PRIMARY HEALTH NETWORK

We have...

STRATEGIC PLAN CLOSE OUT REPORT 2018-2023

Last updated November 2023

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phn
HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

Hunter New England and Central Coast (HNECC) PHN acknowledges the traditional custodians of the lands we walk, reside and work upon. We pay our respects to First Nations people and value the continued connection to culture, country, waterways and contributions made to the life of our vast region.

phn
HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

PRIMARY HEALTH NETWORK

FIRST NATIONS HEALTH

CONTENTS

NOTE FROM THE CHAIR AND CEO

The Primary Health Network's five-year Strategic Plan 2018-2023 was launched in January 2018, following extensive consultations with key stakeholders, staff, the Primary Health Network Board and Clinical and Community Advisory Committees. In the time since, a considerable amount of work has been undertaken to ensure the PHN's day-to-day work has been meaningful and efforts have been directed toward our purpose of "Healthy People and Healthy Communities" through innovation, performance, collaboration, and local engagement.

The "We will" statements underpinning our Strategic Plan were deliberately developed in partnership through an engagement, education, and consultation focused process. These tangible statements provided the organisation with a way of helping staff to recognise their contribution, and the value of how their own role plays into achieving our vision of 'Healthy People and Healthy Communities.'

As part of this process, nineteen, "We will" commitments were developed and publicly declared to benchmark against. We have now reached the conclusion of our plan and can see what has been transformed from commitments "We wills" into outcomes "We haves".

Between 2018 and 2023, the Primary Health Network continued to establish its business-as-usual operations, develop plans, evolve partnerships and alliances, and commission services to respond to the community's health needs. We also commenced key work on our secondary and tertiary horizons, including the development of key organisational frameworks to build rigour and transparency to assess specific needs in key service areas to ensure we understood the needs of our community and its people, including First Nations Health, Mental Health, Alcohol and Other Drugs.

We built on our ideas for innovation in primary care, to share the successes of primary care services, to generate new ways of thinking among other stakeholders, and to increase opportunities for services to bring their ideas to the table. Most importantly, we reassessed how we saw ourselves as an organisation and the value we provide to our communities through a rebranding process, and our value was shown by our agile response to the COVID-19 pandemic.

During the past five years the PHN has grown and risen to multiple challenges and emerging needs across the region including, but not limited to, the COVID-19 global pandemic, drought, floods, bushfires, and a mouse plague. In responding to these challenges, we have continued to advocate for our communities, prioritise needs and ensure we stay on the course of our vision "Healthy People and Healthy Communities".

With another five-year Strategic Planning (2023-2028) period on the horizon we are focusing our attention on improving access to primary care, while continuing to adapt to the changing PHN landscape. As we move into 2023-2028, we will respond to two key strategic challenges, supported by evidence from our needs assessment: to *demonstrate exceptional commissioning through leadership and performance*, and to *enhance the primary care workforce and incorporate digitally assisted services.*

TIMELINE 2018-2023

2015

- Innov8 online hub & Peoplebank
- Health Planning Compass
- Commissioning maps
- Collaborative innovation grants
- eReferral development
- Diabetes Alliance clinics
- Pilots – Low Intensity Mental Health and Indigenous
- Family Wellbeing

2016

- Primary Health Networks established

2017

- Healthy Weight Strategy and Primary Care model development
- Cervical Screening Course
- Inaugural Pitch Night
- Centre for Innovation in Regional Health Application & Establishment
- Mental Health & Drug & Alcohol Capacity Building Strategy
- National Health Care Homes trial
- Projects – Aged Care eHealth, Ambulance Alternate Pathways
- Pilots – Black Dog eClinics, Wellnet Chronic Disease
- Scholarships – Aboriginal Health Worker
- Baseline Commissioning Competency Review completed

2018

- Aboriginal Cultural Framework development
- Primary Mental Health Stepped Care Redesign
- Pitch Night
- Central Coast Mobile Imaging commencement
- New Practice Networks – AoD, headspace
- Pilots – Rural ENT Telehealth-enabled clinic, We Yarn suicide prevention, Mental Health Transitional Packages, Patient Reported Measures, Patch'd
- Scholarships program – including Medical Practice Assist
- Hosted Inaugural Commissioning Showcase (coming up to its 4th year, and now a NSW/ ACT Commissioning Network joint event)

2019

- Headspace funding boosted
- PHN hosts Youth Mental Health Forum
- Launch of Rural Communities Strategy
- Supports General Practice to participate in Quality Improvement Activities
- Care Navigation Pilot
- Early Start Pilot
- Dynamic Simulation modelling used to explore suicide prevention in the region
- After Hours Needs Assessment

2020

- Commissioning performance measures quality initiative
- PHI national data storage and analysis implementation
- eReferral rollout
- Aboriginal Healing Forums and Indigenous Mental Health redesign
- Rural Workforce proposal completion
- Emergency Operations Centre
- PPE distribution and logistics
- Livestream Webinar implementation
- Capacity Tracker development and implementation
- Allied Health strategy development
- Counselling support – General Practice and Allied Health
- National policy papers – Telehealth, Distribution Priority Areas
- Grants – Telehealth, GP Wellbeing
- Re-assessment of Commissioning Competency Review

2021

- Pilots – Domestic Family Violence, Movement Disorder Nurse
- Primary Care Quality and Innovation Awards
- Primary Care Sharing Success Strategy
- COVID-19 Innovation Showcase
- General Practice and Allied Health Wellbeing Grants
- Central Coast Sea Change grants and marketing campaign
- Q-KPI's development

2022

- Bush GP Grants
- Digital Health Grants
- Inaugural Allied Health Conference
- Care Navigation Program – Ezidi Community
- Primary Care Domestic Family Violence Program
- Movement Disorder Nurse Pilot
- RACF Digital Health Grants – Telehealth Carts
- Too Deadly for Diabetes
- Commissioning Innovation Showcase

July 1 2018	June 30 2023
PHN Budget	
$49.3 million	$108.1 million
PHN FTE	
74.9	100.08
PHN head count	
79	116
Total PHN individual contracts commissioned with service providers	
65	139

STRATEGIC PLAN 2018-2023

	KEY STRATEGIC AREAS	KEY PRIORITIES	OUR KEY OBJECTIVES
VISION Healthy People and Healthy Communities	 **FLAGSHIP SERVICES FOR COMMUNITIES**	– Staying Well – Accessing Services – Experiencing Quality Primary Care – Engaging Communities – Engaging Aboriginal Communities	1. To improve access by commissioning coordinated and effective primary health services 2. To engage with our communities to implement effective prevention and self-management strategies 3. To pioneer new models of care that will consolidate our reputation as a leader in innovative primary care design
PURPOSE To keep people well in our communities, through innovation, performance, collaboration and local engagement	 **A HEALTHIER SYSTEM**	– Engaging Clinicians – Fostering innovation – Connecting care through Digital Health – Facilitating alliances & partnerships to improve care	4. To develop high quality care pathways that improve access to local primary care services and keep people out of hospitals 5. To demonstrate improved clinical outcomes and experiences in primary care services through primary care improvement and digital health strategies 6. To improve patient journeys of care through alliances and partnerships with the key primary care stakeholders in our region
VALUES Respect, Innovation, Accountability, Integrity, Cooperation, and Recognition	 **A FIT & HIGH PERFORMING BUSINESS**	– Measuring and Demonstrating Success – Embedding Culture & Values – Designing for Rural & Urban Flexibility – Raising Our Voice – Building Aboriginal Cultural Responsiveness – Agile and Efficient Operation – Sustainability	7. To focus performance on the Quadruple AIM through measurement of clinical, operational and patient experience metrics, and health outcomes for indigenous and non-indigenous populations 8. To implement strategies to develop the financial and operational sustainability of the PHN 9. To collaborate nationally to strengthen primary health care and the PHN program

PRIORITY GROUPS: ABORIGINAL HEALTH, MENTAL HEALTH, AGED CARE, HEALTHY START AT LIFE

PRIORITY AREAS: DISEASE PREVENTION, CHRONIC DISEASE, POTENTIALLY PREVENTABLE HOSPITALISATION

FLAGSHIP SERVICES FOR COMMUNITIES

KEY PRIORITIES

- Staying Well
- Accessing Services
- Experiencing Quality Primary Care
- Engaging Communities
- Engaging Aboriginal Communities

OUR KEY OBJECTIVES

1. To improve access by commissioning coordinated and effective primary health services.
2. To engage with our communities to implement effective prevention and self-management strategies.
3. To pioneer new models of care that will consolidate our reputation as a leader in innovative primary care design.

OUR 'WE WILLS'

- We will develop, implement, and coordinate communications to promote wellness and prevention.
- We will commission culturally safe programs and services that are easy to navigate and access.
- We will support and develop primary care providers to implement effective person-centered care, including prevention and self-management strategies.
- We will collaboratively develop a primary care workforce that is skilled and delivers efficiently with available resources.
- We will know our communities, including vulnerable groups, and use information provided by them to inform our programs.
- We will pioneer new models of care that will consolidate our reputation as a leader in innovative primary care design.
- We will drive health transformation across the region by generating innovative solutions to improve the health of our communities.

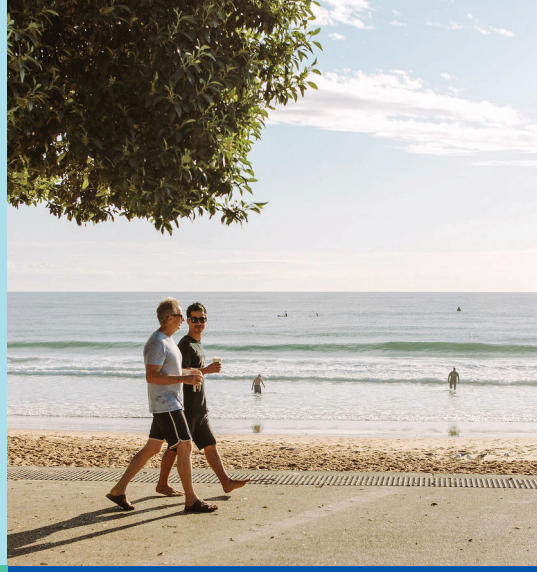
FLAGSHIP SERVICES
FOR COMMUNITIES

WE HAVE...

- ✓ Identified opportunities and actively sought partnerships that build on and complement PHN work.
- ✓ Re-designed and re-tendered primary Mental Health services to improve equity of access and to match the type of care to a person's need.
- ✓ Piloted innovative Care Navigation services.
- ✓ Developed and formalised an Income and Business Diversification Framework.
- ✓ Established a grants program that empowers and promotes our communities contributing to, engaging with, and connecting to improving their health.
- ✓ Established and grown an annual Quality and Innovations Awards program, recognising, and sharing the achievements of primary care providers across our region.
- ✓ Continued to build our alliance with the Local Health Districts, expanding our diabetes alliance work and improving patient's journeys through care.
- ✓ Built and improved clinician preparedness for emergency and disaster response through education, training, and support.
- ✓ Completely redesigned and through a competitive tender process successfully commissioned Suicide Prevention programs based on Dynamic Simulation Methods.
- ✓ Implemented a Best Practice, Equity Analysis Pilot (BEAP) to test the concept that software technology can improve Allied Health clinician experience in data input and in sharing of that information to other care providers.
- ✓ Developed and rapidly rolled out additional mental health services throughout the pandemic, including piloting new models of care and delivery methods.
- ✓ Established and grown an Older Persons Mental Health program –based on needs, piloting new models of care and evaluating their success.
- ✓ Undertaken an older persons and palliative care needs assessment, developing a strategy to ensure where possible we can respond to these needs and facilitate supporting these groups into the right care at the right time.
- ✓ Developed a Rural Health Framework including considerable investigation, collaboration, and partnership with targeted communities.
- ✓ Implemented a range of innovative models of care that respond to and educate primary care providers on the significance of Domestic and Family Violence as a significant health concern in the region, which has led to us being the lead for the State consortium delivering work in this space.
- ✓ Launched Bounce into Better Health and Wellbeing – a campaign designed to encourage and raise awareness of the benefits of healthy lifestyles and to support local primary health practitioners providing them access to tools and resources to improve preventative care of patients across the region.
- ✓ Launched a "Coffee on Country" Podcast for First Nations people to connect with health information.
- ✓ Hosted the first virtual immunisation conference for more than 320 immunisers, practice nurses, GPs and health students.
- ✓ Distributed around $325k in Flood Recovery, Community Wellbeing and Resilience Grants of between $5,000 and $50,000 to the region's NGOs and community groups to deliver projects and initiatives that promote mental wellbeing and resilience for residents. Of 30 applications received, 12 projects were selected for funding providing activities, initiatives, and programs for people in Narrabri, Central Coast, Marlee, Wollombi Valley, Gunnedah, Moree, Yarramalong, Cessnock, Singleton, and Muswellbrook.
- ✓ Injected more than $8 million through 339 general practice grants under the Federal Government's Strengthening Medicare Grants Program.
- ✓ Launched Care Finders, a face-to-face support service for vulnerable older people who cannot arrange care services without assistance.

Mental Health Close Out Snapshot

3 new headspace full centres



$1.5 million

mental health services commissioned to support those impacted by natural disasters in response to drought, flood and bushfire

Undertook Dynamic Simulation Modelling for Suicide Prevention and commissioned a new suite of services as a result

Designed and implemented an evidence-informed suite of mental health services for older people, including approaches such as animal assisted therapy and music therapy

Redesigned our Primary Mental Health Services to incorporate a central intake that uses the Commonwealth's Initial Assessment and Referral Guidance

Established 2 new headspace satellites and

3 outposts, which has improved coverage for young people across the region

Commissioned services specifically to support children, including a Primary Mental Health for Children program across the region and a psychosocial support program in the New England region

Broadened the Mental Health Nurse Incentive Program to create clinical care coordination, now supporting more than 1600 people annually

Codesigned and commissioned Youth Complex Mental Health programs to provide a continuum of care for young people across the region

A HEALTHIER SYSTEM

KEY PRIORITIES

- Engaging clinicians
- Fostering innovation
- Connecting care through digital health
- Health system improvement
- Facilitating alliances and partnerships to improve care

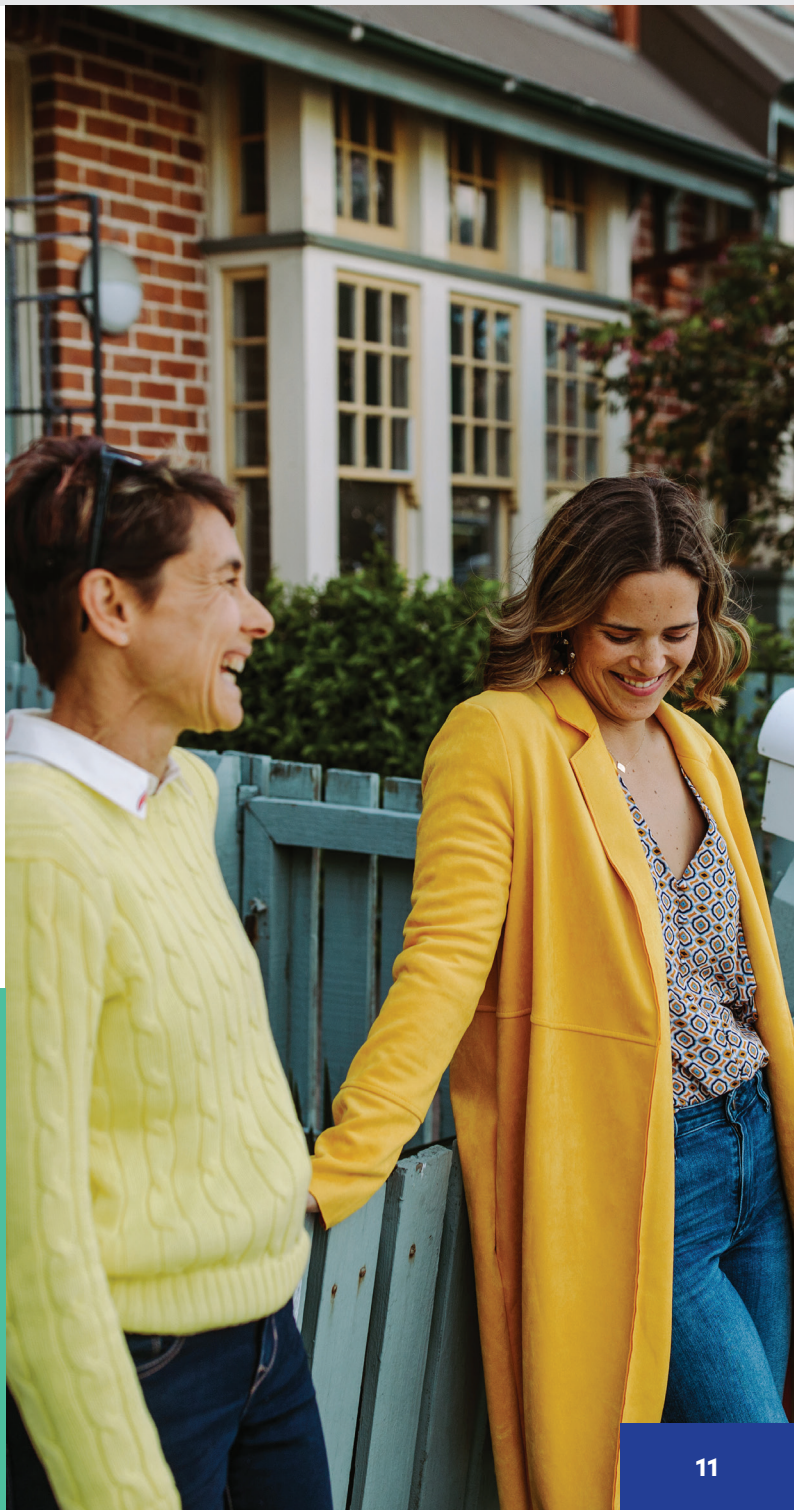
OUR KEY OBJECTIVES

1. To develop high quality health care pathways that improve access to local primary health services and keep people out of hospital.
2. To demonstrate improved clinical outcomes and experiences in primary care improvement and digital health strategies.
3. To improve patient journeys of care through alliances and partnerships with key primary care stakeholders in our region.

OUR 'WE WILLS'

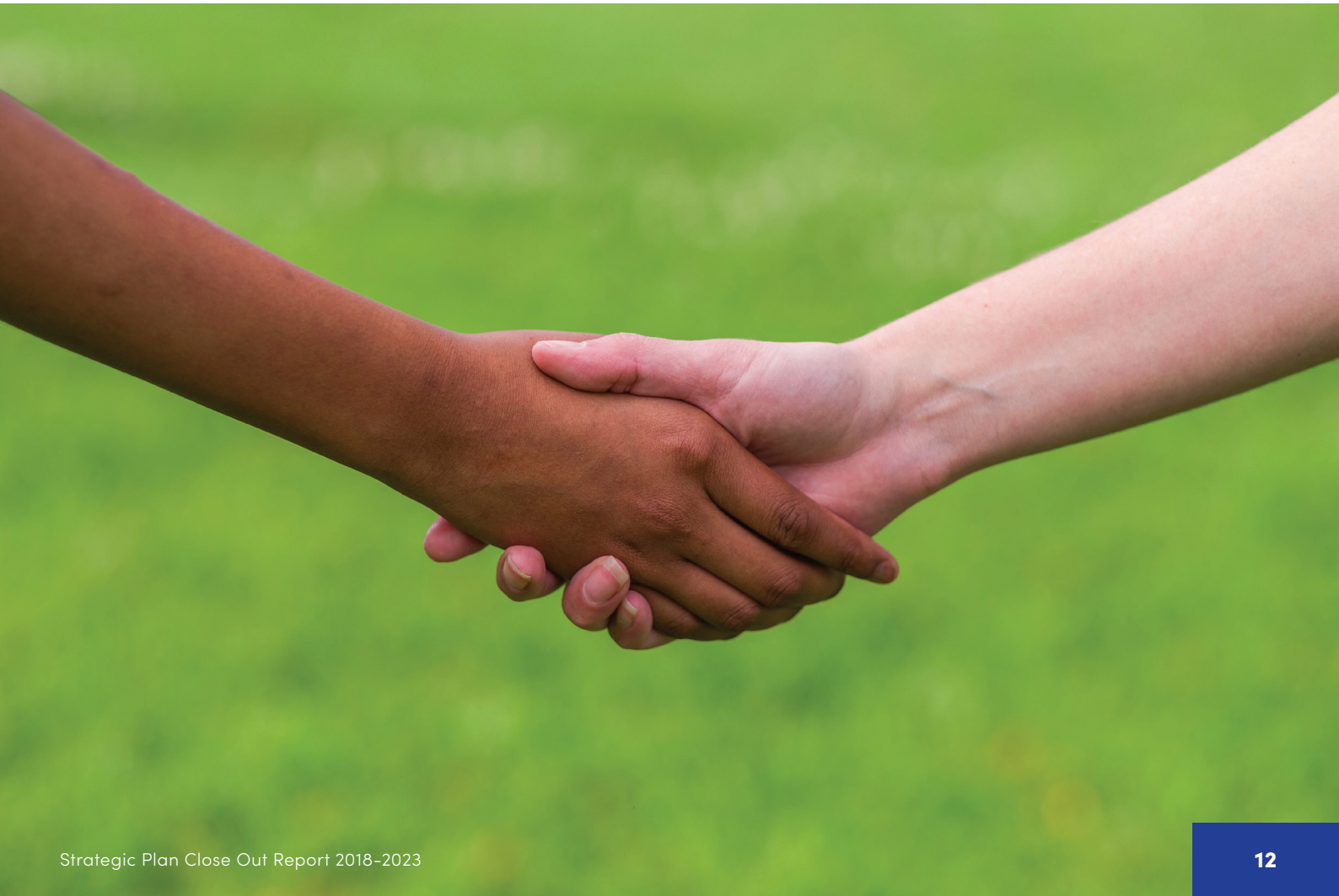
- We will be informed by clinicians in identifying locally relevant solutions and ensuring sustainable decisions are made.
- We will collaborate with LHD alliances and other partners, consumers, families, and carers, to continue to implement high quality health care pathways that improve the journey of care in our region.
- We will support the effective use of health information by primary care practices to facilitate quality improvement (QI) and improve their ability to deliver high quality health care and outcomes.
- We will work with First Nations people, communities, and primary care providers to increase access to culturally appropriate and responsive care.

A HEALTHIER SYSTEM



We have...

- ✓ Continued HealthPathways leadership, development and localisation including leading work across the State throughout the COVID-19 Pandemic.
- ✓ Developed a Preventive Health Framework.
- ✓ Funded 'The Resilience Project' to deliver mental health well-being workshops to students in schools across the New England Northwest and Upper Hunter.
- ✓ Developed and continued to use data dashboards to assist practices to deliver quality care for patients and communities.
- ✓ Continued care through digital health, working with more than 206 General Practices and 161 Residential Aged Care Facilities to assess their digital capability with the view to assisting with the development of identified and appropriate digital technology.
- ✓ Established an Allied Health reference group and built engagement with the sector.
- ✓ Supported more than 80 Allied Health Professionals to attend Business skills workshops designed to: help develop a high-level business plan for their practice, understand and apply business measures to monitor performance and support quality improvement and soft skills to run an effective practice.
- ✓ Implemented a National Commissioning Review for all PHNs, and leading ongoing work.
- ✓ Developed a partnership with the Department of Veterans' Affairs and implemented a successful Veterans Mental Health Pilot on the Central Coast.
- ✓ Clocked up an impressive 150,000 referrals electronically transmitted to over 450 Hunter New England Local Health District and private health providers. Over 95per cent of eligible General practices in the region are currently accessing the SeNT eReferral system. Several of the region's practices, including Mayfield Medical Connection and Appletree Family Practice; have each processed more than 2,500 SeNT eReferrals.
- ✓ Developed and launched a suite of recruitment videos designed to assist health care practices to recruit and retain staff.



Digital Health Close Out Snapshot

131 grants were tendered for RACF telehealth bundles to digitally-enable access to health care for aged care residents

Enabled My Health Record access in

95%+

of General Practices and community pharmacies, and

60%+ of private specialist practices in the HNECC PHN region

160,000 +

SeNT eReferrals generated since commencement in 2016

KPIs achieved for Provider Connect Australia (PCA) with an extensive awareness and education campaign

Collected essential data on Digital Health Maturity levels in 309 primary healthcare organisations, including General Practice, Aboriginal Medical Services, Allied Health, and Residential Aged Care

860+

organisations assisted in updating NASH digital certificates to meet Australian Government cybersecurity standards, ensuring ongoing connectivity to digital health services, including My Health Record and Medicare online claiming

$1 million

in Health-e Together Digital Care grants distributed to General Practices, Allied Health Practitioners and those supporting Residential Aged Care Facilities to enable or improve digital health capability

Supported 206 General Practices and

161

Residential Aged Care Facilities to assess their digital capability

Commissioned Services contracts were updated to include digital health requirements

Facilitated over 30 digital health webinars and education sessions to increase digital health and data literacy within the PHN and for health care providers across the region

Establishment of a multi-disciplinary Digital Health Advisory Panel in 2022

A FIT AND HIGH PERFORMING BUSINESS

KEY PRIORITIES

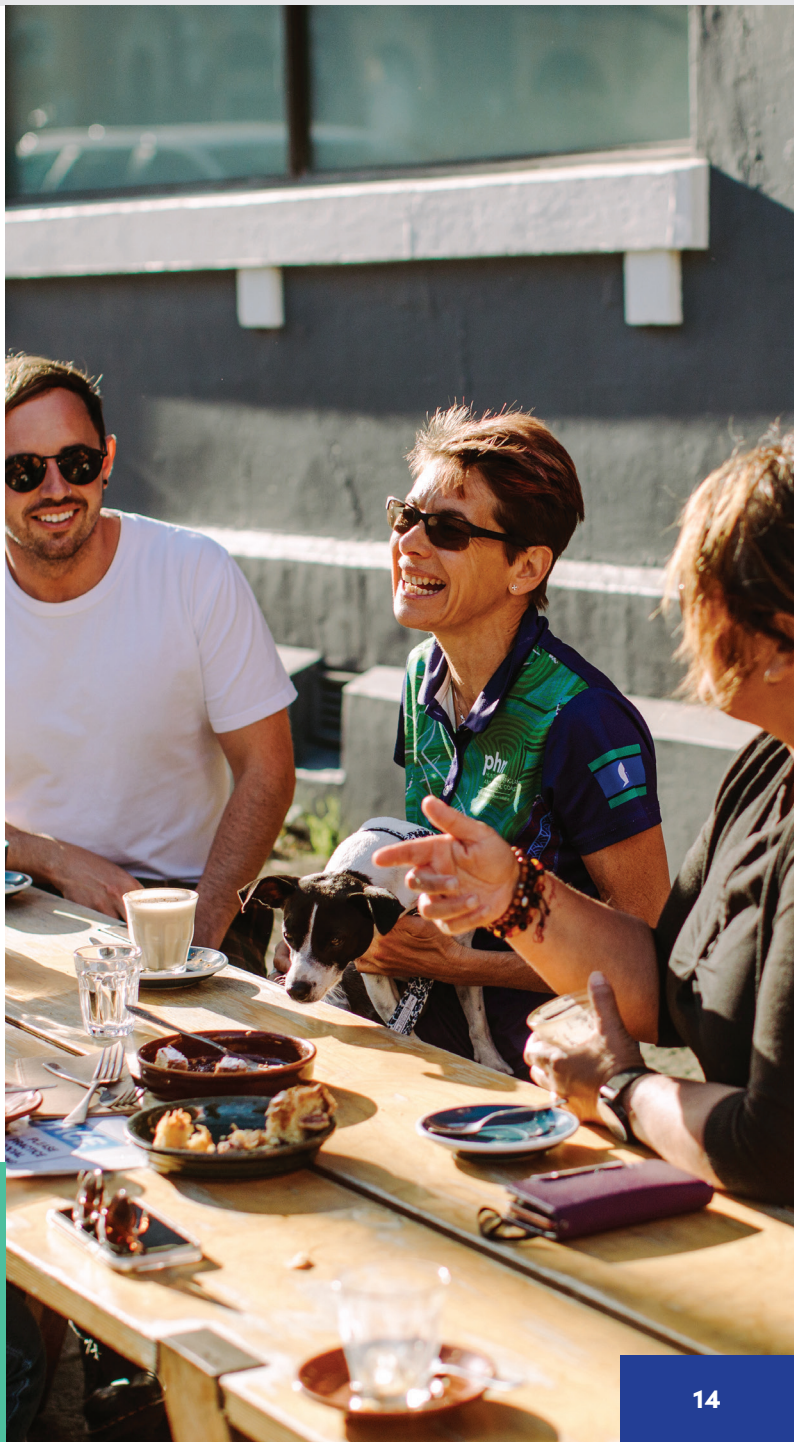
- Measuring and Demonstrating Success
- Embedding Culture & Values
- Designing for Rural & Urban Flexibility
- Raising Our Voice
- Building Aboriginal Cultural Responsiveness
- Agile and Efficient Operation
- Sustainability.

OUR KEY OBJECTIVES

1. To focus performance on the Quadruple AIM through measurement of clinical, operational and patient experience metrics, and health outcomes for indigenous and non-indigenous populations.
2. To implement strategies to develop the financial and operational sustainability of the Primary Health Network.
3. To collaborate nationally to strengthen primary health care and the PHN program.

OUR 'WE WILLS'

- We will measure the efficiency, effectiveness, and value of primary health services by using tools designed to report on the health and well-being of the population.
- We will measure the experience of consumers and providers so we can support and drive performance improvement.
- We will ensure funded health services and systems represent value for money.
- We will live our culture and values through everyday actions and conversations.
- We will engage locally and nationally to develop and share 'stories' that underline the importance of primary care services, and our role in supporting and positively transforming primary care.
- We will actively seek opportunities for co-investment to enable growth and organisation sustainability.
- We will review and implement operational systems, processes, and resources to ensure operational efficiency which enables innovative health solutions and is in line with best practice and industry developments.
- We will develop and implement research partnerships to assist the Primary Health Network and primary care providers to improve the health of our communities.



A FIT & HIGH PERFORMING BUSINESS

We have...

- ✓ Maximised our expenditure of funds into services for communities, including a comprehensive grants program.
- ✓ Redesigned, re-branded and engaged with community to build the PHN profile, building trust in the PHN Brand as a single-source of truth through quality content, professionally produced communications, and marketing products.
- ✓ Developed and implemented an organisational People and Culture Strategy that recognises and responds to the varying needs of our employees, supports diversity and inclusion, and promotes values-based culture.
- ✓ Conducted a commissioning price benchmarking exercise to ensure services we fund show evidence of value for money, for us as commissioner and for our communities as consumers.
- ✓ Identified and implemented a new operational finance system and human resource system.
- ✓ Refined reporting requirements for commissioned services, removing 50 per cent of the reporting burden in some contracts and increasing the value of information in reports.
- ✓ Improved Quality Improvement in services through collection of appropriate data information against quality indicators.
- ✓ Developed and implemented ongoing contract system reviews and refinements to improve visibility and increase efficiency.
- ✓ Created systems and processes to manage optimal funding expenditure in the relevant financial period.
- ✓ Embedded and improved formal communication between the contracts and finance systems to build efficiency and viability.
- ✓ Developed, tested, and implemented more automated systems to support our staff to deliver their work.
- ✓ Developed a First Nations Framework.
- ✓ Developed an Insights platform to support interactive reporting across the organisation.
- ✓ Developed operational sustainability, rolling turnover reduced by 10% in last 12 months: April 2023 rolling turnover 6.03% compared to April 2022 rolling turnover of 16.18%.
- ✓ Developed and implemented the PHN Diversity and Inclusion Strategy.
- ✓ Established an LGBTQIA+ collaborative.
- ✓ Implemented Cultural Intelligence training.
- ✓ Achieved no voluntary First Nations employee's attrition from April 2022 – April 2023. First Nations retention was reviewed for the last 3-year period and turnover is less than half that of total turnover. First Nations turnover in last 3 years is 4.6% of total PHN leavers.
- ✓ Achieved a 118% increase in professional development spend, translating to great performance, 98% of PHN programs are delivered on time and within budget.
- ✓ Established and launched an 'Always be learning' program implemented with LinkedIn e-learning platform and implemented an action learning sets program run for staff. All PHN leaders participated in a leadership development program.
- ✓ Built capacity in our organisation from within, 22% of employees acted in higher grade duties and 13% of full-time or part-time employees were seconded or promoted in the last 12 months.
- ✓ Executed an employee value proposition across platforms used to attract and retain our top talent.
- ✓ Implemented a PHN wellbeing program - 44% full-time & part time employees registered to participate.
- ✓ Coordinated several national PHN collaborative submissions to various government requests for input.
- ✓ Aligned research and evaluation within the PHN creating a clearer scope of activity.
- ✓ Led the development of a National PHN Allied Health in Primary Care Engagement Framework – designed with the intention of strengthening engagement between PHNs and the Allied Health sector.
- ✓ Hosted an inaugural Parkinson's Symposium for Allied Health Professionals and Nurses.

First Nations Health Close Out Snapshot

Consulted to develop a First Nations Health and Wellness Framework

$10 million+
increase in primary health care support and services in First Nations health

15,000+
First Nations clients, received health support from 16 commissioned service programs

$13 million+
funding for the Integrated Team Care (ITC) Program since 2015, enabling 200,000+ unique services by 4 Aboriginal Medical Services and 2 General Practices from 2018 to 2022

$2.2 million+
invested in grants to meet local First Nations community needs

440
HealthPathways with First Nations information

and **19** First Nation specific pages

Worked collaboratively with

9 Aboriginal Medical Services across the region

2.5 times
more funding spent on First Nations Mental Health Services between 2018-2022

Initiated and delivered General Practice Quality Improvement Program to improve cultural awareness and increase 715 Health and Wellness Checks

32,000 clients, including 6,000+ First Nations clients, received mental health support from commissioned services

Initiated Coffee on Country Podcast and community engagement to build relationships in First Nations communities to better understand health needs

OUR CHANGING LANDSCAPE

Care for Older People

PHNs were provided new funding under the Australian Government Aged Care Reform Package in 2021 with the focus on delaying older Australians' entry into Residential Aged Care Facilities (RACFs), reducing avoidable hospitalisations, and improving equitable access to the services that older Australians require.

In response to the new funding the PHN developed a Care for Older People team, dedicated to the support of health services, professionals, aged care providers, community support services, consumers, carers, and families to improve peoples' experiences and health and well-being outcomes.

Initiatives implemented by the Care for Older People team, informed by needs across the Hunter New England and Central Coast included:

- Aged Care Information and services
- Aged Care Emergency (ACE) services
- Care Finder Service
- Early Intervention – frailty and wellbeing initiatives
- Improving telehealth between General Practices and Residential Aged Care facilities including equipment and training
- Palliative Care needs assessment, community information and support
- Piloting alternative care models including Nurse Practitioners in Residential Aged Care facilities.

Domestic and Family Violence

The PHNs role in Domestic, Family and Sexual Violence has increased considerably since 2020.

The PHN now has a dedicated team Safe and Healthy Families, who lead our response to Domestic, Family and Sexual Violence across the region.

Key components of this work in the last three years have included the provision of training for primary care professionals including General Practitioners, to enhance their skills to spot the signs, start conversations with their patients and provide them the tools to connect survivors to appropriate support services.

The PHN has developed a Domestic, Family and Sexual Violence Primary Care Action Plan, designed to enable clinicians to identify patients at immediate risk, plan, manage, record and refer via a pathway for patient triage and support, established local LINKs- DFV (Domestic and Family Violence) specialists who can support patients and clinicians by providing: safety planning and risk assessments, links to supports and services in the relevant service area, telephone advice and supports and feedback to clinicians on their referral outcomes.

In mid-2023 the PHN was successful in a further grant application to the Department of Health and Aged Care will continue to expand its work supporting primary care clinicians to deliver appropriate care for patients who experience Domestic and Family Violence.

Movement Disorder Nurse Specialist

In 2021, the PHN was funded to trial an innovative approach to improve the quality of life of people with movement disorders in the New England Northwest.

The Movement Disorder Nurse Specialist (MDNS) pilot program was co-designed with community members and clinicians and based on available prevalence data. It was determined the initial focus should be on Parkinson's disease and resulted in six key delivery components being developed:

1. A central hub and spoke (Tamworth) outreach service for people living with Parkinson's Disease (potentially expanding to other neurological diseases upon pilot analysis and reflection, after the implementation phase).
2. A new Nurse Specialist role, responsible for program management and clinical governance (Scope currently being developed and refined through co-design process)
3. A new part-time Aboriginal Nurse/Health Worker co-located with the Nurse Specialist to assist in providing culturally appropriate care, linking with Aboriginal communities and Aboriginal Medical Services and or providing further research into Aboriginal people with Parkinson's disease.
4. In-practice case conferencing (including telehealth) to build local capacity.
5. A range of professional development strategies including mentoring, education, scholarships, and a local community of practice.
6. Project guidance and support from an expert advisory group

Allied Health Close Out Snapshot

80+ Allied Health Professionals supported to attend business skills workshops

Established an Allied Health Reference Group to provide multidisciplinary input and advice to the PHN

Partnered with local Allied Health Clinicians to develop an annual strategy focussing on four key workstreams: Health Information, Education, Telehealth and Advocacy

62747 contracted Priority Allied Health Services Program sessions

80+ practices completed the first Digital Health Maturity Assessment developed for Allied Health

Worked with HNE Diabetes Alliance to host the first Diabetes Dietitian Update Day with

55 attendees

$100,000

provided for value based Allied Health reconnection grants

Developed and launched the National PHN Allied Health in Primary Care Engagement Framework to strengthen relationships between Primary Health Networks and the Allied Health Sector

60x $5,000

digital health grants to Allied Health practices

10x $2,600

Pride in Health & Wellbeing Lite Memberships provided for Allied Health to work with a mentor to enhance LGBTQ care

27 Allied Health clinicians completed coaching to support wellbeing and leadership in Allied Health in 2021 and 2022

Veterans Care Navigation

Almost 5,000 former defence personnel call the Central Coast home and in response to the health, mental health, and support needs of Veterans in the region, the PHN commissioned not-for-profit organisation Social Futures to pilot a care navigation program, Veterans Connect, in 2020.

Veteran's Connect, connects former Australian Defence Force (ADF) members and their families to the right health, wellbeing and community supports – everything from peer groups to clinical services – acting as a central point of contact to ensure returned service personnel are well supported in civilian life.

The pilot was initiated after data showed veterans and their families are more vulnerable to mental health disorders resulting in a higher need for assistance with understanding and accessing appropriate health services. It aims to see a reduction in the rate of mental health disorders and suicide in the Central Coast region and expand the service to the Hunter and New England regions within our Primary Health Network.

The pilot's co-design process recognised that the health, mental health, and support needs of veterans are diverse and varied and set the goal for the program of helping veterans, their families and even carers navigate all these services and overcome any barriers to accessing care. Veterans Connect can be their single point of contact.

Disaster and emergency response

Following the COVID-19 pandemic and numerous natural disasters including floods, bushfire, and a mouse plague across parts of our region the PHN's role in emergency preparedness and disaster response has been formalised across the footprint through the development of relevant frameworks, establishment of an Emergency Operations Centre (EOC) and the evolution of Capacity Tracker.

To ensure rapid responses to emerging issues are possible, the PHN has developed a General Practitioner (GP) Emergency Register. This includes interested GPs who are available to assist the acute disaster response in catastrophic events and are available to support from their own premises or in Local Health District evacuation centres when they are mobilised. The register was developed following a co-design process and series of information events held throughout the Hunter, the New England, and the Central Coast regions in late 2022.

The PHN has actively engaged with the two local health districts, Hunter New England Local Health District and Central Coast Local Health District, to develop a collaboration agreement on how to include primary care providers in the acute response to catastrophic disaster events. These discussions have included different models of employment, insurance, and assistance.

A series of education events have been hosted for primary care providers, including "Community Practices in Disaster Recovery", held in May 2023 with speakers from all relevant disaster response agencies.

In winter 2023 the PHN hosted a winter trilogy event "When a disaster affects your practice", which discussed six different locally relevant disaster scenarios, and provided primary care providers with increased knowledge on how to develop a business continuity plan; prepare for disastrous events and how to effectively safeguard primary care provision in such situations.

The ongoing impacts of a global pandemic

Throughout the COVID-19 pandemic the scope of work for the PHN broadened and significantly increased, particularly following the activation of the Australian Health Sector Emergency Response Plan in February 2020.

Key areas of pandemic response work included:

- Rapid distribution of Personal Protective Equipment
- Establishment of Community Respiratory Clinics (testing)
- Comprehensive information and education campaigns
- Development of clinical Health Pathways
- Focused general support across General Practice, Aboriginal Medical Services, Commissioned Services, Allied Health and supporting General Practice into Aged Care.

Several key challenges presented during this time included understanding the lack of a formalised and well-defined role of the Primary Health Network and primary care clinicians in Emergency Management, and the undefined intersections with other agencies causing duplication or misalignment of activities.

General Practice Close Out Snapshot

$9.5 million

funding dispersed to 361 general practices through Strengthening Medicare Grants Program

580 GPs, nurses, practice staff & Allied Health Professionals trained in domestic violence identification and referral

2,500+

focused reports to General Practices (including Diabetes, Cervical screening, Cardiovascular Disease, Mental Health, Chronic Kidney Disease, and First nations health)

Investigated, developed and implemented alternative primary care workforce models to provide care in regions with limited workforce

5,000+ Quality Improvement Practice Incentive claims submitted on behalf of General Practices and

5,800+ clinical data summary dashboards generated

The GP Relocation Program awarded 20 Recruitment Starter Grants to 20 General Practices and 9 incentive grants to 8 General Practices

6,000+ health pathways established to improve service navigation for referring Clinicians resulting in

854,000+ page views on Hunter New England and Central Coast HealthPathways

8000 Health professionals participated in 370 professional education events in the 2022-2023 financial year

300+ average PIP QI claims are submitted quarterly on behalf of General Practices in the region

Supported General Practices across the region to achieve accreditation, increasing the percentage of accredited practices in the region to

91%

958 patients, 219 GPs and 105 General Practices participated in Diabetes Alliance face-to-face case conferences at GP clinics

Digital Health

One of the lasting impacts of the global COVID-19 Pandemic on Primary Care was the willingness of Primary Care providers to pivot their service delivery methods to accommodate patients. This resulted in the PHN rapidly responding to an increase in support of the sector to improve digital maturity.

Research into the digital capability of General practice and Residential Aged Care facilities was prioritised and a significant investment was made by the PHN to fund grants to improve infrastructure, provide education and implement change management opportunities to ensure the new infrastructure was subsequently utilised and incorporated into daily workflow.

A fit-for-purpose digital health change toolkit was developed, enabling teams to provide change support to General Practice based on their current maturity. Looking to the future, the PHN will leverage off its understanding of digital technology and current capability in primary care and set goals to drive the meaningful use of digital health solutions.

Priority work will target uptake of cloud-based practice management systems, cyber-security, and disaster recovery; continued and improved telehealth utilisation and increasing primary care digital literacy.

General Practice Stratification

In 2018 -2019 the PHN developed a Primary Care Improvement Model, introducing a tiered structure of support for General Practices across the region.

At the time, there were 4 four tiers of practice classification, but a review indicated the model did not discriminate the type of support offered to the general practices across the region.

The Stratification Model was redesigned in 2019 and implemented in 2020. The new model identified three levels of practice stratification with essential and desirable criteria for each level. The three-tier model aligned to the national system of stratification based on Bodenheimer's work.

Level 1- non accredited, not sharing data, non-engaged and non-participative in PHN projects.

Level 2 - engaged, sharing data participating, dependant on PHN support/guidance and

Level 3 – sharing data, high performing autonomous practices that required little PHN support per se.

This model aimed to eliminate subjectivity, helped the PHNs Primary Care Improvement Officers to target criteria that would support a practice to move up a tier (i.e., evolve towards a fit and high performing business and provide high quality care).

It also enabled the Primary Care Improvement Team to manage their workload and focus time and effort on those practices engaged and participating (i.e., level 2).

As a result of this work in July 2023 of the region's 293 general practices 56 (19%) had moved up a tier.

The outcomes of this work will now inform further, targeted engagement with the region's General Practices, including development of an innovative General Practice Viability tool as a foundational project of the PHN's Strategic Plan 2023-2028.

PHN Grant Program

To support our vision of Healthy People and Healthy Communities, the PHN initiated an annual grant program in 2019. Each year since inception, the program, has grown.

An estimated $16.28m of funding was distributed to services and communities between 2021 and 2023.

The PHN Grant program enables agile responses to emerging needs and funding streams and has been particularly successful in providing supports through various emergency and disaster situations such as flood, bushfire and the COVID-19 Pandemic.

In 2022-2023 the PHN grants program expanded further to include supporting recruitment and retention of primary care workforce and increase digital health capabilities across the sector. All PHN grant exercises are supported with training/resources and promotion where applicable. The gathering of impacts is prioritised including good news stories and a particular focus is also placed on capacity building in the primary care sector and communities to be active participants in their own health and wellbeing.

2022-2023

- Strengthening Medicare GP Grants – 361 totalling $9,565,000.
- Bush GP Grants – 9 grants totalling $375,000.
- Flood Recovery Grants – 45 grants totalling $668,325.

phn
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AND CENTRAL COAST
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PRIMARY
HEALTH
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