headspace is that they not only gave me advice in how to deal with my problems, they did it while getting to know me
>
> -client at **headspace** Miranda

> I feel really comfortable in the "space" at headspace....I could not speak more highly of my Youth Access Clinician who was amazing. Thank you. Coming here was a bit scary but I am really looking forward to coming back!
>
> -client at **headspace** Miranda

Highlights this Year

- celebrating **headspace** Hurstville's first birthday
- Youth Reference Group (YRG) and their projects including Film Competition and Work Ready Project at Miranda as well as Mental Health Leaders Day and Humans of **headspace** Hurstville Project at Hurstville
- YRG also participated in training around LBGTIQ, and Mental Health First Aid
- workshops and presentations at schools
- partnerships with the Cronulla-Sutherland Sharks and the St George Illawarra Dragons National Rugby League teams
- celebrating Youth Health Week, Fair Day, NAIDOC Week and Mental Health Month
- fundraising for Miranda at the Step Ahead Walk at Wanda Beach

Community Mental Health

The Community Mental Health Team has had a very productive past 12 months. An important initiative has been continuing to work in partnership with Sydney Local Health District on the Mental Health Collaborative Care Project.

In 2015-16 activities included modifying and streamlining an annual cycle of care for integrating physical and mental health across all participating clinicians and SLHD community mental health services, and promoting a suite of solutions to underpin sustainability of the new model of care.

Our role has included developing a collaborative care HealthPathway and GP templates to facilitate information sharing, promoting lists of participating GPs and assisting in a new trial of an in-reach mental health clinic model. Three practices are currently participating, and we are currently helping to recruit four more.

Another important aspect of the Community Mental Health Team's work has been community engagement. Partnerships and alliances have been made with local community, interagency and non-government organisations, leading to CESPHN contributing to a number of community events.

This has included information stalls for the inner city homeless population; promoting mental health services and healthy lifestyle strategies, such as the benefits of exercise for depression; promoting awareness and services around family violence, suicide, and organising culturally appropriate mental health events. In addition, a CESPHN Program Officer has been appointed chair of the Sydney Inner West Mental Health Interagency Group.

The Community Mental Health Program has continued to support GPs and allied health professionals to identify and better respond to mental health issues by conducting CPD events on mental health and related topics including alcohol and other drugs and domestic violence.

Connecting Care

We continue to successfully deliver high quality and effective chronic care services in partnership with SESLHD and SLHD. The NSW Chronic Disease Management Program - Connecting Care - provides additional support to clients and their primary health care providers to enable improved self-management and avoidance of unnecessary hospitalisations.

Connecting Care staff have assisted clients with chronic conditions and their carers to access the range of specialists, primary and allied health services required for their ongoing care. The program has supported clients to adhere to their treatment regimens, develop chronic condition self-management skills and connect with appropriate community based services such as those providing support to ensure clients are empowered, educated and actively engaged in their health care.

Since July 2015, our Connecting Care Coordinators have provided care coordination services to more than 400 clients with chronic disease and complex care needs. The model of service provision in collaboration with patient coordination with Regal Home Health and phone based coaching with Healthways Australia has further extended the reach of the program. Care coordination services have been in high demand with program staff managing large case loads.

The Care Coordinators have continued to work in close partnership with the SLHD community nurse teams and other primary health providers in discussing case management strategies and providing an integrated system of care for referred clients and their carers.

The challenge and future focus of the Connecting Care program is to work closely with GPs to redesign and foster strengthened partnerships between the acute, community and primary care sectors. This is to ensure streamlined patient management and to provide person-centred care through clinical best practice. The proposed redesigned Connecting Care model, aptly named 'Integrated Care for People with Chronic Conditions' (ICPCC) will offer GPs and other primary care clinicians the opportunity to improve current health pathways. There is a priority to enhance opportunities for care integration and an increased linkage with general practice as well as the community to enable clients and carers to better manage their health, prevent hospital admissions and improve their health outcomes.

Sarah's* journey with the Connecting Care program

Sarah is a 75 year old woman who lives alone with multiple chronic conditions including type 2 diabetes, uncontrolled hypertension, congestive cardiac failure, chronic renal failure, chronic back pain and lifelong anxiety.

She was on a daily complex therapeutic regimen and has had multiple admissions to hospital in the last year mainly due to severe hypertensive episodes. Consequently, she was finding it very difficult to manage her life at home because of her deteriorating health and resultant anxiety.

Through the Connecting Care program, Sarah was educated on her disease conditions and medications which enabled her to better adapt and prioritise her concerns. Her Care Coordinator linked her to various community services and support programs which assisted her to remain at home and become a productive community member.

Counselling services were also arranged to manage her anxiety issues. Her GP was informed of her progress throughout the entire course.

At present, Sarah's overall health has improved tremendously. As a result of a healthy diet and lifestyle, she has lost weight, experiences less breathlessness and has better blood glucose and blood pressure control.

She has reported increased confidence and remains very keen to continue maintaining and improving her health.

*not her real name

After Hours

The goal of our After Hours Program is to improve the access, efficiency and effectiveness of after hours primary care within the central and eastern Sydney region. In 2015-2016, we embarked upon a number of innovative solutions to meet these objectives.

The initiatives built upon our existing relationships with primary care providers, local health districts and key stakeholders within after hours services.

One of the initiatives that will deliver immediate impact to our residents is the expansion of Geriatric Flying Squads.

These teams provide rapid services to residents in aged care facilities, including assessments, triage services, care planning and follow up. Partnering with SESLHD, the After Hours Team implemented a project to expand and improve services within St George Hospital and Southcare Sutherland Hospital and Community Health Services.

Clinical Stream Director, Aged Care and Rehabilitation, SESLHD, Peter Gonski, highlighted the value these services deliver to the community and the impact that enhanced services will have,

"Reduction in hospital transfer and admission has been excellent and there has been very good feedback from families, GPs and aged care facilities regarding the services. ...with the benefit of funding from the PHN, these services can be enhanced....It is a credit to the PHN that this valuable partnership can be realised."

The team also partnered with SLHD to expand their version of care within residential facilities, helping to fund an initiative with their outreach team. Both of these initiatives will improve health outcomes for our residents.

Building upon the success of these projects, we plan to continue to work with our local health districts to implement similar models of care within the Prince of Wales, War Memorial and St Vincent's Hospitals' regions.

In our second year of operation we will continue to identify and address the needs of the community for after hours services.

A number of innovative projects are being developed and will be implemented, including:

- emergency department research project
- communicable diseases education and training initiative
- telehealth project to improve access to and equity of care services
- reducing inappropriate emergency department presentations
- innovation grant proposal requests
- engaging local GPs to increase the uptake and use after hours Practice Incentive Payments
- improved access to medical deputising services
- increasing service integration between providers of care through technology
- marketing and promotional material to ensure appropriate service utilisation.

Strengthening

Corpo

ser

for our PHN

g support

orate

vices

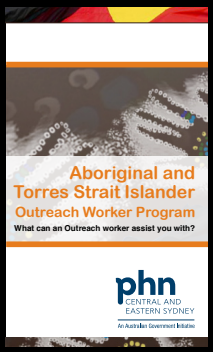
and stakeholders

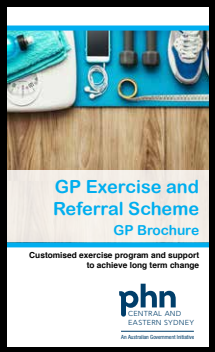
Clear communications and streamlined operations to meet the needs of health professionals and the community


SYDNEY HEALTH ISSUE
A PUBLICATION OF CENTRAL AND EASTERN SYDNEY PHN
VOL 1. DEC 2015/ JAN 2016
Page 10. Child Health and Wellbeing Plan
Page 18. Domestic and Family Violence
Page 25. Supporting Nurses
Page 27. CPD Calendar and Update

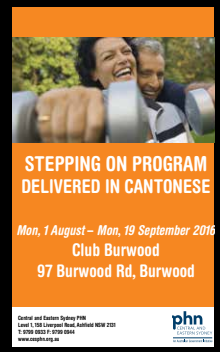

SYDNEY HEALTH ISSUE
A PUBLICATION OF CENTRAL AND EASTERN SYDNEY PHN
VOL 2. MARCH 2016
Page 5. February community forums
Page 11. Translating and interpreting services
Page 17. Improving health literacy
Page 20. New hepatitis C treatments
Page 23. CPD calendar

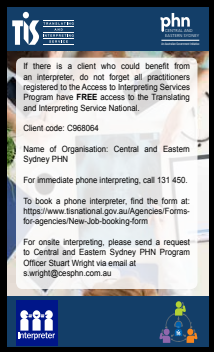

SYDNEY HEALTH ISSUE
A PUBLICATION OF CENTRAL AND EASTERN SYDNEY PHN
VOL 2. JUNE 2016
Page 4. Tackling mental health at a regional level
Page 8. It's never too late for quality improvement
Page 27. Misuse of the emergency department
Page 15. CPD calendar


Aboriginal and Torres Strait Islander
Outreach Worker Program
What can an Outreach worker assist you with?
phn
CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative


GP Exercise and Referral Scheme
GP Brochure
Customised exercise program and support to achieve long term change
phn
CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative


COMPLETING THE CYCLE OF CARE
DIABETES BREAKTHROUGH SERIES COLLABORATIVE
PROGRAM AT A GLANCE...
88%
70%
8.1%
8.5%
PRIMARY GOAL: BY DECEMBER 2016
70% OF PATIENTS WITH TYPE 2 DIABETES MELLITUS WHO HAVE VISITED THEIR GP IN THE LAST 2 YEARS WILL HAVE A RECORDED HBA1C WITHIN THE LAST 12 MONTHS
METHODOLOGY AND MEASUREMENT
DIABETES IN THE REGION
MAKING A DIFFERENCE
IN A NUTSHELL
CHALLENGES
NEXT STEPS

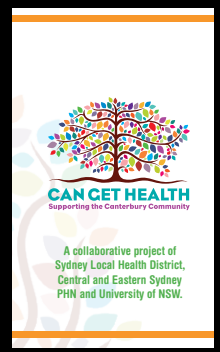

STEPPING ON PROGRAM
DELIVERED IN CANTONESE
Mon, 1 August – Mon, 19 September 2016
Club Burwood
97 Burwood Rd, Burwood
Central and Eastern Sydney PHN
Level 1, 158 Liverpool Road, Ashfield NSW 2131
T: 9700 0922 F: 9700 0944
www.cesphn.org.au
phn
CENTRAL AND EASTERN SYDNEY

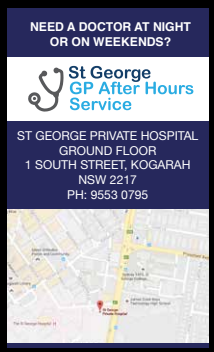

phn
CENTRAL AND EASTERN SYDNEY
If there is a client who could benefit from an interpreter, do not forget all practitioners registered to the Access to Interpreting Services Program have FREE access to the Translating and Interpreting Service National.
Client code: C968064
Name of Organisation: Central and Eastern Sydney PHN
For immediate phone interpreting, call 131 450.
To book a phone interpreter, find the form at: https://www.tisnational.gov.au/Agencies/Forms-for-agencies/New-Job-booking-form
For onsite interpreting, please send a request to Central and Eastern Sydney PHN Program Officer Stuart Wright via email at s.wright@cesphn.com.au
Interpreter

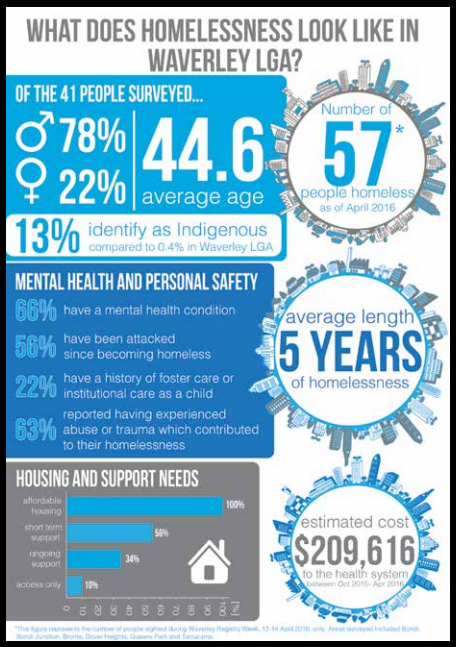

2015-2016
Central and Eastern Sydney PHN
Annual Report
phn
CENTRAL AND EASTERN SYDNEY

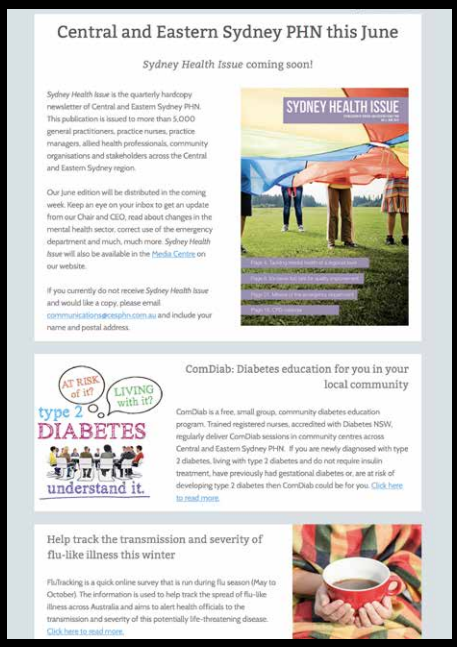

Obstetrics and Gynaecology Update
Saturday 21 May 2016
THE ROYAL HOSPITAL FOR WOMEN
CENTRAL AND EASTERN SYDNEY PHN
The Royal
phn
CENTRAL AND EASTERN SYDNEY

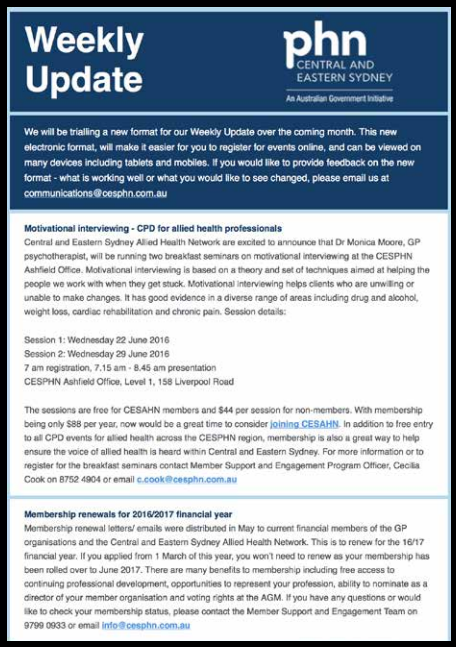

Mr David ANDERSON Male , 61 years
Estimated 5 year CVD Risk
Vascular Related Medical Conditions
Smoking
Weight
Blood Pressure
Cholesterol
Kidneys
HbA1c
Current CV Medications
Go To Recommendations


CAN CET HEALTH
Supporting the Canterbury Community
A collaborative project of Sydney Local Health District, Central and Eastern Sydney PHN and University of NSW.


NEED A DOCTOR AT NIGHT OR ON WEEKENDS?
St George GP After Hours Service
ST GEORGE PRIVATE HOSPITAL
GROUND FLOOR
1 SOUTH STREET, KOGARAH
NSW 2217
PH: 9553 0795


WHAT DOES HOMELESSNESS LOOK LIKE IN WAVERLEY LGA?
OF THE 41 PEOPLE SURVEYED...
78%
22%
44.6
average age
13% identify as Indigenous
compared to 0.4% in Waverley LGA
Number of
57*
people homeless
as of April 2016
MENTAL HEALTH AND PERSONAL SAFETY
66% have a mental health condition
56% have been attacked since becoming homeless
22% have a history of foster care or institutional care as a child
63% reported having experienced abuse or trauma which contributed to their homelessness
average length
5 YEARS
of homelessness
HOUSING AND SUPPORT NEEDS
affordable housing
short term support
ongoing support
access only
100%
56%
34%
19%
estimated cost
$209,616
to the health system
between Oct 2015- Apr 2016


Central and Eastern Sydney PHN this June
Sydney Health Issue coming soon!
SYDNEY HEALTH ISSUE
ComDiab: Diabetes education for you in your local community
AT RISK of it? LIVING with it?
type 2 DIABETES
understand it.
Help track the transmission and severity of flu-like illness this winter


Weekly Update
phn
CENTRAL AND EASTERN SYDNEY
An Australian Government Initiative
We will be trialling a new format for our Weekly Update over the coming month. This new electronic format, will make it easier for you to register for events online, and can be viewed on many devices including tablets and mobiles. If you would like to provide feedback on the new format - what is working well or what you would like to see changed, please email us at communications@cesphn.com.au
Motivational interviewing - CPD for allied health professionals
Membership renewals for 2016/2017 financial year

Communications

Establishing a new brand

Our Communications Team hit the ground running from 1 July 2015 to build awareness of our new identity, Central and Eastern Sydney PHN, across the region. Building and strengthening the stakeholder relationships formed by our founding Medicare Locals, was a key priority for the Communications Team. In addition, keeping target audiences informed of our work to achieve our vision - supporting, strengthening and shaping a world class, person centred primary health care system - has remained front and centre.

We have established a Weekly Update distributed by email and fax to more than 4,000 general practitioners, allied health professionals and community organisations. We also issue three monthly eNewsletters specific to allied health, community and general practice audiences. On average, our eight editions have been read by 970 GPs, practice nurses and practice managers, 865 allied health professionals and close to 90 community organisations and members of our local community each month. Our hardcopy newsletter, *Sydney Health Issue*, is distributed to more than 6,000 stakeholders across central and eastern Sydney including our local health districts, state and federal members of parliament in addition to the above audiences. We also support the Antenatal Shared Care Team and Immunisation Team to produce bi-monthly program-specific eNewsletters which are well-received with more than a 50% open rate. We also supported the Immunisation Team to produce a poster which was accepted for display at the 15th National Immunisation Conference.

Our Communications Team supports our program teams to showcase their work, achievements and program initiatives across CESPHN publications as well as through external media. In our first year of operation we have been published in *NSW Doctor magazine*, *Public Health Research & Practice*, *The Health Advocate* and the *Wentworth Courie*r. Similarly, our Communications Team ensures branding compliance with Department of Health guidelines for primary health networks, our internal style guide and key messaging strategy.

Social media accounts were established for the new organisation to assist the Communications Team deliver the messaging strategy. Social media platforms include Twitter, Facebook and LinkedIn. Engagement has increased gradually, with impressions, interactions and followers increasing each month for the past 12 months.

Establishing the initial primary health network website required a content management and event registration system, which was operational from our from our first day of business, and built upon the foundations laid by our Medicare Local predecessors. To keep the transition as smooth as possible, all remaining Medicare Local websites were operative for a period of twelve weeks. This was essential as we consolidated each website's voluminous information - catering to the uniqueness of each region - into a new website representing the larger demographic region. With a framework established, we were then able to focus on ensuring the website is tailored to the needs of our primary health care stakeholders. A large task was also to provide a searchable service directory that provides information on contacting GPs, allied health practitioners and medical specialists within the new region.

In the coming year, the website will be updated to reflect our newly commissioned activities and to improve the user experience.

Member Support

The Member Support and Engagement Team are responsible for providing membership, governance and secretariat support to the following member organisations:

- Central and Eastern Sydney Allied Health Network
  266 ordinary members 9 associate members
- General Practice Eastern Sydney
  84 ordinary members 1 associate member
- Central Sydney GP Network
  565 ordinary members 47 associate members
- GP Crew
  82 ordinary members 1 associate member
- Sutherland Division of General Practice
  175 ordinary members 1 associate member
- Sydney Health Community Network
  47 ordinary members 20 associate members
  (15 individual; 5 organisation)

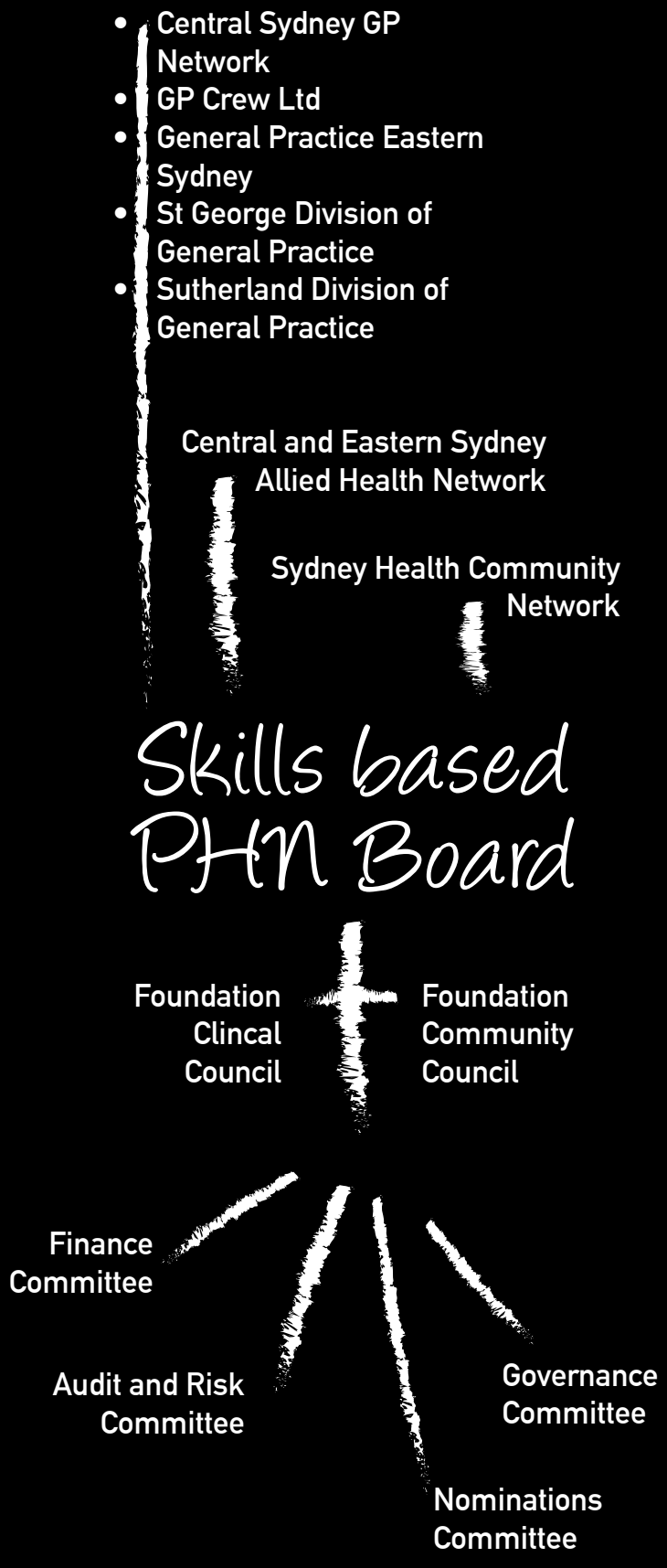
*St George Division of General Practice manage their own membership. (**171 ordinary members 1 associate member)**

We also assist with arrangements for annual general meetings, other events and projects initiated by the member companies.

Membership Officers facilitate the communication of information between member chairs, boards and EIS Health Ltd.

During the year, membership numbers for all organisations have continued to increase. The member organisations are an important way for CESPHN to engage with allied health, community organisations and general practice within the region. The organisations play a key role in advocating for their members.

Additionally, the team provides administrative support to the Foundation Community Council and Foundation Clinical Council who provide strategic advice to the EIS Health Board.



Infrastructure

The Infrastructure Team covers administration, information technology management as well as database administration. Since the launch of EIS Health in July 2015, the Infrastructure Team has worked exceptionally hard to ensure our organisation operates efficiently and effectively.

Key accomplishments include:

- attainment of Office365 charity status (first PHN in Australia to attain this – reducing operating costs significantly)
- launch of SharePoint
- amalgamation of ChilliDB (database) from three Medicare Local databases with more than 19,000 records
- deployment of Folio risk management system, and Tickit incident and task management system
- negotiation of more than 100 service agreements with suppliers and business partners
- development of risk register
- implementation of Work Health and Safety Committee

The Infrastructure Team is a small but dedicated group who ensure our offices and facilities are well managed, supported and systems are maintained. It continues to be a team that punches above its weight to do more with less and has been pivotal to the success of the PHN in the first 12 months.

Finance

Finance Team leads a seamless transition

From the first day of operations, the Finance Team had the important responsibility of migrating all employee details, as well as vendor information from the three former Medicare Locals into MYOB, in order to pay staff and be in a position to make vendor payments. This was completed successfully, on schedule within two weeks.

Implementing new software to improve efficiency

By mid-October 2015, the Finance Team migrated payroll from MYOB to Meridian, which supported 204 active heads by the end of the year. The ConnX system was introduced at the beginning of February 2016, which replaced manual timesheet entry. This involved an initial migration of employee data from Meridian including entitlement balances and work patterns. We also went live with Microsoft Dynamics NAV in mid-December 2015, after completing a thorough user acceptance testing and user training phase in the two months prior. This system has allowed our organisation to efficiently manage payments with approximately 750 vendors. In April/ May 2016 we implemented the BI360 module – an add on to the NAV system – which is used to prepare budgets, financial forecasts and monthly reports.

Member company accounts

The Finance Team has provided accounting services for six of the seven member companies. Working closely with the Stakeholder Engagement Team, we have produced monthly financial accounts, paid vendor invoices and director stipends.

Committees

External Committees

CESPHN is represented on a number of hospital councils by the following GPs who provide a report to the EIS Health Board on key issues and updates:

- Balmain Hospital Clinical Council (Dr Kate George)
- Canterbury Hospital Clinical Council (Dr Aline Smith)
- Concord Hospital Clinical Council (Dr Joe Cordaro)
- Prince of Wales Hospital Clinical Council (Dr Hilton Shapiro)
- RPA Hospital Clinical Council (Dr Allison Bielawski/ Dr Charlotte Hespe)
- St George Hospital Clinical Council (Dr Klaus Stelter)
- Sutherland Hospital Clinical Council (Dr Owen Brookes)
- SLHD Clinical Council (Dr Charlotte Hespe)
- SLHD/CESPHN Liaison Committee (Dr Allison Biellawksi, Dr Joe Cordaro, Dr Kate George, Dr Charlotte Hespe and Dr Aline Smith)
- SLHD Aged Care DON meeting - Canterbury Hospital (Dr Sumana Daniel)
- SLHD Aged Care DON meeting – Concord Hospital (Dr Peter Piazza)
- SLHD Aged Care DON meeting – RPA Hospital (Dr Ashley Morgan)

Governance Committee

Mark Harris (Chair), Gerry Marr, Gary Nichols and Rob Ramjan

The purpose of the Governance Committee is to ensure the Board fulfils its legal, ethical and functional responsibilities through adequate governance policy development, recruitment strategies, training programs, monitoring of Board activities and evaluation of Board members' performance. The Committee also provides oversight of clinical governance of the clinical activities of the PHN and its commissioned services. This includes review of clinical policies and any clinical incidents. The Committee is appointed by the Board and meets at least quarterly and up to six times each year.

Functions of the Governance Committee include maintaining an induction process for new Board directors, maintaining the Board member professional development and education policy, recommending policy on CEO induction, performance management and succession planning, overseeing the clinical governance of any clinical programs commissioned or contracted by EIS Health Ltd and ensuring that the governance and clinical governance policies, systems and procedures are adequate and regularly reviewed by management.

Mark Harris
Governance Committee Chair

Audit and Risk Committee

Trisha Cashmere, Steven Kouris (Chair), Gerry Marr and Ron Switzer

The purpose of the Audit and Risk Committee is to:

- advise the Board on the integrity of EIS Health Limited's financial information and systems and reporting
- advise regarding the external auditor's scope, independence and activities
- advise regarding the management process for the identification of significant business risks and operational risks and exposures
- assist the Board in discharging its responsibilities to oversee management reporting processes including finance, risk management, audit and compliance and to recommend a framework of internal controls and appropriate ethical standards to ensure ethical corporate governance.

This Committee has an external expert as a member and meets at least six times per year.

Functions of the Audit and Risk Committee include annual review of the risk management systems, review of financial reports and audited financial statements and oversight over the internal and external audits, ensuring the auditor meets the required standards for auditor independence.

Finance Committee

Teresa Anderson, Trisha Cashmere, Steven Kouris (Chair) and Shirley Liew

The purpose of the Finance Committee is to advise the Board on strategic, financial and asset management issues, including financial reporting and frameworks, overall budget frameworks, funding mechanisms and to ensure EIS Health Ltd is operating within its allocated budgets. This Committee has an external expert as a member and meets at least six times per year.

Functions of the Finance Committee include ensuring that various financial reports are accurate and presented in a timely manner, oversight of financial performance including expenditure, revenue and cashflow, ensuring governance mechanisms comprehensively identify, treat and monitor risks, and reporting to the Board on EIS Health Limited's performance against the various contract budgets.

The Audit and Risk, and Finance committees are critical parts of the Board's governance and oversight of EIS Health's financial, risk and external audit environment. During the 2015/16 financial year, the committees have been well served by directors, externally appointed members and staff, and have provided timely reporting and recommendations to the Board.

The committees have successfully achieved the following:

- reviewed and monitored annual budgets, and made related recommendations to the Board
- ensured EIS Health operates consistently with its funding requirements and objectives
- addressed key risks relating to funding, such as the degree and extent of over and underspend, and funding carry over
- oversaw the organisation transitioning to a commissioned environment, including the introduction of third party service delivery, particularly for the headspace and After Hours programs
- developed a comprehensive risk register, which remains a working document capturing key issues as the organisation continues evolving
- managed the external audit process (through Cutcher & Neale, Mark O'Connor).

Steven Kouris
Audit and Risk, and Finance Chair

The financial statements for EIS Health Ltd (Central and Eastern Sydney PHN) are available to be viewed on our website via this link

bit.ly/CESPHN2016Financials

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Central and Eastern Sydney PHN is a business unit of EIS Health Ltd ABN 68 603 815 818