2017/18 ANNUAL REPORT

phn
NORTHERN SYDNEY
An Australian Government Initiative

SYDNEY NORTH
Primary Health Network

ACKNOWLEDGEMENT OF COUNTRY

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

Artist Acknowledgement: Jessica Birk

CONTENTS

SYDNEY NORTH PRIMARY HEALTH NETWORK
HEALTH PROFILE

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

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

HEALTH DRIVERS

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

1.4% of people aged 16-64 years receive unemployment benefits
NSW: 4.8%

49.8% of people aged 17 years participating in tertiary education
NSW: 33.1%

28.8% of low-income families experience financial stress from mortgage or rent
NSW: 29.3%

VULNERABLE GROUPS

Children
6.1% (10,821)
of children in low-income, welfare-recipient families
NSW: 22.3%

Older People
15.6% (142,463)
of the total population aged 65+ years
NSW: 15.7%

Between 2016-2036, there will be an increase of **55.1%** in the 65+ years population
NSW: 67.1%

Disability
3.7% of the population have severe or profound disability
NSW: 5.4%

HEALTH RISK FACTORS

Obesity
18 per 100
(18+ years) obese
NSW: 28.2

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

Smoking
9.4 per 100
(18+ years) current smokers
NSW: 16

CHILDHOOD IMMUNISATION

IMMUNISATION RATES LOWER THAN THE NATIONAL ASPIRATIONAL TARGET OF 95%

1-year-old	2-years-old	5-years-old
92.2	88.3	91.4
92.2% fully immunised	**88.3%** fully immunised	**91.4%** fully immunised
NSW: 92.2%	**NSW: 89.1%**	**NSW: 93.1%**

CANCER SCREENING

Bowel cancer screening participation rates among people aged **50-74 years in SNPHN (39.5%)** higher than the NSW rate (37.8%).

Cervical cancer screening participation rates among women aged **20-69 years (63.1%)** higher than the NSW rate (56.3%).

Breast cancer screening participation rates among women aged **50-69 years (53.5%)** higher than the NSW rate (53%).

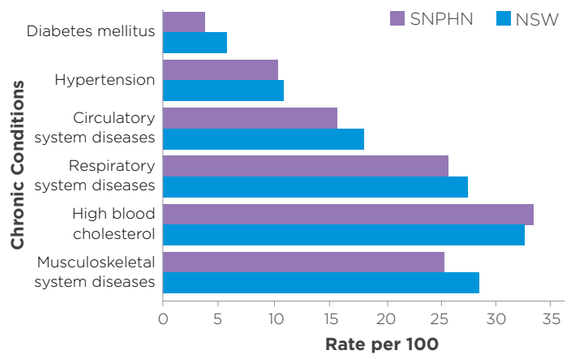
MENTAL HEALTH

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

7.3 per 100
(18+ years) report high or very high psychological distress
NSW: 11

2,097 per 100,000
mental health related hospitalisations
NSW: 1,894

CHRONIC CONDITIONS



POTENTIALLY PREVENTABLE HOSPITALISATIONS

1,647 per 100,000
NSW: 2,126 per 100,000
Cellulitis, kidney and urinary tract infections, and dental conditions accounted for 36.3% of potentially preventable hospitalisations.

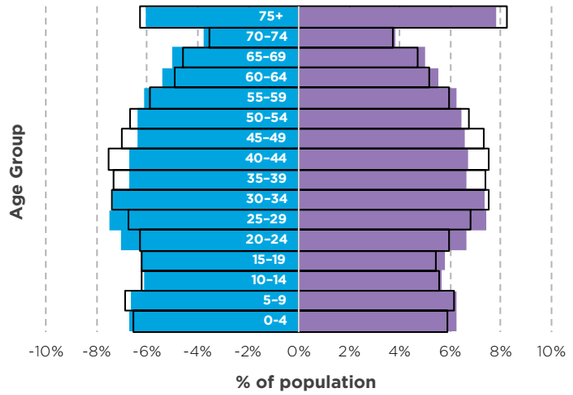
PRIMARY HEALTHCARE

289 GP practices in the SNPHN region

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

DEMOGRAPHY

Age structure comparison by sex for SNPHN and NSW



Total population 914,298. Between 2016-2036, the total population will increase by 23.5% to 1,122,930
NSW: 28.1%

Area: 899.9 km²

CALD
SNPHN has a higher proportion of people culturally and linguistically diverse (25.7%) compared to NSW (21%).
Chinese and Indian largest culturally and linguistically diverse groups.

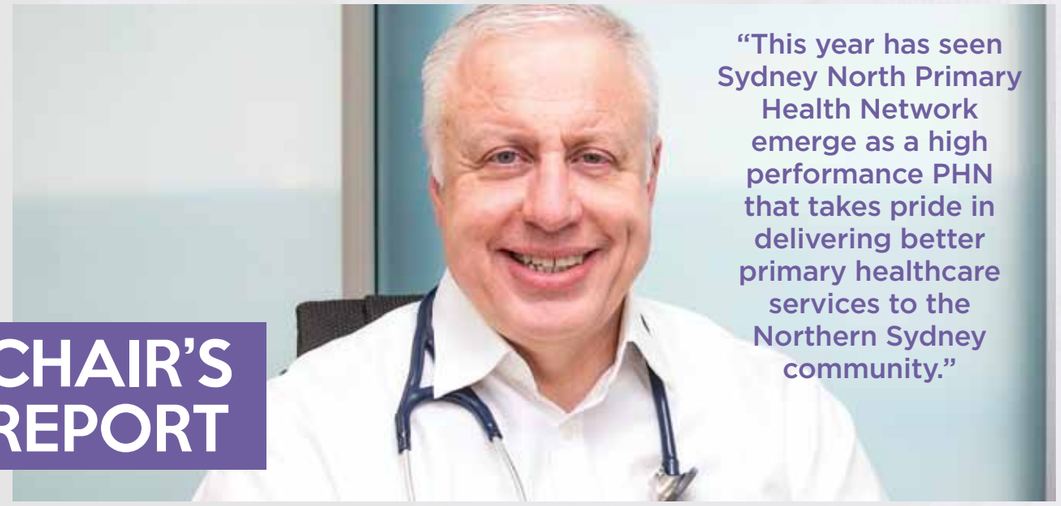
3.4% of people born overseas report poor proficiency in English
NSW: 3.8%

Aboriginal
0.4% (3,327) of the population identify as Aboriginal and Torres Strait Islander
NSW: 2.9%

Sources

- Australian Bureau of Statistics (ABS) 2017, *Census of Population and Housing 2016*, ABS, Canberra, viewed December 2017, www.abs.gov.au
- Cancer Institute NSW 2017, *Reporting for Better Cancer Outcomes Performance Report 2017 Northern Sydney Primary Health Network*, Cancer Institute NSW, Sydney
- Centre for Epidemiology and Evidence 2017, Health Statistics New South Wales, NSW Ministry of Health, Sydney, viewed December 2017, www.healthstats.nsw.gov.au
- Department of Health 2015, Health Workforce - Online Data Tool, Department of Health, Canberra, viewed 16th August 2016, hwd.health.gov.au/webapi/jsf/login.xhtml
- NSW: Department of Planning & Environment 2016. 2016 New South Wales State and Local Government Area population and household projections. NSW Planning Department of Planning & Environment, Sydney, viewed October 2017
- Public Health Information Development Unit (PHIDU) 2017, *Social Health Atlas of Australia December 2017 release*, PHIDU, Adelaide, viewed December 2017, phidu.torrens.edu.au/social-health-atlases

01 SNAP SHOT



"This year has seen Sydney North Primary Health Network emerge as a high performance PHN that takes pride in delivering better primary healthcare services to the Northern Sydney community."

CHAIR'S REPORT

The Board's major focus since the last Annual General Meeting has been to move the Sydney North Primary Health Network (SNPHN) from the establishment phase to ensuring the future of the organisation.

The transition from the Divisions of General Practice to the Medicare Local and then to the Primary Health Network, required the new organisation to 'start again'. The goodwill that had developed, particularly, from the Divisions was lost. General practitioners and allied health professionals were again required to develop trust in a new organisation.

Trust that can only be garnered over time and through the actions of the Sydney North Primary Health Network.

This year has seen Sydney North Primary Health Network emerge as a high performance PHN that takes pride in delivering better primary healthcare services to the Northern Sydney community. As an example, we have established excellent commissioning processes that have been recognised by other PHNs. This is only one of a myriad of services that is offered by the SNPHN.

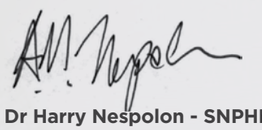
The PHN now needs to look to establish a permanent presence that doesn't rely on Government funding alone. Some of this work is demonstrated in our updated Strategic Plan. Successful implementation of the strategy will see a more independent organisation that will benefit our members and our patients.

Throughout the year we have continued to work hard to strengthen the relationship between the SNPHN and the many organisations that we work with, particularly the Northern Sydney Local Health District.

I must thank our CEO, Lynelle Hales, for her leadership during the last year. This strong leadership will be required during the next more difficult phase of our development. Lynelle's work has been strongly supported by all the members of the PHN, and the Board acknowledges and thanks all our staff for their hard work and professionalism.

I would also like to acknowledge the hard work and wisdom of my fellow Board Directors. There is a lot of work required as we strive to make our PHN one of the best performing Primary Health Networks in the country.

Finally, but most importantly, thank you to the members for your support as we continue to develop an organisation that will assist all of you in delivering primary healthcare services to the people of Northern Sydney to maximise their good health.



Dr Harry Nespolon - SNPHN Chair

CHIEF EXECUTIVE OFFICER'S REPORT

"We work hard to earn the trust of our community every day. By working in partnership with GPs, allied health professionals, nurses, local hospitals, local Government and the local community over the past three years, SNPHN has established programs and commissioned services to deliver on our primary healthcare strategic plan."

2017/18 has been a crucial year in the delivery of our three-year strategic plan, launched in 2015.

The Sydney North Primary Health Network has an important role to drive, support and strengthen primary healthcare in the Northern Sydney region. We have utilised the quadruple aim to target initiatives so that the benefit can be realised in all four areas of the quadrant in our region – health outcomes, patient experience, provider experience, and cost effectiveness.

In line with our vision of ***Achieving together – better health, better care,*** this Annual Report focuses on the **impact** made through the work undertaken in partnership to:

- Strengthen primary healthcare;
- Integrate care;
- Improve access; and
- Connect our community with the services available.

AN ORGANISATION IS FOUNDED ON TRUST

We work hard to earn the trust of our community every day. By working in partnership with GPs, allied health professionals, nurses, local hospitals, local Government and the local community over the past three years, SNPHN has established programs and commissioned services to deliver on our primary healthcare strategic plan. The impact of this work is starting to show, and the achievements and personal success stories of our initiatives have been highlighted in this report. I would like to thank our community partners and acknowledge their contribution in helping us understand the needs in the region and working with us to design and implement initiatives to meet these needs.

The rapid growth and progression of the Sydney North Primary Health Network has required a highly skilled, high performing, and adaptable workforce. Our strong achievements this year demonstrate the continued hard work, passion and resilience of our team throughout an ever-changing primary healthcare landscape. We have further strengthened our training and support program to ensure staff are continuously improving and adapting to maintain a strong and positive organisational culture.

Our achievements are only possible through the continued commitment, support and leadership provided by our Board, our Clinical and Community Councils and Advisory Committees.

LOOKING FORWARD

In a changing and often challenging operating environment, we have made strong and influential progress towards our vision. We now move forward with a new strategy, one that will transform our organisation and position it for long-term success. The new strategic priority areas agreed by the Board for 2018-2023 have been highlighted on the next page.

I am proud of our organisation's achievements so far and look forward to working together with our partners to maximise the impact of primary healthcare in Northern Sydney.

Lynelle Hales - SNPHN Chief Executive Officer

Engaged Communities. Best Health. For All.

2018 - 2023

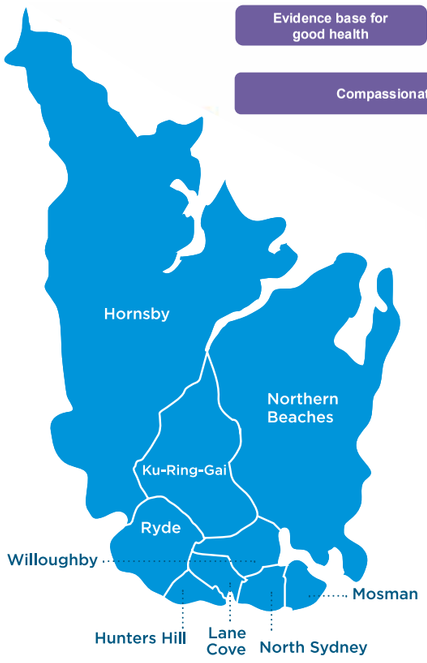
phn NORTHERN SYDNEY — An Australian Government Initiative

SYDNEY NORTH Primary Health Network

Our Investment

1. Services are delivered where and how people want them.
2. People can find and get what they need.
3. People understand and build fundamental habits for best health & wellbeing.
4. Communities are supportive of each other.

- Complex conditions & multi-factorial needs managed in general practice
- Post-acute early discharge in the home
- Suites of GP, nursing, allied health delivered in-home
- Assessments: personalised, home-based
- GP-based specialists / nurses
- Pathways and entry
- Concierge / navigation service
- Evidence base for good health
- Independent lifestyle advice
- Compassionate communities



Our Value to Our Communities

Our service system offers . . .

- **Self-determination** = Customised and tailored to individual needs
- **Affordability** = Blends of public and private funding
- **Certainty** = Predictable and sufficient supply & access
- **Coherence** = Well coordinated and integrated
- **Ease** = User friendly and understandable

- Older people remain independent, longer
- Young people are resilient and connected
- People with mental health conditions maximise economic and social participation
- Those who are vulnerable know about, and get, care that is relevant to them

Goals — Roles — Strategies

	Goals	Roles	Strategies
A	Community Activation	Support our community to self-determine and help itself	• Grow health literacy to enable self-determination • Enable health advocacy on highest-impact determinants of health • Facilitate communities to mutually support one another
B	System Transformation	Catalyse change by enabling new approaches to health and healthcare	• Develop new partner and health services initiatives • Redesign services to heighten Quadruple Aim • Build digital system enablers
C	Commissioning	Attract and distribute resources to provide services that people need most	• Carry out targeted health planning • Leverage service improvements through commissioned services
D	Member & Provider Support	Build capacity for all providers of primary healthcare to adopt new tools, deal with disruption and improve outcomes	• Provide core practice support for quality improvement • Develop future change and skills capability
E	An Exceptional Organisation	Develop excellence in our operations, our people and our visibility	• Communicate our purpose and achievements powerfully • Grow the capabilities and culture of our people • Develop financial and information systems that support ongoing investment & growth • Develop a subsidiary business entity

Our Values — Purpose | Collaboration | Impact | Agility | Capability

WHO'S WHO? THE BOARD

DR HARRY NESPOLON
Chair

KATHRYN LOXTON
Deputy Chair

PROF. SIMON WILLCOCK

DR MAGDALEN CAMPBELL

CAROLYNN HODGES

BRYNNIE GOODWILL

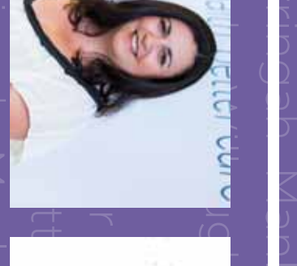
SAMANTHA CHALLINOR

DR STEPHEN GINSBORG

THE EXECUTIVE

LYNELLE HALES
Chief Executive Officer

CYNTHIA STANTON
General Manager – Primary Care Advancement & Integration



RAMON DEL CARMEN
Chief Financial Officer

DAVID GRANT
General Manager – Commissioning & Partnerships

ANDI LUISKANDL
Chief Information Officer

OUR COUNCILS

Together the two Councils help inform the SNPHN Board and Management on local health needs, priorities and gaps, and to help shape local services and programs.

CLINICAL COUNCIL

The Sydney North Clinical Council assist the Sydney North Primary Health Network to develop local strategies to improve the operation of the healthcare system for people in Sydney's North. The Council focuses on facilitating effective, person-centred primary healthcare to improve the overall health of our population and reduce avoidable hospital presentations.

The Clinical Council provides guidance to the SNPHN Board on clinical issues relevant to primary care to:

- Support local primary care providers to improve peoples' outcomes and experience with the healthcare system;
- Evaluate and identify inefficiencies and optimise the use of existing services and resources; and
- Purchase or co-commission new services and propose strategies for redesign or reinvestment.

All members of the Clinical Council practice within, or work with, the community inside the SNPHN catchment.

The Sydney North Clinical Council comprises 17 members with experience working within one or more of the following disciplines:

- General Practice
- Allied Health
- Nursing
- Northern Sydney Local Health District
- Specialist Medical Care
- Aboriginal Health
- Private Health
- Private Hospitals

The Clinical Council has two SNPHN Board Members, one of which Chairs the Council and is required to report to the SNPHN Board.

COMMUNITY COUNCIL

The SNPHN Community Council represent their community with life experience from the following areas – Aged Care, Culturally and Linguistically Diverse, Youth, Aboriginal, Disability, Law, Community and Family Health, Chronic Disease, Workforce Health, Mental Health, Carers, Governance, and Homelessness.

Comprising of 10 members representing diverse communities, health priorities and perspectives, the Community Council has provided consultation and feedback throughout 2017/18 on:

- The SNPHN Activity Plan
- HealthPathways
- Digital self-management tools
- Mental Health Services
- After Hours Services
- Local Coordinated Networks
- SNAPO (Smoking, Nutrition, Alcohol, Physical Activity and Obesity) Community Campaigns and Events
- PeopleBank
- Health Literacy Projects

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

Community Council members represent numerous community groups, raise public concerns in response to primary care, are healthcare advocates and champions, and provide vital information and resources back into the local community. The Community Council give the broader Northern Sydney community an important voice in local healthcare.

MEMBERSHIP

Membership of Sydney North Primary Health Network is an important way for the PHN to engage with the regions general practitioners, community organisations and allied health professionals.

SNPHN offer annual membership to Individuals, Associates and Organisations, with **1,454** members registered as of 30 June 2018.

Our membership base continues to increase, reflecting the dynamism of the Sydney North healthcare sector and health professionals' willingness to be involved in primary care developments.

At the close of the 2017/18 financial year, SNPHN had the following membership numbers:

- **1,238 Individual members**
- **91 Associate members**
- **125 Organisational members**

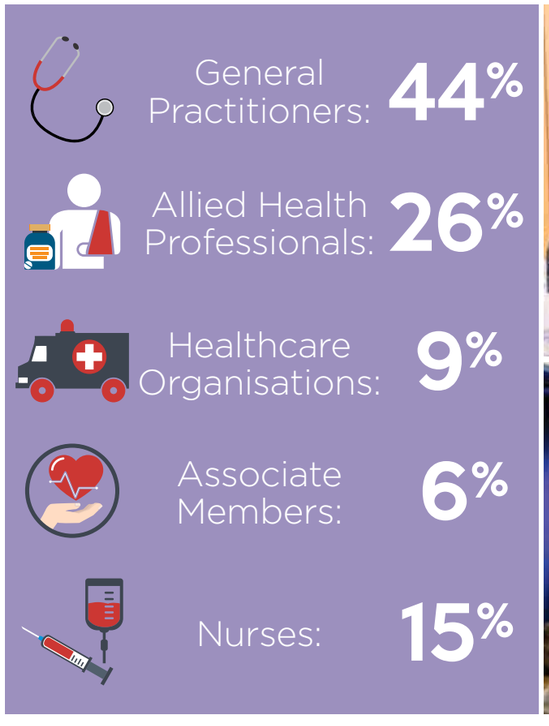
This is a 34% increase over 2016/17 fiscal year membership.

Membership with SNPHN provides healthcare professionals with:

- The opportunity to present views on primary healthcare.
- Priority access to continuing professional education events.
- Networking opportunities with other health professionals.
- The right to be nominated, to nominate and to vote at Board Elections.
- An invitation to attend the Annual General Meeting

In addition, Membership also delivers the opportunity to drive improvements in primary healthcare; ensuring services are better aligned with the health and wellbeing needs of our local community.

MEMBERSHIP TYPES



02 STRENGTHENING PRIMARY HEALTHCARE

QUALITY IMPROVEMENT

Strengthening primary care is a key objective of the Primary Care Advancement Team. Core to achieving this goal is the development of a range of Quality Improvement (QI) initiatives for general practice.

A key component of quality improvement is the ability to collect and visualise relevant data to measure and track changes over time. SNPHN facilitates this by providing licenses for data extraction tools, so that general practices can examine their own data to identify areas for further improvement and target specific populations for review and management.

At the practice level the tools provide essential population health graphs, charts and reports to best assist the practice team to implement and drive change to improve patient health outcomes. Since the launch of the QI program, **153 general practices (52% of practices in Northern Sydney)** have signed agreements to participate in data collection and uploading of de-identified data to the PHN.

Each quarter, reports are created and distributed by the Primary Care Advancement Team (PCAT) to provide meaningful, practical feedback to practices for discussion around quality improvement activities. All practices are trained in the use of the **Plan, Do, Study, Act (PDSA)** cycles to support change. During the year PCAT actively worked with 69 practices to accomplish their goals using PDSAs as part of the quality improvement/accreditation process. The focus of QI activity in previous years has been on data quality and any clinical improvements have largely been practice-led. This year, the content of feedback reports has shifted to be more clinically focused and included key indicators on diabetes, chronic heart disease (CHD) and chronic kidney disease (CKD). These practices were invited to be involved in a "Share and Learn" networking event to facilitate the spread of new ideas and share successes, barriers and enablers. A quality improvement toolkit was also developed to be used to generate ideas for the future development of general practices in the quality improvement journey.

This year, SNPHN also commenced a **Dementia Quality Improvement Program (DQIP)** with five practices – the first of its kind in Australia. The 12-month program aims to improve the quality of care for patients with dementia, measured by a set of indicators developed in partnership with the Improvement Foundation[1] using an expert reference panel. The panel developed a list of over 10 indicators in line with current dementia guidelines. The DQIP program is using 7 of these indicators as part of the program:

1. Development of a dementia register (patients with a diagnosis of dementia)
2. Health assessments performed (over 75 health assessment)
3. Reducing cardiovascular disease risk
4. My Health Record currency (health summary uploaded)
5. Carer identified (person most responsible and support provided)
6. Home Medicine Review (including anticholinergic load and use of anti-psychotic medication)
7. Identification of patients at high risk of dementia

Dementia has a profound life-changing impact not only on the person with dementia, but their carers, family members and friends. GPs have an important role to play in recognising, assessing, diagnosing, providing and coordinating care. The DQIP program will support practices to analyse current dementia care management and develop individualised improvement plans to support the implementation of evidence-based best practice care. This will be achieved through regular education events delivered by experts in the field of dementia and delivery of supportive resources for health providers, their patients, and carers.

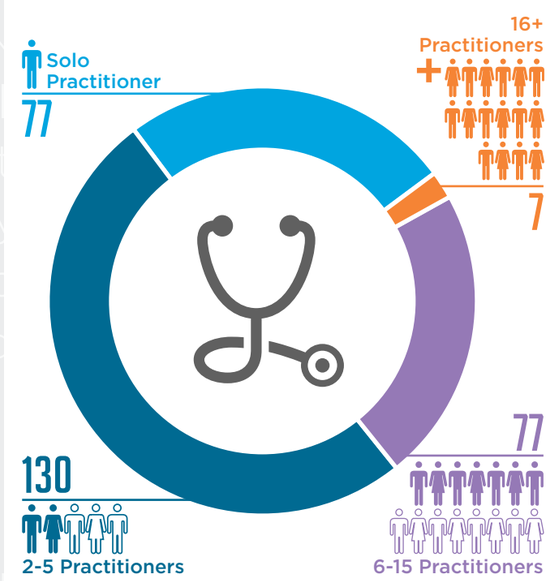
1. *For more information on the Improvement Foundation go to www.improve.org.au*

General Practice PROFILE FACT SHEET

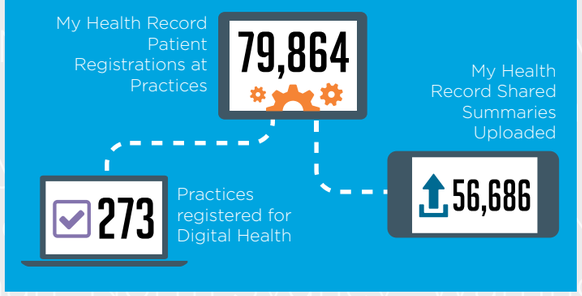
GENERAL PRACTICE

- **291** General Practices
- **1,432** General Practitioners
- **360** Practice Nurses
- **151** Practices with a Nurse
- **229** Accredited Practices to RACGP Standards

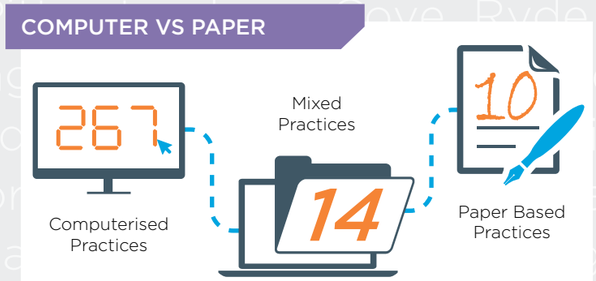
PRACTICE SIZE



DIGITAL HEALTH



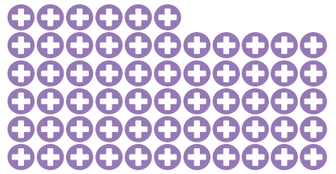
COMPUTER VS PAPER



REGISTRARS

100 Registrars in General Practice

TRAINING



61 Accredited Training Practices

CATPLUS

153 Practices with CATPlus Data Extraction Tool

General Practice
PROFILE FACT SHEET

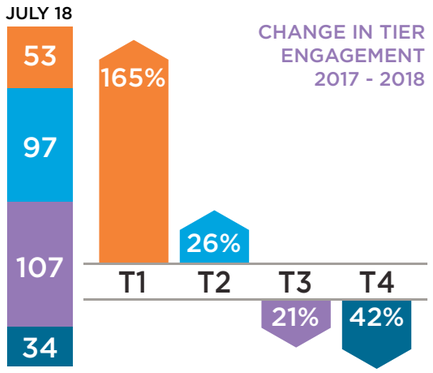
GP ENGAGEMENT TIERS

TIER 1 Advanced quality improvement skills, frequent input into health system design & planning.

TIER 2 Intermediate quality improvement capability & regular participation in programs/initiatives.

TIER 3 Basic quality improvement capability & occasional participation in SNPHN programs/initiatives.

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



CHANGE IN TIER ENGAGEMENT 2017 - 2018

DIGITAL HEALTH

My Health Record patient registrations at practice

'16 16,560

'18 79,864 ▲ 382%

My Health Record shared summaries uploaded

'16 9,802

'18 56,686 ▲ 478%

Practices registered for digital health

'16 213

'18 273 ▲ 28%

INTENSIVE QUALITY IMPROVEMENT PROGRAMS

CHAMPION PRACTICES INVOLVED IN INTENSIVE QUALITY IMPROVEMENT PROJECTS

8 Completed dedicated Quality Improvement program with trained QUALITY IMPROVEMENT COACHES

6 Participation in WELLNET (for patients with chronic disease) and nurse led care coordination

8 PERSON CENTRED MEDICAL HOME participation to align with 10 building blocks of high performing primary care

5 Involvement in DEMENTIA QUALITY IMPROVEMENT PROGRAM

PRACTICE INVOLVEMENT IN QUALITY IMPROVEMENT

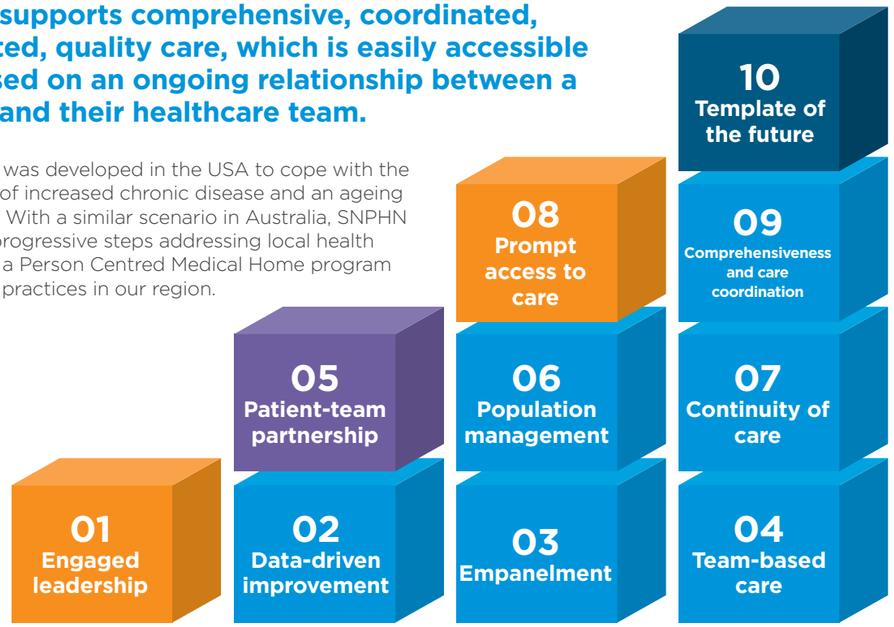
PRACTICE INVOLVEMENT IN QUALITY IMPROVEMENT USING PLAN DO STUDY ACT CYCLES

PRACTICE FIGURES

PERSON CENTRED MEDICAL HOME

The Person Centred Medical Home (PCMH) model of care supports comprehensive, coordinated, integrated, quality care, which is easily accessible and based on an ongoing relationship between a person and their healthcare team.

This model was developed in the USA to cope with the challenges of increased chronic disease and an ageing population. With a similar scenario in Australia, SNPHN has taken progressive steps addressing local health needs with a Person Centred Medical Home program for general practices in our region.



This program, based on the "10 Building Blocks of Primary Care", commenced in January 2017 and has continued successfully into its second year. Eight high performing practices continue to engage in education and support provided by SNPHN. A comprehensive program consisting of Leadership and Mentoring, Practice Network Meetings, and Education Events consolidate on learnings from the previous year and introduce new concepts for delivery of an enhanced level of care to patients in our region. This is a tailored program delivered through the SNPHN Primary Care Advancement Team providing dedicated support and coaching to the entire general practice healthcare team to achieve the Quadruple Aim of:

- Enhancing Patient Experience
- Improving Population Health
- Reducing Cost
- Improving Health Provider Satisfaction

The practices involved in the program continue to analyse their population data along with wider regional data sets, to gain a deeper understanding of their patient population and then take the necessary steps to re-evaluate delivery of care. Practice leaders are actively exploring new ways to engage with patients, provide proactive care, and facilitate better patient outcomes involving the entire healthcare team. Every team member is encouraged to work to the full scope of their licence, from reception staff through to healthcare clinicians and the healthcare neighbourhood.[2] There has been an increased focus on utilising technology to improve communication between healthcare providers and patients. Sharing improvements and outcomes with the team has been a key motivator in driving change.

"I personally take away a better understanding of my position and a greater confidence in being able to do my job to the best of my ability. This program has given me knowledge and information to perform my job to a higher degree than before." Debra Roberts - Practice Manager, Pittwater Family Practice

2. *The healthcare neighborhood is the wider health system that the Person Centred Medical Home operates within and integrates with. The patient's carer, their PCMH and the additional services they use form their healthcare neighborhood.*

"Being part of the PCMH program was so refreshing - to be able to share all of those views with likeminded people and other managers. I gained so much from the leadership and mentoring sessions in how I could deal with the isolation of a Practice Manager role. I was given tools on how to manage the staff, doctors and patients for the best outcome. It was also so rewarding to meet other managers and professionals to network with. The support I receive from the Primary Care Team at Sydney North Primary Health Network is priceless – it's like having practice helpline."

Patricia Rigg
Practice Manager, Lindfield Medical Practice

"The PCMH program has been of great value to The Cottage Surgery and our patients. It has motivated us to use our data to identify and bridge health gaps in our patients. The leadership program has been beneficial to encourage us in our styles of leadership and the one-on-one mentoring was a great support. We developed a business plan which will guide our activities into the future."

Dr Kiril Goring-Siebert
GP, The Cottage Surgery

WELLNET

The WellNet Program commenced in 2016 with six practices in the Northern Sydney region and in partnership with Sonic Clinical Services, HCF, NIB, Bupa and Teachers Health Fund.

The program brings together elements of best practice chronic disease management (see WellNet model diagram on page 18) to improve care for patients with high care needs and determine the impact on preventable hospitalisations.

A WellNet data extraction and risk stratification tool was developed, to identify potentially eligible patients from data captured by the general practice, initially focussing on five broad chronic disease categories – cardiovascular, respiratory, diabetes, major joint disease and mental health. The tool was further refined during the program to include osteoporosis, lower back pain, cancers, kidney failure and liver disease. These patient records were assessed by a Nurse Care Coordinator and those eligible were sent to the patient's GP for selection into the program. Once enrolled in the program, participants underwent a thorough assessment process and were provided with a tailored care plan. Patients are regularly in contact with the Nurse Care Coordinator and other health providers involved in their care including the GP.

As part of the WellNet Program, patients are also "prescribed" targeted educational materials via the online portal 'GoShare' which aims to supplement the information and education provided by each individual's healthcare team. Access to the general practice team is provided through face-to-face, phone, and tele coaching services. This allows for a more flexible approach to providing care and gives the patient support without the inconvenience of physically attending all consultations.

The WellNet Program uses cdmNet, a web-based coordinated care platform that securely connects healthcare providers and patients. All enrolled patients are set-up with a shared electronic health record that enables shared care planning and tracking by all members of the patient's care team including the GP, nurse, specialists, hospital doctors, and allied health professionals.

Responses from GPs who completed a survey indicated **100% agreement that 'the WellNet program is good for patients, clinicians and the practice'.** A common theme appears to be the ability for the patient's comprehensive health assessment to uncover issues not previously identified. Comments included "identifies previously unrecognised problems", "uncovering aspects of patient health sometimes overlooked by busy doctors", "we discover things we did not know about our patients", "identification of clinical issues which clinicians ordinarily don't have time to delve into", and "many silent or unattended issues are uncovered and dealt with".

The Nurse Care Coordinators have extensive knowledge of available services in both the public and private healthcare sectors and have been able to improve patient access to social and care services such as walking and social groups, overeaters anonymous, assistance for people with financial hardship, and programs such as Healthy Weight for Life and Stepping On Falls Prevention.

GPs report positively about working with the Nurse Care Coordinators and more generally in the team setting. Comments included "excellent care from the WellNet nurses", and "working in the team framework is the way things should be done".

The program aligns with the Healthcare Home principals and the 10 buildings blocks of high performing primary care, where the patient is at the centre of their care. WellNet is also aligned to achieve the Quadruple Aim for patients, providers and the wider health system.

The Quadruple Aim consists of:

- Improved patient experience
- Improved patient outcomes
- Cost efficiency across the system
- Improved provider experience

To date there have been **977 patients enrolled in the program across 6 general practices**, 165 patients have completed the program and a further 22 have re-enrolled. Patients will be followed for a period of 3 years as part of the program evaluation to assess progress and the possibility of preventable hospitalisations over the 3-year period.

The WellNet Program has been well received by the patients enrolled. Feedback from GPs include "the program gives patients opportunity to address health concerns", "patients love the program because of its comprehensive care", and "patients are so much more motivated to take charge of their lifestyle issues and health."

WELLNET MODEL

IMMUNISATION

Sydney North Primary Health Network aims to reduce the incidence of vaccine preventable diseases in the community by providing information and support on the National Immunisation Schedule.

SNPHN have been working with our general practices to improve immunisation rates using a quality improvement approach, particularly in ensuring overdue children are recalled.

Ongoing collaboration with the Public Health Unit (PHU), has led to SNPHN identifying areas in Northern Sydney with lower immunisation rates and promoting support strategies including data cleansing, cold chain management and use of Australian Immunisation Register (AIR) reports, to aspire to rates above 95%. Fifty-one general practices have been offered practice visits by the PHU and/or SNPHN which are either completed or underway, with excellent feedback. As a result, the rates for 5 year-olds who are fully vaccinated have increased by 2% in the last 12 months. As of March 31st 2018, 92.3% of children aged five years are fully immunised in the SNPHN region compared with 94.2% nationally and 94.2% in NSW. North Sydney / Mosman, at 89.8% having the lowest immunisation rate and Hornsby, at 94%, having the highest.

SNPHN was also actively involved through 2017/18 in co-design workshops with NPS MedicineWise and the National Centre for Immunisation Research and Surveillance (NCIRS), to develop a national PHN Immunisation Support Program, which enables shared knowledge and resources between PHNs and other key stakeholders. SNPHN continue to participate in several working groups in the areas of cold chain management, registers, and data to develop resources that will enable our team to provide quality immunisation information and resources to our practices and the Northern Sydney community.

EDUCATION

2017/18 has seen 3,536 GPs, practice staff and health professionals attend over 85 education opportunities hosted by SNPHN.

Sydney North Primary Health Network remains committed to providing a high quality, relevant education program for health professionals that service the Sydney North region.

Our Education Program supports general practice and primary care providers to build capacity to develop a high performing, modern local primary healthcare workforce that is well equipped to meet the changing demands of healthcare delivery.

SNPHN are a Royal Australian College of General Practice (RACGP) accredited provider with three RACGP endorsed providers on staff. We understand the importance of delivering an education program that encompasses adult learning principles and provides participants with access to education that is both relevant and evidence informed.

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

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

2017/18 has seen 3,536 GPs, practice staff and health professionals attend over 85 education opportunities hosted by SNPHN.

“I really appreciate the great work of SNPHN – thank you for your commitment to quality education and cross discipline networking.”

Allied Health Provider

Education opportunities have included:

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

The education program provides a comprehensive education events listing on the SNPHN website (www.sydneynorthhealthnetwork.org.au/education-events/) which includes links to online learning opportunities and continued professional development education events and conferences being held externally. This page also includes a comprehensive video library of filmed education events.

All education events are evaluated to ensure SNPHN remain dedicated to offering education that is relevant and engaging. We would love to hear from you with any feedback you may have and can be contacted at events@snhn.org.au

“Excellent update – very relevant topics, thank you for all your ongoing hard work!”

GP

“Outstanding workshop and presentations – very informative and an overall excellent day!”

GP Shared Antenatal Care ALM

NURSE TRANSITION PROGRAM

“I feel very fortunate to have been selected to participate in the Nurse Transition Program coordinated by SNPHN. I am very much enjoying my role as a practice nurse at Hunters Hill Medical Practice. I have been supported throughout the program by the Nurse Transition Program Coordinator and her colleagues, who have provided valuable skills and knowledge at the education days. I would very much recommend this program to new graduates who have an interest in primary healthcare and general practice.”

Ellen Patterson, Graduate Nurse

Starting a new career can be a challenging experience for any recent graduate from nursing which is why Sydney North Primary Health Network offers a specific program to help the transition from university into a primary care nursing career.

General practice nursing is one of the fastest growing areas in healthcare, and nurses play a critical role in care coordination, chronic disease management, preventive health and ongoing practice quality improvement.

The benefits of mentorship and supported, structured education on nurse retention in primary care are proven. SNPHN graduates from the Nurse Transition Program are offered employment in local Northern Sydney general practices and become part of the practices vibrant multidisciplinary primary healthcare teams, whilst being supported by a Nurse Transition Program Coordinator. The 2017 program achieved a 100% retention rate, a positive sign for the future of the local primary care nursing workforce.

The 2018 program has developed to enlist 8 new graduates and also saw the addition of a placement opportunity in a community nursing organisation, further diversifying the program options. The Nurse Transition Program Coordinator has spent the last year promoting the program at university career days, as well as offering ongoing support to nurses new to general practice who are not formal participants of the transition program.

TESTIMONIAL: HUNTERS HILL MEDICAL PRACTICE

Hunters Hill Medical Practice is a busy accredited general practice. We have 9 doctors, 3 registered nurses and allied health practitioners. As a team we are committed to high standards in every aspect of medicine and nursing.

The SNPHN Nurse Transition Program Coordinator has been supportive to our graduate nurse and we have been so impressed with her commitment to developing skills that are so important to nursing.

We have been extremely happy with our graduate nurses. The registered nurses enjoy teaching and passing on their knowledge in all aspects of primary healthcare, including wound care, immunisation, chronic disease management, triage, and health assessments.

We are looking forward to our next graduate nurse placement.

Deirdre Stacey, Senior Registered Nurse

CONGRATULATIONS KERRY

Kerry McBride, a graduate nurse who completed the 2017 nurse transition program, received recognition as a finalist in the Australian Primary Health Care Nurses Association (APNA) New Graduate of the Year Awards. The GP’s at the practice where Kerry completed the Nurse Transition Program, and was consequently employed fulltime, nominated Kerry for her dedication to her role as practice nurse. Kerry’s nomination focused on her innovation and changing practice processes to improve the care and management of patients to achieve better health outcomes.

CANCER SCREENING

This year saw an intensified focus on cancer screening across our region, in alignment with the NSW Primary Care Strategy, to increase the involvement of primary care providers in recommending Bowel, Cervical and Breast cancer screening and follow-up for eligible people.

Across these three national screening programs, SNPHN screening rates are slightly higher than the NSW average. However, we know that primary healthcare providers can have a significant impact on encouraging people to screen, so supporting local health professionals with easy access to quality information has been a key focus throughout 2017/18.

This was achieved through a new web page (www.snhn.org.au/programs/cancer-screening), which directs providers to relevant resources developed by key stakeholders and organisations such as Cancer Institute NSW, Cancer Council NSW and the National Cancer Screening Register.

With the National Cervical Cancer Program changes taking effect on 1st December 2017, SNPHN played a key role in the dissemination of information to general practice, to ensure GP's in the area were aware of the changes and where they could source more information if necessary. SNPHN also encouraged a quality improvement approach and developed a Methodology and Ideas Toolkit (QI Toolkit) to support our ongoing commitment to increasing cancer screening participation

In addition, we continued to provide opportunities for networking and professional development through events in partnership with BreastScreen NSW.

"Regular mammograms every two years, especially after the age of 50, remain the clinically recommended method of detecting breast cancer early, and women who have their breast cancer detected early through a screening are statistically much less likely to need a mastectomy or chemotherapy. Prevention is the key."

Dr Gilda Brunello

"My journey would have been very different if I hadn't been diagnosed early. Yes, having cancer was upsetting and hard for me and my beautiful family, but because I detected the cancer early through screening I was able to have a mastectomy and the treatment necessary to beat cancer and continue to be a mother, wife and now breast screening advocate."

Regina Marchant – Breast Cancer Survivor

03 INTEGRATING CARE

HealthPathways

HealthPathways celebrate one year live and 200 pathways published!

Sydney North HealthPathways is an exciting collaboration between the Sydney North Primary Health Network and Northern Sydney Local Health District. It is a program designed to drive integration, care coordination and system improvements across the region.

The HealthPathways program delivers an online local health information tool that aims to improve the patient journey throughout the Northern Sydney region, by supporting informed management and streamlining the referral process between general practice, acute care and community settings.

It is a resource designed for general practice but can be used by any primary care, community or inpatient clinician.

BENEFITS

The long-term benefits of HealthPathways include:

For the Local Health District and Specialist Care Providers:

- Better quality, quantity, and content of patient referrals to specialist care which will reduce the number of inappropriate referrals received.
- Better care coordination with primary care resulting in less hospital attendance.

For Primary Care Providers:

- Better awareness of services available in the Northern Sydney network.
- Time saved when navigating district services and sending referrals.
- Assistance in finding the most appropriate service for patients quickly.
- Fast access to centralised relevant clinical information to support management of best practice care including assessments, standard tests and management.
- Better care coordination and support with specialist services.

For Patients:

- Shorter waiting times due to appropriate referrals.
- Less hospital admissions due to appropriate and timely care in the community.
- Better patient satisfaction due to transparency and understanding of their care and coordination.
- Better access to the right care in the right place.
- More time in your appointment with the GP due to efficiencies.
- Better health outcomes from system redesign opportunities.

Reduced cost of care through:

- Less ordering of unnecessary tests.
- Hospital avoidance savings.
- Specialist efficiency cost savings.

HealthPathways has now been live for one year, with 200 pathways complete and 97 more currently in development. There have been over 2000 users accessing the site and over 1600 health professionals engaged through promotional activities and events across Northern Sydney.

Pathways live and in development include:

- Aboriginal Health
- Aged Care
- Dementia / Cognitive Impairment
- Diabetes
- Hospital in the Home
- Mental Health
- Musculoskeletal
- Paediatrics / Child, Youth and Family Health
- Palliative Care
- Pregnancy / Shared Antenatal Care
- Respiratory
- Sexual Health
- Immunisation and Vaccinations
- Domestic Violence and more.

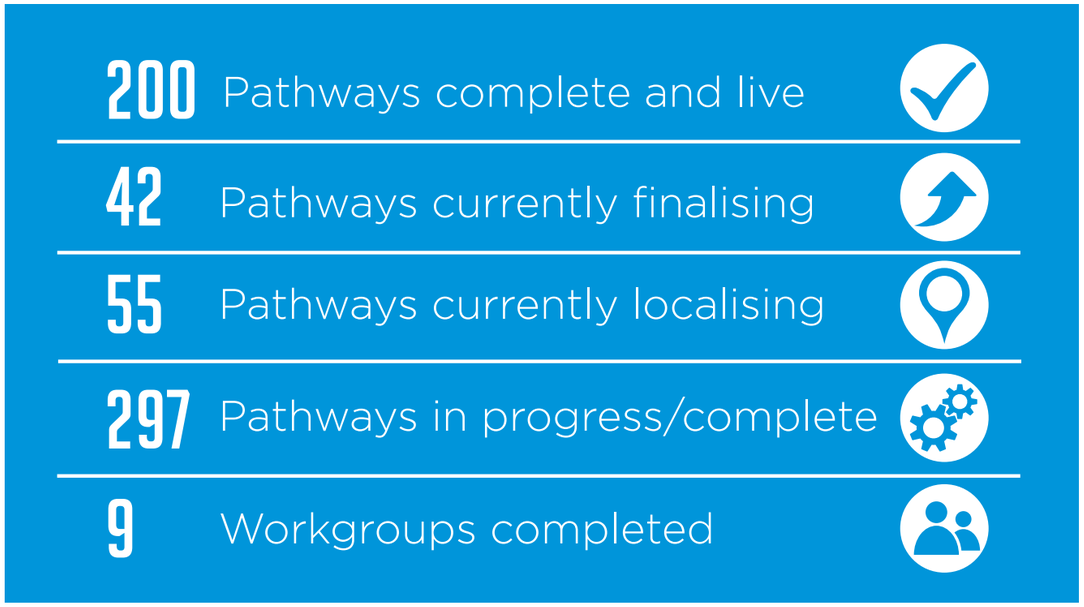
"HealthPathways has now been live for one year, with 200 pathways complete and 97 more currently in development. There have been over 2000 users accessing the site and over 1600 health professionals engaged through promotional activities and events across Northern Sydney."

Since the program's inception, **9 HealthPathways Clinical Work Groups have been held involving over 156 participants** to support development of pathways and identify opportunities for health system improvement through re-design and education. The feedback received from the consultation lead to a redesign project that investigated 37 issues and prioritisation of the following areas:

- Electronic communications and secure messaging;
- Shared care projects (diabetes and osteoarthritis surgery prevention);
- Ferinject[3] use / Acute Post Acute (APAC) or Hospital in the Home service review; and
- Access to mental health services in Residential Aged Care Facilities.

"Health Pathways is a wonderful resource for GPs and other health professionals working in primary care. With succinct clinical information, and management and referral options for a growing number of presentations, the platform will continue to expand and provide our patients with the best possible care."

HealthPathways GP Clinical Lead,
Dr Fiona Robinson



3. Ferinject is indicated for the treatment of iron deficiency when oral iron preparations are ineffective or cannot be used. The diagnosis must be based on laboratory tests.

LOCAL COORDINATED NETWORKS

Reflecting a 'healthcare neighbourhood' model, a Local Coordinated Network (LCN) is a group of general practices and other healthcare providers based in a geographical region.

The ongoing development of LCNs gives Sydney North Primary Health Network the opportunity to work closely with general practices, local allied health providers with the NSLHD, the Agency for Clinical Innovation, local private providers, private hospitals, and local government areas. This enables alignment of services to the needs of each LCN. By facilitating local partnerships, improving communication pathways and improving holistic care, consumers receive optimal care from engaged providers.

Sydney North Primary Health Network has continued to build on the Local Coordinated Networks throughout 2017/18 with several activities aimed at bringing each LCN together.

BUILDING NETWORKS

Between February and March 2017/18, five LCN networking events were attended by 280 GPs, nurses, allied health and other providers. These events gave the opportunity for local experts to speak on a topic previously identified as an area of need by each LCN. Each event also provided the opportunity for attendees to network and share resources for their services and to hear about SNPHN's commissioned services, which have been aligned to the LCNs based on need.

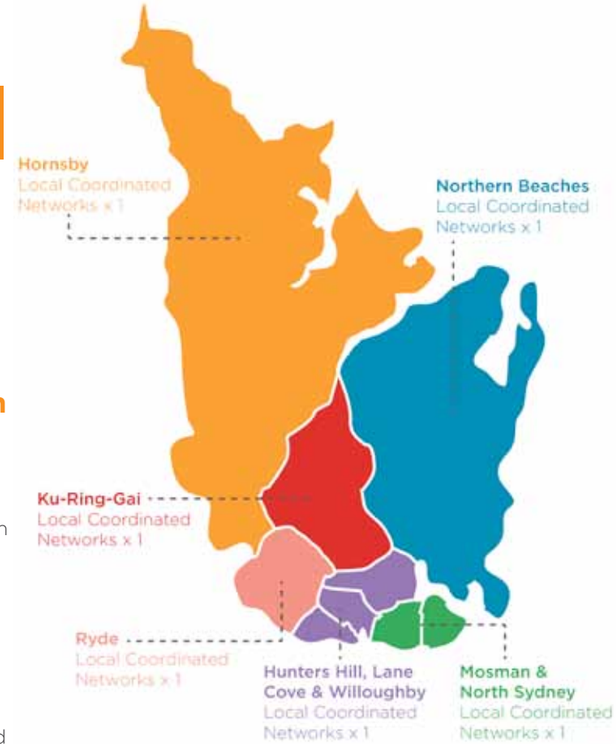
SNPHN has started delivery of quarterly LCN specific eNewsletters, incorporating local data and updates on services. Collaboration with NSLHD has made data provided to each LCN more meaningful, creating the opportunity for GP centric data.

COMMISSIONED SERVICES

LCNs provide an opportunity to commission services which align to needs identified from engagement with general practices, consumers, other stakeholders as well as needs assessment data.

SNPHN has provided ongoing funding to support local service delivery and provide access to:

- Aged care social work services
- Aged care hospital avoidance services
- Falls prevention services
- After hours GP services



BUILDING LOCAL PARTNERSHIPS

SNPHN, Northern Sydney Local Health District and the NSW Agency for Clinical Innovation are working in partnership as a pilot site for the Healthcare Neighbourhood, utilising the LCN model in the Hornsby and Ku-ring-gai areas. Two workshops have been held with 100 local attendees, representing general practice, community nursing, allied health, and community service providers from both the acute and primary care sectors.

The workshops involved:

- Networking activities to build local relationships.
- Building understanding and awareness of existing pathways that facilitate local partnerships.
- Exploring barriers to delivering optimal care as a neighbourhood.
- Identifying and building on local opportunities for change.

FURTHER OPPORTUNITIES

- Ongoing opportunities to test new ways of working.
- Consultation of GPs in LCN regions to identify and address local areas of need.
- Commissioning services according to local need.
- Building opportunities with local councils and service providers to explore opportunities for co-commissioning and collaboration.
- Collaboration with NSLHD to continue to improve integration across our region.
- Further contribution to eNewsletters and events by local providers.

DIGITAL HEALTH

Digital Health is the convergence of the technology revolution alongside healthcare.

It is empowering us to better track, manage, and improve our own and our family's health, and live better and more productive lives. It also helps to reduce inefficiencies in healthcare delivery, improve access, reduce costs, increase quality care, and make medicine more personalised and precise.

CURRENT ISSUES AUSTRALIA WIDE:

- **230,000** admissions from medication errors costing 1.2 billion annually
- **17%** pathology and radiology tests are duplicated
- **20%** of medical errors are due to incomplete patient administration or admission information
- **50%** of nurses' working hours are spent on basic administration and paper work
- Silos of information that delay care and cause frustration and poor health outcomes
- Only **3%** of medications match between Residential Aged Care Facilities and General Practices

SNPHN's Digital Health programs, initiatives and collaborations are helping to drive the revolution in healthcare towards a better future, not just for people in Sydney's North, but for all Australians.

MY HEALTH RECORD

Spearheaded by the Australia-wide My Health Record program where every Australian will receive a digital summary (unless they don't want one and opt out) of their health information that can be shared with their healthcare providers, aligning with the National Digital Health Strategy.

The key focus this year for the SNPHN Digital Health Team has been on health professional awareness, education, readiness, support, and local consumer engagement and awareness, so that people can make informed choices about having a My Health Record and its benefits.

RESULTS TO DATE IN NORTHERN SYDNEY:

- ➔ **100%** general practice and pharmacy awareness
- ➔ Over **90%** of general practices registered
- ➔ Over **60%** of pharmacies registered
- ➔ A **250%** increase in dispense record uploads
- ➔ Over **140** allied health providers trained
- ➔ Visits to all private hospitals in the region

MY HEALTH RECORD BENEFITS FOR CONSUMERS AND PROVIDERS

AVOID ADVERSE DRUG EVENTS

ENHANCED PATIENT SELF-MANAGEMENT

IMPROVEMENTS IN PATIENT OUTCOMES

REDUCED TIME GATHERING INFORMATION

AVOIDED DUPLICATION SERVICES

SECURE TWO-WAY COMMUNICATION

The SNPHN Digital Health Team are also working with Residential Aged Care Facilities (RACFs), acute care, GPs, public and private Hospitals, universities and private vendors to implement, monitor and maintain secure digital communications between stakeholders, to improve the flow of relevant clinical information and provide better health outcomes for all Australians.

AMBULANCE NSW – SECURE MESSAGING PROJECT

In January 2017, SNPHN started a secure messaging pilot with Ambulance NSW Extended Care Paramedics (ECPs) based in Lane Cove.

To improve communication between Ambulance NSW ECPs and GPs within the region, SNPHN provided the Extended Care Paramedics with a laptop, printer, internet, secure messaging portal and an eReferral form to enable the ECPs to send an electronic referral straight to a patients' treating GP.

This pilot is now being rolled out to **115 paramedics** within the Artarmon Superstation.

DIGITAL HEALTH TEST BEDS

In association with the Australian Digital Health Agency the SNPHN were also successful in obtaining two Digital Health Test Bed project grants, which aim to enhance digital communications using secure messaging and the My Health Record by:

1. Closing Aged Care Integration Gaps

Building on our existing program using secure messaging to connect Residential Aged Care Facilities (RACFs) with general practice, pharmacy and acute care hospital avoidance (HAPOP) providers, this program will examine how enhanced use of secure messaging and My Health Record to exchange clinical information can improve the experience of providing care for health professionals.

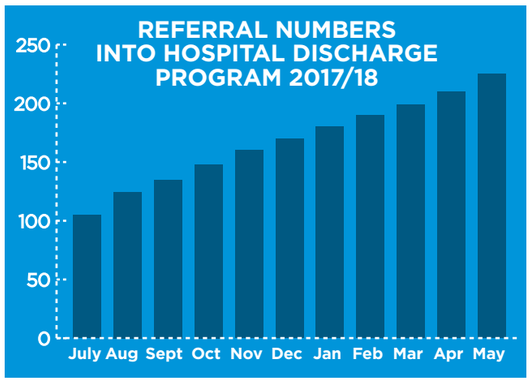
2. Connectivity in the Private System

This project will accelerate efforts in the Sydney North region to enhance shared care models by driving an increase in the digital maturity of private specialists through engagement with the My Health Record.

"My Health Record reduces the burden on carers and families in trying to keep up-to-date records. It has assisted hospital emergency departments in assessing patients' conditions. It has allowed patients to have more confidence in knowing that if their healthcare professional is not available, there will always be a readily available record following them."

Dr Hans Blom

CARE COORDINATION & HOSPITAL DISCHARGE SERVICES



This year SNPHN has continued to work closely with service providers KinCare and Just Better Care, who were commissioned to provide a short-term, hospital-to-home transition service that is designed to reduce the likelihood of re-admission to hospital after discharge.

The organisations have been working closely with each other across the Northern Sydney region to support patients leaving hospital, providing services such as:

- Organising transport to get patients home safely.
- Shopping for essential items.
- Organising medication supply.
- Respite care.
- Short term personal care.
- Daily monitoring.
- Short term case management and referral to appropriate services such as My Aged Care.
- Organising appointments and transporting patients to follow-up care with their GP.

The main referrers to these services are health professionals from public and private hospitals in the Northern Sydney region. They have found the services to be extremely helpful and valuable for the following reasons:

- It gives patients and their families' confidence to go home.
- Timely review of patients on discharge, especially on weekends.
- Services in place quickly to support patients on discharge.
- Assists patients and families to navigate complex aged care system.
- Patients able to be discharged on time, so they weren't occupying a hospital bed unnecessarily.

Through feedback and identified gaps, both providers are now also working with a range of community and primary healthcare providers to coordinate care for patients that are otherwise at risk of hospitalisation, where short term management could be beneficial.

Both services are agile and responsive to feedback, and continuously adapting their model of care to ensure the best outcomes for both the patients and providers they support.

"I have referred patients to the program on several occasions over the past year, especially recently. The patients have been admitted for cancer treatment, often some patients have been for palliative community care," said a Case Manager of Oncology and Palliative Care.

A patient of one of the services said, "I was very happy with your service, the woman who came to my house was extremely efficient and worked quickly, she was also very pleasant."

"The Just Better Care stay at home program is unlike any other service that we can link our vulnerable and socially isolated clients to."

END OF LIFE / PALLIATIVE CARE

The quality of care improvements in Northern Sydney include an increase in advance care planning, increase in the proportion of residents dying in their preferred location, increase in care coordination and access to bereavement support for families.

Northern Sydney has a higher than average ageing population. Between 2016-2036, the population of those aged 65 years and over is expected to increase by 55.2% to 222,000 people, accounting for 20% of the total population in 2036 (NSW Department of Planning and Environment 2017).

For these reasons, SNPHN has undertaken a service mapping and market analysis of end of life and palliative care coordination, noting three key areas of need:

1. Strengthening quality of end of life care provided in residential aged care.
2. Increasing primary care led provision and quality of end of life care services in general practice.
3. Home care support, with the aim of increasing opportunity for people to die at home.

With the guidance of the SNPHN Clinical Council, SNPHN commissioned HammondCare, to build capacity within Residential Aged Care Facilities (RACFs) to deliver a palliative approach to care.

The model includes provision of advice and training to RACF staff and GPs within the SNPHN region, by HammondCare liaison nurses and palliative care specialists. The aim being to strengthen professional networks through the development of "Communities of Practice" and integrating care pathways so families receive increasing choice and control over end of life care options. This model also ensures that residents are not unnecessarily transferred to hospital in the last weeks of life.

The initiative involved 24 local RACFs selected to participate from a total of 42 applications. Each RACF was required to nominate 2 palliative care "link nurses" and 2 palliative care "champion care workers" to receive offsite education and onsite mentoring involving action and case-based learning from HammondCare's experienced palliative care liaison nurses. The program also involved local GPs who visited residents in the selected facilities.

This program is being independently evaluated by a team from the University of Technology Sydney, led by Professor Deborah Parker.

Expected outcomes include:

- Increased choice and control for patients and families;
- Decreased unplanned hospital admissions;
- Earlier identification of deteriorating patients and timely access to palliative care; and
- Increased knowledge, skills and confidence of staff;

Early results are promising; with one of the participating RACF Directors of Nursing reporting that advance care planning for residents in their facility has **increased from 15% to 85%** as a result of their participation.

"The Sydney North Primary Health Network wanted to explore new and innovative ways of delivering initiatives that would improve the quality of end of life care provided in residential aged care facilities that may be scaled up and delivered more widely in the future."

Cynthia Stanton – SNPHN General Manager, Primary Care Advancement & Integration

"This opportunity was offered to all Northern Sydney aged care providers. A third of all these nursing homes in the region have applied to be part of this project. That's an overwhelming response."

Kelly Arthurs – HammondCare Project Lead

Early results are promising; with one of the participating RACF Directors of Nursing reporting that advance care planning for residents in their facility has increased from 15% to 85% as a result of their participation.

AGED CARE

It is estimated that over 12,000 people in Northern Sydney are living with dementia and this figure will continue to grow as the population ages.

AGED CARE PROVIDER SUPPORT

In collaboration with the Northern Sydney Local Health District (NSLHD) Hospital Avoidance Teams, SNPHN is educating staff of Residential Aged Care Facilities (RACFs) to use a triage guide to help them identify patients who show signs of rapid decline. By recognising these signs earlier, hospital avoidance teams and GPs can be called in to provide appropriate treatment at the facility, without the person needing to be taken to hospital.

In 2017/18 more than **160 RACF staff attended face-to-face training.** The additional component to this training is access to an online module, based on case studies and requiring participation in an online forum. Staff utilise their skills from the face-to-face training and the triage flipchart to work through each case study. Over 100 staff have completed the module since it was launched.

DEMENTIA COLLABORATIVE

The Northern Sydney Dementia Collaborative was established in 2014, with assistance from the NSW Agency for Clinical Innovation's "Building Partnerships" program, which aimed to form alliances that work together to integrate care for older people with complex health needs. Nowhere is this more needed than in people with dementia. There are a range of services available in Northern Sydney for people with dementia and their carers. However, information about these services and how to access them is not well understood by the people who need them the most or by health professionals. It is estimated that over 12,000 people in Northern Sydney are living with dementia and this figure will continue to grow as the population ages.

The Collaborative includes representatives from SNPHN, Northern Sydney Local Health District, Alzheimer's Australia NSW, Community Care Northern Beaches, Northern Sydney Regional Dementia Advisor, local GPs and a carer with lived experience caring for a family member with dementia. The partnership is working together to develop strategies to improve the healthcare journey for people with dementia and their carers in the community. This includes:

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

It is expected that with access to this information, people with dementia will have better plans in place to manage their care, more timely access to support, and there will be reduced unplanned admissions to hospital for people with dementia.

FALLS PREVENTION

iSOLVE

Over 75 GPs, 27 general practices, and 579 allied health providers have engaged in the iSOLVE program.

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

Falls Prevention Decision Tool and Resources: Professor Lindy Clemson and a team of multidisciplinary researchers, including GPs, have developed a clinical decision tool and resources based on the latest research evidence and practice guidelines. "We anticipate that these will help GPs and practice nurses identify people at risk of falling and provide tailored management options," says Professor Clemson. GPs are also offered a directory of trained falls prevention service providers in their local area to facilitate patient referral.

- The clinical decision tool, resources and referral directory are available online on the SNPHN website www.bit.ly/isolve
- Practices are welcome to express interest in organising educational visiting at their practice through SNPHN's Primary Care Advancement Team

GP Practice Interviews: Interviews were conducted with 27 GPs, four practice nurses and one practice manager during their participation in a trial to test the decision tool and resources. Preliminary findings included:

- GPs reported a shift in the practice approach from fall screening to fall prevention.
- Assumptions were challenged:
  - GPs were surprised how worried people were about falls – even those 65-75 years old.
  - GPs were familiar with treating a fall injury, and valued the training on how they can help patients manage falls risk.
- Reported barriers:
  - Time and competing priorities.
  - IT problems.
  - Ad hoc information flow between allied health professionals and general practice.
- A better chance of embedding iSOLVE into routine practice if the GP internalised the decision tool.
- GPs see the iSOLVE falls prevention process as a low tech "simple system".

Allied Health Interviews: Interviews with allied health professionals included six physiotherapists, four occupational therapists, three podiatrists, one exercise physiologist, and one service manager. Preliminary findings included:

- The iSOLVE workshops were perceived as important in supporting existing practice and providing strategies to enhance practice.
- Falls prevention was valued in practice and recognised as complex.
- Allied health professionals have started adopting strategies for integrating falls prevention routinely.
- Working through challenges:
  - Relating to patients multi-morbidity, complex living situations, and motivation.
  - Working alongside other health professionals and understanding respective roles, overlapping tasks and communication flow.
  - Associated with funding systems perceived as complicated and constantly changing.

The next steps in the iSOLVE project include the further development of:

- The online GP decision tool.
- Online GP quality improvement and continued professional development activities.
- The relationship with software partners HotDoc and GP clinical software Medical Director to integrate the tools.
- Integrating iSOLVE resources within HealthPathways.

iSOLVE will also be coordinating an area wide roll-out within NSW Ambulance, the Sydney North Primary Health Network and nationally. The iSOLVE implementation guide of lessons learnt will additionally be widely distributed.

STEPPING ON

Stepping On is an evidenced based, free, community falls prevention program for people 65+ that has been provided in Northern Sydney since 2009. The structured group program involves tailored exercise sessions over a 7-week period, each consisting of 2 hourly interactive education and exercise sessions with a follow-up session at three months.

In the Northern Sydney region an average of 16 groups have been run per term - each group consisting of 10-14 participants. Specialised groups are also run for culturally and linguistically diverse (CALD), older persons with mental health concerns, and sessions for carers. **In 2017/18, 128 Stepping On group sessions were delivered.**

After consultation and co-design sessions within Local Coordinated Networks, SNPHN decided to commission extra sessions to increase the services provided over a 12-month period. This funding covers an extra 16 groups and has enabled the program to expand into new suburbs and cultural groups to meet the need across the SNPHN region, reducing the programs wait list.

The 8 new Stepping On CALD group sessions include additional Chinese groups in both Mandarin and Cantonese and new groups have been formed for Italian and Spanish speaking clients.

Participant Quotes – the most helpful parts of the Stepping On program were:

"The exercises and information hand outs were very useful."

"Advice on selecting proper shoes and appropriate medication was great."

"Recognising home hazards, exercising and moving about safely was good advice."

All participants said the Stepping On program met their expectations, if not exceeding them.

"My balance has improved, and the program actually exceeded my expectations."

"My knowledge of falls prevention has increased."

"I feel confident to take action to prevent falls and my physical fitness has improved."

"I feel more confident to move around safely in the community."

"I feel more motivated to participate in ongoing physical activity."

FRAILTY

The frailty identification and management project (The Frailty Initiative) has been established as a joint initiative between the Northern Sydney Local Health District and the Sydney North Primary Health Network, supported through Ministry of Health Integrated Care funding.

The project is now in the planning stage and aims to implement an integrated model of care that supports the delivery of a frailty identification tool for people aged 70+ and supporting management plans to address the reversible contributing factors of frailty.

What is Frailty?

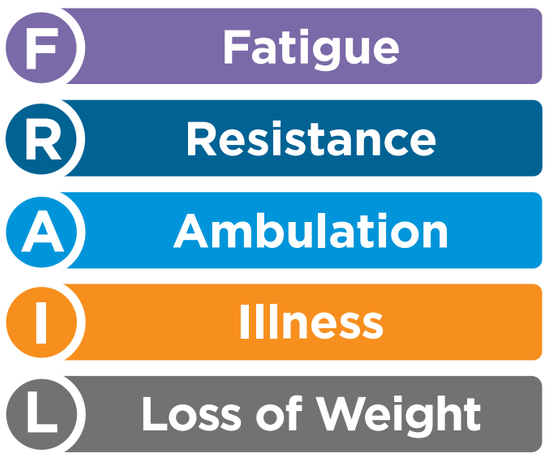
- Affecting 25-27% of the population aged 70+ (approximately 35,000 people).[4]
- It is associated with vulnerability and poor health outcomes.
- Frail older people have increased risk of falls, longer length of hospital stays, decline in function, increased chance of institutionalisation, and death.
- Early identification and targeted intervention can reduce frailty, avoid inappropriate hospital admissions, and improve health outcomes for people who are frail.

The Frailty Initiative commenced in May 2018 as a pilot project with locations selected in general practice, community care and the hospital inpatient setting.

The pilot sites will utilise the Frail Scale (frailty screen) and the associated management content will include:

- A physical activity plan.
- Review and addressing polypharmacy.
- A nutrition plan for weight loss with appropriate dietary supplements.
- Addressing self-reported exhaustion.
- Review for Vitamin D deficiencies.

FRAIL SCALE



0=Robust, 1-2=Pre-frail, 3≥=Frail

4. *Asia Pacific Clinical Practice Guidelines for the Management of Frailty (2017), JAMDA, 18, 564-575*

SHARED ANTENATAL CARE

Shared antenatal care (SAC) is sharing pregnancy care between the general practitioner and the hospital antenatal clinic, according to an agreed protocol.

In Northern Sydney, it is available for Manly, Mona Vale, Hornsby and Royal North Shore hospitals. SAC is an option for pregnant women with no adverse maternal or foetal pregnancy risk factors.

Some women like shared care because they're familiar with their GP, their GP knows their medical history, and the care is usually closer to home. It is also particularly valuable for women from culturally and linguistically diverse (CALD) backgrounds, where their GP speaks the same language and understands their unique cultural needs.

Sydney North Primary Health Network works closely with Northern Sydney Local Health District, under the guidance of a joint advisory committee, to increase the awareness and benefits of SAC across health professionals as well as the community. This includes maintaining a list of GPs who are available and trained to participate. This year, the number of shared antenatal care registered GPs grew by 22% from 292 to 355.

By using the search function on the shared antenatal care page (www.snhn.org.au/programs/shared-antenatal-care) on the SNPHN website GPs offering SAC can be found by the language they speak as well as the suburb they practice in, making it easier for hospital staff and pregnant women find a GP that matches a person's individual cultural needs and speaks their language. Brochures about the program are also available in Chinese and Korean languages.

SNPHN also support local GPs by offering education events specific to SAC three times a year. These events are extremely popular, with 159 GPs participating in 2017/18.

This year, the number of shared antenatal care registered GPs grew by 22% from 292 to 355.

04 IMPROVING ACCESS

PLANNING & PERFORMANCE

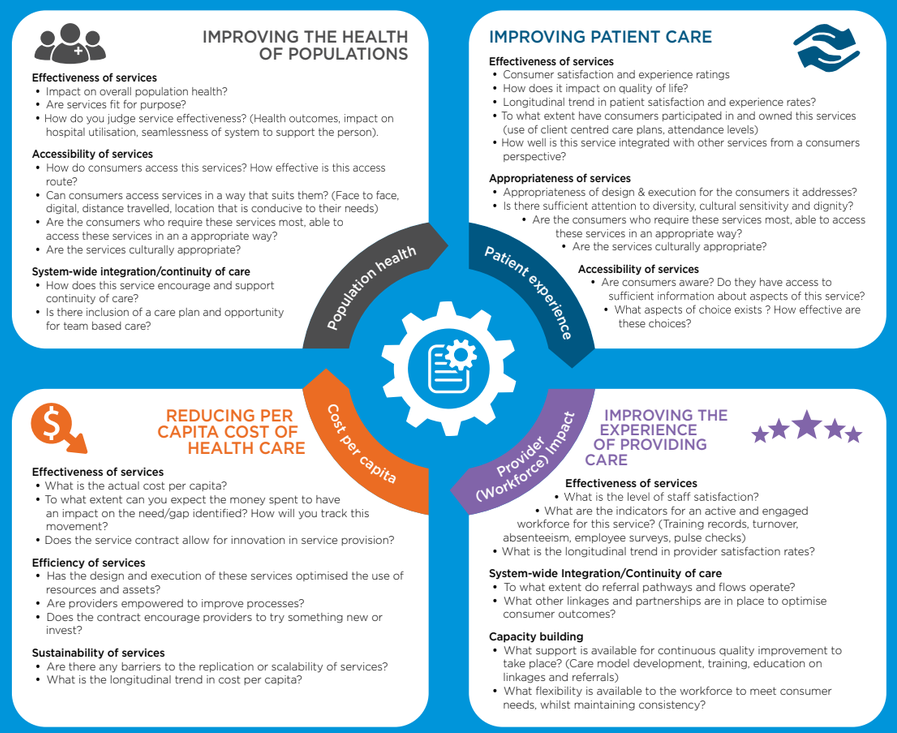
Over the last three years Sydney North Primary Health Network (SNPHN) has reviewed community needs, built partnerships, and co-designed solutions through commissioning processes.

A key priority for this year has been to implement a consistent mechanism to measure the impact and outcomes of services through development of the **SNPHN Commissioning Evaluation Framework.**

The SNPHN Commissioning Evaluation Framework utilises the **Quadruple Aim** as a foundation to understand "success" across commissioned services and builds with continuous improvements on future services through measures based on impact and outcomes.

The Quadruple Aim encourages a population health approach that balances delivery of high value care at an appropriate cost, allowing for better patient experience delivered from an engaged workforce.[5] This diagram below provides examples of prompting questions considered when setting in place a service to be evaluated, enabling a holistic view and a focus on delivering value to consumers, providers, and the system as a whole.

The SNPHN Commissioning Evaluation Framework has identified success across a range of commissioned services during the last year and ensured continuous improvement for all services, with identified areas for service improvement built into future contracts as stretch targets and key performance indicators. As we move into 2018/19, SNPHN will continue to deliver outcome-based commissioning to drive improved health results in the local community.



5. Bodenheimer T, Sinsky C 2014, From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider, Annals of Family Medicine, vol 4, issue 6, pp. 573-576.

MENTAL HEALTH

10 mental health services commissioned across the stepped care continuum, supporting access to the most appropriate level of care tailored to individual needs.

83% increase in service uptake for newly established mental health services across 2017/18, with a total of 3,690 clients receiving mental health treatment through these services.

"The best thing about the service is the friendliness of the staff. I feel safe and welcomed. I do not feel judged and I feel listened to."

Young person, Karrikin service

Throughout 2017/18, the Sydney North Primary Health Network has worked with community-based service providers to implement a range of mental health and suicide prevention services to meet the identified needs of the local community.

Building on the services launched in 2016/17, SNPHN has commissioned services providing outreach-based care coordination and clinical support for young people and adults experiencing severe mental illness, a service for young people experiencing eating disorders and a new psychiatry support line to assist GPs with assessment and treatment.

In addition to the development of new services, SNPHN is leading the expansion of existing services providing support to young people with mental health concerns. In late 2017, SNPHN undertook a review of local youth mental health needs. The review found that there were sections of the PHN region, including the upper Northern Beaches, Hornsby and Ryde that require greater access to mental health services. In response to this review, SNPHN developed a revised and expanded model for headspace services in the region.

The new headspace service model incorporates co-location in regional hubs and outreach into areas of need, care coordination to assist young people and their families access the range of services they need and greater integration with primary care and psychiatry. Established mental health organisation, New Horizons, was successful in its application to provide headspace services in the region. SNPHN has worked closely with New Horizons, GPs, and other youth service providers to integrate headspace services within the local service sector.

In the year ahead, SNPHN will be focused on improving access to services along the stepped care continuum, supporting navigation for GPs and service users and enhancing service integration. This will involve the rollout of additional digital support tools, care navigation services, and in-practice education and support for GPs and practice nurses.

PATIENT STORY

Susan* was referred to Community Care Northern Beaches (CCNB's) Seasons suicide prevention service by her psychologist following a suicide attempt. She had been homeless for over 18 months, and was struggling to find accommodation, support, and income.

Providing regular face-to-face and telephone support, Seasons assisted Susan to connect with affordable housing and provided some practical resources to help her settle into her new home. Susan was supported to finish her studies and in collaboration with her psychologist worked on safety planning for times of crisis, and setting goals for the future.

Susan reports hope for the future, and a chance to start again. Her future goals include employment and continuing to develop her wellbeing.

*Not real name for patient confidentiality.

ALCOHOL AND OTHER DRUGS

3 newly established services to support community-based alcohol and other drugs (AOD) treatment tailored to vulnerable and high-risk groups.

578 clients received support for drug and alcohol misuse from the newly established AOD services in 2017/18.

"I was treated so respectfully and without judgment, felt in a safe place to talk and open up."
Client, Odyssey House

Access to community-based treatment and support for alcohol and other drugs misuse has been identified as a key health need in the Sydney North Primary Health Network region.

SNPHN has worked with commissioned service providers to increase the availability of individual and group counselling services and strengthened service expansion into underserviced communities. Odyssey House now provides treatment services for adults aged 18 years and over from service hubs in Chatswood, Manly and Pymble. Youth specialist service, Sydney Drug Education and Counselling Centre (SDECC) provides services for young people aged 14-25. SDECC has built on its base in Manly to provide additional services in Chatswood and Avalon, with services planned to expand into Hornsby and Ryde.

In addition to increasing the availability of treatment services, SNPHN has invested in supporting the capacity of the local clinical workforce. SNPHN has provided a series of education events to enhance clinicians' capacity to identify, treat and refer adults and young people with risky drug and alcohol use. The SNPHN website has developed into an online resource hub for clinicians providing clinical guidelines, screening tools, treatment protocols, prescribing, and patient factsheets and resources. Later in 2018 SNPHN is partnering with Northern Sydney Local Health District to offer clinical attachments for GPs to work closely with addiction medicine specialists as well as other opportunities to support peer learning.

As part of its capacity building work, SNPHN has piloted an alcohol screening and brief intervention model in numerous local general practices. The pilot includes a patient resource kit with information about the impacts of alcohol on health, and practical tools to help reduce drinking. Future plans include the development of a nurse led home withdrawal and education service which will be delivered in collaboration with local stakeholders.

PATIENT STORY

Sky* presented to SDECC with cannabis dependence and symptoms of depression and anxiety. She was not engaged in work or study and her treatment goals were to quit cannabis and find a job. Following an initial assessment, it was determined that Sky would benefit from in-patient treatment to assist her withdrawal. SDECC staff supported Sky to access residential treatment and remained engaged with her mother as she returned home. As Sky's treatment in the community continued, SDECC helped Sky to find independent accommodation and get a part-time job. Sky continues to receive counselling support from her SDECC worker to maintain her recovery and pursue further life goals.

*Not her real name.

ABORIGINAL INTEGRATED TEAM CARE

The Integrated Team Care (ITC) program is a chronic disease management program designed to support and improve health outcomes for Aboriginal and Torres Strait Islander People in the region.

The service provides culturally appropriate care coordination to Aboriginal and Torres Strait Islander people with long-term, complex conditions. The ITC team at Sydney North Primary Health Network works closely with clients, general practitioners, and other medical and allied health providers involved in client care.

This service has assisted over 60 people in the ongoing management of their conditions, providing a range of supplementary services, including transport, payment of allied health and specialist medical appointments, medication management, and access to medical aids. The service also provides care coordination, facilitating social supports such as Centrelink, housing and emotional wellbeing services.

Working with individual clients often highlights needs in other members of the family, and the ITC program has been instrumental in referring these family members on to a range of services.

GP SOCIAL WORK SERVICE

GP Social Work client Teresa and her husband/ carer Frank

Socio-economic factors have an important impact on a person's health and wellbeing.

These include education, employment, social isolation, housing and income. Social determinants can strengthen or undermine the health of individuals and communities. For example, in general, people from disadvantaged social or economic circumstances are at greater risk of poor health than people who are more advantaged.

To build capacity in general practice and improve patient outcomes, Sydney North Primary Health Network commissioned a community based social work service that provides support for people to stay well and in their own homes, particularly in relation to psychosocial, health, social and welfare needs, in order to reduce the likelihood of admission or readmission to hospital.

The service model includes:

- The ability for a GP to refer to a community based social worker for patients with chronic and complex health conditions, improving their capacity to coordinate appropriate non-health related care.
- Timely and flexible access to holistic, practical support to ensure the social determinants of good health are identified and managed to improve patient outcomes.
- Regular appointments and visits offered by a mobile social work team.
- Support for patients to develop strategies to build their capacity to self-manage their condition, take control and reduce stress.

The best example of the impact these services are making in the community is evident in Teresa's story. Teresa, a 62-year-old mother of two and grandmother of three, couldn't get off her couch. Teresa's health condition had deteriorated over time. Her physical and mental health complications resulted in days increasingly spent at home in the living room, watching television, with limited sunshine and social interaction except with her immediate family. Frank, Teresa's husband of almost 40 years, had become her full-time carer. "Frank does all the cooking and cleaning. He's a very good man," says Teresa.

Sarah Melvin from Primary and Care Community Services (PCCS) was appointed Teresa's social worker. "Working in partnership with Teresa's GP, I am here to help Teresa and her family navigate the complex social services sector – helping her to be more independent and socially active. When I first came to meet Teresa, she told me she never left the house. So, one of my suggestions was to help her access community, social and group activities. Originally Teresa resisted the idea, but after six weeks of working together, I now receive phone calls from Teresa about what groups and activities she can attend. Teresa is much more confident, social, and wanting to get out and about and try new things," Sarah said.

From a GP's point of view, this service has taken the burden away from GPs having to deliver both medical and social services care. Dr Caroline Rogers, GP and Medical Director of Warringah Medical and Dental Centre, says, "Some of my patients who are trying to access complex social services are at vulnerable, ageing, or declining points in their lives. The social workers through the GP Social Work Service help my patients as advocates, navigating systems, lodging appeals, and helping those who sometimes fall through the gaps. They are amazing!"

Since July 2016, these services, provided by both Community Care Northern Beaches and Primary and Community Care Services, have **provided support and assistance to over 450 people with activities** such as accessing the National Disability Insurance Scheme (NDIS), or helping people access housing or aged care pensions. On average, the social workers are coordinating care between 3 non-health related services, but in some cases have had to refer to over 9 different services to help their clients achieve their health and non-health related goals.

Nearly 300 individual GPs have referred into the social work service throughout 2017/18 to support their clients to manage the social determinants of their health. One woman commented, "As a carer for my daughter, the most important thing to hope for is that information about services will become more widely advertised. The social worker has been such a help with filling in forms for the NDIS, things that I wouldn't have known where to start with! They have also supplied services that help her state of mind immensely and encouraged her to take part in social groups."

One of the community nurses said, "These social work services have been invaluable. What a fabulous service!"

In a recent evaluation of these services at a joint workshop with consumers, providers and referrers, the feedback is the GP Social Work Service continues to provide much needed to support GPs to get the best health outcomes for their vulnerable patients.

Nearly 300 individual GPs have referred into the social work service throughout 2017/18 to support their clients to manage the social determinants of their health.

AFTER HOURS

The After Hours Program aims to support the community to care for their family's illnesses in the after hours period, by providing information so people can make informed decisions about accessing the services they need.

It aims to prevent unnecessary hospitalisations by strengthening urgent care skills within the primary care workforce and implementing strategies to better coordinate care.

The SNPHN After Hours Program, in collaboration with the Adult Migrant English Program at the Northern Sydney Institute (NSI) of TAFE, has been engaging local GPs to speak to participants about how to access healthcare within Australia. This forum gives the participants the opportunity to connect with local GPs in an informal setting, ask questions about health services and general health issues, and develop a better understanding of the healthcare system in the new country they live in.

Frequently asked questions from participants include:

- Private and bulk billing
- Selecting a GP
- Accessing allied health providers
- Contacting HealthDirect Australia to obtain 24 hour health advice
- The difference between private and public hospitals
- Costs for home doctor services

The SNPHN After Hours Program also continues to organise numerous community awareness activities, which in 2017/18 included a Primary Health Network After Hours Road Show held in Chatswood, Hornsby, Eastwood and Collaroy, where SNPHN partnered with 38 primary healthcare organisations and reached over 1000 community members.

In 2017/18 a media campaign titled "Keep the Emergency Department for Emergencies" was developed and launched in partnership with the Northern Sydney Local Health District (NSLHD).

Each year, the five hospital Emergency Departments (EDs) in NSLHD see more than 200,000 patients – many of whom could have been treated in the community setting, either by their family GP, at their local medical centre, or through a GP home visit service. In response, NSLHD and SNPHN joined forces to highlight the important role GPs can play in dealing with many medical issues which do not need attention in a busy hospital emergency department. The campaign featured Deputy Director of Royal North Shore Hospital's Emergency Department, Dr Liz Swinburn, and Sydney North Primary Health Network Board Member and GP Dr Magdalen Campbell. This video was also translated into Chinese and Korean.

To strengthen local workforce skills, this year SNPHN provided training for GPs and nurses on the "Management of Wrist and Hand Injuries". This was well received and hosted in partnership with the Walk in Specialist Emergency (WiSE) centre. We also conducted an Urgent Care Conference, with topics including:

- Emergency eye problems
- Managing medical emergencies in general practice
- Headache diagnoses you do not want to miss
- New approaches to dizziness

Over 550 primary healthcare professionals participated in after hours urgent care events this year. Feedback from GPs included "Great selection of topics and presenters", "So much terrific information", and finally, "Thank you for a very useful day!"

05 CONNECTING OUR COMMUNITY

ABORIGINAL HEALTH

During 2017/18, the Sydney North Primary Network has developed and implemented a range of initiatives and programs aimed at supporting culture, health and wellbeing within Aboriginal and Torres Strait Islander communities across the Northern Sydney region.

INDIGENOUS EYE HEALTH CLINICS

In partnership with Dresden Optics, NSW Rural Doctors Network and Vision Australia, SNPHN provided indigenous eye health clinics for communities within the Manly and Ryde local government areas. Eye clinics were also provided to students at 9 schools in the Hornsby and Lane Cove regions. A total of **180 students were screened, with 65 students requiring and receiving spectacles.**

CULTURE, HEALTH AND WELLBEING

SNPHN has facilitated the development and implementation of several cultural, health and wellbeing initiatives across the Northern Sydney region including:

- The **Caber-ra Nanga Wellbeing Ceremony** held at the Narrabeen Sport Centre in February 2018, attracting over 170 people, including local community members and health and wellbeing services.
- **On Track at Christmas** - introduced to the Ryde region in December 2017. On Track is designed to bring local families together, enjoy cultural food and games, and help people develop their own sense of self through mindfulness.

Three social and emotional wellbeing groups were also established by SNPHN during 2017/18:

- **Women's Gathering** - meet fortnightly in Eastwood.
- **Men's Group** - meet fortnightly in the Northern Beaches.
- **Youth Group** - meet fortnightly in the Northern Beaches.

The three groups were established after consultation with communities. The groups focus on the cultural and spiritual impact on general physical health and emotional wellbeing. Activities include traditional crafts, dance, mindful nature exploration, and eating for good nutrition. Recognition of the impact of culture to a person's health and social and emotional wellbeing provides an individual with deeper significance and understanding of self.

IMPROVING CULTURAL FITNESS IN PRIMARY CARE

SNPHN has partnered with TAFE NSW to provide the **Aboriginal Cultural Education Program**. The program aims to equip primary care providers with a better understanding of the health and emotional issues that face Aboriginal peoples in our region. The program supports general practice, allied health and commissioned services.

"The Yarning Circle at the Riverview Eye Clinic provided a young Aboriginal man with 6 months' worth of therapy."
Leanne Neal - Health Care Coordinator

"I think the Women's Gathering is helping me come out of my depression." Amanda

GPs IN SCHOOLS

Our GPs in Schools Facilitators

The GPs in Schools Program aims to increase the health literacy of young people aged 15-17 years in the Northern Sydney region.

The students have access to a GP or nurse during a student lead open discussion, with the program empowering students to ask questions that matter to them in a safe environment.

This year, the GPs in Schools Program was delivered to over **2300 students**, the highest attendance achieved by the program.

TOPICS INCLUDED:

- Physical, sexual and emotional health
- Drugs and alcohol
- Stress and mental health
- Relationships (friends and parents)

L to R – Ella (year 12 student), Ian Bowsher (Principal at Barrenjoey High School), Hudson (year 12 student)

NEW FACILITATORS

During the last year, 50 new GPs and nurses were trained to be facilitators. Training workshops have included interactive face-to-face education and practical peer learning with GPs experienced in delivering the program. The increase in facilitators will allow Sydney North Primary Health Network to expand the program across more schools in the Northern Sydney region moving into 2018/19.

QUOTES FROM STUDENTS AFTER TAKING PART IN THE GPS IN SCHOOLS PROGRAM

"I liked having the option to ask health questions that I normally wouldn't. I also found out you could get your own Medicare card at age 15." Female - 16 years-old

"The small group discussions really got everyone involved talking about mental health, sexuality, and drugs and alcohol." Male - 16 years-old

"It was good to be with your friends, and the doctor answered some pretty awkward questions."
Male - 16 years-old

"I liked the anonymous questions box, it means that you can ask really embarrassing questions without feeling embarrassed."
Female - 17 years-old

SNAPO+

The SNAPO+ program aims to work with community members to support the identification and management of lifestyle factors that impact health and wellbeing.

This year, SNPHN has facilitated 20 activities across the North Sydney region, reaching over 2,500 local people.

The SNAPO acronym stands for **Smoking, Nutrition, Alcohol, Physical Activity and Obesity**, which are all well known risk factors for developing long term conditions.

We have expanded the scope of this program by adding plus, **SNAPO+**, where extra health topics such as Cancer Screening, Emotional Wellbeing, Living Longer, Chronic Disease, My Health Record and SNPHN commissioned services are included.

The SNAPO+ program has been developed and implemented in consultation with the community, local councils, community housing providers, private sector, and broader community organisations to improve access to services for the most vulnerable populations in the Northern Sydney region.

People in our focus include young people and their parents, people from culturally and linguistically diverse backgrounds (including refugees), older people, and Aboriginal and Torres Strait Islander Peoples.

Examples of activities undertaken in 2017/18 within the SNAPO+ program include:

HEALTHY MIND, HEALTHY BODY

This program encourages young people and their parents to discuss emotional wellbeing and causes of stress in young people, including school and study, body image, relationships with friends, family and romantic attachments, and cultural and generational differences.

HEALTH, SENIORS AND COMMUNITY EXPOS

Six expos were held across the Northern Sydney region and promoted to target groups including older Australians, people from culturally and linguistically diverse backgrounds, as well as the general community. The expos promoted local services, including SNPHN commissioned services, to increase awareness and access within the local community.

HEALTHY BODY, HEALTHY MIND - ENGLISH AND MANDARIN

"Great to be able to talk to a professional, especially in my own language."

"I felt safe to speak openly."

"My daughter tried boxing, and enjoyed herself."

SENIORS EXPO

"It makes us feel like people care when you have all the services here to help us."

COMMUNITY EXPO

"It is great to know what services are out there because it is really hard when you need help to find the right people".

COMMUNITY ENGAGEMENT & ACTIVATIONS

COMMUNITY HEALTH LITERACY & ACCESS

With the launch of the community website in 2017 (www.snhn.org.au/communityhealth), the focus has been on developing easily accessible content for the local Northern Sydney community to improve health literacy, access to health services, and empower people with healthcare options and information.

Informational videos were developed throughout 2017/18, featuring local community members and health professionals.

Topics covered included:

- Advanced Care Planning
- When does sadness become depression?
- Falls Prevention
- What makes a good GP?
- Signs my child is struggling emotionally

PEOPLEBANK

This year, SNPHN launched PeopleBank, offering members of the local community the opportunity to help SNPHN shape a healthier Northern Sydney. By registering with PeopleBank, people can indicate their areas of interest and life experience and are provided the opportunity to share these experiences. SNPHN wants to consult with the local community when developing or enhancing existing healthcare and social services, and the PeopleBank gives the Primary Health Network access to community members who are interested in contributing to this consultation process.

The first PeopleBank eNewsletter was distributed in June 2018, the first of quarterly seasonal editions, keeping the subscribers to PeopleBank up-to-date on what SNPHN has been doing and what is coming up.

CLEVERTAR

clevertar digital coaches

Clevertar is an App that provides Low Intensity Cognitive Behavioural Therapy (LI-CBT) via an animated counsellor. The App has been developed with in a partnership between Clevertar and Flinders University and the Sydney North Primary Health Network has invested in numerous licenses to help members of the Northern Sydney community. This type of therapy is recommended for people that may have mild to moderate anxiety or depression.

SNPHN has made the App accessible:

- For general practitioners to recommend to their patients.
- To the general community via local newspapers and the website.
- Via the Lifeline Way-to-Wellness coaching program.

COMMUNICATIONS & MARKETING

The Communications and Marketing team help build awareness of the Sydney North Primary Health Network brand in supporting primary healthcare within the Northern Sydney region.

In addition, the team assists the various SNPHN departments achieve their specific organisational targets through communications and marketing advice, and dissemination of program information through a range of mediums.

The team is responsible for managing the brand and reputation of the organisation through the strategic use of SNPHN's internal and external communications channels. Communications and marketing aims to strengthen stakeholder relationships and engagement, improve internal communications, and inform our key target audiences about our organisation's work through the development and dissemination of relevant content. The objective is to strive to attain our vision of:

Achieving together - better health, better care.

STRATEGIC COMMUNICATIONS AND MARKETING CAMPAIGNS FOR 2017/18

The aim of this year's strategic communications and marketing campaigns were targeted to effectively tell the story of SNPHN's commissioning work whilst emotionally engaging our community through the sharing of local and personal stories in primary healthcare. The objective was to illustrate how SNPHN has benefited primary healthcare services and improved the lives of Northern Sydney locals - achieving better health outcomes for all involved.

The people of Sydney's North were at the heart of all of our 2017/18 campaigns. These monthly campaigns featured the personal stories of those who have experienced and benefited from the PHN's work. These stories have been authentic, moving, heart-warming, and informative whilst highlighting the enabling work of SNPHN and our local primary healthcare providers.

The campaign's themes followed the commissioning work of SNPHN, such as:

- Improving the lives of those facing socio-economic challenges along with chronic disease through the support of our GP social work services;
- Reducing the local need for people to go to hospital emergency departments during the winter months with influenza symptoms by encouraging flu vaccination;
- Increasing the understanding of the benefits of early detection of cancer through screening programs for breast, cervical and bowel cancers; and
- Building awareness of the portability, flexibility and benefits of digital health records through the expansion of My Health Record.

SNPHN will continue these campaigns through 2018/19, ensuring people's personal stories demonstrate how the Primary Health Network is enabling local primary healthcare delivery and health outcomes to change people's lives for the better.

MEDIA, PUBLIC AND EXTERNAL STAKEHOLDER RELATIONS

By distributing our strategic stories and supporting the other departments of SNPHN, the Communications and Marketing team has worked across all forms of media including print, radio and digital. The use of this media has helped to build a better understanding of SNPHN's role in every day health. Our contribution to programs and events is in the creation of key messaging and developing a range of program materials including flyers, fact sheets, booklets, posters and advertisements.

SNPHN have obtained coverage in a wide range of health consumer, professional publications and newspapers such the Manly Daily, North Shore Times, Peninsula and North Shore Living, Australian Doctor, and online media such as The Zine, and Medical Republic.

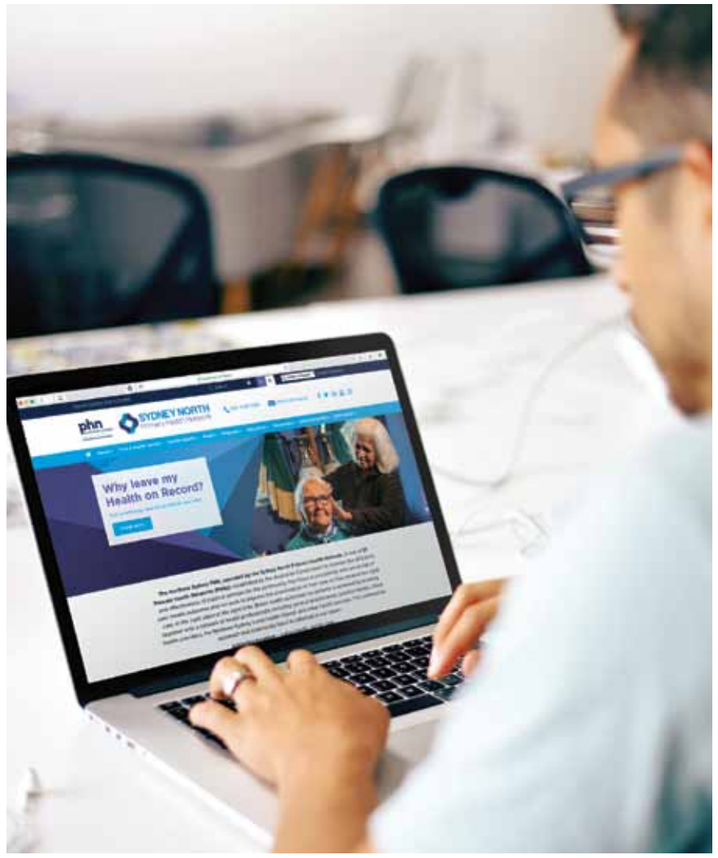
We acknowledge the positive contribution of local stakeholders such as Community Care Northern Beaches (CCNB), Primary and Community Care Services (PCCS), Lifeline, Clevertar digital avatar health application, Northern Sydney Local Health District (NSLHD), NSW Health, the Australian Digital Health Agency and Federal and State Members of Parliament, who have partnered with us to highlight personal healthcare stories and support key health initiatives through collaborative communications.

DIGITAL – WEBSITE

SNPHN have continued to effectively integrate digital and social media into our regular communication framework and strategy.

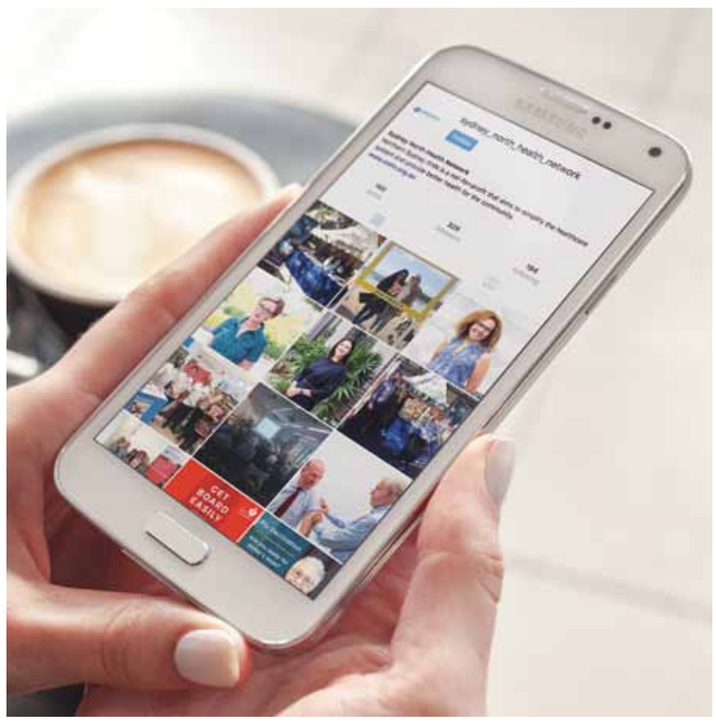
Our website is the centrepiece of our online activity. It features detailed content supporting both health professionals and our region's health consumers. The aim being the improvement of the local population's healthcare and health literacy. From a clinical perspective, the SNPHN website provides a hub of information and practice support materials to assist health professionals to provide or refer patients to the most appropriate care and improve their navigation experience of the local healthcare system. The comprehensive education event listings and registration system provides an efficient means for health practitioners to attend beneficial continued professional development education events for skills, knowledge and capacity enhancement.

Website traffic continues to grow, with a total of 50,522 unique visitors over the past financial year.



DIGITAL - SOCIAL MEDIA

We engage the Sydney North community with regular posts with reference to relevant content and health issues, fostering two-way communication and sharing of health information. Over the past year we have grown our social media engagement to 7,773 people interacting with us on Twitter, Facebook, Instagram and LinkedIn. Our YouTube channel helps bring to life key aspects of better health and better care in an easy to comprehend format through video storytelling and audio-visual information sharing.



CAMPAIGN QUOTES

Teresa and her PCCS social worker Sarah

TERESA'S TURNAROUND THROUGH CONNECTED CARE

Teresa says, "As a result of my GP and social worker working together as a team, my health has improved. I feel more alive, I feel better, and life is beautiful again. Thanks to them I now go out most mornings walking, shopping, watching people and enjoying a cappuccino. With the social groups I have joined I have been able to talk to more people, go to dinner at the local club, visit Sydney Harbour, and see the Christmas lights."

ARE YOU READY FOR WINTER'S WOES? WHY YOU SHOULD GET YOUR FLU VACCINATION

Neutral Bay general practitioner and Chair of the Sydney North Primary Health Network Dr Harry Nespolon says, "The treatment of influenza is not as robust as the prevention. Antivirals or antibiotics can sometimes make a patient with the flu more comfortable, but prevention by getting your flu vaccination is really the key."

Chair of SNPHN Dr Harry Nespolon giving flu shot to Trent Zimmerman, MP for Northern Sydney

Breast Cancer Survivor Regina Marchant

REGULAR CANCER SCREENING MAY SAVE YOUR LIFE

"My journey would have been very different if I hadn't been diagnosed early. Yes, having cancer was upsetting and hard for me and my beautiful family, but because I detected the cancer early through screening I was able to have a mastectomy and the treatment necessary to beat cancer and continue to be a mother, wife and now breast screening advocate," says breast cancer survivor Regina Marchant.

06 OUR TEAM

i INNOVATION · C COLLABORATION · A ACCOUNTABILITY · R RESPECT · E EXCELLENCE

HUMAN RESOURCES

As the Sydney North Primary Health Network concludes their third year of operation, the foundations of a strong, vibrant and healthy organisation are clearly visible.

From the moment you enter the SNPHN premises, you feel an air of comradery, support and commitment in all that we do, and towards the community we serve. Our iCARE values play an important part in forming out workforce culture, and continue to underpin the SNPHN People Strategy. Our recognition program 'Living the Values' has continued to provide opportunities for staff to recognise their colleagues for their contribution supporting each other in the workplace and working towards outstanding outcomes and targets for SNPHN. This program continues to be a valuable motivator for SNPHN employees.

At the end of June 2018, SNPHN had 69 employees (77% female, and 23% male). The 69 staff fall under four key business and operational units representing the Sydney North Primary Health Network including:

- Commissioning and Partnerships
- Primary Care Advancement and Integration
- Finance Management
- Human Resources and Administration

Employee wellbeing has again been an on-going focus this year. SNPHN have provided advisory sessions to all staff on superannuation and salary packaging, and our Employee Assistance Provider (EAP) conducted Mental Health Awareness training for all staff, and helps support our managers to identify signs of stress in their staff and refer where to go to for further assistance and support if needed.

SNPHN have extended our range of eLearning courses available to staff and will be promoting these to help build excellence in our operations and our people throughout the coming year. During the 2017/18 period 304 modules of compliance training were also completed - that's an average of 4.4 modules completed per employee. In addition to compliance training SNPHN continue to support staff's learning and development through numerous other opportunities such as staff away days, team and individual coaching, specialist training, and we have developed a partnership with Ignite Purpose to deliver a range of training and coaching interventions throughout the coming year.

Several SNPHN employees also developed and submitted abstracts which they were invited to present at a number of conferences and workshops over the 2017/18 year. This indicates and demonstrates the high level of regard and professionalism with which our PHN is held.

SNPHN are pleased to have been in a position to promote several staff from within the Primary Health Network, and in the year ahead we will look at continuing to strengthen our capacity and support our PHN to remain an exceptional organisation focused on a positive and inclusive work culture that delivers meaningful primary healthcare results.

07 FINANCIAL REPORT

SNPHN LTD ABN 38 605 353 884

DIRECTORS' REPORT

30 June 2018

The Directors present their report on SNPHN Ltd for the financial year ended 30 June 2018.

1. General information

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

Names

Dr Magdalen Campbell	Carolynn Hodges
Dr Harry Nespolon	Kathryn Loxton
Dr Stephen Ginsborg	Prof. Simon Willcock
Brynnie Goodwill	Samantha Challinor

Directors have been in office since the start of the financial year to the date of this report unless otherwise stated.

Economic Dependence
SNPHN Ltd is dependent on the Department of Health for almost all of its revenue. At the date of this report the Directors have no reason to believe the Department of Health will not continue to support SNPHN Ltd. The Department of Health has extended the core funding arrangements for Primary Health Networks for an additional three years, to 30 June 2021. The Company also has funding contracts in place which extend to 30 June 2021.

Company Secretary
The following person held the position of Company Secretary at the end of the financial year: Lynelle Hales (AICD Company Director Graduate (2013), Governance Institute of Australia's Accidental Company Secretary course (2016)) has been the Company Secretary since 10 August 2015. Lynelle has four years' experience as a voting Executive Director on NHS Boards (UK). In addition, Lynelle has worked with Boards for over 13 years in Executive roles.

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

At 30 June 2018 the collective liability of members was $ 10,760 (2017: $ 10,760).

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

(a) identifying the health needs of the community, developing locally focused and responsive services and addressing service delivery gaps;
(b) strengthening the effectiveness, vitality and responsiveness and performance of the Primary Health Care sector through support to Primary Health Care organisations and entities (including without limitation to Members);
(c) advocating and representing Primary Health Care organisations and entities to the Australian public to improve the provision of health care;
(d) improving the patient journey and outcomes through the development, integration and coordination of an equitable Primary Health Care sector;

DIRECTORS' REPORT

30 June 2018

(e) promoting quality in Primary Health Care and improving patient care by providing support to clinicians and Service Providers;
(f) improving consumer access to health services by working to coordinate and integrate care within the Primary Health Care system and across other sectors of the health system;
(g) collaborating with consumer and community groups to ensure consumer engagement and representation in the provision of Primary Health Care;
(h) identifying health needs of the community and developing locally focussed and responsive health services to improve local patient care, including:
  (i) analysing and reporting on the Primary Health Care service gaps; and
  (ii) identifying strategies to improve health outcomes and quality of services including for disadvantaged or under-serviced groups;
(i) promoting quality and evidence-based leading practice;
(j) contributing to development, regional leadership, innovation and research on Primary Health Care methods, technology, teaching, skills and practice;
(k) promoting cooperation, collaboration and communication with other regional organisations with an interest or impact in health and social care;
(l) facilitating the implementation of successful Primary Health Care and preventive health initiatives and programs;
(m) initiating and promoting policy and other matters related to the Primary Health Care sector and activities of Members; and
(n) doing all such other things as are conducive or incidental to the attainment of the objects and aims of any or all of the above.

Operating results
The surplus / (deficit) from ordinary activities amounted to $103,700. (2017: $139,836).

2. Other items

After balance date events
A new six year operating lease has been entered into in August 2018 for Level 5, 475 Victoria Avenue, Chatswood, New South Wales commencing 2 September 2018.

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

Procurement of Services – Common Directorships
The Company operates within a commissioning framework that establishes the probity and governance practices for procurement of services.

During the year services were commissioned directly with organisations whose Boards include some common SNPHN Limited Directors or Key Management Personnel. Whilst these transactions are not classified as "related parties" for the purposes of financial reporting or PHN funding contract, for transparency the Board makes the following disclosures:

PAYMENTS TO
- Primary and Community Care Services for the Mental Health, After Hours and Innovation Programs $2,672,945.
- Community Care Northern Beaches for the Mental Health, After Hours and Innovation Programs $1,075,000.
- Northern Sydney Local Health District for the Mental Health, Innovation and Integrated Team Care Programs $2,405,904.

Auditors independence declaration
The lead auditor's independence declaration in accordance with subdivision 60-C of the *Australian Charities and Not for profits Commission Act 2012* for the year ended 30 June 2018 has been received and can be found on page 7 of the financial report.

DIRECTORS' REPORT

30 June 2018

3. Director Information

Dr Magdalen Campbell Qualifications	**Member** M.B.B.S, FRACGP, MAICD
Experience	Inaugural SNPHN Board Member. GP and Principal of own practice. Training and experience in Corporate Governance and Strategic Planning. Previously on the General Practice Network Northside Board from 1992 to 2012, holding positions of Chair, Treasurer and Secretary. Board member for Northern Sydney Medicare Local from 2012 to 2015. Chair of the SNPHN Nominations and Remuneration Committee. Elected to the Board of Networking Health NSW in November 2014. Co-Chair of the ACI Chronic Disease Management Committee. Member of the ACI General Practice Advisory Group.
Dr Harry Nespolon Qualification	**Board Chair** BM BS, DipRACOG, FRACGP, BEc, LLB (Hons), GCLP, FACLM, MBA, FAICD, MHL
Experience	Director, Northern Sydney Local Health District. Member of SNPHN Finance, Audit and Risk Management Committee. Former Chair of GP Synergy. Former Chair, Sydney North Shore and Beaches Medicare Local. Former Chair, Northern Sydney Division of General Practice.
Dr Stephen Ginsborg Qualifications	**Member** MB BCh, MA, MAICD
Experience	Director of the Manly Warringah Division of General Practice. Former Deputy Chair of the Sydney North Shore and Beaches Medicare Local. Chair of the SNPHN Clinical Governance Committee. Medical Director of the National Home Doctor Service. Board member Council on the Ageing (NSW). Board member of Community Care (Northern Beaches) Limited.
Brynnie Goodwill Qualifications	**Member** JD International and Corporate Law, AB cum laude, GAICD
Experience	Executive Director of BKG Group. Non-Executive Director of Earth Trust. Chair of the SNPHN Community Council and Member, Finance, Audit and Risk Management Committee. Former CEO of LifeCircle Australia and Jubilee Australia. Former Health Consumer Director of Sydney North Shore and Beaches. Medicare Local and Chair of its Consumer Advisory Council. Former Strategy and Partnerships Director, SharingStories Foundation.
Carolynn Hodges Qualifications	**Member** BA (Hons), MPsych(Clin), BPsych(Hon), DipClinHyp, MAPS MASH, CEAP, MAICD
Experience	Principal of a Clinical Psychology private practice. Previous mental health delivery experience in both public and private sectors. Member of SNPHN Clinical Governance Committee and SNPHN Clinical Council. Board member of Primary & Community Care Services, member of Primary & Community Care Services Clinical Governance Committee.
Kathryn Loxton Qualifications	**Deputy Chair** BaAppSc (Occupational Therapy), GAICD
Experience	Director of a Case Management and Occupational Therapy private practice working with older people and people living with disabilities. Member of the SNPHN Clinical Governance Committee. Member of the SNPHN Community Council

SNPHN LTD ABN 38 605 353 884

DIRECTORS' REPORT

30 June 2018

Prof. Simon Willcock Qualifications	**Member** MBBS (Hons 1), PhD, FRACGP, Dip Obs, GAICD
Experience	Director of Primary Care Services at MQ Health. Board Chairman - Avant Mutual Group. Board member - Avant Insurance Limited. Board member - The Banksia Project. Clinician and academic with extensive experience in medical education and workforce development
Samantha Challinor Qualifications	**Member** BBus (Accounting), FCPA, JP, GAICD
Experience	Board member – RSL Lifecare Limited. Chair of the SNPHN Finance Audit and Risk Management Committee. Former Corporate Services Director of the Agency for Clinical. Innovation, NSW Health (ACI). Former Deputy CEO of Sydney North Shore and Beaches Medicare Local. Former Chief Accountant, Lexmark International (Australia) Pty Ltd.

Meetings of directors

During the financial year, 31 meetings of Directors (including Committees of Directors) were held. Attendances by each Director during the year were as follows:

	Directors' Meetings		Finance Audit & Risk Management		Remuneration & Nominations		Clinical Governance		Community & Clinical Council	
	Number eligible to attend	Number attended	Number eligible to attend	Number attended	Number eligible to attend	Number attended	Number eligible to attend	Number attended	Number eligible to attend	Number attended
Dr Magdalen Campbell	6	6	5	4	4	4	-	-	-	-
Dr Harry Nespolon	6	6	10	9	-	-	-	-	-	-
Dr Stephen Ginsborg	6	6	-	-	4	4	5	4	-	-
Brynnie Goodwill	6	6	10	9	4	4	-	-	6	6
Carolynn Hodges	6	6	-	-	-	-	5	5	6	6
Kathryn Loxton	6	6	-	-	1	1	5	4	6	4
Prof. Simon Willcock	6	5	-	-	-	-	5	5	6	5
Samantha Challinor	6	6	10	10	-	-	-	-	-	-

Indemnification and insurance of officers

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

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

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

Dated 26 September 2018

AUDITORS INDEPENDENCE DECLARATION

30 June 2018

I declare, that to the best of my knowledge and belief, during the year ended 30 June 2018 there have been no contraventions of;

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

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

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

M.J. O'Connor
Director

19 September 2018
NEWCASTLE

INDEPENDENT AUDIT REPORT TO THE MEMBERS OF SNPHN LTD

30 June 2018

Report of the Independent Auditor on the Summary Financial Statements

Opinion

The summary financial statements, which comprise the summary statement of financial position as at 30 June 2018, the summary statement of comprehensive income, summary statement of changes in equity and summary cash flow statement for the year then ended, and related notes, are derived from the audited financial report of SNPHN LTD for the year ended 30 June 2018. In our opinion, the accompanying summary financial statements are consistent, in all material respects, with (or a fair summary of) the audited financial report, on the basis described in Note 1.

Summary Financial Statements

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

Management's Responsibility for the Summary Financial Statements

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

Auditor's Responsibility

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

In preparing the financial report, the Directors are responsible for assessing the the Company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors either intend to liquidate the Company or to cease operations, or have no realistic alternative but to do so.

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

M.J. O'Connor
Director

27 September 2018
NEWCASTLE

DIRECTORS' DECLARATION

30 June 2018

The Directors of the Company declare that the summary financial statements of SNPHN Ltd for the year ended 30 June 2018, as set out on pages 10 to 16:

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

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

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

Director: A.M. Nyda Director: M Campbell

Dated 26 September 2018

SUMMARY STATEMENT OF SURPLUS OR DEFICIT AND OTHER COMPREHENSIVE INCOME

For the Year Ended 30 June 2018

	Note	**2018 $**	2017 $
Operating revenue	2	**18,830,080**	17,114,085
Other income	2	**258,687**	324,153
Program expenses		**(11,172,841)**	(9,846,462)
Employee benefits expense		**(5,916,139)**	(5,676,884)
Equipment and IT expense		**(107,074)**	(140,615)
Marketing and communication expense		**(403,088)**	(292,945)
Management and administration expenses		**(1,385,925)**	(1,341,495)
Surplus / (deficit) before income tax		**103,700**	139,836
Income tax expense		**-**	-
Surplus / (deficit) after income tax		**103,700**	139,836
Other comprehensive income for the year		**-**	-
Total comprehensive income for the year		**103,700**	139,836

SUMMARY STATEMENT OF FINANCIAL POSITION

For the Year Ended 30 June 2018

	2018 $	2017 $
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	**5,687,194**	6,081,881
Trade and other receivables	**206,280**	353,692
Prepayments	**201,662**	82,269
TOTAL CURRENT ASSETS	**6,095,136**	6,517,842
NON-CURRENT ASSETS		
Property, plant and equipment	**-**	-
TOTAL ASSETS	**6,095,136**	6,517,842
LIABILITIES		
CURRENT LIABILITIES		
Trade and other payables	**1,625,744**	3,193,638
Other liabilities	**3,427,556**	2,059,086
Provision for ATAPS referrals	**-**	462,240
Employee benefits	**284,440**	274,215
Provision for make good of premises	**362,879**	-
TOTAL CURRENT LIABILITIES	**5,700,619**	5,989,179
NON-CURRENT LIABILITIES		
Employee benefits	**150,981**	96,160
Provision for make good of premises	**-**	69,600
Other liabilities	**-**	223,067
TOTAL NON-CURRENT LIABILITIES	**150,981**	388,827
TOTAL LIABILITIES	**5,851,600**	6,378,006
NET ASSETS	**243,536**	139,836
FUNDS		
Accumulated Surplus	**243,536**	139,836
TOTAL FUNDS	**243,536**	139,836

The accompanying notes form part of these financial statements.

SUMMARY STATEMENT OF CHANGES IN FUNDS

For the Year Ended 30 June 2018

2018	**Accumulated Surplus $**
Balance at 1 July 2017	**139,836**
Total comprehensive income	**103,700**
Balance at 30 June 2018	**243,536**

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

The accompanying notes form part of these financial statements.

SUMMARY STATEMENT OF CASH FLOWS

For the Year Ended 30 June 2018

	2018 $	2017 $
CASH FLOWS FROM OPERATING ACTIVITIES:		
Receipts from government grants and services	**21,947,849**	17,730,487
Payments to suppliers and employees	**(22,497,522)**	(15,744,661)
Interest received	**154,986**	184,317
Net cash provided by (used in) operating activities	**(394,687)**	2,170,143
Net increase (decrease) in cash and cash equivalents held	**(394,687)**	2,170,143
Cash and cash equivalents at beginning of year	**6,081,881**	3,911,738
Cash and cash equivalents at end of financial year	**5,687,194**	6,081,881

The accompanying notes form part of these financial statements.

NOTES TO THE SUMMARY FINANCIAL STATEMENTS

For the Year Ended 30 June 2018

1. Accounting Policies

The summary financial statements have been prepared from the audited financial report of SNPHN LTD for the year ended 30 June 2018. The audited report for the year ended 30 June 2018 is available at request from SNPHN LTD.

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

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

SNPHN Ltd is dependent on the Department of Health for almost all of its revenue. At the date of this report the Directors have no reason to believe the Department of Health will not continue to support SNPHN Ltd. The Department of Health has agreed to extend the core funding arrangements for Primary Health Networks for an additional three years, to 30 June 2021. The Company also has funding contracts in place which extend to 30 June 2021.

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

2. Revenue and Other Income

	2018 $	2017 $
Revenue from ordinary operations		
- Operating grants	**18,830,080**	17,114,085
	18,830,080	17,114,085
Other income		
- Interest revenue	**154,986**	184,317
- Sundry income	**103,700**	139,836
	258,686	324,153
Total revenue & other income	**19,088,766**	17,438,238

The accompanying notes form part of these financial statements.

SNPHN LTD ABN 38 605 353 884

NOTES TO THE SUMMARY FINANCIAL STATEMENTS

For the Year Ended 30 June 2018

Statement of Surplus or Deficit and Other Comprehensive Income

The surplus from ordinary activities for the year was $103,700 (2017: $139,836).

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

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

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

Revenue

Operating revenue for the year was $18,830,080 (2017: $17,114,085). Almost all of this revenue was derived from delivering outcomes in accordance with Commonwealth Department of Health funding contracts.

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

Expenditure

Total expenses incurred for the year were $18,985,067 (2017: $17,298,402).

Employment costs amounted to $5,916,139 (2017: $5,676,884) and the number of employees at balance date remained consistent with the prior period (2017: 59 employees at balance date).

Program costs amounted to $11,172,841 (2017: $9,846,462). These costs represent the cost of allied health professionals and similar direct costs incurred for planning, developing, promoting and delivery of primary health care services. The increase in program expenses is due mainly to the expected growth and maturity of commissioning of services resulting in more payments to 3rd parties for service delivery.

NOTES TO THE SUMMARY FINANCIAL STATEMENTS

For the Year Ended 30 June 2018

Statement of Financial Position

The Company's statement of financial position discloses net assets of $243,536 as at 30 June 2018. The net asset position is consistent with the requirements of the Company's reciprocal funding arrangements with the Commonwealth Department of Health. Unspent grant funds are recorded as liabilities and represent amounts carried forward to be applied in future periods in accordance with plans and strategies approved by the Department of Health.

The Company has reported current assets of $6,095,136 (2017: $6,517,842) and current liabilities of $5,700,619 (2017: $5,989,179). Assets consist mainly of cash of $5,687,194 (2017: $6,081,881) which is of similar value to the sum of unspent current year funding $1,267,679 (2017: $603,302), grant funding received in advance of $2,159,877 (2017: $1,455,784) and trade and other payables of $1,988,623 (2017: $3,655,878).

Statement of Cash Flows

Operating Activities

Cash inflows from operating activities were $22,102,835 (2017: $17,914,804). Almost all of the cash receipts represented funding received from the Department of Health. Cash payments to suppliers and employees amounted to $22,497,522 (2017: $15,744,661).

Achieving together - *better health, better care*

Australian Government

phn NORTHERN SYDNEY
An Australian Government Initiative

SYDNEY NORTH
Primary Health Network

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Northern Sydney PHN (operated by the Sydney North Primary Health Network) is supported by funding from the Australian Government under the PHN Program.

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

Published in October 2018.

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