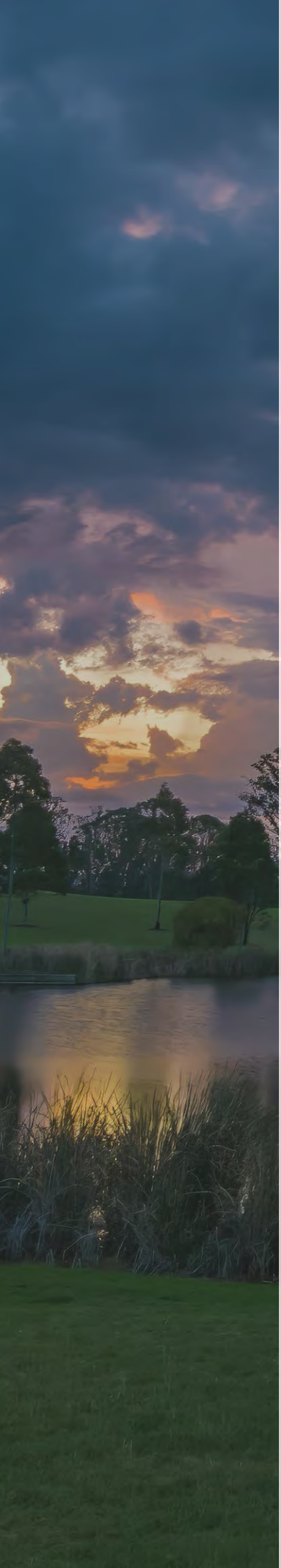
ANNUAL REPORT 2024

Improving health and wellbeing for the communities of the Blue Mountains, Hawkesbury, Lithgow and Penrith

phn
NEPEAN BLUE MOUNTAINS
An Australian Government Initiative

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith



Photos on covers and on this page by Penrith local Tom Walsh, capturing the beautiful sunset at Wentworth Healthcare, looking west towards the Blue Mountains.

We acknowledge that we work on the traditional lands of the Darug, Gundungurra and Wiradjuri peoples. We pay our respects to Aboriginal Elders past and present.

Throughout this document, the term 'Aboriginal' may be used to refer to all Aboriginal and Torres Strait Islander peoples.

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FINANCIAL REPORT

nbmphn.com.au/AnnualReport2024

ABOUT US WHO WE ARE

Wentworth Healthcare is a not-for-profit organisation established in 2012 with the purpose of improving the health and wellbeing of people in the Blue Mountains, Hawkesbury, Lithgow and Penrith local government areas.

Our founding members were the Nepean Division of General Practice, the Blue Mountains GP Network and the Hawkesbury-Hills Division of General Practice.

Initially trading as the Nepean-Blue Mountains Medicare Local, we became the provider of the Nepean Blue Mountains Primary Health Network (NBMPHN) on 1 July 2015, when the Primary Health Network (PHN) program was established.

The PHN program is an Australian Government initiative with the key objectives of increasing the efficiency and effectiveness of health services for patients, and improving the coordination of care to ensure patients receive the right care, in the right place, at the right time. There are 31 PHNs nationally.

Our work as a PHN is focused in three main areas:

SERVICES WE FUND FOR THE COMMUNITY	SUPPORTING PRIMARY HEALTHCARE	INTEGRATING HEALTHCARE
		
Providing health services that meet the needs of our community.	**Supporting the delivery of high-quality healthcare to patients.**	**Connecting the local health system, so people don't get 'lost' when moving from one health service to another.**
Read more on page 24.	*Read more on page 44.*	*Read more on page 58.*

To be successful in our work we must develop and maintain key collaborations and partnerships to improve health outcomes for our community. Our role as a planner, funder and facilitator of services requires us to identify potential partners so that together, we can respond to the needs and aspirations of our community. We are committed to adding value to, rather than duplicating existing services and community initiatives.

As an organisation, we are committed to the journey of reconciliation. Our Vision is for an Australia where Aboriginal and Torres Strait Islander peoples' community needs, interests and priorities are embedded into primary healthcare to improve health and wellbeing outcomes in our community. We work with other healthcare providers across the region, through our funding and partnership leader role, to build communities of healthcare practice that recognise, support and empower Aboriginal and Torres Strait Islander peoples and communities to enhance access and improve health equality across the region.

OUR VISION

Our community experiences better health and wellbeing.

OUR MISSION

Empower primary healthcare providers to deliver high-quality, accessible and integrated care that meets the needs of our community.

OUR VALUES

Respect

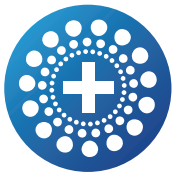
Quality

Continuous Improvement

Ethical Practice

Collaboration

OUR PRIORITY AREAS



Aboriginal Health

Healthy Ageing

Health Workforce

Alcohol and Other Drugs

Mental Health and Suicide Prevention

Vulnerable Communities

Digital Health

Population Health

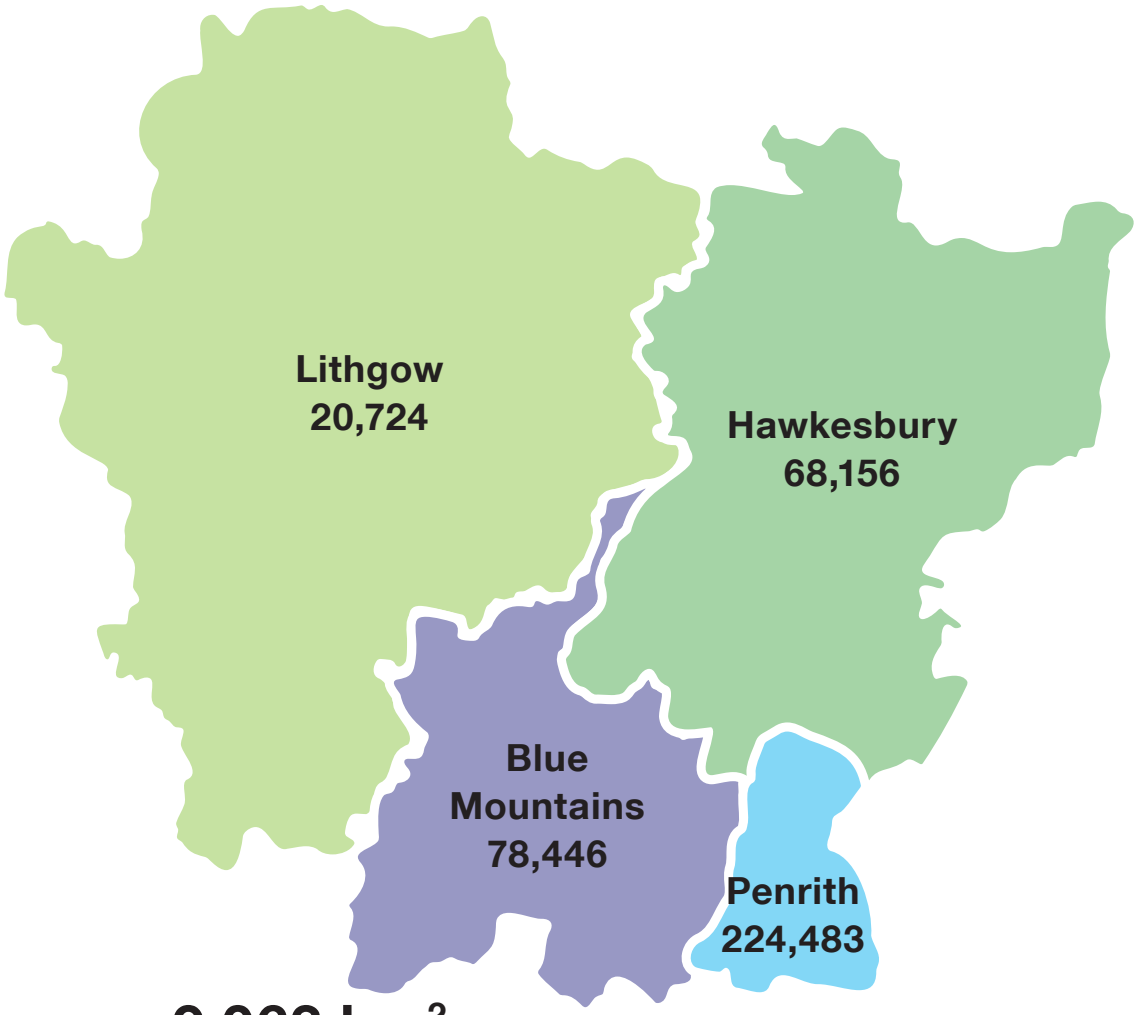
Disaster and Emergency Management

OUR STRATEGIC OBJECTIVES

1	2	3	4	5
A capable and influential primary healthcare sector	Outcomes and quality focused health services	Integrated services within and across sectors	Engaged and empowered consumers and communities	Organisational excellence and impact

REGIONAL PROFILE

Population by Local Government Area



9,063 km²

4 Local Government Areas

Wide geographical diversity

– major cities, inner regional and outer regional Australia remoteness classifications

1 new airport

under construction at Badgerys Creek, due to open in 2026

The development of the new Western Sydney Aerotropolis and International Airport will increase demand on health services in greater Western Sydney. The population of the Penrith LGA is expected to grow to 369,250 by 2041.

DEMOGRAPHICS

391,809+ people

51% female

49% male

452,747
expected population by 2041

The most rapid increase is projected for those aged 65+ years

4.7% identify as Aboriginal and Torres Strait Islander
which is higher than NSW average of 3.4%

19.7% born overseas
which is lower than NSW average of 29.3%

13.9% speak a language other than English at home
which is lower than NSW average of 26.6% *(2023)*

AGE BREAKDOWN

0-11 years of age **15.8%**

12-17 years of age **7.8%**

18-34 years of age **21.8%**

35-49 years of age **20%**

50-69 years of age **23.6%**

70+ years of age **11%**

HEALTH SERVICES

132 general practices

86 pharmacies

4 major hospitals

29 Residential Age Care Homes (RACHs) providing **2,641** beds

2 urgent care services

(2024)

482 GPs (plus 109 GP registrars)

236 practice nurses

1,672 allied health professionals

(2024)

308 million+
visits to a GP utilising a Medicare service item *(2022-2023)*

MESSAGE FROM THE CEO
MS LIZZ REAY

I am pleased to present our 2023-24 Annual Report, which showcases the outstanding efforts of our team and the positive difference our organisation is making to the health and wellbeing of our community.

It was wonderful to celebrate the launches of a number of key commissioned services this year that were made possible through our advocacy and collaboration with other community stakeholders. In particular, The Street University in Katoomba, committed to at the 2019 Federal Election, the Hawkesbury Head to Health service, which evolved from a temporary Pop Up service that we championed to be made permanent and the headspace Hawkesbury centre, which was the culmination of seven years of advocacy.

We were pleased to enhance our well-established domestic family violence program to include sexual violence and child sexual abuse, and to work with key partners such as NSW Health to scope and establish an Urgent Care Service in the Hawkesbury. After years of advocacy, I was thrilled to contribute to the review of the NSW State Health Plan, which saw for the first time the inclusion of PHNs and Primary Care in this state-wide emergency management plan.

In the suicide prevention area, we have made continued progress through the implementation of our Joint Regional Mental Health and Suicide Prevention Plan together with Nepean Blue Mountains Local Health District. We acknowledge the complexity and challenges of the current healthcare system and recognise that a collaborative approach, and one that values the lived experience at its centre, is the only way to holistically address gaps and issues. We are proud to be the backbone organisation in the establishment of the Regional Suicide Prevention Collaborative, which is a key milestone in this work.

As Chair of the national PHN Co-operative Healthy Ageing CEO Working Group, I have been excited to see the extent of work focusing on healthy ageing early intervention initiatives as well as the role of PHNs supporting residential aged care homes to connect with the broader health system, enhancing care for residents. This supports the Government's response to the Royal Commission into Aged Care Quality and Safety. At our own PHN, we continued to support residential aged care homes and we delivered programs to keep older people healthier and at home longer, including immunisation, dementia, palliative care, social isolation, occupational therapy home assessments, medicines education and service navigation. Our Intergenerational Connections program, which brings together preschool children and older adults for meaningful social connections, was one example that showed the difference these types of early intervention programs can make to improving the quality of life, health, wellbeing and ongoing independence of older people in our community. We encourage the Government continue to invest in more of these important upstream initiatives.

As Chair of the NSW/ACT PHN CEO Group in 2023/24, it was encouraging to work at a state level with colleagues to address and advocate for common issues that affect us all, particularly championing solutions to achieve more integrated care and a one-health system mindset.

Health workforce shortages, particularly in Greater Western Sydney, are an ongoing challenge. We continue to advocate at national, state and local levels for short and long-term solutions to make primary care, and specifically general practice, more sustainable. This year we undertook important stakeholder consultation with our General Practice and Allied Health Clinical Councils and others, around models of multidisciplinary team care. This informed the foundations of our work for initiatives we look forward to piloting in 2025.

Finally, I'd like to thank my incredible Executive and staff for their dedication and contribution to another successful year towards achieving our mission and vision.

MESSAGE FROM THE CHAIR
MR GARY SMITH AM

Our strength as a PHN lies in our ability to leverage our local knowledge, alongside our strong commissioning processes, to apply place-based approaches to national initiatives, ensuring they fit our local needs.

This year, a key organisational priority was the development of our 2024-2029 Strategic Plan, which launched in July 2024. We undertook extensive consultation with staff, stakeholders and community representatives to create a plan that builds on the successful outcomes of our 2019-2024 Strategic Plan, while addressing the future changing health needs of our region. Our new Plan ensures that our collective energy is focussed on delivering a more efficient, equitable, integrated and patient-centred health system that meets the needs of our growing community and that our work continues to be outcome-based and sustainable.

Another key priority for the Board was fostering strong stakeholder engagement and cross-sector collaboration, to increase our role in health reform and advocacy, to further champion the needs of our local region. To support this, we developed our first Advocacy Framework and Stakeholder Engagement Framework to guide our approach moving forward.

Working together as a broader PHN network on shared challenges at national, state and local levels demonstrates our commitment to cross-sector collaboration. The national PHN Co-operative worked on 26 shared PHN priorities. One example is our continued advocacy for a formalised role for primary care and PHNs in disaster management at national, state and regional levels. In NSW, PHNs have played a key role in numerous joint initiatives and policy reforms, further strengthening our partnership with NSW Health. I was privileged to continue my role as Chair of the NSW/ACT PHN Council in 2024 and maintained regular meetings with the NSW Health Minister, The Honourable Ryan Park, to identify areas where we can work together to achieve better health outcomes.

Closer to home, recognising the unique needs and growth in our broader region, we have partnered with our neighbours Western Sydney and South Western Sydney PHNs to develop a combined Greater Western Sydney Health Workforce Strategy, to address common workforce challenges. In our own region, we continue to work collaboratively with our partners at the Nepean Blue Mountains Local Health District through our formal Memorandum of Understanding, joint Community Advisory Committee, Integrated Health and Wellbeing Joint Boards Sub-Committee and our Joint Regional Mental Health and Suicide Prevention Strategic Plan. This joint governance has helped facilitate many co-operative projects and is crucial in helping us to work closely together, especially during times of disaster.

Advancing our organisation's efforts toward reconciliation remains important. This year the Reconciliation Action Plan (RAP) Working Group began work on our third RAP, a Stretch Reconciliation Leadership RAP. Organisations who undertake a Stretch RAP need to have established a strong approach to advancing reconciliation internally and within their sphere of influence externally. We are proud to have reached this next stage of our reconciliation journey.

On behalf of the Board, I would like to thank our Advisory Committees for their ongoing engagement and valuable contributions. These clinical and consumer committees represent the voices of our health and community stakeholders and are integral in shaping and guiding our priorities.

Lastly, I would like to acknowledge the leadership of our CEO Lizz Reay, who this year celebrated 25 years of service through the various iterations of our organisation. Lizz continues to demonstrate her dedication and commitment to providing an organisational culture that strives to deliver value-based and person-centred outcomes for our community.

GOVERNANCE AND ACCOUNTABILITY

Wentworth Healthcare Limited is a not-for-profit company limited by guarantee. Our member organisations are Allied Health Professions Australia; Australian Primary Health Care Nurses Association; Blue Mountains GP Network; Lithgow City Council; Nepean GP Network and Western Sydney Regional Organisation of Councils.

The Board of Directors is the principal governing body and is supported by the CEO and the Executive Team. There are four Board Committees that assist the Board to carry out its role:

1. Finance, Audit and Risk Management Committee

- Bruce Turner AM (Chair)
- Dr Nicole Langsford
- Prof Andy Marks
- Andrew Bissett (non-Director Member)

2. Governance and Nominations Committee

- Heather Nesbitt (Chair)
- Gary Smith AM
- John Yealland

3. Clinical Governance Committee

- Fleur Hannen (Chair)
- Jeffery Jenkins
- Dr Madhu Tamilarasan

4. Wentworth Healthcare and NBMLHD Integrated Health and Wellbeing Joint Boards Sub-Committee

Together with the Nepean Blue Mountains Local Health District (NBMLHD), we continue to develop and deliver models of care that support integrated health services in the region across acute, community and primary care. Joint governance of integrating care is strengthened through the Integrated Health and Wellbeing Joint Boards Sub-Committee with Gary Smith AM as Co-Chair and Dr Madhu Tamilarasan as a member.

STAKEHOLDER GOVERNANCE

Our Governance Framework includes three consultative bodies that advise the Board and help guide the work we do. Members come from our four local government areas of the Blue Mountains, Hawkesbury, Lithgow and Penrith, ensuring all areas have a voice to share their concerns and ideas. This framework plays a fundamental role in how we identify and commission new health services and cater for the health needs of our region.

1. GP Clinical Council (GPCC)

Represents the GP workforce and advises the organisation on strategies to address region-wide issues facing GPs, while also considering the unique needs and concerns of each local community.

- 7 meetings held

MEMBERS 2023-2024:
Dr Louise McDonnell (Chair)
Dr Alex Williams (Hawkesbury)
Dr Babak Adeli (Lithgow)
Dr Anju Aggarwal (Penrith)
Dr Hilton Brown (Lithgow)
Dr Kate Brunton (Hawkesbury)
Dr Jialiang Chin (Blue Mountains)
Dr Thu Dang (Penrith)
Dr David Foley (Hawkesbury)
Dr Hany Gayed (Penrith)
Dr Ben Hanson (Lithgow)
Dr Simone Heiler (Blue Mountains)
Resigned members
Dr Michael Crampton (ex-Chair)
Dr Sue Owen (Blue Mountains)
Dr Linda McQueen (Blue Mountains)

KEY MATTERS CONSIDERED 2023-2024

- **Voluntary Assisted Dying** – including service implementation and GP education needs
- **headspace Hawkesbury** – new youth service consultation
- **MyMedicare** – implementation consultation
- **Statewide Referral Pathways** – including GP education needs
- **Collaborative Commissioning** – respiratory care pathways
- **Residential Aged Care Homes** – workforce and IT system issues and their potential current and future impacts
- **PHN Communication to GPs** – to ensure important information is conveyed in the best possible ways
- **Palliative Care** – NBMLHD sought feedback on challenges and enablers in palliative care to incorporate into a new model of care being developed
- **Suicide prevention training for GPs** – consultation resulted in tailored training programs being developed in line with GP suggestions to increase accessibility for GPs to complete this training
- **How to best utilise some short-term mental health funding** – following consultation, the Psychological Therapy Services program increased access for people experiencing financial difficulties and broadened the range to include expressive therapies and dialectical behaviour therapy
- **Strategic Plan** – feedback on Wentworth Healthcare's 2024-2029 plan
- **Combined Clinical Council event** – this brought together GPs and allied health professionals to discuss multidisciplinary team care, identifying barriers and enablers, informing PHN work during 2024

Dr Louise McDonnell (Chair).

MESSAGE FROM THE CHAIR – Dr Louise McDonnell

"In January 2024, I took over from Dr Michael Crampton and I am delighted to be the new Chair. GPCC gives critical feedback to the Wentworth Healthcare Board on issues that affect general practice. We have a new two-way communication that allows our current GPCC members to feed back to the Board on issues that are currently challenging grass roots general practice. This enables both parties to further understand and work together to resolve the issues and challenges that together we face, to ensure high-quality primary healthcare in our area.

So far, we have had some constructive discussions on the mental health education needs of our GPs and the challenges faced by GPs working in residential aged care homes. The information gathered has directly informed the programs and directions of the PHN. We have also provided vital input to the Palliative Care District Model of Care, currently under review by the NBMLHD.

I warmly welcome two new GPCC members, Dr Jialiang Chin representing the Blue Mountains LGA and Dr Ben Hanson representing Lithgow LGA.

Finally, I would like to take this opportunity to thank the fantastic team at the PHN who provide incredible support and make my role so much easier."

2. Allied Health Clinical Council (AHCC)

Represents allied health professionals from a range of disciplines and advises the Board on recommended strategies to address region-wide issues facing the allied health workforce.

- 4 meetings held

MEMBERS 2023-2024:
Jillian Harrington (Chair, Penrith) *Clinical Psychologist*
Christine Colusso-Craig *Public Health Representative*
Dr Rudi Crncec (Penrith) *Clinical Psychologist*
Rebecca Hannon (Hawkesbury) *Exercise Physiologist*
Rainy Johnston (Blue Mountains) *Pharmacist*
Anne Lyell (Hawkesbury) *Chiropractor*
Gobika Srikanthan (Lithgow) *Pharmacist*
Sally Webb (Lithgow) *Physiotherapist*
Resigned members
Jacqualine Faehringer
Emily Standen

KEY MATTERS CONSIDERED 2023-2024

- **Voluntary Assisted Dying** - including service implementation and allied health education needs
- **CPD Opportunities** - potential multidisciplinary options for allied health in 2024
- **Strategic Plan** – valuable feedback incorporated into Wentworth Healthcare's new 2024-2029 plan
- **Suicide prevention** – consultation resulted in work to better tailor training to meet the needs of allied health professionals
- **Role of allied health professionals in reducing ED presentations** – consultation
- **Cost of living pressures** – members noted an increase in cancellations or putting off medical appointments due to current cost of living pressures
- **Combined Clinical Council event** – this brought together GPs and allied health professionals to discuss multidisciplinary team care, identifying barriers and enablers, informing PHN work during 2024. This topic is an ongoing area of focus for the AHCC
- **Workforce pressures and barriers to access** - allied healthcare services in our region

MESSAGE FROM THE CHAIR – Jillian Harrington

"This year has been another busy year for the Allied Health Clinical Council, with a full agenda and much productive discussion and collaboration, centred on the issues that impact allied healthcare in our region. The group is a useful sounding board for the Board and team and mirrors the primary care landscape we'd all like to see – with communication and collaborative problem-solving around the issues facing people in our region."

Encouraging multidisciplinary team-based care, Nov 2023.

Jillian Harrington – AHCC Chair.

3. Community Advisory Committee (CAC)

A joint committee with NBMLHD and Wentworth Healthcare. The purpose of the committee is to provide a community perspective to ensure that decisions, investments and innovations are patient-centred, locally relevant and aligned to local care experiences and expectations.

- 5 meetings held. Additionally, CAC members were invited to meet with the Board on 27 March 2024.

MEMBERS 2023-2024:
Belinda Leonard (Chair) (Blue Mountains)
Caroline Allen (Hawkesbury)
Peter Gooley (Hawkesbury)
Simon Griffin (Hawkesbury)
Priya Jensen (Blue Mountains)
Joe Rzepecki (Penrith)
Colleen Winterburn (Lithgow)
Andrew Wilson (Blue Mountains)
Resigned members
Natalie Rosten (Penrith)

CAC members Joe Rzepecki and Priya Jensen.

KEY MATTERS CONSIDERED 2023-2024

- **GP Workforce Survey** engagement strategies
- **Medicare Urgent Care Clinic Penrith**
- **Joint Boards Integrating Care** priorities
- **PHN Health Needs Assessment** engagement strategies
- **PHN Strategic Plan 2024-2029** consultation
- **Best Practice** in Co-Design
- **Closure of Nepean Hospital Paediatric Emergency Department** and referral pathways
- **Hawkesbury District Hospital acquisition** (from a private to a public hospital)
- **Nepean Hospital Fracture Clinic and Urgent Care Clinic** pathways
- **PHN Consumer engagement** plans
- **PHN Suicide Prevention** Community Event
- **Advance Care Planning** consultation
- **Needs Assessment 2023** – consultation on Disaster Management and Cancer Screening and feedback was incorporated into the 2023 Needs Assessment

Lizz Reay, CEO Wentworth Healthcare; Simon Griffin, CAC member; Joe Rzepecki, CAC member; Bruce Turner, Board Director; Caroline Allen, CAC member; John Yealland, Board Director; and Peter Gooley, CAC member.

MESSAGE FROM THE CHAIR – Belinda Leonard

"We have a very engaged and active CAC with members engaged in various consumer advisory capacities across the PHN and LHD leading to rich and well-informed discussions. The CAC continues to focus on the Joint Board priorities and the elevation of the consumer voice as an outcome.

CAC members have contributed to a range of initiatives, including HealthPathways, palliative care, mental health and suicide prevention and to broader activities including Nepean Hospital redevelopment, and the Greater Western Sydney Health Partnerships initiative.

As we look forward, there will be an increased focus on recruitment of additional members to align with our recently updated Terms of Reference and to ensure we achieve a balance between diversity of input and geographic representation."

Belinda Leonard – CAC Chair.

STAKEHOLDER ENGAGEMENT

We recognise that in addition to population and health data, local health needs are best understood and addressed through extensive stakeholder engagement, particularly when identifying emerging needs, trends and service gaps.

We value stakeholder engagement in all that we do ensuring our community, and those most at risk of poor health outcomes, have a voice. We are committed to consulting and engaging with the community, healthcare professionals and others, to better understand what works, where there are gaps and to design solutions together.

In addition to our Board Advisory Committees, we seek advice from the community, health professionals and others in a range of forums to better inform the work that we do.

The groups below represent a snapshot of some of our stakeholder engagement activities.

Health Literacy Review Group

The Health Literacy Review Group are community members with a passion for health literacy. The group review public facing materials and provide feedback on aspects including readability, accessibility and the application of health literacy principles. During the year the group have reviewed and provided input on Urgent Care resources, the Doctor Closed website, community surveys, our complaints management approach and more.

Regional Suicide Prevention Collaborative

The Nepean Blue Mountains Suicide Prevention Collaborative was established this year. The Collaborative plays an important role in ensuring that our community is equipped with the skills and knowledge needed to work together to reduce suicide across the region. The priorities collectively identified by the Collaborative help generate action plans and develop working groups to progress specific projects and contribute to public awareness campaigns and education.

*Read more about the **Suicide Prevention Collaborative** on page 68 of **Integrating Care**.*

Primary Care Advisory Committee

This committee is a multidisciplinary group that help inform the initiatives delivered in primary care, including population health management, the use of digital health and technology to support quality improvement activities and continuing professional development activities. The group includes GPs, practice nurses, practice managers, allied health professionals and community members from across the region. During the year the committee has had a particular focus on workforce issues in the region.

Stakeholder Engagement Framework

To further strengthen our approach to stakeholder engagement, this year we have launched our Stakeholder Engagement Framework to promote a consistent approach to high quality stakeholder engagement across the organisation.

Our stakeholder engagement vision and purpose:

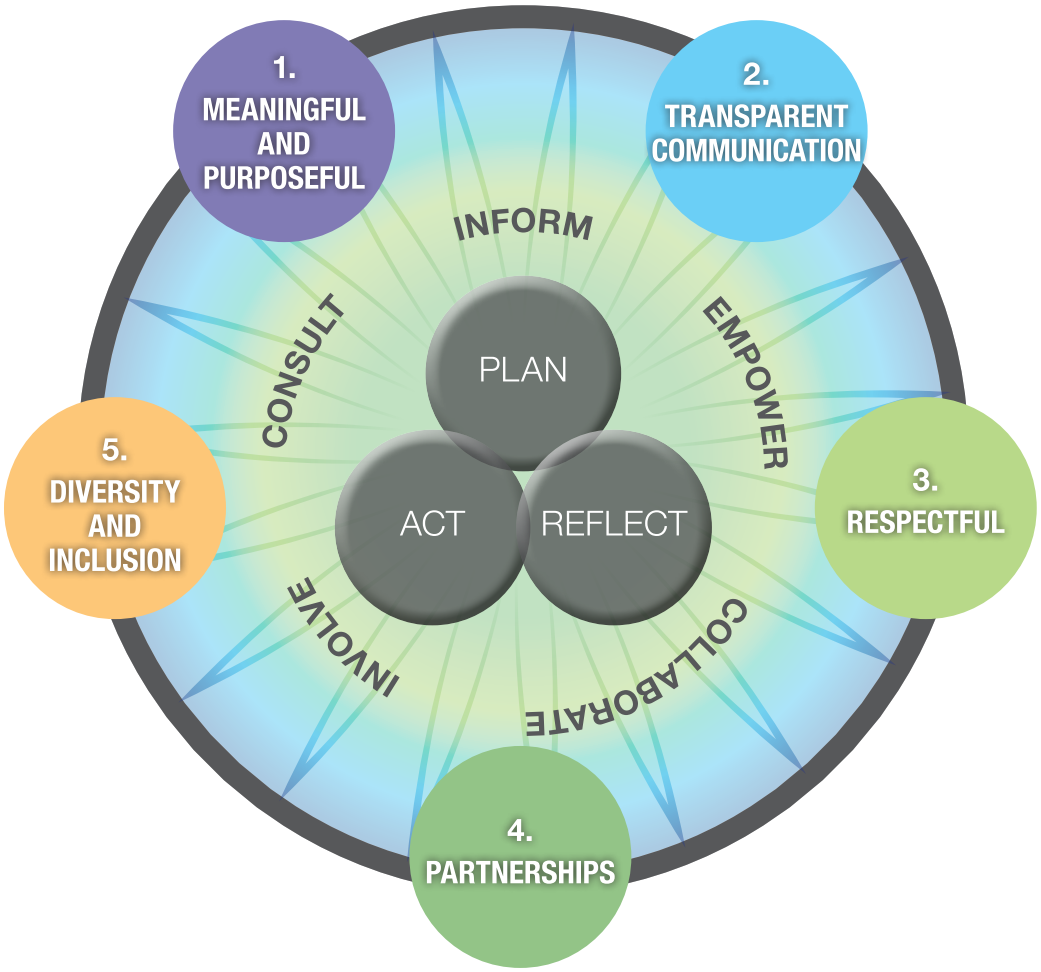
Vision

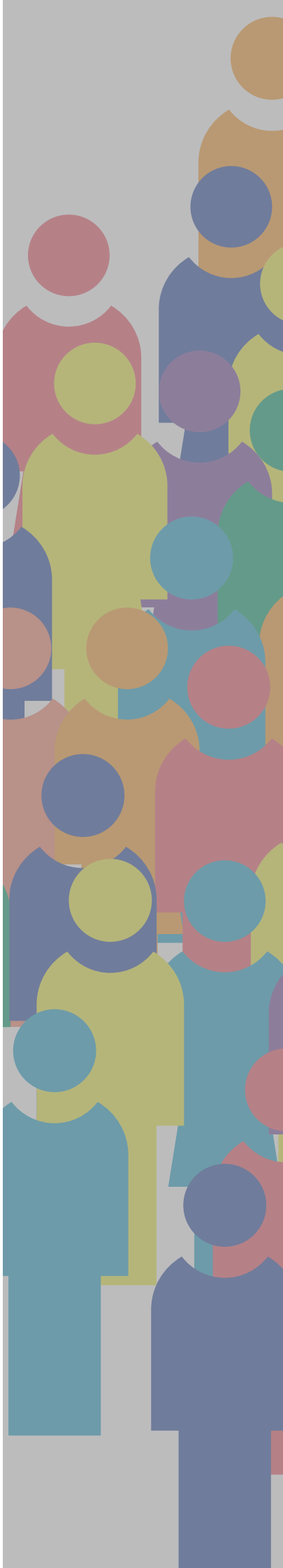
High quality and meaningful stakeholder engagement is embedded in all that we do to enable us to better identify and respond to the needs of our community.

Purpose

To ensure a consistent approach that supports collaborative and considered stakeholder engagement as much, as often, and as early as possible.

We look forward to demonstrating ongoing improvements in stakeholder engagement as we further embed the framework across the organisation.





OUR BOARD

Good governance is vital to ensure our organisation is effective and accountable in our work. Wentworth Healthcare is governed by a skills-based Board consisting of nine directors. These directors are appointed to the Board based on the **Board of Directors Skills Matrix** and with due consideration to the benefits and needs of diversity, as per our **Diversity Policy**.

Mr Gary Smith AM

Director since November 2018
Appointed Chair November 2021

Mr Smith has extensive experience in the management of healthcare facilities and the provision of health services, predominately in general practice. He has been involved in general practice management since 1985 and has taken a keen interest in the operation of general practices and the major organisations which influence and shape them. Mr Smith is currently a Director with the Australian General Practice Accreditation Ltd (AGPAL), Chair of Quality Innovation Performance (QIP), Quality in Practice Consulting and QIP-International, Deputy Chair, General Practice Workforce Tasmania, Chair, Client Focused Evaluation Program (CFEP) Australia and Member, Consortium of Accredited Health Care Organisations (CAHO) International Advisory Committee India. Mr Smith has extensive representation on Commonwealth and State Government Advisory Boards, Working Parties and task groups and relevant healthcare industry committees both here and internationally, which allows him to contribute to the shape and delivery of healthcare in Australia. In 2021, Mr Smith was awarded an Honorary Doctor of Letters honoris causa by the University of New England for the professionalisation of practice management in Australia and Internationally. In 2023 he was appointed a Member of the Order of Australia (AM).

Mrs Fleur Hannen

Director since November 2020

Fleur is a clinical care expert with over 34 years of experience working as a leader and registered nurse (RN) in the aged/home care and disability sectors. Fleur operates an aged care consultancy business across Australia, which partners with care providers to create solutions for clinical and governance requirements including conducting audits on Standards, developing and delivering policies and training programs to ensure compliance, resilience and sustainability for organisations and their governing bodies. Fleur holds a range of healthcare Board advisory positions and regularly presents to Boards and conferences to share her knowledge of the care industry and the regulatory requirements. Some of the key projects she has delivered include: Nurse Advisor, organisational reviews in aged/home/disability care, and development and implementation of clinical and governance processes. Fleur has clinical (RN) and business (MBA) qualifications as well as a Diploma of Company Directors. Fleur lives in the Blue Mountains, and she has raised her family and lived in the Blue Mountains for 30+ years.

Mr Jeffery Jenkins

Director since November 2022
Resigned September 2024

Mr Jenkins is a podiatrist and co-founder/Director of a large multidisciplinary healthcare organisation in the Nepean Blue Mountains region. Mr Jenkins has a passion for teaching and is involved in the development, implementation and analysis of clinical training programs of existing and new graduate practitioners, along with building evidence-based treatment and general practice protocols. He also has a keen interest in enhancing

the efficiencies and access to high-level multidisciplinary healthcare within the primary healthcare setting. Mr Jenkins undertakes ongoing clinical research, as well as holding various university clinical supervision and lecturing positions. He also holds a number of council and committee positions within the healthcare industry, including a regional council position in the Australian Podiatry Association.

Dr Nicole Langsford

Director since November 2021

Dr Langsford is a GP living and practising in the Blue Mountains, with 20 years of clinical experience. She is passionate about primary healthcare that supports patients across allied health and community services, and commits much of her medical practice to creating this environment for her patients. Dr Langsford has a keen interest in preventative medicine and developing healthy communities, and is currently studying a Masters of Medicine (Paediatrics) at Sydney University. She has a Fellowship from the Royal Australian College of General Practitioners, and is as a graduate of the Australian Institute of Company Directors (AICD).

Professor Andy Marks

Director since November 2020

Professor Marks is a Vice-President at Western Sydney University leading major strategic initiatives with government, industry and the community. He has a PhD and first-class honours in political science and literature. Professor Marks writes regularly for the Sydney Morning Herald and the Daily Telegraph and is a panellist on ABC Sydney's 'political forum'. Professor Marks is the Executive Director of the Centre for Western Sydney, Chair of the Western Sydney Community Forum, and a Trustee of the Royal Botanical Gardens and Domain Trust. He is the founder of the CatalystWest forum and co-founder of the Launch Pad start-up incubator. Professor Marks was formerly a researcher in the social services sector, a Council member at the University of New England and an ARIA nominated musician.

Ms Heather Nesbitt

Director since November 2019

Ms Nesbitt is an urban and regional planner with 30 years' experience in the government, non-government and private sectors. Ms Nesbitt is a Hawkesbury local and was most recently Social Commissioner with Greater Sydney Commission, where she led the agenda to deliver inclusive, connected and healthy communities through innovative urban planning and community/stakeholder engagement and collaborations across Greater Sydney. Ms Nesbitt has strong networks with local, state and Federal government as well as business, universities and community organisations. Ms Nesbitt is a Fellow of Planning Institute of Australia, Graduate Australian Institute of Company Directors, Councillor NSW Parks and Leisure Australia and volunteer with Australian Red Cross Emergency Services.

Dr Madhu Tamilarasan

Director since November 2020

Dr Tamilarasan has been a rural general practitioner in Lithgow since 2005. She is passionate about access to quality healthcare for all residents within the Nepean Blue Mountains region and supporting our healthcare workforce. She is committed to improving support for rural and regional GPs, so that others are tempted to work in smaller centres and find the same joy she experiences from living and working in a small community. Dr Tamilarasan has extensive experience in general practice training having previously managed the GP training program for Western NSW for many years. She knows the importance of nurturing our future medical workforce by supervising medical students and GP registrars within her practice and remains involved in GP training external to her practice.

Mr Bruce Turner AM

Director since November 2017

Mr Turner's (FAICD, FFIN, FIPA, FFA, FIML, PFIIA, CGAP, CRMA, CISA, CFE) diverse experience spans financial services, manufacturing, transport, energy, health, and public administration in executive and prior board roles. In addition to international and national experience, Mr Turner has worked throughout the Nepean Blue Mountains region. He chairs or sits on numerous audit committees, including several focused on the region. He has authored several governance, risk and audit books, including Powering Audit Committee Outcomes and Rising from the Mailroom to the Boardroom. Over recent years he authored local history books in the Banks of the Nepean trilogy. In 2015 he was appointed a Member of the Order of Australia (AM).

Mr John Yealland

Director since November 2018

Mr Yealland has had a diverse career across many different sectors with expertise in business process improvement, leadership and management. Mr Yealland is currently a business advisor who provides services to organisations supporting people with intellectual disability in the Western Sydney region, including the Blue Mountains and Penrith areas. Mr Yealland is of Wiradjuri heritage and understands the issues that confront Aboriginal people and has a keen interest in the enhancement of health outcomes and economic participation of Aboriginal and Torres Strait Islander community. He has a deep understanding of the challenges faced by people with disability and by Indigenous people in accessing services for their needs. Mr Yealland is passionate about equity and quality service delivery.

Find out more:
nbmphn.com.au/About/Governance

OUR PEOPLE

Our Executive Team

Lizz Reay BAppSc, MNutr&Diet, AdDipBusMgt, GAICD

Chief Executive Officer

Lizz has a proven track record of applying strategic and adaptive leadership to achieve outcomes. With a background in clinical and public health nutrition both in Australia and the UK, Lizz has over 26 years of experience in the healthcare sector.

Bobby Stefansen Acevski

BBus (Acc and Fin), LLB (Hons), MTax&IntBus, CPA, CTA, Solicitor

Executive Manager Business Services

Bobby is a Certified Practising Accountant, Chartered Tax Advisor, Barrister and Solicitor with extensive experience in financial leadership and business strategy. With over 15 years experience in leading accounting and legal private practices, commerce and government entities, Bobby has expertise in all aspects of business, risk and compliance, and law.

Wayne Dalton BA (Hons)

Executive Manager Corporate Services

Resigned September 2024

Wayne brings over 20 years of experience in people management, operations, and leadership across commercial, government, not-for-profit, and community-controlled organisations. He has a strong interest in social impact and values working with like-minded people to create practical, positive change. His approach is grounded in collaboration and focused on achieving meaningful outcomes that benefit both the organisation and communities.

Elisa Manley BNursing, MPubHlth

Executive Manager Strategy & Integration

Elisa has worked for over 40 years in health, government and not-for-profits. Her background in hospital nursing, occupational health and safety, and expertise in public health and primary care, supports commissioning, planning and integration of health services within the region.

Kate Tye BHACS, GradCertCaseMgt, MHLM

Executive Manager Primary Care Development

Kate has over 25 years of experience working in leadership roles across health, aged and community services including significant experience working with socioeconomically disadvantaged and Aboriginal communities nationally. She has worked across large not-for-profits, health services and with local government.

OUR STRUCTURE

We value diversity and foster a culturally safe workplace that embraces flexible work practices. We employ 98 skilled and talented professionals – 57% full time, 36% part time and 7% casual. Many of our employees (62%) live in the Nepean Blue Mountains region.

98 employees (80.79 FTE)

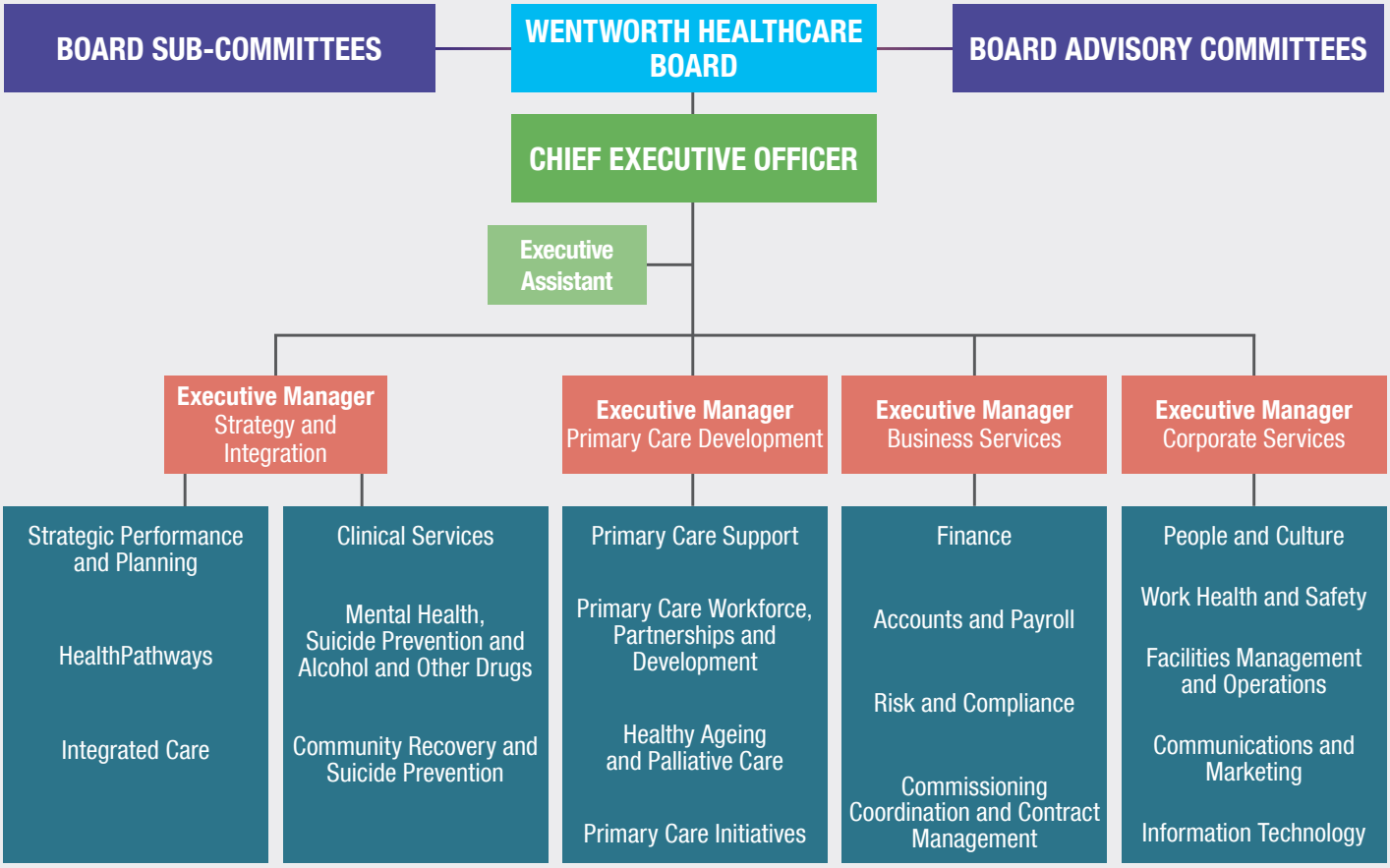
82% Female

18% Male

62% living in the NBM region

2% identify as Aboriginal and/or Torres Strait Islander

Organisational Structure



Cultural immersion art activity at Staff Development Day 2023.

RECONCILIATION ACTION PLAN

We cemented our commitment to reconciliation in 2018 with our first Innovate Reconciliation Action Plan (RAP). Our vision for reconciliation is an Australia where Aboriginal and Torres Strait Islander peoples' community needs, interests and priorities are embedded into primary healthcare to improve the health and wellbeing of Aboriginal and Torres Strait Islander peoples in our community.

In 2024, we completed our second Innovate RAP and commenced work on our Stretch Leadership RAP, due to launch in 2025. Our Innovate RAP provided the opportunity for us to learn, grow and mature as an organisation through our journey towards reconciliation. The Innovate RAP has a specific focus on internal development. This has enabled us to further enhance relationships with Aboriginal and Torres Strait Islander peoples and organisations, and increase our understanding of, and growing respect for, culture and the role it plays in the lives of Aboriginal people. The following are some of the achievements of our Innovate RAP:

- Since 2018, 55 Board Directors, Executives and RAP Working Group members have completed the Cultural Competency Course through the Centre for Cultural Competency Australia, and 100 staff have completed Aboriginal and Torres Strait Islander Cultural Competency training.
- Our Board, Executive and Management teams participated in Bystander Anti-Racism Training delivered by Western Sydney University.
- Annually we provide opportunities for staff to participate in cultural immersion activities to increase their knowledge and experience of culture. These have included language learning, cultural learning related to kinship, Aboriginal art and the purpose of Welcome to Country.
- Since 2018, 46 staff have participated in the coordination and delivery of NAIDOC events, with many more staff attending events.
- Since 2018, our staff have participated in, and contributed to, 30 events during National Reconciliation Week, promoting the importance of reconciliation.
- We developed and delivered a cultural competency training package for primary care and mental health practitioners. Since 2018, 127 GPs, practice nurses, allied health professionals and administration staff and 42 mental health professionals have completed this training with much positive feedback.
- We developed an Aboriginal and Torres Strait Islander Engagement Strategy including cultural protocols that were developed in consultation with nine Aboriginal Elders and Community Leaders.
- We have had commercial contracts with six Aboriginal suppliers and have purchased goods and services to support activities from another 10 Aboriginal owned businesses through the duration of our Innovate RAP period.

Primary Care Cultural Competency Training Impact

"Our practice will be more open to the needs of Aboriginal patients including any assistance to make their visit to our practice culturally safe and easier."

"I have a greater understanding now specifically in relation to non-compliance with medication, reluctance and mistrust of health providers, this will assist us to consider how we can provide better support and will not charge Aboriginal patients for missed appointments."

"This training is so much better than I have completed previously, very well done and helpful, objective and practical, by far the best education activity for Aboriginal and Torres Strait Islander culture I have done so far!"

"So much good information, great presentation absolutely amazing. So generous!"

"The presenters opened up with a lot more information regarding their culture and reasons for current issues."

RAP Working Group

Our RAP Working Group operates with a specific Terms of Reference and consists of staff representing all streams of our organisation, providing a diverse and whole of organisation approach to reconciliation.

MEMBERS 2023-2024:
Lizz Reay – CEO
Kate Tye – Executive Manager, Primary Care Development *(Executive Sponsor)*
Jodie Abbey – Health Program Development Officer
Kirrilee Barlow – Program Development Officer, Primary Care Initiatives
Mitchell Beggs Mowczan – Aboriginal Health Lead
Saskia Creed – Human Resources and Quality Officer
Melanie Hartmann – Program Development and Contracts Officer, Mental Health
Muriel Herring – Project Lead – Digital Marketing Systems
Tracy Kane-White – Manager, Primary Care Initiatives
Daya Nanda – Finance Manager
Monique Pryce – Program Development Officer, Community Development
Nick Rosser – Health Pathways Manager
Katie Taylor – Health Data Officer
Alex Tsoukas – Contract and Development Officer, AOD
Michelle Vernon – Commissioning and Contracts Officer, MHAOD
Hayden Welsh – Program Officer, Healthy Ageing
Nicole Williams – Design and Publications Coordinator

STAFF WORKING GROUPS

We value the contribution and expertise of our employees and have a number of staff working groups where they can contribute to fostering our diverse and inclusive corporate culture, improving our systems and operations, that help maintain quality service delivery.

Environmental Sustainability Working Group

Our Environmental Sustainability Working Group (ESWG) is responsible for overseeing and promoting sustainability initiatives and practises within the organisation. The ESWG plays an important role in promoting responsible business practises, reducing environmental impact and helping the organisation to integrate sustainability into our core operations and strategy. We believe this will result in benefits for the environment, local community and the organisation itself.

MEMBERS 2023-2024:
Wayne Dalton *(Executive Sponsor)*
Tina Calarco
Lauren Crisell
Claudia Grab
Melanie Hartmann
Jackie Janosi
Alex Tsoukas

Social Club

The Social Club aligns with our values and promotes a supportive and enjoyable work environment. The Club facilitates team-building activities and opportunities for employees to get to know each other inside and outside of the workplace, as well as supporting charities and relevant causes. By encouraging our staff to maintain a healthy work-life balance through physical and mental wellbeing initiatives, we believe this provides a happier and more engaged workforce, improving company culture and contributing to the overall success of the organisation.

MEMBERS 2023-2024:
Mitchell Beggs Mowczan
Tina Calarco
Sourav Das
Barbara Mossman
Julie Rigelsford
Kerrie Roche
Katie Taylor

International Women's Day.

Biggest Morning Tea.

Work Health and Safety Committee

Our Work Health and Safety (WHS) Committee plays a vital role in fostering a culture of safety and ensuring legal compliance within the organisation. With oversight from the Board and Executive team, the committee enhances employee safety by identifying and mitigating risks, reducing accidents and injuries, and ensures compliance with WHS regulations. It also provides a forum for open communication and employee involvement in safety matters.

MEMBERS 2023-2024:
Wayne Dalton *(Executive Sponsor)*
Liwayway Aba
Mitch Beggs Mowczan
Bridget Challis
Kirsty McLeod
Vicky Ogden
Kerrie Roche
Julia Totman
Michelle Vernon
Antoinette Web
Resigned members
Saskia Creed *(Resigned from Committee May 2024)*

BUSINESS SERVICES

Commissioning

The Commissioning team, guided by the Commissioning Framework, provides ongoing support to staff directly involved in the procurement and contract management aspects of commissioning. The team also participates in and implements quality improvements to ensure commissioning processes remain fit for purpose.

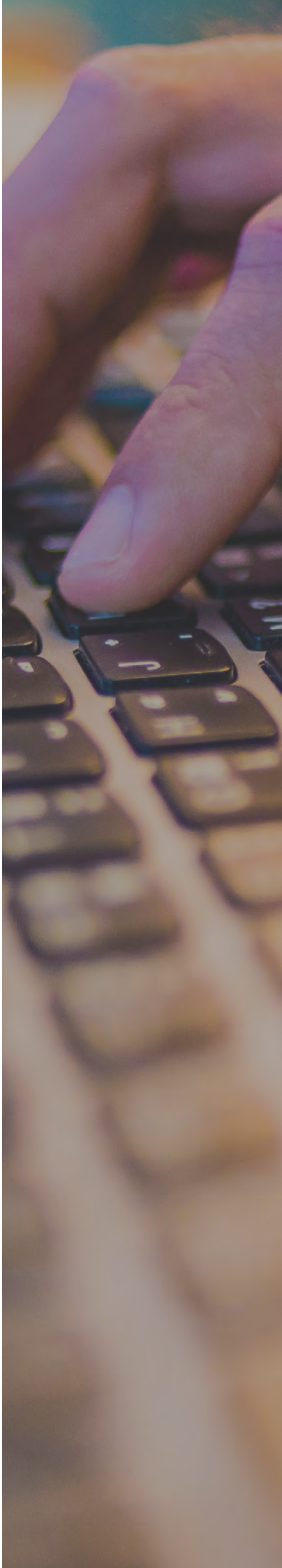
During 2023-24 Wentworth Healthcare managed **152 active commissioned services contracts**. This number does not include community grants provided to bushfire and flood affected communities, general practice grants to support COVID-19 vaccination, general practice quality improvement activities and general practice data sharing agreements.

Finance

This year, our Finance team has increased efficiency by introducing new systems, procedural improvements and process automation to manage many of our finance functions including program budgets, financial reporting and supplier performance monitoring. These new systems help optimise payments, invoicing, purchase orders and accruals. They have also transformed reporting to our funding bodies, the Board, Board Committees, executives and program managers.

Risk and Compliance

We work to ensure best practice in the areas of risk and compliance management and alignment with ISO Standards. We have implemented pioneering platforms and systems to ensure that the organisation manages all of its material business risks, and regulatory and non-regulatory compliance obligations, with maximum effectiveness in accordance with bespoke frameworks and policies, to instil confidence in all our stakeholders.



CORPORATE SERVICES

Communications and Marketing

The Communications team supports the dissemination of key healthcare information from government and other clinical sources to our local health professionals. Our website, email newsletters and social media channels are viewed as trustworthy and up-to-date information sources. The team also promote the many services and resources we offer to health professionals, stakeholders and the community through media and advertising activities.

- 186 email blasts, delivering 85,371 emails (average of 3.6 emails a week) to general practices, allied health and other stakeholders
- 240,749 website page views by 91,383 web users
- 1,232 social media posts across 4 channels with a reach of 3.9+ million and 16.2+ million impressions
- 28 media releases, resulting in 56 articles with a reach of 8.3+ million

Information Technology

The Information Technology team plays a crucial role in ensuring that technology is utilised efficiently and helps safeguard our data, enhance operational efficiency and stay agile in a rapidly evolving technological environment. Over the last year, like many organisations and PHNs across Australia, there has been a heightened emphasis on cybersecurity and efforts to achieve ISO27001 certification. This initiative aims to establish robust and reliable systems that adhere to best practices, effectively shielding the organisation's digital assets from cyber threats.

People and Culture

This year, the People and Culture team have continued work to improve employee satisfaction, development and engagement and assisted with the recruitment of a range of new employees. The team have organised training opportunities for employees including presentation skills, and management coaching and training. Key projects include development of a Career Development Framework, Recruitment and Retention Strategy and implementation of a new Human Resources Information System to streamline workflows and processes. Additionally, the team led a project to improve and optimise office space, including updating of meeting rooms and the introduction of a wellbeing room.

Wentworth Healthcare staff 2023.

Advocating for services in our community

After seven years of advocacy we were excited to launch headspace Hawkesbury. This has been a major achievement for Wentworth Healthcare and for the community.

Elisa Manley, Executive Manager Strategy and Integration, Wentworth Healthcare; Susan Templeman, Federal Member for Macquarie; Ngan Pham, Operations Manager, headspace Primary Care, Uniting; Melanie Hartmann, Program Development & Contracts Officer Mental Health, Wentworth Healthcare; and Chantal Nagib Duffy, Head of Uniting Recovery, Uniting NSW.ACT; visiting headspace Hawkesbury.

SERVICES WE FUND FOR THE COMMUNITY

We support the health of our region by identifying local needs and commissioning health and wellbeing services to meet those needs – when and where people need them. We use health data and work in collaboration with others in the local healthcare system, including GPs, allied health professionals, community stakeholders and other organisations, to ensure that the services we fund provide evidence-based high quality care that improve the health outcomes of our community, while delivering value for money.

Below are examples of SERVICES WE FUND FOR THE COMMUNITY through our Priority Areas.

ABORIGINAL HEALTH
Priority Area

Case-Management: Aboriginal and Torres Strait Islander Youth

A service delivered by Ted Noffs Foundation for Aboriginal and Torres Strait Islander peoples aged 12-25 years of age identified as at risk for alcohol and other drug or mental health issues. Services include therapeutic crisis intervention, clinical assessment, treatment planning, counselling and psychological therapy, assistance accessing other services and mentoring.

- 230 clients assisted

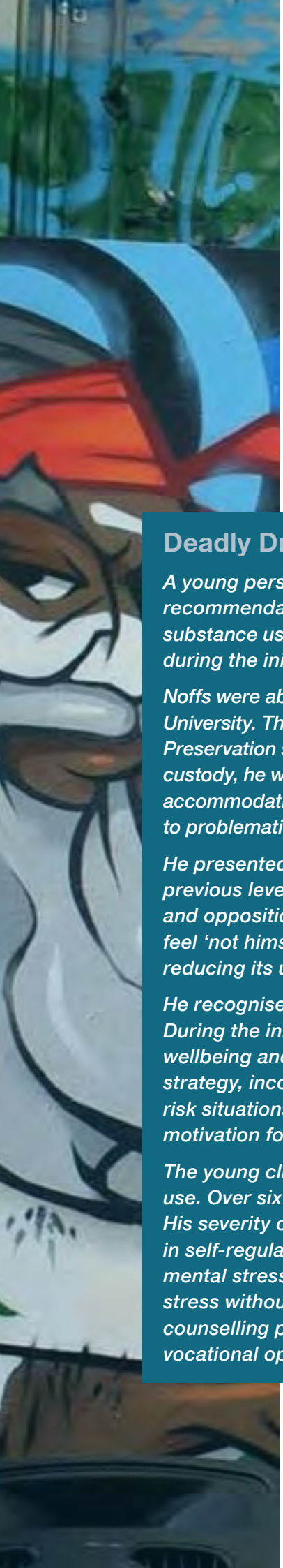
Find out more:
nbmphn.com.au/AODYouthCaseManagement

Greater Western Aboriginal Health Service (GWAHS) Aboriginal Psychiatry Clinic

We partnered with GWAHS in Penrith to deliver a specialist psychiatry clinic for Aboriginal and Torres Strait Islander peoples until April 2024. We also provided psychiatry services at GWAHS Katoomba as part of our outreach funding.

- 14 full day clinics provided 96 patient consultations, seeing 19 new patients

Find out more:
gwahs.net.au



Deadly Dreaming

A 10-week early intervention drug and alcohol program for Aboriginal and Torres Strait Islander young peoples that uses culture, and connection to country, interventions. It is delivered in high schools across the region and in Cobham Juvenile Justice Centre. The service uses creative and traditional workshops to provide experiences of custom, lore and value systems to build connections and a sense of belonging for young people.

- 6 schools participated in the Deadly Dreaming Program across 200 group sessions, where 189 young people were assisted
- 80 group sessions conducted at Cobham Juvenile Justice Centre, where 53 young people were assisted

Find out more:
nbmphn.com.au/DeadlyDreaming

Deadly Dreaming Impact

A young person first attended The Street University in August 2022 upon a friend's recommendation. An assessment revealed he was at risk for criminal behaviour and substance use. Despite multiple attempts by the counsellor to engage him in counselling during the initial six months, he never opted to engage beyond the initial assessment.

Noffs were able to work with his school to create a partial attendance plan at The Street University. The Noffs Aboriginal case manager facilitated a referral to an Intensive Family Preservation service, but soon after, he was arrested. Following his release from juvenile custody, he was placed in a local supported youth accommodation. At this point, the accommodation service referred him for alcohol and other drugs (AOD) counselling due to problematic cannabis and nicotine use.

He presented with daily cannabis and vaping use, although this was a reduction from previous levels. He had been diagnosed with attention deficit hyperactivity disorder and oppositional defiant disorder but was not taking his medication, as it made him feel 'not himself.' He indicated that cannabis helped manage his moods and that reducing its use increased his volatile and risky behaviours.

He recognised the negative impact of substance use on his motivation and relationships. During the initial assessment, he expressed a desire to cut back to improve his mental wellbeing and family communication. The Noffs counsellor developed a treatment strategy, incorporating cognitive behaviour therapy to identify triggers and high-risk situations, while also utilising motivational interviewing to enhance his intrinsic motivation for change.

The young client set various goals, starting with practical steps to reduce his cannabis use. Over six months, he successfully decreased his use from daily to 2-3 times a month. His severity of dependence score dropped from 9 to 3, and he showed improvements in self-regulation, problem-solving, and overall quality of life. While his K10 score for mental stress remained moderate, he demonstrated increased self-efficacy in managing stress without substances. He will continue receiving support from the Noffs AOD counselling program and his accommodation service as he explores educational and vocational opportunities.

*Read about other Aboriginal initiatives in our **Integrating Care** section on page 59 and the **Supporting Primary Healthcare** section on page 48.*

ALCOHOL AND OTHER DRUGS
Priority Area

Aftercare and Relapse Prevention Program

A support program to prevent alcohol and other drug (AOD) relapse that includes treatment planning and weekly Self-Management and Recovery Training (SMART) groups, over a period of six months. We fund WHOS in Penrith and Hawkesbury, and Lives Lived Well in the Blue Mountains and Lithgow, to deliver the programs.

- 141 clients assisted through 463 individual occasions of service

Find out more:
nbmphn.com.au/AODinformation

Dianella Cottage

A non-residential AOD day rehabilitation service in Katoomba and Lithgow delivered by Lives Lived Well. The service employs an additional part-time peer worker and a full-time Aboriginal worker to provide culturally appropriate care to Aboriginal and Torres Strait Islander clients.

- 474 clients assisted through 1,806 individual occasions of service (including SMART groups)
- 322 group sessions provided

Find out more:
nbmphn.com.au/DianellaCottage

Dianella Cottage Impact

A 39-year-old woman self-referred through Dianella Cottage, for support with reducing her alcohol consumption and gaining employment. The client has a history of mental illness and psychosocial difficulties, as well as complex trauma arising from experiences in early childhood and adolescence, including family and domestic violence, bullying and a close loss.

Through the program, she was supported to meet her goals of reducing alcohol consumption, gaining meaningful employment, practicing good sleep hygiene and reducing isolation. At her three month follow up, she reported a decrease in alcohol consumption and significant improvements in her mood and emotional regulation. Staff noted enhanced emotional insight and better handling of conflict. Her housing stability improved and she enrolled in a Certificate III in Fine Arts, reconnected with her GP and established new supportive social connections.

The client's positive engagement with Dianella Cottage enabled her to improve interpersonal relationships, develop an openness to addressing mental health issues, explore the connections between her past and present experiences, and consider various support options.

Dianella Cottage in Katoomba.

WHOS Hub Penrith

A non-residential AOD day rehabilitation service for adults run by WHOS with services including counselling, case management and support, aftercare and relapse prevention.

- 571 clients assisted through 3,538 individual occasions of service (including SMART groups)
- 117 clients identified as Aboriginal and/or Torres Strait Islander (20% of all clients)
- 815 group sessions providing 2,653 group occasions of service

Find out more:
nbmphn.com.au/WHOSHub

The Street University

We fund Ted Noffs Foundation to deliver The Street University (TSU) program in Penrith and Katoomba. It is designed for young people aged 12-25 years and provides a free community space that embraces art, music and culture while providing early intervention support services for addiction and mental health issues. A mobile outreach service across all four local government areas is delivered from TSU Penrith in addition to the Deadly Dreaming program. TSU Katoomba also provides outreach to Lithgow and Portland with specific programs for young Aboriginal and Torres Strait Islander peoples.

Penrith:

- 1,330 clients assisted through 5,774 individual occasions of service
- 159 individuals provided with outreach services
- 140 clients assisted with clinical support services
- 966 workshops were delivered to 457 young people

Find out more:
nbmphn.com.au/TSUPenrith

Katoomba:

- 633 clients assisted through 4,381 occasions of service
- 97 clients assisted with clinical support services
- 1,236 workshops delivered to 327 young people

Find out more:
nbmphn.com.au/TSUKatoomba

Mental Health Commission of NSW visit to The Street University Katoomba, June 2024.

Official Launch of The Street University Katoomba

We celebrated the official launch of The Street University Katoomba in September 2023. The service provides a free community space for young people (aged 12-25) that embraces art, music and culture while providing early intervention support for alcohol, drug, mental health and wellbeing concerns.

The Street University concept, developed by the Ted Noffs Foundation, is a unique intervention centre structured around drug, alcohol and mental health services. A diverse range of artistic, cultural and educational programs (called "hooks") are designed to engage difficult to reach young people and bring them into the centres. This "non-traditional" health setting provides counselling to young people that delivers a significant decrease in drug use and crime, and improvement in their mental health and wellbeing.

An internationally peer-reviewed independent study by the UNSW of the Street Universities found that young people with the highest levels of psychological distress, drug use and lowest overall quality of life, demonstrated the most significant improvements in all three areas after taking part in Street University programs and counselling.

Susan Templeman, Federal Member for Macquarie; Elisa Manley, Executive Manager Strategy & Integration Wentworth Healthcare; and Matt Noffs, CEO Ted Noffs Foundation and co-founder of The Street University concept.

HEALTHY AGEING
Priority Area

WiseMind RACH Mental Health Support

Our WiseMind program assists residents of Residential Aged Care Homes (RACHs) with mild to moderate symptoms of mental illness, or who are experiencing early symptoms and are assessed as 'at risk' of developing a diagnosable mental illness. Services are delivered by mental health professionals including psychologists and mental health nurses. This year, the WiseMind program expanded from 22 to 26 RACHs.

- 273 people assisted through 2,376 occasions of service

Find out more:
nbmphn.com.au/WiseMind

Mobile Occupational Therapy in Lithgow

We fund Tablelands Sports & Spinal Physiotherapy to provide a free occupational therapy (OT) service for older adults living at home in Lithgow. This service includes an initial home visit by an OT to identify patient needs and develop a personalised intervention plan. The service commenced in February 2024 operating for one day per week.

- 21 clients assisted with in-home assessments through 112 hours of service delivery
- 35 equipment requests and 25 home modifications were provided

Find out more:
nbmphn.com.au/MobileOT

Mobile Occupational Therapy Impact

A thorough assessment was conducted in the home environment of an 85 year old client with a history of falls. It was observed that his difficulties with mobility and balance meant he was unable to stand in the shower, transfer from chairs, or access help if he fell when his wife was not at home.

Fall prevention education and balance exercises were provided, together with the installation of equipment and home modifications, including grabrails, a hand-held shower hose, utility chairs, non-slip mats and a personal alarm. The client has reported that he is doing his fall prevention exercises daily and that the changes made by the OT have been very useful, assisting greatly with access inside his home.

*Read about other **Healthy Ageing** initiatives in our **Integrating Care** section on page 62 and the **Supporting Primary Healthcare** section on page 54.*

MENTAL HEALTH AND SUICIDE PREVENTION
Priority Area

Community Recovery

Bushfire and Flood Psychological Therapy Services

Our Psychological Therapy Services program was able to enhance their existing bushfire and flood stream with additional funding to further support those impacted by multiple disaster events. The ability to access this service without the need for a referral meant that people could directly access trauma trained mental health professionals without the need to see their GP first.

- 45 providers assisted 136 clients through 936 occasions of service

Find out more:
nbmphn.com.au/PsychologicalTherapy

Community Wellbeing and Resilience Grants

The Community Wellbeing and Resilience Grants are funded through the Commonwealth Department of Health and Aged Care and NSW Ministry of Health to support the mental health of those affected by the 2022 floods. Three rounds of funding were allocated to successful applicants across Blue Mountains, Hawkesbury, Lithgow and Penrith to address social connection, resilience, wellbeing and healing.

- $239,674 awarded in Round 3 for 31 projects that reached 4,892 participants from July to December 2023
- A total of $506,096 awarded across all three Rounds reaching 17,133 participants

Find out more:
nbmphn.com.au/CommunityWellbeingResilienceGrants

School Programs

To address the long-term effects of trauma caused by natural disasters in the region, consultation with school counsellors, teachers and other stakeholders highlighted the need for resilience skills programs to be delivered within schools. We funded the following four programs:

The Resilience Project delivered an evidence-based wellbeing program focussed on Gratitude, Empathy, Mindfulness (GEM) and emotional literacy in flood affected schools in the Hawkesbury. The whole of school approach involved partnering with teachers to build their capacity in wellbeing, educating parents and embedding behavioural changes in students through year level specific curriculum.

- 14 schools participated reaching 3,960 students

Esther Perry– Regional Suicide Prevention Coordinator.

Learning Links were funded to deliver small group evidence-based programs like Bounce Back and Friends for Life, supplemented with individual counselling sessions in disaster impacted schools in the Blue Mountains and Hawkesbury. Webinars provided the wider school community with information and tools to support wellbeing at home.

- 80 people from the wider school community participated

Tackling Tough Conversations disaster response program, provided by Lifeline Central West, delivered the interactive program across the region. Collaboration with other youth-based organisations helped to reach in-need youth that were not enrolled in school.

- 66 students across 4 schools and a small number of young people participated and enrolled in an employment program

The **Mindflare Program** was funded to provide a group program and individual counselling sessions within schools, as well as webinars for the wider school community, offering practical strategies and tools to support the wellbeing of children/youth at home.

- 137 students across 5 schools participated
- 27 students enrolled in counselling sessions
- 3 webinars were hosted, which were attended or viewed by over 300 people

Celebrating Flood Recovery in the Hawkesbury

*Our **Community Wellbeing and Resilience Grants** program funded free events that provided a much needed opportunity for the local community to come together and focus on some of the positive steps taken towards recovery following the devastation of the floods. The Hawkesbury region experienced the trauma of three major flood events in succession (February 2021, March 2022 and July 2022), which had a major impact on the mental health of the community.*

Hawkesbury Paddlewheeler

*The return of the historic **Hawkesbury Paddlewheeler** was celebrated at a Gala Day in November 2023, coordinated by the **Windsor Experience Group**. Once an icon in the local area and a major tourist attraction, the Paddlewheeler suffered major damage in each of the three major floods. The event celebrated the return of the Paddlewheeler and featured a range of entertainers throughout the day, food, drinks and some market stalls.*

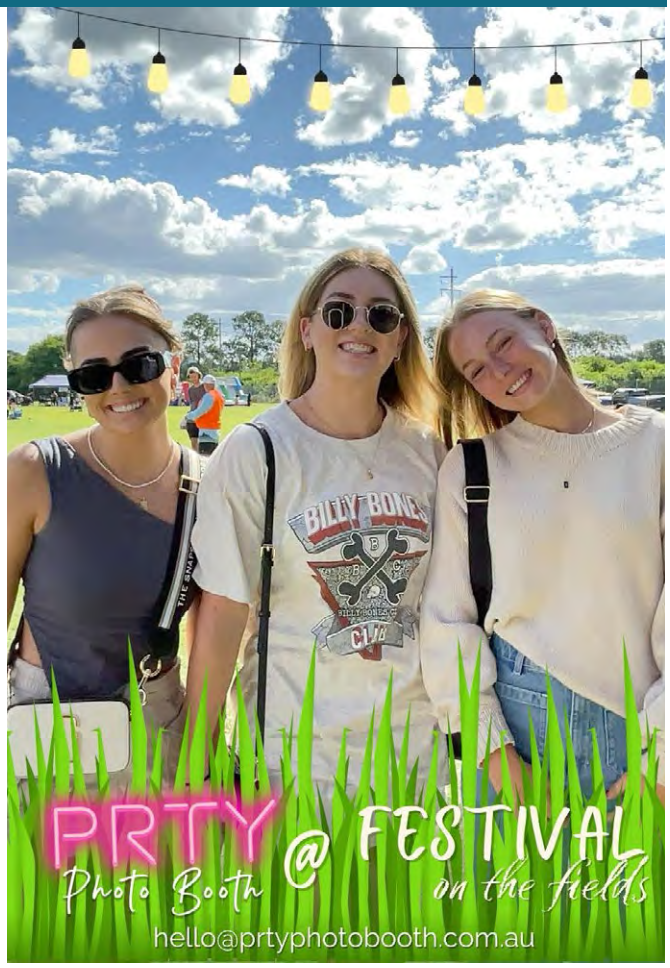
Festival on the Fields

*In February 2024, over 400 locals enjoyed the **Festival on the Fields** event at Cougar Park, home of the Colo Soccer Football Club. The Club suffered significant infrastructure damage and losses through the multiple flood events. Many of the volunteers who assisted the Club in the clean up after each flood event, were also personally affected by the floods. Event organisers, **Colo Soccer Football Club**, said that this event was a chance for the Club to thank volunteers for their support and to lift the spirits of the extended community.*

Research shows the importance of people coming together, socialising and providing informal support to each other after a natural disaster. This was particularly relevant to the Hawkesbury community that had been severely affected. The funding of these events focussed on social cohesion and connectedness, supporting mental health healing, and building on the existing strength of the community by encouraging post-trauma growth.

Federal Member for Macquarie Susan Templeman, enjoying Festival on the Fields with the community.

The Festival on the Fields.



Supporting the Recovery of the Lithgow Community

The Lithgow area was impacted by six natural disasters, which severely affected the mental health and wellbeing of the community. Through our Community Wellbeing and Resilience Grants program, the Glen Alice Community Association Inc. received funding to host a series of events to help the community rebuild, including a working bee at the community hall, barn dance, movie night, Christmas lunch, Gatsby themed dinner and Melbourne Cup luncheon. Nearly 300 community members attended the combined events from September 2023 to March 2024. These events facilitated and fostered ongoing community get-togethers. The Glen Alice Community Association said the events provided "benefits which can not necessarily be measured, but manifest through a broad, positive and inclusive community spirit".

Walking with Little Footsteps

Walking with Little Footsteps, an initiative of Western Sydney University (WSU) Early Learning, involved engaging Aboriginal children in various resilience activities On Country at a local creek. Children in the program were encouraged to look at plants, insects, wildlife and trees and incorporate these images into drawings. In small groups, they learnt about the importance of being On Country to help build their sense of place and identity, particularly after flood related trauma. Following completion of the activity, WSU Early Learning were awarded a National Sprout Award as recognition of some of the research undertaken with the children. "The award would not have been possible without the generous funding of Wentworth Healthcare Limited". – WSU Early Learning

Colour Run for Mental Health

The Aboriginal Cultural and Resource Centre in Katoomba hosted a Colour Run for residents and community members to bring awareness to the importance of mental health. The event was funded through our Community Wellbeing and Resilience Grants program and ran in partnership with a local football club and local service providers in the region. Over 65 Aboriginal and non-Aboriginal children and adults attended the Colour Run, which also included a BBQ, local service information bags and mental health support services for parents and carers, while the children played with colour and water pistols. Participants said it was "a fun and colourful day for the kids" and stated they would attend another Colour Run for mental health awareness in the future.

Wellbeing Outreach Program

This program was built on the successful model used to support bushfire affected communities following the Black Summer bushfires, where we commissioned Gateway Family Services to provide qualified mental health workers to enhance the Step-by-Step bushfire support service.

In February 2023, the Wellbeing Outreach Program transitioned from bushfire support to flood support and became part of the designated lead disaster recovery service through Peppercorn Services. This service provides individualised assistance to flood affected communities primarily in Hawkesbury and Penrith local government areas. Flexible wellbeing support is provided in cafés, parks and homes, and can include individual or group support, to assist those impacted on their recovery journey. This holistic model of disaster recovery provides those affected with access to the services they need, from known and trusted practitioners embedded within the community.

- 79 clients assisted through 1,505 occasions of service involving 69 community engagement activities and 270 hours of community participation

*Read about other **Disaster and Emergency Management** initiatives in our **Integrating Care** section on page 61 and the **Supporting Primary Healthcare** section on page 52.*

Mental Health

Head to Health Services

The Head to Health adult mental health centre in Penrith and the Hawkesbury satellite service provide walk-in mental health support, without the need of a prior appointment, to people experiencing distress or crisis. We fund Neami National to deliver the services, with the Penrith centre open 7 days per week, 365 days a year, including public holidays. Head to Health supports those needing short-term mental health support, or those wanting to find other mental health support for themselves, or someone they care about. Services are free and support is provided by a multidisciplinary team including trained mental health professionals and peer support workers.

Penrith Head to Health Centre:

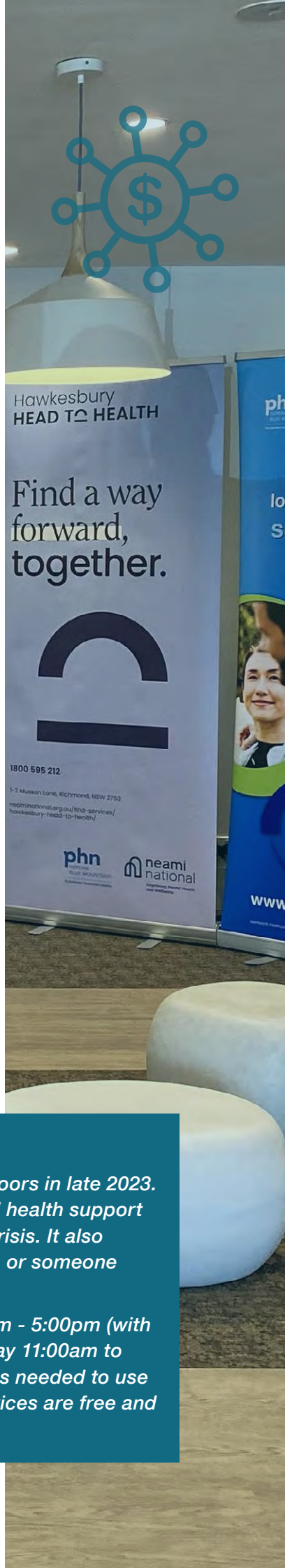
- 602 individuals assisted across 629 episodes through 8,622 occasions of service

Hawkesbury Head to Health Satellite:

- Service transitioned from Head to Health Pop-Up to the new Satellite model in August 2023
- Satellite services commenced from new premises December 2023
- 288 individuals assisted across 296 episodes through 2,237 occasions of service

Find out more:
nbmphn.com.au/PenrithHeadtoHealth or **nbmphn.com.au/HawkesburyHeadtoHealth** *or read about our* ***Head to Health Phoneline*** *in the* ***Integrating Care*** *section on page 66.*

The Hawkesbury Head to Health launch with Lizz Reay, CEO, Wentworth Healthcare; Tom Dalton, CEO, Neami National; the Hon Emma McBride MP, Assistant Minister for Mental Health and Suicide Prevention and Assistant Minister for Rural and Regional Health; together with Susan Templeman, Federal Member for Macquarie.



Hawkesbury Head to Health Launch

The new permanent Hawkesbury Head to Health site officially opened its doors in late 2023. Located at 1-2 Musson Lane in Richmond, the service provides free mental health support in a safe and welcoming environment for people experiencing distress or crisis. It also supports those wanting to find other mental health support for themselves, or someone they care about.

The new centre is open on Monday, Tuesday, Wednesday and Friday 9:00am - 5:00pm (with walk-in support available from 1:00pm - 5:00pm) and Thursday and Saturday 11:00am to 7:00pm (with walk-in support available from 1:00pm - 7:00pm.) No referral is needed to use the service and during walk-in hours, no prior appointment is needed. Services are free and support is provided by trained mental health professionals.

headspace

headspace provides early intervention support to young people aged 12-25 years old across mental health, physical health, work and study, and alcohol and other drug needs. We fund Uniting NSW.ACT to deliver full headspace centres in Penrith and Hawkesbury and a headspace satellite service in Katoomba, with Marathon Health funded to deliver a headspace satellite service in Lithgow.

- The Hawkesbury service opened in December 2023, with 144 young people assisted through 585 sessions
- In Katoomba, 193 young people assisted through 768 sessions
- In Lithgow, 240 young people assisted through 1,385 sessions
- In Penrith, 696 young people assisted through 2,427 sessions

Find out more:
nbmphn.com.au/headspace

headspace Hawkesbury Launch

The new headspace Hawkesbury centre was officially declared open on Friday 1 March, by Hon Emma McBride MP, Assistant Minister for Mental Health and Suicide Prevention and Assistant Minister for Rural and Regional Health, together with Federal Member for Macquarie, Susan Templeman.

Uniting NSW.ACT were commissioned to establish the full-service centre. Together with the community, we have been advocating for over seven years for additional youth mental health services in the Hawkesbury.

The official launch welcomed stakeholders from across the region who played a part in helping to secure and establish the centre, including young people from the community.

Left-Right: Lizz Reay, CEO, Wentworth Healthcare; Jason Trethowan, CEO, headspace National; the Hon Emma McBride MP, Assistant Minister for Mental Health and Suicide Prevention and Assistant Minister for Rural and Regional Health; Leah Venables, headspace Hawkesbury Youth Advisory Committee; Susan Templeman, Federal Member for Macquarie; Chantal Nagib Duffy, Head of Uniting Recovery, Uniting NSW.ACT; together with young people from local high schools.

headspace Lithgow Youth Plus

A brief intervention service available in the Lithgow area offering young people aged 12-25 who are in crisis, a set of specific individual appointments.

- 45 young people assisted through 102 occasions of service

Find out more:
nbmphn.com.au/YouthPlus

headspace Youth Early Psychosis Program

This early intervention program provides young people aged 12-25 years, who are experiencing a first episode of psychosis or at high risk of experiencing psychosis, with a care team of multidisciplinary professionals. The program offers a comprehensive recovery-oriented service to meet the needs of this group.

- 358 young people assisted through 8,072 occasions of service

Find out more:
nbmphn.com.au/hYEPP

headspace Youth Early Psychosis Program Impact

headspace Youth Early Psychosis Program was able to assist a young person who was hearing voices, engaging in self-harm and faced challenges due to developmental hurdles related to her deafness. These difficulties led to feelings of isolation, inadequacy, and struggles with interpersonal relationships and social integration.

Through the program, the young person actively engaged with headspace throughout the year, attending weekly sessions with her clinician who provided support with the aid of an Auslan interpreter. She was connected with other health professionals in the program, including an occupational therapist, dietitian, and exercise physiologist. The treatment objectives focused on psychoeducation, stress management and self-care, aiming to enhance her emotional processing and regulation skills.

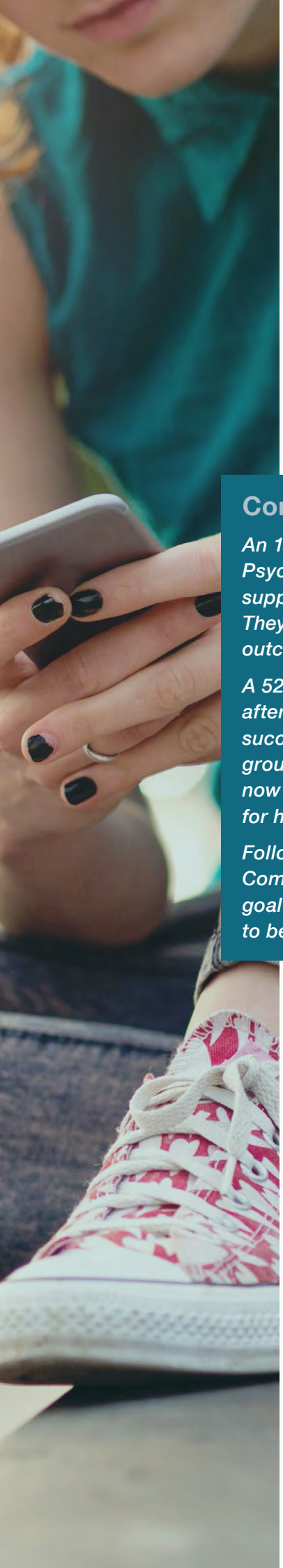
The young person was successfully discharged from the program and is in now in the care of an National Disability Insurance Scheme (NDIS) service provider, an Auslan-signing counsellor, NDIS support staff and her GP. Her progress underscores the value of a collaborative therapeutic approach, where various professionals, including clinicians, interpreters, and support workers, work together to support the client's needs.

Youth Enhanced Support Service (YESS)

An outreach service offering wrap around clinical care for young people at risk of or living with severe mental illness in the Blue Mountains, Hawkesbury and Penrith. The program offers a comprehensive recovery-orientated service to meet the needs of this group.

- 204 young people assisted through 4,293 occasions of service

Find out more:
nbmphn.com.au/YESS



Commonwealth Psychosocial Support

We fund Flourish Australia to provide this program to assist people with a severe mental illness who have reduced psychosocial function and who are not supported by the NDIS. The program strengthens the capacity of people to live independently, safely and productively in their community, form meaningful connections in a supportive environment, and reduce the need for acute care. Support also includes assisting those eligible in NDIS Access Requests.

- 262 individuals assisted across 268 episodes through 5,126 occasions of service

Find out more:
nbmphn.com.au/CPS

Commonwealth Psychosocial Impact

An 18 year old unemployed male from Penrith was referred to Commonwealth Psychosocial Support with suicide ideation and depression. They were supported to enrol and participate in an 8-week construction bootcamp course. They reported that they now feel hopeful for their future, and are awaiting the outcome of an interview for a construction apprenticeship program.

A 52 year old female from the Blue Mountains became socially isolated after moving from Parramatta. Commonwealth Psychosocial Support staff successfully connected her with social groups, community library and walking groups, and she now has the capacity to make plans during the weekends. She now attends a book club and engages in bushwalking, and thanks the service for helping her to "find her voice".

Following a significant period of social isolation due to chronic anxiety, the Commonwealth Psychosocial Support program enabled a man to achieve his goal of social engagement. He has now commenced TAFE studies in Youth Work to be able to give back to the community.

Dokotela Telepsychiatry Service

We commission Dokotela to provide free telepsychiatry services across our region. The service provides access to over 40 experienced psychiatrists, with a range of different specialities, who work collaboratively within a multidisciplinary team of mental health professionals. Many of these psychiatrists can speak another language, or if they can't speak the patients' desired language, interpreters are available through the Translating and Interpreting Service (TIS National). Appointments are delivered via telehealth at the patient's home, office of a support service, or their nominated GP practice.

- 381 people assisted across 787 occasions of service

Find out more:
nbmphn.com.au/Telepsychiatry

Live Life Get Active

We fund Live Life Get Active to deliver an outdoor physical exercise program for people with emerging to mild mental health issues with a focus on reducing social isolation and increasing mental health literacy and self-care behaviour.

- 7 locations – (2 in Blue Mountains, 2 in Hawkesbury, 1 in Lithgow and 2 in Penrith)
- 620 active clients across 9,871 occasions of service

Find out more:
nbmphn.com.au/LiveLifeGetActive

St Mary's Live Life Get Active. Right: Hawkesbury Live Life Get Active.

Mental Health Nurse Incentive Program

This program provides community-based mental health support for people living with severe and persistent mental illness. Mental Health Nurses provide clinical care and work in collaboration with the patient's carers, doctors and service providers.

- 9 nurses in the program assisted 105 people

Find out more:
nbmphn.com.au/MHNIP

Psychological Therapy Services

Subsidised, short-term psychological support for people with mild to moderate mental health concerns.

- 1,681 referrals (including people at low to moderate risk of suicide or self-harm)
- 11,272 occasions of service (including SOS)
- 72 providers
- 365 suicide prevention referrals (SOS)
- 58 bushfire affected people assisted with 487 sessions provided
- 50 flood affected people assisted with 449 sessions provided
- 46 providers for bushfire and flood streams

Suicide Prevention

Suicide Prevention Training

Building on the community mental health training rolled out in response to the 2019/2020 bushfires, we funded training through several organisations to assist people in the community to recognise and support people in distress.

Adopting a community led and systems-based approach, we funded:

LivingWorks Australia to deliver the World Health Organisation recognised Assisted Suicide Intervention Skills Training (ASIST) and SafeTALK training including SafeTALK LGBTQIA+, and I-ASIST (Indigenous ASIST).

- 9 community events with 182 attendees

Suicide Prevention Training Impact

"The emphasis on keeping safe for now highlighted the importance of my role as an intervenor of suicide. ASIST has given me the tools to confidently approach an individual and talk directly about suicide."

"I feel much better prepared to identify a person who has suicidal thoughts. How to talk to them about it and how to help them if they need it."

Blue Knot Foundation, the National Centre of Excellence for Complex Trauma, to provide Managing Wellbeing and Recognising Vicarious Trauma workshops.

- 12 community events with 240 attendees

Roses in the Ocean, the national lived experience of suicide organisation in Australia, were funded to deliver TouchPoints training that is facilitated by people with a lived experience of suicide. Four local community members with lived experience became accredited to deliver TouchPoints throughout the year, building both capacity and sustainability in our region.

- 9 community events with 83 attendees

Seek Out Support (SOS)

The SOS program is designed to provide patients, with low to moderate risk of suicide or self-harm, access to short-term therapeutic support. This service can support people aged 14 years and above and interventions can include family members and/or carers of the person being referred. Family or friends considered at risk in the aftermath of suicide are also eligible for the service.

- 375 clients assisted through 2,025 occasions of service

Find out more:
nbmphn.com.au/SOS

*Read about other **Suicide Prevention** initiatives in our **Integrating Care** section on page 67.*

POPULATION HEALTH
Priority Area

After Hours

We fund a variety of services across the region to facilitate access to primary healthcare services and resources outside of the normal business hours when regular GPs aren't open. This helps prevent people from unnecessarily presenting at hospital emergency rooms.

- 5 services funded, including two After Hours practices, the National Home Doctor, My Emergency Doctor for RACHs and Penrith 24 Hour Pharmacy
- 37,716 consultations provided by after hours GP services
- 357 consultations by National Home Doctor
- 25,734 visits to Doctor Closed website
- 518,575 people reached through Doctor Closed Facebook advertising
- 20,152 people used Penrith 24 Hour Pharmacy in the after-hours period
- 117 consultations by My Emergency Doctor to support residents in local RACHs (service delivered from July-January)

Find out more:
DoctorClosed.com.au

Penrith Medicare Urgent Care Clinic

Urgent Care services were developed to improve access to primary care services, bridging the gap between primary and acute care for patients, by providing an alternative to presenting to the emergency department when a regular GP isn't available. This service accepts walk-ins from 8:00am - 8:00pm, seven days a week, 365 days a year, and treats minor illnesses and injuries that are urgent, but non life-threatening. All services are free for Medicare cardholders and patients have access to a team of healthcare professionals.

- 8,574 unique patients attended UCC
- 10,777 total visits
- 32% of visits were after hours
- Main reasons for attending were injury, laceration and pain
- 25-44 year olds are the most frequent patients seen by UCC
- Without UCC, 51% would have waited for their usual GP and 26% would have gone to the Emergency Department

Find out more:
nbmphn.com.au/UrgentCare

Medicare Urgent Care Clinic Penrith

After an open tender process, we commissioned Cornerstone Health to establish the service in Our Medical Penrith at the Penrith Homemaker Centre. In August 2023, we officially opened the Commonwealth-funded Medicare Urgent Care Clinic in Penrith, together with Federal Member for Macquarie, Susan Templeman, and Cornerstone Health Henry Bateman.

*Read about other **Population Health** initiatives in our **Integrating Care** section on page 70 and the **Supporting Primary Healthcare** section on page 56.*

VULNERABLE COMMUNITIES
Priority Area

Chronic Obstructive Pulmonary Disease Services

CALM Program

The Chronic Airways Limitation Management (CALM) Program is designed for people in the Hawkesbury with a lung disease who have difficulty breathing and impacting their ability to undertake activities of daily living.

- 50 people completed the program
- 218 people have completed the program since 2018

Find out more:
nbmphn.com.au/COPD

Lungs in Action

Developed by Lung Foundation Australia, this program is a community-based maintenance exercise program for people in the Hawkesbury with stable chronic lung conditions who have completed a pulmonary rehabilitation program.

- 102 groups were held with an average of 9 participants in each group

Patient surveys from the program have shown that all patients agree or strongly agree that the Lungs in Action classes have a positive affect on their mood, ability to remain independent with activities of daily living and feel confident in managing their COPD.

Find out more:
nbmphn.com.au/LungHealth

Chronic Pain Management Program

Chronic pain imposes a significant burden of disease on the community with one in five people reported to experience chronic or persistent pain. This six-week small group program runs in Lithgow, helping those with low to moderate chronic pain improve functional capacity through self-management of their pain.

- 44 participants
- 85% of program participants completing the program reported an improvement in each of the patient outcome measures

Find out more:
nbmphn.com.au/ChronicPain

Domestic, Family and Sexual Violence (DFSV) Lithgow Outreach Speech Therapy Program

We fund Direct Focus Solutions to deliver this program, providing a speech therapist who works one day a month with children who have been impacted by domestic violence and/or homelessness who have been referred through Lithgow Community Projects.

- 25 children assisted across 32 occasions of service

Find out more:
nbmphn.com.au/OutreachSpeechTherapist

HEAL Pilot Program

Healthy Eating Activity and Lifestyle (HEAL) is a pilot program that provides strategies around healthy eating, exercise and behaviour change targeted at supporting people who are obese, or who have or are at risk of, developing a chronic disease.

- 16 participants with a waitlist of 25

Find out more:
nbmphn.com.au/HEAL

Outreach Clinics

With funding from the Rural Doctors Network NSW, we coordinated Specialist Outreach Clinics at Katoomba, Lithgow and Windsor. Aboriginal and Torres Strait Islander peoples, and those who may experience difficulty in accessing health services due to long distance or other barriers, are given priority access to these bulk-billed services covering speech pathology, psychiatry, paediatrics and endocrinology (diabetes).

Better Ears, Healthy Listening

- 179 individual consultations over 37 clinic days
- 64 consultations with Aboriginal patients

Paediatric Outreach Clinic

- 399 individual consultations over 44 clinic days
- 302 consultations with Aboriginal patients
- 96 telehealth consultations

Psychiatry Outreach Clinic

- 421 individual consultations over 34 clinic days
- 49 consultations with Aboriginal patients
- 85 telehealth consultations

Endocrinology Outreach Clinic

- 866 individual consultations over 25 clinic days
- 64 consultations with Aboriginal patients
- 1 telehealth consultations

Find out more:
nbmphn.com.au/OutreachServices

HEAL Program Impact

- *13 program participants demonstrated improved results in their cardiovascular 6 minute walk test and in their sit to stand assessments*
- *14 participants reported continuing to engage in regular, independent physical activity*
- *5 participants engaged with the onsite dietitian and have regular follow ups for guidance and support to maintain their healthy eating habits formed throughout the HEAL program*
- *13 participants have engaged with the service provider's own maintenance program post completion of the HEAL pilot*
- *2 participants have achieved remarkable weight-loss results, with both continuing to engage in regular physical activity and seeing a dietitian to maintain weight-loss*
- *2 participants have reported improvements in their pain management, which has allowed them to continue with regular physical activity*

Dr Arman Babajanyan and Dr Kieran Webb, presenting to the Wentworth Healthcare Board about the outcomes of the Paediatric Clinic.

*Read about other **Vulnerable Communities** initiatives in our **Supporting Primary Healthcare** section on page 57.*

Supporting our primary care partners

Wentworth Healthcare Primary Care Development teams play a crucial role in supporting our primary care partners across the region.

Primary Care Engagement Officers at Wentworth Healthcare.

SUPPORTING PRIMARY HEALTHCARE

We believe that primary healthcare, incorporating general practice, allied health professionals and other community-based organisations, is the cornerstone of health in our community. We support primary healthcare to build their capacity to deliver high quality patient-centred care and implement models that reflect best practice, support wellness, are culturally appropriate and enhance multidisciplinary team care.

Below are examples of SUPPORTING PRIMARY HEALTHCARE through our Priority Areas.

HEALTH WORKFORCE
Priority Area

Supporting General Practice

Our Primary Care Engagement Officers (PCEO) work collaboratively with general practice and offer support with accreditation, quality improvement, immunisation, digital health, business support and more.

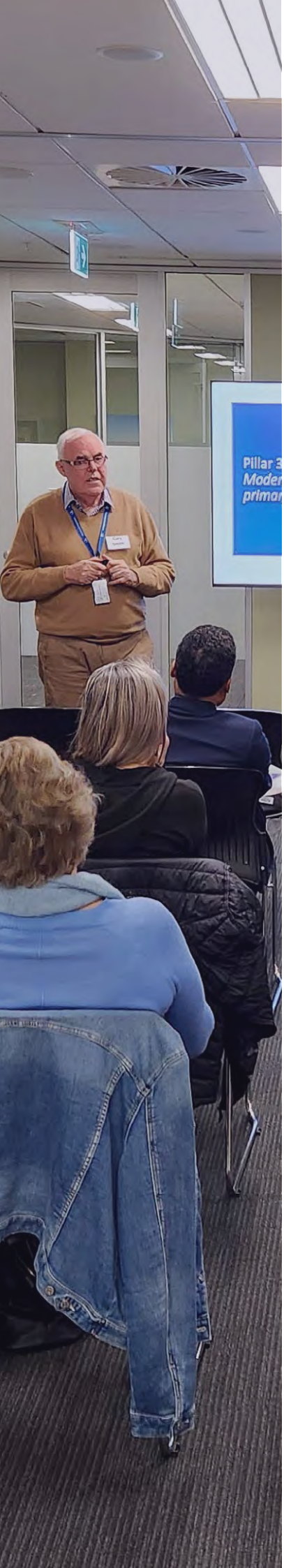
- 2,358 support activities across 136 practices
- 76% of total practices are Accredited
- 98% of Accredited practices share de-identified data with us

Find out more:
nbmphn.com.au/PracticeSupport

Practice Support Impact

"Wilberforce General Practice requested our support to become accredited, to enable them to grow their practice in the region. We assisted them throughout the process to ensure that the practice understood and applied the RACGP standards correctly. Our team provided advice and helped the practice to complete their accreditation survey. The practice was successful in gaining an accredited status." *– Gabe Treble, Primary Care Engagement Officer*

"We provided support to a new general practice that was planning to open in Lithgow. Our staff provided assistance in preparing the practice leading up to the opening by supporting the new practice with MyMedicare registration, cultural awareness training, registrar orientations, preparation for accreditation and cold chain management training. The practice successfully opened on 7 February 2024."
– Rosemary Mason, Primary Care Engagement Officer



Quality Improvement Practice Incentive Program

The Quality Improvement Practice Incentive Program (PIP QI) supports accredited practices that commit to improving the care they provide to their patients. To qualify for a PIP QI payment, a practice works closely with us using de-identified data, to focus on priority areas for continuous quality improvement activities.

- 98 practices registered for PIP QI
- We offered 7 QI programs involving 53 practices. These included the COPD Collaborative, Cancer Screening, LUMOS, Winter Strategy and Wound Management

*Read more about the **Winter Strategy Quality Improvement Program** on page 57.*

Find out more:
nbmphn.com.au/QualityImprovement

Practice Nurse Engagement

Our primary care nurses are integral to providing safe, efficient and high-quality primary care. With the ongoing challenges faced by general practices this year, we continued to see a growing number of nurses employed in practices in our region. Our nurse orientation sessions provide new practice nurses with local guidance, resources and support to settle quickly into busy practices. We also held a Practice Nurse Education Day that was attended by 55 people.

- 239 practice nurses employed in the region
- 37 practice nurse orientations completed
- 38 practice nurse support sessions delivered

Read more:
nbmphn.com.au/PracticeNurseSupport

Online Peer to Peer Networking

We administer and moderate several closed Facebook groups for health professionals in our region including GP registrars, practice managers, health professionals and practice nurses. The Practice Nurse Network in particular is highly engaged, with members regularly posting questions about nursing in general practice and sharing resources and information.

- 223 Health Professionals Group members
- 183 Practice Nurse Network members
- 98 Practice Managers Group members
- 38 GP Registrars group members

Primary Care Advisory Committee

This Committee includes representation from GPs, practice nurses, practice managers, allied health and consumers who share challenges, promote innovation and help identify priorities for improvement in primary care. The Committee has been running for almost five years and the group continues to grow and expand its areas of focus. The Committee provides their insights and feedback on several areas with a key focus on our quality improvement

initiatives, continued professional development and workforce challenges. In particular, the Committee has provided valuable input into our Workforce Planning and Prioritisation work, which ensures we maintain GP registrars in the region and will help inform how the RACGP will place registrars in the future. The Committee continues to be instrumental in providing innovative ideas for the orientation of new registrars within our region.

- 4 meetings held

Workforce Support

We help develop a sustainable and skilled primary healthcare workforce through initiatives that attract, recruit and retain primary health professionals. We coordinate a job matching service by advertising local primary healthcare positions, receive proactive applications from healthcare job seekers, and put local practices in touch with potential, suitable candidates.

- 474 support consultations
- 76 job vacancies advertised across 44 practices
- 129 GP registrars per year maintained due to our advocacy
- 32 orientation sessions provided to 54 GP registrars and new GPs in the region

Health professionals recruited:

- 5 GPs, 3 practice nurses and 5 practice staff

Read more:
nbmphn.com.au/workforce

Workforce Planning and Prioritisation Program

GP Registrars Welcome Dinner.

GP Workforce Planning and Prioritisation (WPP) consortiums have been established by the Commonwealth Government to combat workforce issues and provide advice on workforce needs and training capacity across Australia. We are a member of the NSW and ACT GP WPP consortium, which is led by Capital Health Network (ACT PHN). The key role of GP WPP consortiums is to analyse and provide evidence-based recommendations to the Department of Health and Aged Care. This will guide the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) in their decision-making regarding the future allocation and placement of GP registrars to meet the community's GP workforce needs. As part of the program, our Workforce team conducted a range of engagement activities with GPs, supervisors, GP registrars, community, GP training colleges, medical students, and local universities to collect qualitative and quantitative feedback regarding workforce needs, training capacity, placement priorities and GP training pathways across the region. For the first time we also hosted a GP Registrar Welcome Dinner, which provided an opportunity for new registrars to network with supervisors, GPs and other health professionals in the region.

Strengthening Medicare – GP Grants Program

The Strengthening Medicare – GP Grants Program provided a one-off grant to general practices, of between $25,000 to $50,000 based on practice size and accreditation status, for investments in innovation, training, equipment and minor capital works. All general practices that met the RACGP Standards (5th edition) were eligible to receive a grant. We administered grants to 118 of our 133 general practices. Grant payments were made to 85 practices during 2022-23 and another 33 practices in 2023-24. All grant recipients completed the Financial Acquittal Report as requested by the Department and 94% of grant recipients also completed the self-evaluation survey designed by the Department, which is higher than the national average of 73%.

The Clinical Paediatric Conference.

Continuing Professional Development

We are committed to providing continuing professional development (CPD) to GPs, practice nurses, practice managers, allied health professionals and their teams across our region, which is predominantly free to access. One of the many ways we ensure we provide quality education is by being a CPD Education Provider under the RACGP CPD Program. We also partner with training organisations, professional bodies, the Nepean Blue Mountains Local Health District (NBMLHD), universities and local clinicians. We provide our own online learning management system, 'Your Practice Portal', to provide regular, high-quality CPD education and events. This year we provided an extensive calendar of education events, which also saw full days of education on offer, including Practice Nurse Education day, Navigating Women's Health day and the popular Clinical Paediatric day.

- 62 CPD events with 1,057 health professional attendances
- 100% of participants who attended an event reported it improved their knowledge and/or skills

Find out more:
nbmphn.com.au/Workforce

Antenatal Shared Care Event.

GP Nurse Education Day.

Aboriginal Cultural Awareness Training

Mitch Beggs Mowczan, our Aboriginal Health Lead, together with Eliza Pross from Ochre and Salt delivered RACGP Accredited Aboriginal Cultural Awareness training to primary healthcare including staff, general practice and mental health professionals. The course provides targeted and practical information that contributes to cultural safety when working with Aboriginal and Torres Strait Islander peoples and information about kinship systems, totems, connection to country, effective engagement in a healthcare setting and much more.

- 26 attendees
- 4 training sessions

"Most engaging, positive, facilitator. Truly made me reflect on my practice, strengthen, increase my knowledge and understanding. Learning and consolidating my understanding was invaluable to me." *– Participant feedback*

DIGITAL HEALTH
Priority Area

Supporting the Uptake of Digital Health

Our Digital Health Officer, together with our PCEOs, promote the uptake and use of digital health in general practice to improve access to healthcare, continuity of care, collaboration between providers and patient outcomes. Digital health technology assists healthcare professionals to provide patient-centred care and ongoing management. It reduces wait times by streamlining and improving access to healthcare data and information. Utilising information systems such as My Health Record, provides real-time support to practices and improves clinical decision-making.

- 128 digital health support activities across 136 practices

Data Analysis Support

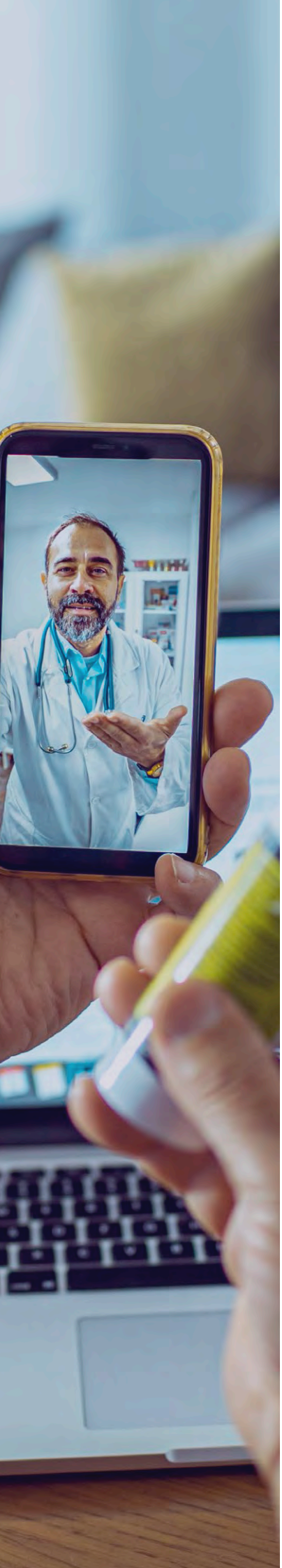
As part of our Population Health, General Practice Engagement and Digital Health Strategies, we provide clinical audit tools to practices in our region at no cost. Our PCEO team helps practices to use these tools to improve patient care through data analysis and quality improvement initiatives. We assisted additional practices transition to Primary Sense Primary Sense to gain better insights into our region's population health.

- 90% of eligible practices use Primary Sense

Primary Sense Impact

We are one of 12 PHNs that have funded the development of Primary Sense, a data extraction and clinical support tool delivered by WA Primary Health Alliance. Primary Sense is free for eligible practices that share their de-identified data. Data sharing throughout our region provides broader population health insights, which helps us to plan and commission services that better support practices to meet local heath needs.

- *39,891 prompts were triggered through Primary Sense with 24% of recommended interventions implemented, equating to over 9,700 interventions that might have otherwise been missed.*
- *Primary Sense triggered 7,138 medication alerts for GPs. For 34% of these, GPs responded "Appropriate – I will take action". With adverse drug reactions accounting for 2-3% of hospital admissions, with a cost of $6,000 per admission, this indicates that changes in prescribing contributed to potential savings of $14.4 million to the local health system.*
- *Influenza vaccination reduces the risk of hospitalisation from influenza by 68%. GPs using the Primary Sense Desktop app administered an average of 19.8 immunisations per GP, compared to 12.3 per GP without the app, resulting in an additional 4,236 vulnerable patients receiving influenza immunisations. With an average respiratory hospitalisation rate of 3,445 per 100,000 population among older people, and an average cost of $7,175 per admission, this additional vaccination coverage could result in potential local savings of $709,325 from avoided influenza-related hospitalisations.*
- *86% of practices with Primary Sense downloaded at least one report. The top three reports are Health Assessments (19%), Patients booked in with missing PIP QI measures (11%), and Accreditation (10%).*



My Health Record

We assist general practices in using My Health Record (MHR) effectively. This helps improve access to services, increase health-provider collaboration, and facilitates the delivery of safe, high-quality and effective patient care, which can save lives. Additional support was given to general practices to help them establish security and access policies that comply with legislative requirements for accessing My Health Record.

- 106 digital practices are registered to use MHR
- 29,294 Shared Health Summaries uploaded
- 656,879 documents viewed on MHR (increased from 408,206 views last year)
- 91 pharmacies are registered to use MHR
- 1.1 million uploaded prescriptions to MHR by general practices

E-Prescribing and SafeScript

Electronic Prescribing (ePrescribing) provides an option for prescribers and their patients to receive an electronic prescription (eScript) token as an alternative to a paper-based prescription. SafeScript NSW is a real-time prescription monitoring system that allows prescribers access to their patients' prescription history for certain high-risk monitored medicines. SafeScript NSW supports prescribers in making safer clinical decisions and reduces the prevalence of unsafe use of monitored medicines. We support practices to implement e-Prescribing and SafeScript NSW.

- 95% of pharmacies are e-Script ready
- 353 (82%) of GPs registered for SafeScript NSW
- 258 (77%) of pharmacists registered for SafeScript NSW
- 465 (40%) of other health practitioners (eg. nurse practitioners, specialists etc.)

Secure Messaging

Enables healthcare providers to send and receive sensitive and confidential clinical information like referrals, reports, pathology and radiology requests, results and discharge summaries in a secure and encrypted environment. We assist practices to implement and use secure messaging.

- 132 practices (100%) have Secure Messaging capabilities (increased from 94% last year)
- 4,030 eReferrals were received by specialists in our region
- 81% increase in eReferrals by Nepean GPs in the region compared to last year

LUMOS

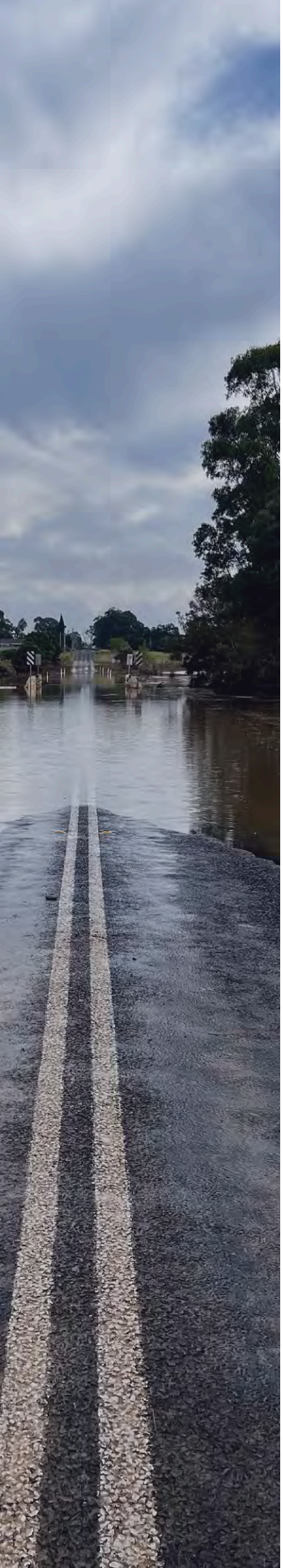
LUMOS, a partnership initiative between NSW Health and PHNs, assists practices to better understand their patients' journey across the health system. LUMOS securely links encoded data from general practices to other health data in NSW, including hospital, emergency department, mortality, ambulatory and other data. Linking information about the healthcare people receive helps GPs understand what patients need, where and when, and allows better decisions for managing population health and patient care.

- 39 practices shared de-identified data

What LUMOS Brings to Light

Being involved in LUMOS means that we get a more holistic view of our patient's journey through our local health system and what interventions may be helping and hindering health outcomes. This helps us with future health planning. LUMOS data in our region shows that:

- *A follow-up visit to the GP after an unplanned hospital stay significantly lowers the chance of readmission, both immediately and over time. Seeing a GP within two days of discharge led to a 32% reduction in readmissions within the first week. A visit within the first week after discharge was associated with a 7% decrease in readmissions within 28 days. Additionally, a GP visit within the first four weeks after discharge resulted in a 13% reduction in readmissions over the following 1-3 months.*
- *Residents of aged care homes access primary care more frequently than older adults living in the community. From July 2016 to June 2021, older individuals in the LUMOS cohort visited GPs an average of nine times per year. Nearly half had over 16 visits per year, compared to less than a quarter of older adults in the community. GP visits increased with age, with those aged 85 and over visiting on average 15 times annually.*
- *There was a temporary drop in average annual GP visits across all age groups during 2019-20, coinciding with COVID-19 lockdowns. Visit rates returned to pre-pandemic levels by 2020-21.*
- *Proactive diabetes care is more frequent among those first diagnosed by GPs, with 50% prescribed antidiabetic medications compared to 27% receiving medication following a hospital diagnosis. GP diagnosis also showed a higher likelihood of having GP management plans, regular health reviews, and recorded measures of blood pressure, cholesterol, and HbA1c. Over a two-year period, individuals diagnosed in GP settings generally accessed fewer hospital services, averaging 16 GP visits, two emergency department visits, two hospital admissions, and eight outpatient services, as opposed to those diagnosed in hospitals, who averaged fewer GP visits (10) but more hospital admissions (four) and outpatient services (12). Additionally, mortality was lower for those initially diagnosed by a GP, with a 4% mortality rate compared to 6% for those diagnosed in hospital settings.*



DISASTER AND EMERGENCY MANAGEMENT

Priority Area

We provide tailored disaster and emergency management support across the emergency management cycle, covering preparedness, response, recovery and mitigation.

This year we provided support to primary healthcare through our Primary Care Engagement team and online education and resources, including our website and Disaster HealthPathways. We provided guidance to general practice on how to be best prepared with emergency and business continuity planning.

General practices have been supported to localise their plans and broaden their thinking around hazards, to be prepared for a range of events that could impact our region, including bushfires, storms, flooding, landslides, heatwaves, power and communication outages, cyber incidents and road closures.

Our Disaster Planning Toolkit for Practices is available online and we have supported general practices in utilising the Toolkit to help meet accreditation requirements.

This year, our region has again been subject to disaster and emergency events and our planning processes, and established relationships with the NBMLHD and other key Emergency and Community stakeholder proved effective. We continue to be a vital part of a well-coordinated health response to emergency and disaster events.

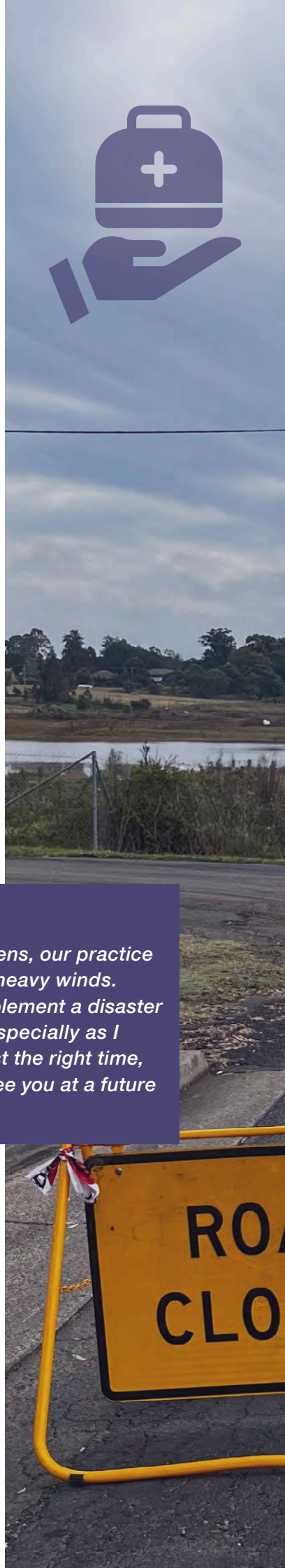
In April 2024, we worked closely with the Nepean Blue Mountains Local Heath District and general practices during storms and floods. These events resulted in major road and bridge closures and Evacuation and Recovery Centres being again stood up in the Hawkesbury region. The Megalong Valley community was isolated by significant damage and closure of road access. All LGAs in our region were declared disaster affected in April 2024.

We worked with primary healthcare to ensure the community had access to continuity of care, particularly for those in the community who were unable to access their usual general practice or pharmacy. We were able to connect emergency management with critical information around vulnerable residents through our relationships with practices servicing affected regions.

We regularly communicated and shared information directly with general practices, allied health professionals and community stakeholders on local arrangements in place for affected areas and impacted residents.

Acknowledging that recovery from emergency and disaster events can take a long time and physical and mental health impacts can be felt for years after, we have continued to provide support for communities in recovery from recent flooding and fire events in the region.

*Read about **Recovery** initiatives including **Disaster Recovery Community Development** and **Grant** funded programs in our **Services We Fund for the Community** section on page 31.*



Disaster and Emergency Management Impact

"I wanted to sincerely thank you for your support and guidance. As it happens, our practice experienced a power outage last Monday due to the severe weather and heavy winds. Thanks to the insights from our last meeting, I was able to prepare and implement a disaster management plan, which proved invaluable during this expected event, especially as I navigate my role as the new practice manager. Your assistance came at just the right time, and I truly appreciate it. I look forward to staying connected and hope to see you at a future network event soon." *– Feedback from local practice manager*

HealthPathways

Our HealthPathways team and collaborators which include our organisation, general practice, allied health and the Nepean Blue Mountains Local Health District (NBMLHD), continued to play a vital role in providing up-to-date disaster and emergency information in line with state and national guidelines.

Find out more:
nbmphn.com.au/HealthPathways

*Read about other **Disaster and Emergency Management** initiatives in our **Integrating Care** section on page 61.*

HEALTHY AGEING
Priority Area

Advance Care Planning

To support primary healthcare through community education, we held several events across the region creating awareness and understanding of advance care planning. These events provided an opportunity for community to be informed about what is involved in advance care planning and to understand the value of discussing and documenting their future health care needs, should they become unwell and unable to communicate their treatment decisions.

- 188 attendees participated in 6 events across the region

Palliative Care

We hosted our inaugural Palliative Care Grand Rounds that provided general practitioners with enhanced skills needed to recognise and manage the care of their palliative care patients, including referral pathways to supportive and palliative care options.

We developed and published a 'Live Well with Palliative Care' information sheet for consumers on the services and support available for those needing or receiving palliative care.

Palliative Care Grand Rounds.

Aged Care Telehealth and After-Hours Support

We developed an education and training manual to support improved telehealth consultations between aged care residents and their general practitioner. The interactive training supported Residential Aged Care Homes (RACH) staff to assist their residents in accessing virtual consultations with their GP. The training promoted the enablers of digital health, including My Health Record, and educated RACH staff in out-of-hours health care options for their residents as part of their after-hours action plan.

- 121 RACH staff participated in training

RACH Training

We supported Residential Aged Care Homes (RACH) in procuring appropriate telehealth technology. This has assisted in supporting residents access virtual consultations with their primary care provider. A total of 17 RACHs have received Telehealth and After-Hours training and support with 121 staff trained over 14 sessions.

We provided training through the Australian College of Nursing to registered nurses working in aged care homes on urinary catheterisation to reduce the need for hospital presentation particularly, in the after hours period. This opportunity allowed nurses to complete a practical workshop on evidence-based knowledge on risk prevention and reduction, management of problems associated with urinary catheterisation procedures and appropriate urinary catheter maintenance and care.

- 60 staff trained

Nurses in aged care received clinical handover training through the ISBAR (Introduction, Situation, Background, Assessment, Recommendation) framework, which is endorsed by the World Health Organisation. The training provided by the Australian College of Nursing provides a standardised approach to communication which can be used in a clinical environment.

- 17 staff trained

RACH Disaster Preparedness

Between April and June 2024, we engaged with 17 of the 29 RACHs within our region and the Local Health District (LHD) to discuss natural disaster preparedness. During these consultations, there was a focus on the importance of networking and collaboration. This engagement process enabled us to plan an event with the LHD that would provide an opportunity to explore resources to assist RACHs to prepare for a disaster.

Nurse Immunisation Scholarships

We provided practice nurses in primary care and registered nurses in aged care the opportunity to become accredited as authorised nurse immunisers, enabling them to provide vaccinations for their patients or residents. Nurses were awarded scholarships to complete the Australian College of Nursing's Immunisation Course for Health Practitioners. This training also equipped nurses with the essential attributes to be immunisation advocates and promote immunisation uptake.

- 54 nurses awarded scholarships

Back row (L to R): Hayden Welsh – Program Officer, Healthy Ageing; Monique Pryce – Program Development Officer, Community Development; Barbara Mossman – Program Development Officer, Palliative Care; Janice Peterson – Healthy Ageing and Palliative Care Manager; Kelly Schmahl – Program Development Officer, Aged Care. Front row (L to R) – Paige Pooley – Program Development Officer, Healthy Ageing; Lauren Crisell – Program Development Officer, Aged Care; Ella Ibbitson – Program Development Officer, Older People.

*Read about other **Healthy Ageing** initiatives in our **Services We Fund for the Community** section on page 30 and the **Integrating Care** section on page 62.*

POPULATION HEALTH
Priority Area

Immunisation

We provide a range of immunisation support to general practices, including cold chain management, customised documentation and training. We communicate regularly with the NBMLHD Public Health Unit, NSW Health and the Department of Health and Aged Care to discuss immunisation strategies and provide up-to-date information to practices in our region. We are further supported by the PHN Immunisation Support Program, an initiative of the National Centre for Immunisation Research and Surveillance. The national aspirational target for childhood immunisation is 95%. The last immunisation on the National Immunisation Program (aside from annual seasonal influenza immunisation) is at 4 years of age. This year, our Primary Care Engagement Officers targeted immunisation rates for 5-year-olds, developing a childhood immunisation toolkit for practices. Once provided with the immunisation rates for 5-year-olds attending their practices, they then worked through data cleansing and patient recalls to improve overall immunisation rates.

The following percentages represent the annualised data to 30 June 2024 for 5-year-olds in our region:

- 93.12% of all children fully immunised
- 93.39% of Aboriginal and Torres Strait Islander children fully immunized

Be Your Own Health Hero Campaign

Over winter, we ran our Be Your Own Health Hero community awareness campaign to encourage COVID-19, influenza and pneumococcal vaccinations in vulnerable groups. The campaign was promoted through retail, washroom, print, social media and cinema advertising over three months.

- 4.5 million+ foot traffic reached across retail and washroom advertising
- 770,000+ Google Ad impressions
- 664,500+ Facebook ad reach
- 1.3 million+ audience reach through local newspaper advertising

*Read about other **Population Health** initiatives in our **Services We Fund for the Community** section on page 41 and **Integrating Care** section on page 70.*

VULNERABLE COMMUNITIES
Priority Area

Winter Strategy Quality Improvement Program

This program supports practices in delivering heightened quality of care for chronic disease patients who are at high risk of being unstable, very unwell, and/or admitted to hospital during the winter (and influenza) season. Practices improved care for vulnerable patients and implemented quality improvement strategies.

- 59% of patients have an influenza immunisation recorded for the current year, an increase of 56% from the beginning of the program
- 66% have an up-to-date GP Management Plan, an increase of 26% from the beginning of the program
- 57% have an up-to-date Team Care Arrangement, an increase of 26% from the beginning of the program
- 56% have an up-to-date pneumococcal immunisation, an increase of 21% from the beginning of the program. However, 90% of patients had their pneumococcal immunisation eligibility checked
- 16% of patients had a Shared Health Summary uploaded in the last 6 months, a 10% increase from the beginning of the program
- 12% had a medication review, a 10% increase from the beginning of the program

Find out more:
nbmphn.com.au/QIopportunities

Winter Strategy Quality Improvement Program Impact

"I enjoyed participating in my first Winter Strategy QI program, the program helped me to identify at risk patients and establish new processes to help prevent them from being hospitalised through the winter months. My engagement officer, Sherie, was very helpful and supportive, providing valuable guidance throughout the program."

– Principal GP at We Care Medical Centre, South Penrith

*Read about other **Vulnerable Communities** initiatives in our **Services We Fund for the Community** section on page 42.*

Improving our community's healthcare journey

Our staff work together with our stakeholders to improve access to care across the local health system and the healthcare journey for people in our community.

Aboriginal Health Lead Mitch Beggs Mowczan at NAIDOC, Jamison Park.

INTEGRATING CARE

We support the local integration of care across the primary, hospital, community and social sectors helping to create a 'one system' approach in our region. This improves access and continuity of care for patients, minimises service duplication and fosters better health outcomes. A priority is helping to connect services and systems for our communities' most vulnerable populations and people with multiple chronic and complex conditions.

Below are examples of INTEGRATING CARE through our Priority Areas.

ABORIGINAL HEALTH
Priority Area

Aboriginal Health Lead

Our Aboriginal Health Lead, Mitch Beggs Mowczan, is a Wiradjuri man who was born and raised on Darug land. He has worked in Aboriginal Health for 14 years, providing support, training and cultural guidance to our organisation, and to practices, stakeholders and community members across our region.

- This year, Mitch had 325 practice interactions to improve cultural safety in primary care and provide information regarding 715 Health Checks and services available for Aboriginal people

Find out more:
nbmphn.com.au/AboriginalHealth

Engaging with our Community – NAIDOC Week

On Friday 7 July 2023, our staff joined with Penrith City Council to celebrate NAIDOC Week at their free community event at Jamison Park, embracing the theme 'For Our Elders'. The event featured performances from First Nations artists, workshops, stalls, a free BBQ and provided the opportunity for us to join the community in celebrating local Aboriginal and Torres Strait Islander culture, heritage and history. Our staff, including our Aboriginal Health Lead, Mitch, engaged with the community and provided information about our services and programs, to educate and demonstrate how we integrate care in our region.

Integrated Team Care – Closing the Gap

We fund Nepean Community & Neighbourhood Services to support Aboriginal and Torres Strait Islander peoples with chronic health conditions to access the services they need to improve care coordination and multidisciplinary care to effectively manage their health conditions.

- 4 care coordinators assisted 357 patients across 27,235 occasions of service

Find out more:
nbmphn.com.au/ClosingtheGap

Integrated Team Care Impact

A 41-year-old woman with numerous chronic conditions was referred to the Integrated Team Care program by St Vincent's hospital in October 2023. The client successfully underwent a double lung transplant but could not afford the transport cost from her home in St Marys to St Vincent's hospital for follow up appointments and ongoing treatments. The Integrated Team Care Coordinator was able to support the client with funding to cover transport and specialist costs.

The client was able to attend her appointments without the worry of how she would afford them, and was very thankful for the program. As the client attended all her appointments and followed the advice of her specialists, she became eligible for a kidney transplant.

A 53-year-old woman with a history of type 2 diabetes was on the Integrated Team Care program from April 2024. Due to her diabetes, she has peripheral neuropathy, particularly in her left foot, which required numerous surgeries including amputation and excision. This resulted in severe deformity and she could no longer wear regular footwear.

The client's Care Coordinator applied for the purchase of appropriate footwear, which the client could not afford on her own. New footwear was provided, and she was overjoyed to be able to move around without pain and discomfort.

Village Café

Village Café, located in Kingswood, North St Marys, Llandilo and Wallacia, is a place to grow community connections and support wellbeing. It has a number of local supporting partners, including Penrith City Council, Nepean Blue Mountains Local Health District (NBMLHD) and Community Junction. It provides the opportunity to share a coffee, connect with local community members and engage with local service providers. We have been involved with the Village Café since it first began in 2017 and have seen it grow in each community, helping to prevent social isolation and maintain connections with the community.

- 32 Village Cafés attended by our Aboriginal Health Lead

*Read about other **Aboriginal** initiatives in our **Services We Fund for the Community** section on page 25 and the **Supporting Primary Healthcare** section on page 48.*

DISASTER AND EMERGENCY MANAGEMENT
Priority Area

Disaster Planning and Response

This year we continued to advocate for PHNs to be recognised and included as key agencies in national, state and regional health emergency preparedness and response plans with clear, formalised roles and responsibilities. This includes funding to coordinate regional primary healthcare responses before, during and after natural disasters and emergencies, as part of the overall health emergency response.

We actively participate in a range of local, regional and state forums and committees to build networks to ensure that primary healthcare perspectives are represented and integrated in disaster management and recovery. This includes participating in working groups with the RACGP, emergency services, community services and local government stakeholders, as well as various community-led initiatives.

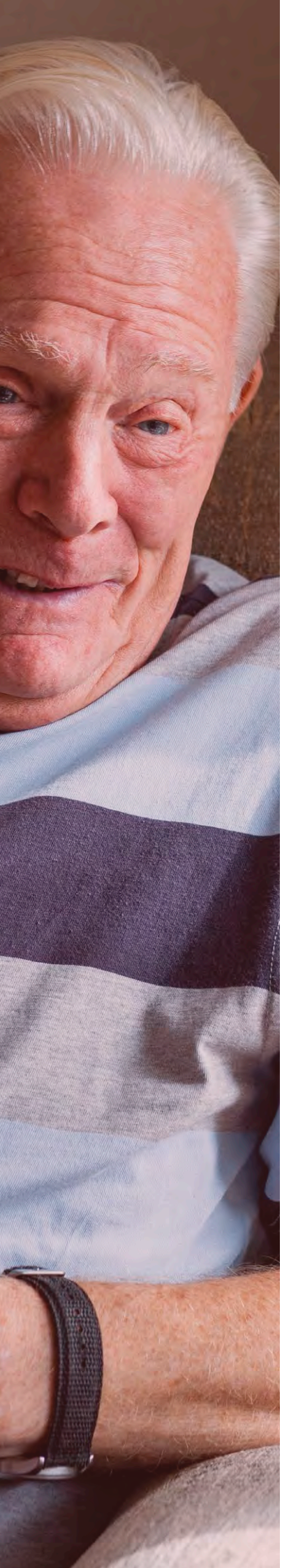
Read more:
nbmphn.com.au/NBMPHN-Library/Disaster-Planning

Community Development Workers

Building on the trusted relationships established as part of our bushfire recovery efforts, the Community Development Worker program in the Hawkesbury was extended to provide support to place-based organisations involved in supporting residents in flood affected areas. The role helped to identify available funding opportunities and provided assistance in the application process, supported organisations to become incorporated and provided training to increase the skills or capacity of the organisation to become self-sustaining.

- 5 projects supported
- 6 events held in rural/remote communities with more than 450 attendees
- 63 organisations supported
- 4 training sessions held with more than 300 attendees
- Supported the Bright Ideas to Build Resilience film
  www.youtube.com/watch?v=VpP9gkx70hc

*Read about other **Disaster and Emergency Management** initiatives in our **Supporting Primary Healthcare** section on page 52.*



HEALTHY AGEING
Priority Area

Care Finder Program

Care finders provide specialist and intensive assistance to help vulnerable older people access aged care services and connect them with other relevant supports in the community. This year we commissioned three organisations to provide our care finder service. Together they provide seven individual care finders, who have been operational since early 2023. Since the establishment of the program:

- 305 new clients assisted
- 183 clients were supported to access services that have successfully addressed their needs
- 100% of the care finder clients surveyed reported an improved understanding of aged care services and felt more open to engage with those supports because of the program
- 100% of care finder clients surveyed reported they would recommend the care finder program to others and were satisfied with the outcome of the support they received

Find out more:
nbmphn.com.au/CareFinders

Care Finder Impact

A 74-year-old woman had been living alone with her dog in a three-bedroom house outside of Lithgow since her husband passed away, seven years ago. She often woke up early and wandered around town, collecting all kinds of items, which she stored in her house. She and her dog slept in the lounge room, which was difficult to access due to the accumulation of clutter.

Three community members had attempted to help declutter the house, deliver food and take the client shopping, however, the client demonstrated resistance and they stopped helping as they did not know how to support her further.

In May 2023, the care finder service was introduced in Lithgow. The woman's neighbours heard about the program through a letterbox drop and reached out. The care finder contacted the client and after three months, she felt comfortable enough to let them into her home. They worked alongside the three community members to mow the client's lawn, initiate visits to the GP for blood checks and provide access to Catholic Health Care to improve her living conditions.

Dementia – National Consumer Support Pathways

In response to the Royal Commission into Aged Care Quality and Safety, we received funding from the Australian Government Department of Health and Aged Care to establish clinical and community dementia support pathways in our region. This included the revision of our clinical HealthPathways and other resources to support primary care to provide timely and appropriate referrals for dementia diagnosis and post diagnosis support, to improve access to support services for dementia patients, their carers and families.

During the year we distributed localised resources to community members in each local government area. These resources provide contact details on national, state and local services and supports that could assist people with dementia and their families. These were distributed through dementia community events, where we brought together service providers and community members to share information and provide connection to local services to support those living with dementia.

- 5 dementia community education events with 171 attendees
- 640 dementia resources distributed across the region

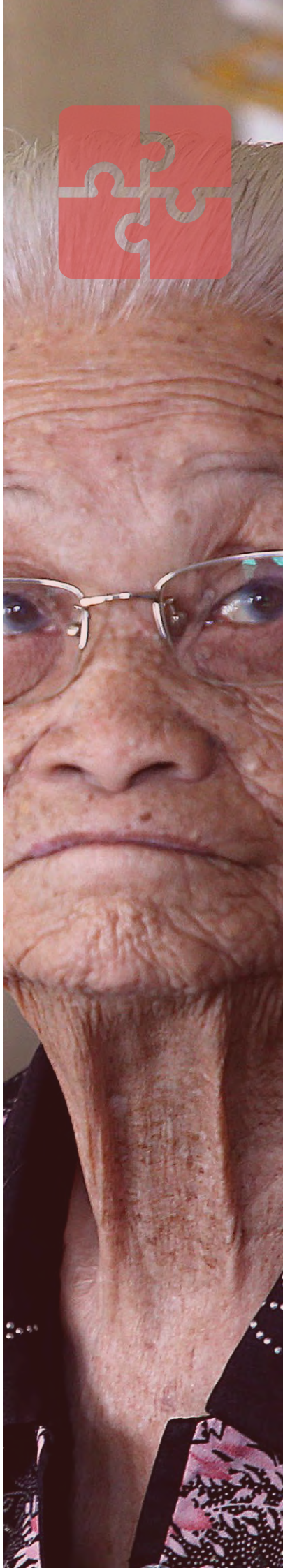
Dementia Event Impact

After a Dementia event at Springwood, several attendees approached the Anglicare service with queries. One attendee's mother, who is living with dementia, was waiting for a Home Care Package to be assigned.

The Anglicare service were able to assist by conducting a home visit, providing information and education on dementia, and putting through a referral for support services to manage the attendee's mother's package.

As a result, the attendee's mother is now supported through Anglicare who manage her Home Care Package, and she has also joined the Dementia Choir Group in Penrith.

*Read about other **Healthy Ageing** initiatives in our **Services We Fund for the Community** section on page 30 and the **Supporting Primary Healthcare** section on page 54.*



Compassionate Communities

Older people without adequate social connections have an increased risk of poorer health and wellbeing outcomes, which negatively impacts their physical health and use of health services. Based on a Compassionate Communities approach, and through the Australian Government's response to the Royal Commission into Aged Care Quality and Safety, we fund a range of social connection programs.

Connector Points

Connector Points are identified community organisations that provide face-to-face or telephone assistance for improving social connections and reducing social isolation of older people, particularly those without internet access.

- 10 Connector Points in libraries and Neighbourhood Centres across Blue Mountains, Hawkesbury, Lithgow and Penrith
- 711 connector conversations with walking groups and dementia supports being the most frequent topics

Health Connectors

Health Connectors are specially trained practice nurses who work with patients and carers. They help people develop their social support networks through mapping and goal setting to improve social connections. This free service is offered in practices across our region.

- 5 practice nurses trained as Health Connectors in 3 practices
- 41 clients assisted through 60 occasions of service
- 31 Health Connectors in total

My Health Connector Website

This free online directory helps older people improve their connections to health and lifestyle services including social and support groups, dementia care and transport options. Healthcare professionals and the community can use this resource to socially prescribe people to support networks and integrate them within their local community.

- 689 services listed
- 29,588 page views
- 13,299 visits/sessions
- 9,169 users

Find out more:
MyHealthConnector.com.au
youtu.be/WKNGBtiI0PU?si=Y-bE60Go8hQcUzS4

Intergenerational Connections

Intergenerational programs bring together older adults from the community and residents of independent living with children aged between 3-5 years for group-based interactions. The programs foster meaningful engagement between the generations supporting older adults physical and mental wellbeing, allowing them to live at home for longer. We funded six Intergenerational Programs delivered by Springwood Neighbourhood Centre, Blackheath Area Neighbourhood Centre, Marathon Health, Mission Australia, NADO Disabilities Services and Nordoff-Robbins Music Therapy.

- 148 clients assisted through 110 sessions
- 68% of individuals who had Geriatric Depression Scale scores indicating depression at the commencement of the program, saw their scores fall below the threshold for depression following the program
- Across all participants, depressive symptoms reduced on average
- Structured observations by facilitators (using the Leuven Scale) during the sessions showed that wellbeing and involvement were high on average and the feedback from older participants was overwhelmingly positive

Find out more:
nbmphn.com.au/SocialConnectedness

Intergenerational Connections Program Impact

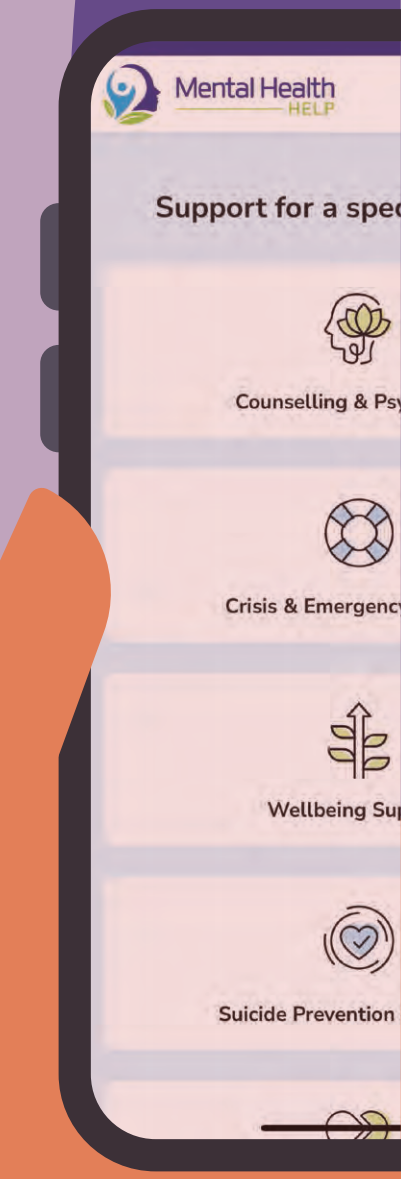
"I come away feeling lifted, is the best way to put it. This is the highlight of my week, it really is." *– Melanie, Program Participant*

"I've come out of my shell a bit more. I was starting to sort of lose confidence in myself. It's made me realise that I have got something to offer." *– Wendy, Program Participant*

"When you engage older people in purposeful and mentally stimulating activities, the studies show you can slow down or reduce the early onset or severity of dementia. Likewise, there's a lot of research supporting having trusted older people in the daily life of children. So, by fostering empathy and compassion in both age groups, the studies show that these interactions can reduce depression and mental health issues in younger students." *– Greg, Intergenerational Learning Australia*

"It's been a lifesaver for me virtually. Otherwise, I'd be sitting at home, seven days on my own. You come here and straight away you all automatically bond together. It really has been a lifesaver." *– Beverly, Program Participant*

Participants of Intergenerational Connections Programs at NADO Disability Services in Penrith and Carinya Neighbourhood Children's Centre in the Blue Mountains.



MENTAL HEALTH AND SUICIDE PREVENTION

Priority Area

Initial Assessment and Referral Decision Support Tool

The Initial Assessment and Referral (IAR) Decision Support Tool (DST) is a national initiative developed by the Australian Government Department of Health and Aged Care. This clinically informed online tool supports health professionals' decision-making at the first point of contact with a patient seeking mental health support. Based on the stepped care model, the tool recommends the most appropriate level of care based on the patient's current needs. It provides a standardised, evidence-based and objective approach to making mental healthcare recommendations in the primary care setting. PHNs have been tasked with rolling out the IAR-DST nationally. We train GPs and other clinicians to learn about, meaningfully use, and embed the IAR-DST into clinical practice. The IAR-DST helps to improve access to mental health services across the health system as it helps to ensure that patients are accessing the right level of care for their needs, at the right time.

- 39 IAR-DST Workshop training sessions completed
- 23% of GPs in our region trained in the IAR-DST

Watch our IAR video:
youtu.be/orc1pT7iy1I

Find out more:
nbmphn.com.au/IAR

Head to Health IAR Intake Line

The Head to Health mental health intake line is available nationally to people of all ages who need mental health support. When people call the phoneline on 1800 595 212, they are transferred to a trained mental health professional who will conduct an IAR assessment using the IAR-DST support tool. Based on this assessment, the clinician will help them find the right local mental health support that meets their individual needs. This may include referring them to see a clinician through Head to Health centres or satellite services, or to other services in their local area. We apply a 'no wrong door' approach to all referrals to ensure individuals receive a warm transfer of care, supporting them throughout the referral process so they don't have to repeat their story multiple times. In our region, we run our own Head to Health IAR clinical intake phone line with intake clinicians working directly for our organisation. Having clinicians answering these calls who work (and in some cases live) in our region means that they understand the local challenges and nuances people in the region face and have a better knowledge of the local services available.

- 2,997 calls taken with 314 IAR assessments conducted
- We received 14% of all calls in NSW, despite our region representing 4.8% of the NSW population

Find out more:
nbmphn.com.au/CallHeadtoHealth

Mental Health Help Website

This free online directory helps the community and health professionals find over 250 local mental health services. Local providers in our region can add their services to the website for free and manage their own listings.

- 13,174 page views
- 15,890 sessions
- 8,986 users

Find out more:
MentalHealthHelp.com.au

Suicide Prevention Coordinators

Suicide is a complex issue that requires coordinated efforts to prevent suicidal distress, implement early intervention, and to provide aftercare for those who have attempted suicide as well as post-suicide supports for individuals and communities.

The 2022-23 Federal Budget included an investment of $43.2 million in Targeted Regional Initiatives for Suicide Prevention (TRISP) expanding activities across 31 PHNs nationally. The funding supports the Regional Suicide Prevention Coordinator role in each PHN. This role supports the identification of tangible improvements in our region's responses, from services and the community, for people seeking support who are experiencing suicidal distress or are impacted by suicide.

Our Regional Suicide Prevention Coordinators have dedicated a significant investment of time to networking throughout our region. This has included various engagements over the course of the year, attendances at events, consultations to inform regional planning, and conversations with community organisations and people with a lived experience of suicide. These opportunities fostered meaningful relationships and partnerships with key stakeholders, leading to achievements in the growth of community social capital and sustainable connections and integration across sectors.

- 111 separate engagement events attended

Joshua Stojanovic – Regional Suicide Prevention Coordinator.

Regional Suicide Prevention Collaborative

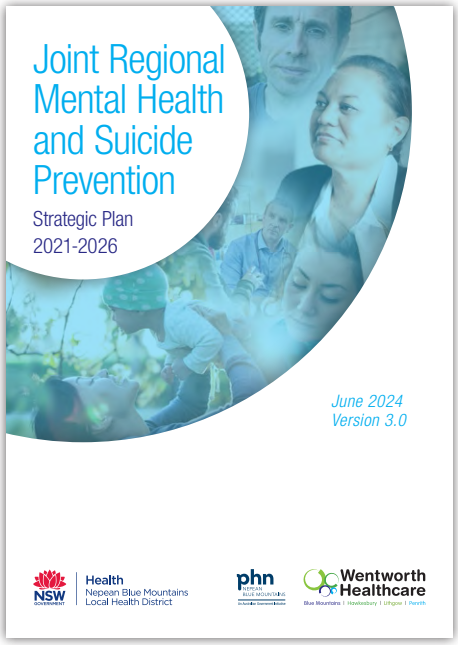
The Nepean Blue Mountains Suicide Prevention Collaborative is made up of a wide range of people who share the common goal of wanting to reduce the impact of suicide across our region. Members include government agencies, non-government organisations, community groups, volunteers, members of public, relevant businesses or sole traders. A third of members bring their own wisdom and insights from their lived and/or living experience of suicide.

We have been the backbone organisation since the Collaborative's inception. Bringing together people from the community and across sectors, providing support to its core membership. Alongside their initial gatherings, Collaborative members participated in the Black Dog Institute's Suicide Prevention Capacity Building Program to broaden their skills in approaches to understanding, and undertaking a systems approach to suicide prevention. Collaborative members are eager to begin work on an action plan to reduce suicide deaths at a local level, fill existing service gaps and support broader approaches to suicide prevention.

- 27 members
- 10 members with lived or living experience of suicide

Joint Regional Mental Health Suicide Prevention Plan

Together with NBMLHD, we updated Version 3 of the Joint Regional Mental and Suicide Prevention Strategic Plan 2021-2026. The Joint Strategic Plan has been developed through consultations with, and contributions from, the lived experience community, service providers and healthcare practitioners. Version 3 of the Joint Strategic Plan has been updated to reflect changes in funding resulting from the Bilateral Agreement between the NSW Health and the federal Department of Health and Aged Care, which provides investment in joint mental health and suicide prevention activities across our region. This agreement and funding enable us to commission new services and expand existing ones with an integrated approach to address local, specific needs.



Find out more:
nbmphn.com.au/JRMHSPP

*Read about other **Mental Health** initiatives in our **Services We Fund for the Community** section on page 31.*

Right Care, First Time, Where You Live

This year we began working closely with The University of Sydney's Brain and Mind Centre on the Right Care, First Time, Where You Live program which develops and implements a local system modelling tool that can be used to help decision-making regarding youth mental health interventions in a local area. We are one of eight PHNs nationally to be involved in the program, which is funded through the BHP Foundation, with the goal of improving youth mental healthcare across Australia.

The Program co-creates a dynamic systems model that can provide a birds-eye perspective on what is happening in a particular region's youth mental health system. The model can be used by decision makers to test 'what-if' scenarios. For example, "what if we increased mental health education programs in schools? Would that reduce the number of young people going to emergency departments in acute psychological distress?" From these scenarios, the system can help determine the types of programs and services that will have the most impact and benefit for young people.

The program held the first of three major workshops in April 2024, with 60 key stakeholders attending including local service providers, GPs, allied health professionals, government and education representatives and 16 young people with lived experience. In May, a Governance Committee and a Data Modelling Working Group were established, including representatives from Wentworth Healthcare, The University of Sydney, the NBMLHD and young people with lived experience. These groups meet monthly to discuss various aspects of the model, including local data, health economics data, the look and feel of the model interface and the interventions for inclusion.

We will utilise the completed modelling tool to support our commissioning and advocacy work. It will also be accessible to those involved in the workshops for the purpose of supporting their program proposals and advocacy.

Find out more:
nbmphn.com.au/RightCare

Right Care, First Time, Where You Live participants at Workshop 1.

POPULATION HEALTH
Priority Area

HealthPathways

HealthPathways is a free online clinical and referral information tool for health professionals designed to increase connection across the primary, secondary and tertiary health systems. HealthPathways content is developed collaboratively by GPs, hospital clinicians and other relevant health professionals. Now into its seventh year, HealthPathways continues to be a joint program between our organisation and NBMLHD. It is one of our flagship integrating care activities – reflecting the collaboration that is facilitated through consultation across health sectors to develop the clinical guidelines and referral pages. Consultation between general practice clinical staff, hospital, community specialists, nurses and allied health providers ensures locally relevant pathways of care are created. HealthPathways continues to successfully respond to our local needs and those of the contemporary environment, to support clinicians with direct patient care in the community. The Nepean Blue Mountains (NBM) HealthPathways program has successfully led the NSW state-wide pathway development for genetics/genomics, and co-led pathway development for COVID-19 vaccinations.

Incorporating the Patient Voice in Clinical HealthPathways

In 2023, the NBM HealthPathways program designed and piloted an innovative model of consumer engagement to provide guidance and advice during the development and review of clinical pathway content. The Consumer Expert Advisory Group (CEAG) utilises the insights and experience of consumers within the group to advise on the role of the person with lived-experience in the medical process, suitability of resources included in the pathways, the language used and things for the GP to consider when working with some patient cohorts. The outcomes of the group will be reviewed in 2024. Recommendations and learnings will be presented to the NBM HealthPathways Steering Committee for consideration, and to the other HealthPathways teams across NSW, to assist them in consumer engagement.

NBM HealthPathways has moved from an establishment and growth phase, to a mature, maintain and improve phase. During this new phase of the program there has been a focus on improving processes, incorporating health equity, sustainability and consumer engagement, whilst still maintaining the core concept of supporting primary healthcare professionals at the point of care.

In the coming year, a major goal is to incorporate new technologies that will lead to improved GP and other end-user experiences when using HealthPathways. In addition, there is a strong focus on ensuring that NBM HealthPathways includes Statewide Referral Criteria, as a joint priority for both the NBMPHN and NBMLHD.

- 555 localised live pathways
- 25,857 sessions
- 74,122 page views
- 2,441 active users
- 82 reviews completed

Find out more:
nbmphn.com.au/HealthPathways

Domestic, Family and Sexual Violence Care and Connect Program

The Care and Connect program continued to support the primary healthcare response to those experiencing, or at risk of, domestic, family and sexual violence (DFSV), including child sexual abuse. This is achieved through the integration and coordination of the DFSV system and primary care sector, which improves overall system responsiveness and outcomes for people experiencing DFSV. The model is a two-phase approach including the delivery of DFSV training to health professionals, and access to three Care and Connect linkers, who assist in the navigation of local DFSV support systems and enhance referral pathways into DFSV services.

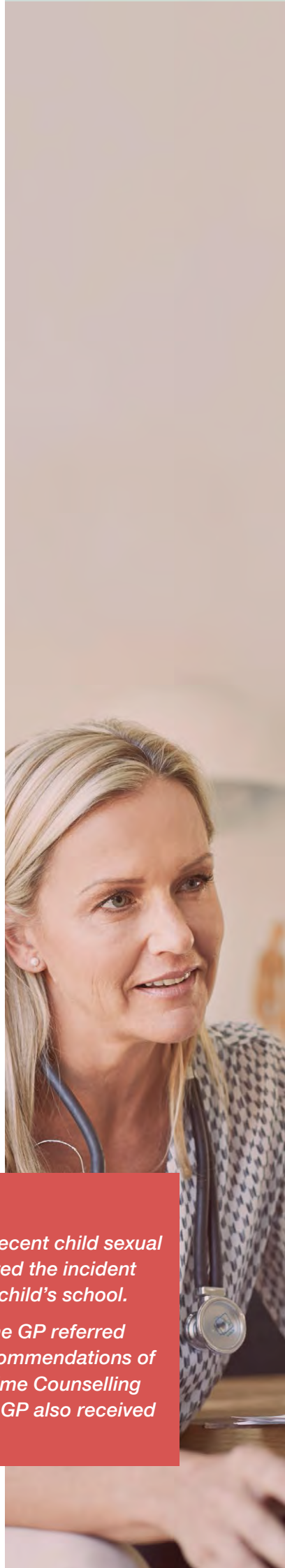
The program has expanded to include training and support for sexual violence and child sexual abuse within the context of primary care. This includes a designated sexual violence/child sexual abuse Care and Connect linker to support health professionals and two GPs skilled in sexual violence and child sexual abuse who will deliver the training.

Care and Connect currently operates through colocation at six practices across our region. Care and Connect linkers position themselves at a practice for the day and support staff with DFSV related questions/cases. The linkers also see patients at the practice.

- 20 Care and Connect training sessions
- 201 attendees including staff from 13 practices, 23 allied health professionals and 61 medical students
- 94 referrals to Care and Connect linkers and over 163 other engagements (case consults, support in completing forms and/or information on DFSV)

Find out more:
nbmphn.com.au/CareAndConnect

PHN Domestic Violence booth at the General Practice Conference Exhibition in Sydney.



Care and Connect Impact – Child Sexual Abuse

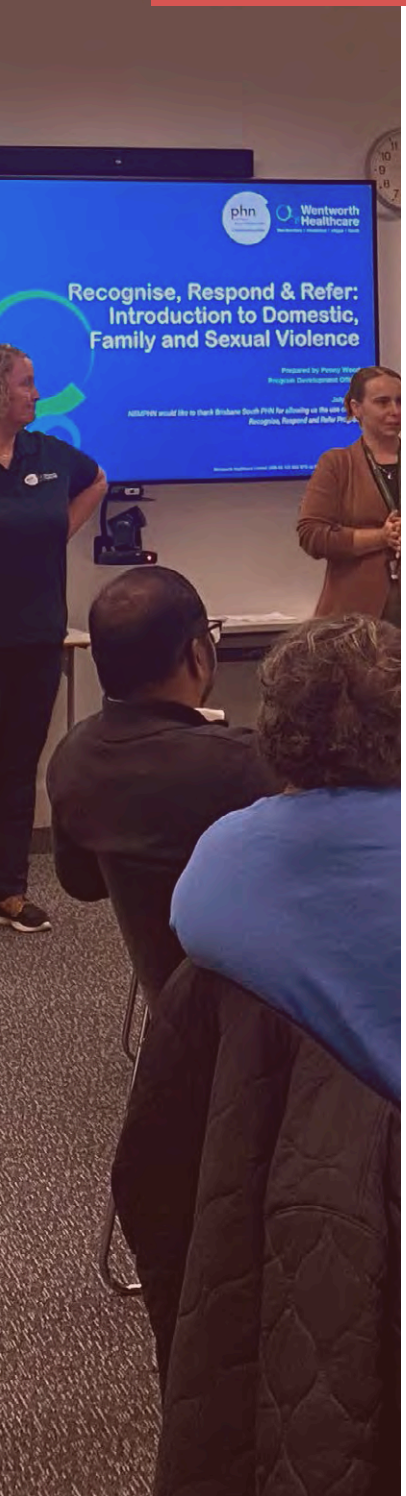
A nine-year-old patient and their mother presented at a GP practice after a recent child sexual abuse incident involving another student at the child's school. The GP reported the incident through child protection and the mother had reported it to police and to the child's school.

No supports had been provided or offered to the mother or the patient, so the GP referred them to the Care and Connect linker who discussed safety planning and recommendations of other supports. The Care and Connect linker also completed a Victims of Crime Counselling and Recognition payment application for both the mother and the child. The GP also received training from the linker on how to complete the form for future reference.

Care and Connect Impact

A 70-year-old woman, presented to her GP explaining that she had recently had a fall and now had bruising on her hip. It was disclosed that violence was occurring in the home, with a recent escalation between the patient and her daughter and grandson. Police were involved and an Apprehended Violence Order (AVO) was issued. The GP had completed the DFSV training and asked her if she would like to talk to a Care and Connect linker who was at the practice that day. The patient agreed, so the GP called the Care and Connect linker into the consult room during the appointment. The Care and Connect linker assessed her situation, gauged her level of safety. It was determined she would benefit from counselling, so the GP completed a referral for a psychologist and the linker completed a risk assessment. The Care and Connect linker also referred her to other supports, including court advocacy and social supports.

The patient's daughter and grandson have since moved, and she is able to manage her wellbeing more positively with the continued support of the GP and Care and Connect linker.



Care and Connect training.

Western Sydney Health Alliance

A collaborative partnership across federal, state and local government, dedicated to improved health outcomes for the Western Parkland City.

The Alliance was established in 2019 to improve coordination and effectiveness of health services and to support the planning and design of healthier, liveable neighbourhoods in the Western Parkland City – a dynamic and rapidly growing area, home to over 1.1 million residents, projected to increase by a further 500,000 residents by 2036. We are proud to be one of 12 members alongside the Nepean Blue Mountains Local Health District, the South Western Sydney PHN and LHD and the councils for Blue Mountains, Camden, Campbelltown, Fairfield, Hawkesbury, Liverpool and Penrith.

Our participation in the Alliance enables us to stay well connected with partners in the region, advocate for our communities and incorporate the insights obtained by the Alliance into our planning and projects. This year we continued to participate in the Access to Health and Wellbeing Services Working Group which included a major focus on health workforce strategies.

Find out more:
wshealthalliance.nsw.gov.au

*Read about other **Population Health** initiatives in our **Services We Fund for the Community** section on page 41 and the **Supporting Primary Healthcare** section on page 56.*

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