Strategic Plan 2019-2021

phn
CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

Central and Eastern Sydney PHN acknowledges the Aboriginal and Torres Strait Islander peoples of this nation.

We acknowledge the Traditional Owners of the land across which we work. We recognise their continuing connection to land, water and community and pay respect to Elders past, present and emerging.

Contents

Executive Summary

Primary health care is the frontline of Australia's healthcare system, with general practice at its core. Primary health care services are based in the community, are broad-ranging and include health promotion, prevention and screening, early intervention and treatment.

Primary Health Networks (PHNs) across Australia support primary care through practice improvement, local health system integration and the commissioning of health services in the community that address identified gaps and needs in their local area.

Central and Eastern Sydney PHN improves health and wellbeing by improving and transforming care. This Strategic Plan is a high level document that describes our vision, our values and the priorities that will drive our work over the coming three years. It will be supported by more detailed annual operational plans.

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CENTRAL AND
EASTERN SYDNEY
An Australian Government Initiative

OUR VISION
Better health and wellbeing

OUR PURPOSE
Improve and transform care

WHAT WE WILL DO...

Improve practice	**Integrate systems**	**Commission services**
S1	S2	S3

HOW WE WILL MAKE THAT HAPPEN...

Governance	Operations	Partnerships	Evidence
E1	E2	E3	E4

OUR VALUES
Collaboration. Integrity. Learning and Growth.

About Central and Eastern Sydney PHN

Primary health care

Primary health care is the frontline of Australia's health care system, with general practice at its core.

General practitioners (GPs), nurses, allied health and other primary care professionals provide services in the community including health promotion, prevention and screening, early intervention, treatment and management.

They address a wide range of chronic and complex health issues including mental health, alcohol and other drugs, Aboriginal and Torres Strait Islander health, aged care and population health. A strong, accessible primary health care system keeps people well and out of hospital by supporting them to manage their own health issues and, by doing so, reduces the need for specialist services and emergency department visits[1, 2].

Primary health networks operate across Australia to support the primary health care system.

The Australian government has supported the role of regional primary health care organisations for many years, starting with Divisions of General Practice in the 1990s. From 2011, Divisions were replaced with Medicare Locals which were charged with encouraging collaboration between health care professionals, undertaking population health planning and, in many cases, providing direct clinical services.

PHNs commission other organisations to deliver clinical services, rather than delivering clinical services directly. This is a key difference between Medicare Locals and PHNs, and represents a fundamental shift in the way that primary health care services are planned for and funded at the regional level. PHNs focus on service improvement, integration and the commissioning of services as needed to address identified gaps and needs in their local areas.
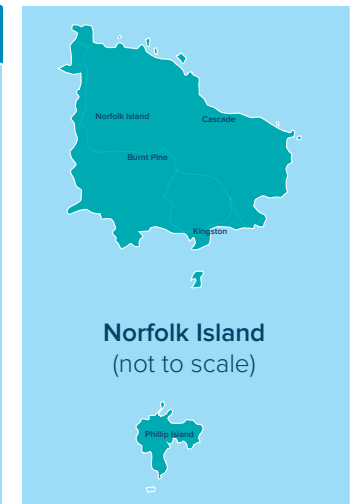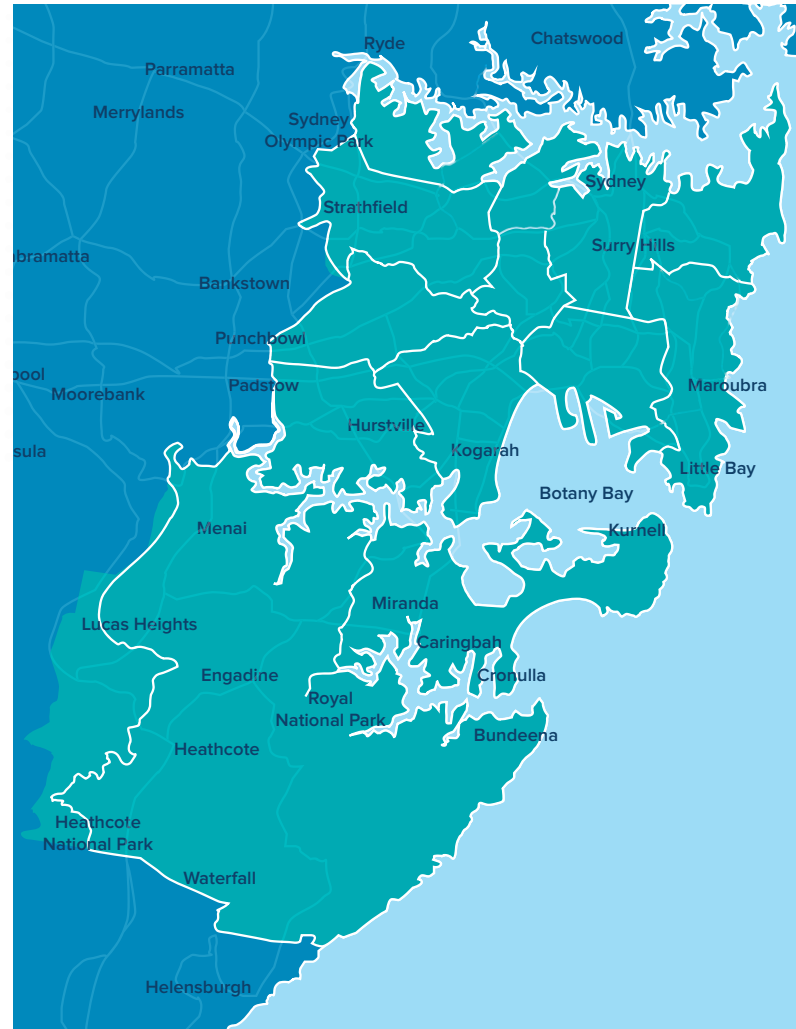
Central and Eastern Sydney PHN

The boundaries of Central and Eastern Sydney PHN align with those of South Eastern Sydney Local Health District (SESLHD) and Sydney Local Health District (SLHD), with whom we work closely. Other important partners across our region include St Vincent's Health Network, Sydney Children's Hospitals Network, Justice Health, local GPs, allied health professionals, nurses, secondary care providers, non-government organisations, community-managed organisations and other organisations across the health and human services sector.

Although the term "primary health" refers to the core element of our work, our full scope is broader, including some secondary and tertiary services.
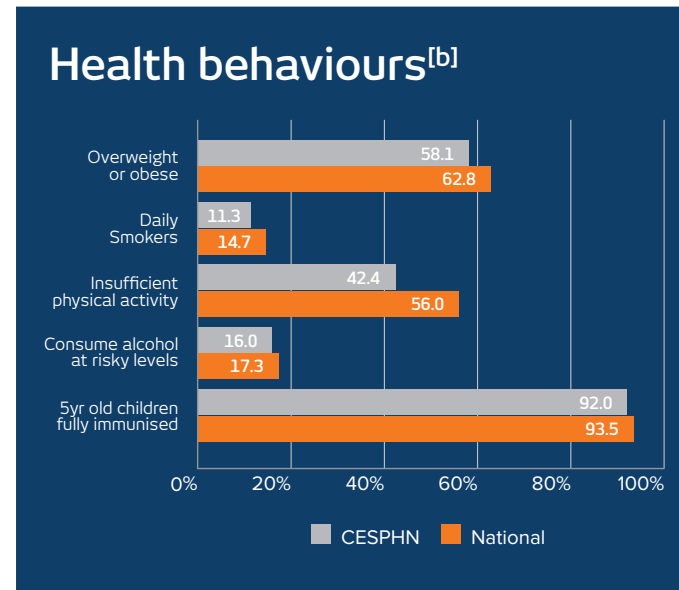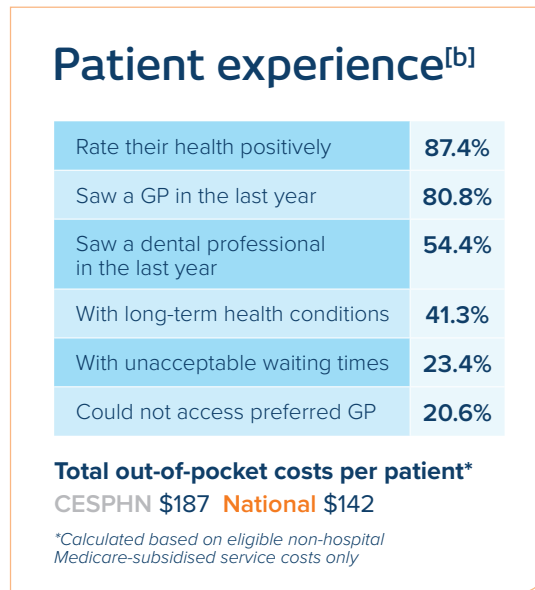
Our region stretches from Strathfield to Sutherland, east to the coastline, and also includes Lord Howe Island and Norfolk Island. Our catchment area spans 667 km^2. We are the second largest of the 31 primary health networks across Australia by population, with almost 1.5 million individuals residing in our region. By 2031 our region's population will reach more than 1.85 million, with the most significant increase to be seen in the number of persons aged over 65 years.

Our catchment population is characterised by cultural diversity. Over 13,000 Aboriginal and Torres Strait Islander people live in our region, with the largest numbers residing in the Sydney Inner City statistical local area (which includes Redfern) and Eastern Suburbs South statistical local area (which includes La Perouse). Forty percent of our residents were born overseas. Forty two percent speak a language other than English at home and six percent do not speak English well or at all.

Norfolk Island
(not to scale)

Lord Howe Island
(not to scale)

A snapshot of our region

Service profile[a]

Public hospitals **18**	General practices in the region **662**
Headspace sites **5**	Practice nurses **538**
Allied health **5043**	General practitioners **2230**
Hospital networks **2**	Aboriginal medical service **1**
Local health districts **2**	Residential aged care facilities **153**
	Practices registered with My Health Record **422**

Patient experience[b]

Rate their health positively	87.4%
Saw a GP in the last year	80.8%
Saw a dental professional in the last year	54.4%
With long-term health conditions	41.3%
With unacceptable waiting times	23.4%
Could not access preferred GP	20.6%

Total out-of-pocket costs per patient*
CESPHN $187 **National** $142

Calculated based on eligible non-hospital Medicare-subsidised service costs only

Health behaviours[b]

	CESPHN	National
Overweight or obese	58.1	62.8
Daily Smokers	11.3	14.7
Insufficient physical activity	42.4	56.0
Consume alcohol at risky levels	16.0	17.3
5yr old children fully immunised	92.0	93.5

Cancer screening participation[b]

- CESPHN
- National

	CESPHN	National
Bowel cancer screening	34.8%	40.9%
Breast cancer screening	50.3%	55.1%
Cervical cancer screening	55.3%	55.4%

Psychological distress[c]

116,837

people in the region have high or very high psychological distress

14,233 people are experiencing homelessness[d]

(more than one-third of NSW homeless total)

[a] My Hospitals n.d., Australian Institute of Health and Welfare, accessed 3 October 2018 <https://www.myhospitals.gov.au/browse-hospitals/nsw/sydney/sydney>. Needs Assessment 2017, Central and Eastern Sydney PHN
[b] My Healthy Communities n.d., Australian Institute of Health and Welfare, accessed 2 October 2018, <https://www.myhealthycommunities.gov.au/primary-health-network/phn101>.
[c] Social Health Australia of Australia: Primary Health Networks n.d., Public Health Information Development Unit, Torrens University Australia, accessed 2 October 2018, <http://www.phidu.torrens.edu.au/current/data/sha-aust/phn_pha_parts/phidu_data_phn_pha_parts_aust.xlsx>.
[d] ABS 2016 Census of population and Housing; Estimating homelessness 2016 Table 5.1 Homeless Operational Groups and other Marginal Housing by place of enumeration, Statistical Level 3.

A snapshot of our region

Total resident population[e]

1,497,186

Norfolk Island	1,748
Lord Howe Island	382

Life expectancy[f]

Life expectancy of residents in CESPHN region is

83.8

YEARS

compared to the national average of 82.4 years

Population Projection[e]

	2033	% INCREASE
TOTAL	1,951,132	24%
0-14	315,372	31%
15-64	1,305,432	16%
65+	330,328	58%

Aboriginal and/or Torres Strait Islander[e]

Total number of residents in CESPHN who are of Aboriginal and/or Torres Strait Islander descent:

13,479

equaling 0.84 % of the total population of CESPHN -% of total Australian population = 2.8%

Highest proportion of Aboriginal and/or Torres Strait Islander people reside in Sydney Inner City and Eastern Suburbs- South areas

No. of standard GP consultations in 2016-2017[h]

7,568,288

Non-resident population[i]

APPROXIMATELY

500,000 people come to CESPHN each day to work, visit or study

Received 50% of NSW HIV notifications 2017[j]

Same-sex couples

CESPHN has the highest number of same sex couples in NSW[k]

Language[g]

1	Mandarin
2	Cantonese
3	Arabic
4	Greek
5	Italian

40% of our residents were born overseas

42% speak a language other than English at home

6% do not speak English well or at all

[e] BS Census of Population and Housing 2016 Aboriginal & Torres Strait Island Population
[f] AIHW Nov 2017 Life expectancy and potentially avoidable deaths in 2013–2015
[g] ABS Census of Population and Housing 2016 Language spoken at home by LGA 2016
[h] Medicare Benefits Schedule Data. MBS data by PHN - MBS Item and Reporting Group 2012-13 to 2016-17 <http://www.health.gov.au/internet/main/publishing.nsf/Content/A1F08249E056C796CA257FD400281DBF/$File/MBS%20Items%20and%20Groups%20by%20PHN%201213-1617%2007NOV17%20A.xlsx>
[i] Journey to Work in Australia 2018, Australian Bureau of Statistics, accessed 2 October 2018, <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0.55.001~2016~Main%20Features~Feature%20Article:%20Journey%20to%20Work%20in%20Australia~40>.
[j] NSW Ministry of Health. NSW HIV Strategy 2016 - 2020: Quarter 4 2018 Data Report. Available from: <https://www.health.nsw.gov.au/endinghiv/Publications/q4-2017-and-annual-hiv-data-report.pdf>
[k] ABS Census of Population and Housing 2016 Same-sex couples in Australia, 2016, accessed 6 December 2018, <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Same-Sex%20Couples~85>
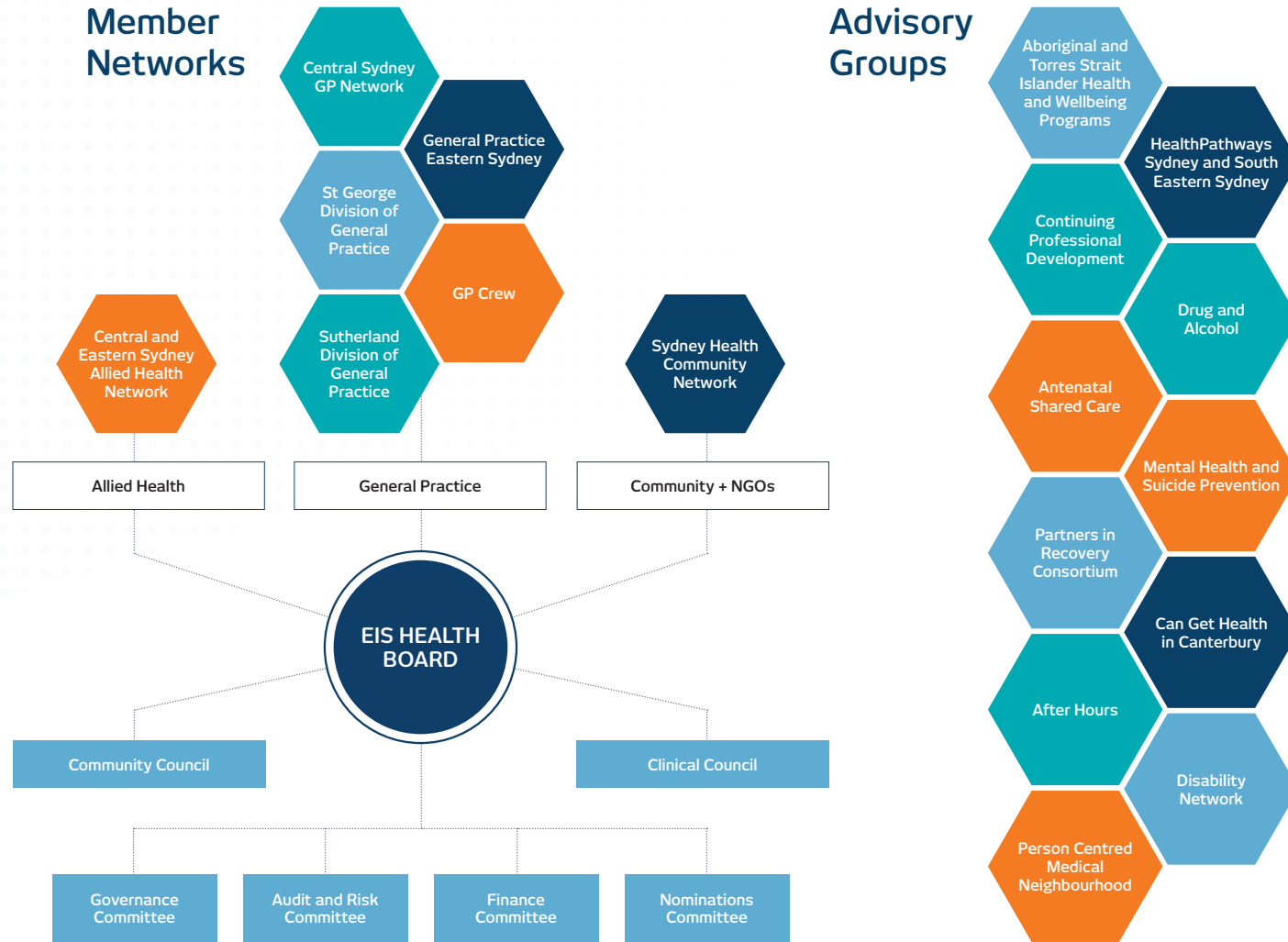
Priorities for action

The Commonwealth Department of Health has identified the following priorities for PHNs operating across Australia:

- Mental health
- Aboriginal and Torres Strait Islander Health
- Population health
- Digital health
- Health workforce
- Aged care
- Alcohol and other drugs

Central and Eastern Sydney PHN has identified additional local priorities through needs assessments and consultation:

- Areas with poor health status
- Child and maternal health
- Health literacy
- Early intervention and prevention
- Service navigation
- Care coordination
- Integrated care

Our governance and advisory structure

Member Networks

- Central Sydney GP Network
- General Practice Eastern Sydney
- St George Division of General Practice
- GP Crew
- Central and Eastern Sydney Allied Health Network
- Sutherland Division of General Practice
- Sydney Health Community Network

Allied Health	General Practice	Community + NGOs

EIS HEALTH BOARD

Community Council	Clinical Council

Governance Committee	Audit and Risk Committee	Finance Committee	Nominations Committee

Advisory Groups

- Aboriginal and Torres Strait Islander Health and Wellbeing Programs
- HealthPathways Sydney and South Eastern Sydney
- Continuing Professional Development
- Drug and Alcohol
- Antenatal Shared Care
- Mental Health and Suicide Prevention
- Partners in Recovery Consortium
- Can Get Health in Canterbury
- After Hours
- Disability Network
- Person Centred Medical Neighbourhood

The Plan

PURPOSE   STRATEGIES   ENABLERS

Plan at a Glance

Primary health care is the frontline of Australia's healthcare system with general practice at its core. Primary health care services are delivered in the community, are broad-ranging and include health promotion, prevention and screening, early intervention and treatment.

OUR VISION
Better health and wellbeing

OUR PURPOSE
Improve and transform care

WHAT WE WILL DO...

Improve practice	Integrate systems	Commission services
S1	S2	S3

HOW WE WILL MAKE THAT HAPPEN...

Governance	Operations	Partnerships	Evidence
E1	E2	E3	E4

OUR VALUES
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Our Vision: Better health and wellbeing

Our vision is better health and wellbeing of the people who live and work across our region. We recognise that this is a long-term, collaborative vision and that results may not be demonstrable within the life of a plan.

We are committed to investing in strategies that will ultimately contribute to **individual and population health outcomes** including:

- Fewer preventable deaths
- Fewer preventable hospitalisations
- Reduced health risks such as smoking, alcohol and drug use and overweight/obesity
- Reduced health inequities
- More prevention behaviours such as immunisation and cancer screening

To achieve our vision, we focus on:

- **People and places experiencing disadvantage and inequities.** This includes Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, from low socioeconomic communities and populations, and people from vulnerable or marginalised groups.
- **Complex issues** including ageing, mental health, drug and alcohol use, disability and complex co-morbidities. Other complex issues include the social determinants of health, poor health literacy and the impact of social isolation on health and wellbeing.
- **Prevention and earlier intervention** including a focus on wellbeing and resilience.

Our Values

Collaboration

Integrity

Learning and Growth

How we work

We are an agent of change

We respond to local needs

We support primary health

Our Purpose: Improve and transform care

The core purpose of Central and Eastern Sydney PHN is to improve and transform care by:

- **Improving the experience of consumers and carers** through better integration, coordination and by encouraging a person-led approach.

- **Improving the provider experience** with consideration of clinician and staff satisfaction, flexibility and scope for innovation, and building a strong quality improvement culture.

- **Improving value for money** with consideration of cost-efficiency and sustainability.

Together with **population health** as described on the previous page, these elements make up the **Quadruple Aim** which is a framework for the delivery of effective and high value health care[3]. This underpins this Strategic Plan and will be further reflected in our evaluation framework (see page 26).

Quality improvement and innovation are essential to this process.

- **Quality improvement** considers the structures, systems, processes and practices that may have an impact on service quality, safety and ultimately on the achievement of improvements in health and wellbeing. These are multi-dimensional concepts that rely not only on tools and training but on the broader culture. We work with local services to invest in that culture, and support them to take a proactive and systematic approach to quality improvement.

- **Innovation** is equally important. In collaboration with our local partners, we explore new approaches to improve and transform health care. We invest in evaluation and research to build an evidence base that will drive service delivery into the future.

Our organisational performance indicators are shaped by the PHN Program Performance and Quality Framework[4] as shown below.

PHN HEADLINE PERFORMANCE INDICATORS

Addressing needs

Quality care

Improving access

Coordinate care

Capable organisations

The Plan: What we will do...

Improve practice

- Quality and safety
- Prevention
- Chronic disease mangement
- Build capacity
- Transform care

S1

Integrate systems

- Advocacy
- Person-led care
- Service navigation
- Care coordination
- Integrated care

S2

Commission services

- Informed by local needs
- Outcomes focused
- Co-designed
- Efficient
- Accountable

S3

S1. Improve practice

We identify gaps and opportunities for improvement in our region through regular needs assessment.

Our priorities and processes for improvement are informed by our **Community and Clinical Councils**. Effective and ongoing consultation through our **member networks** is a key step in guiding this body of work. **Advisory groups** provide input to specific issues.

Central and Eastern Sydney PHN **improves the practice of primary health care** in our region by working with our primary care providers to build the capacity of providers and services to provide high quality, evidence-based, person-centred and led health care[5]. This includes quality improvement and ongoing support for services and health professionals, professional development, cultural awareness and competency, access to information and resources, partnerships and leadership.

What we want to see within the next three years

- More effective and ongoing consultation and communication with primary health care providers.
- A better planned and more structured approach to quality improvement.
- Tailored support to better meet the needs of the local workforce and services.

Strategies
S1. Improve practice

S1.1   **Consult to identify local priorities and opportunities for collaboration and action:**
    ■ Consult with Community and Clinical Councils, member networks and advisory groups.
    ■ Engage with consumers, carers, service partners and community organisations.

S1.2   **Develop and implement plans that include quality improvement and ongoing support for services and health professionals with attention to operational systems, professional development, cultural awareness and competency, access to information and resources, partnerships and leadership.**

S1.3   **Adopt a systematic approach to quality improvement informed by a person-centred model that considers:**
    ■ Improving the experience of consumers and carers
    ■ Integrating health promotion into routine practice
    ■ Improving health literacy
    ■ Improving health equity
    ■ Improving information management including clinical data
    ■ Monitoring progress and measuring outcomes
    ■ Supporting GPs to achieve and maintain accreditation.

S1.4   **Provide ongoing support for practice improvement in particular for improving practice in prevention, chronic disease management and team-based care and uptake of digital health systems.**

S2. Integrate systems

A patient's journey through the health system may take them through many different services and systems. If these are poorly integrated or connected, then wastage, duplication, gaps in and compromised quality of care may lead to poor outcomes[6]. **Integrating systems of care** is therefore a key function of PHNs.

Integration strategies include reducing service gaps and duplication, engaging clinicians as enablers of change, encouraging a multidisciplinary approach to patient care and improving the health literacy of consumers and carers so that they are better prepared to navigate their health journeys[6]. The concept of **person-led care** is central to this.

Central and Eastern Sydney PHN takes a **strategic approach to advocacy** and undertakes **joint planning** to improve care planning and care coordination. Strategies to increase the uptake of **supportive infrastructure such as digital systems** are also a means by which to better coordinate care, improve the efficiency of service delivery, improve access and engage consumers and carers to be more actively involved in their care decisions[6].

What we want to see within the next three years

- More collaborative input to joint action plans.
- Improvements in care coordination.
- A better experience for consumers and carers.

Strategies
S2. Integrate systems
S2.1   **Consult to identify local priorities and opportunities for collaboration and action:** ■ Consult with Community and Clinical Councils, member networks and advisory groups. ■ Engage with consumers, carers, service partners and community organisations.
S2.2   **Advocate for primary health:** ■ Advocate for improvements to primary health collaboration and practice in all relevant forums. ■ Promote support systems such as NDIS and My Aged Care. ■ Support and develop clinical champions and leaders to drive improvement and transformation of the local sector. ■ Influence actions on issues that affect community health and wellbeing, such as urban planning and climate change.
S2.3   **Develop action plans for collaborative local work, including:** ■ Improving the integration and coordination of care ■ Creating a better health care experience ■ Improving health literacy to better navigate systems ■ Better use of resources and eliminating service duplication ■ Improving access for priority populations/equity.
S2.4   **Promote uptake of digital systems to support practice.**

S3. Commission services

PHNs **commission** local services to deliver outcomes. Commissioning is a strategic, evidence-based approach to planning and purchasing services, based on local priorities and needs[7]. We commission primary, secondary and tertiary services in the community where they are needed.

Our commissioning prioritises **those who need it the most**, including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, from low socioeconomic communities and populations, and people from vulnerable or marginalised groups.

Commissioning is a **continual and iterative cycle** that involves strategic planning, co-design, procuring, monitoring and evaluation of commissioned services. This cycle feeds into regional service planning and the commissioning cycle continues[8]. The scope of commissioning is directed by the Commonwealth and includes mental health, alcohol and other drugs, Aboriginal and Torres Strait Islander health, aged care, digital health, and population health funding streams. We work within this scope to align with local context and needs.

What we want to see within the next three years

- A greater focus on outcomes-based commissioning.
- Improved operational systems to support commissioning.
- More integration of commissioned services into the local health care environment.
- More co-design and co-commissioning.

Strategies
S3. Commission services

S3.1	**Consult to identify local priorities and opportunities for collaboration and action:** - Consult with Community and Clinical Councils, member networks and advisory groups. - Engage with consumers, carers, service partners and community organisations.
S3.2	**Commission services according to local needs.**
S3.3	**Develop and implement PHN commissioning protocols, resources and tools so as to prioritise/strengthen:** - Co-design and partnerships - Clinical governance frameworks, policies and procedures - Work that shapes and transforms the sector - Opportunities for joint commissioning - Reaching priority people and places/equity, particularly Aboriginal and Torres Strait Islander peoples - Better data and evaluation of outcomes/PHN indicators - Matching needs to the intensity of service (such as the Stepped Care approach to mental health).
S3.4	**Implement strategies to integrate commissioned services into the broader scope of the health and human services sector.**

The Plan: How will we make that happen...

Governance

- Board of Directors
- Community and Clinical Councils
- Member networks
- Advisory groups

E1

Operations

- People and culture
- Workforce development
- Customer focus
- Efficient and effective

E2

Partnerships

- Consumers and carers
- Primary health professionals
- Health and community sectors
- Universities

E3

Evidence

- Research partnerships
- Needs assessments
- Evidence-based planning
- Monitoring and evaluation

E4

E1. Governance

Our governance structures provide oversight and direction to support the delivery of this Strategic Plan. Our **Board of Directors** is supported by finance, audit and risk, governance and nominations committees and receives strategic advice from our two councils.

The **Community Council** provides advice towards the delivery of person-led care that is relevant and aligned to the experiences and expectations of consumers, carers and communities. The **Clinical Council** advises the board on issues such as the quality, efficiency and effectiveness of care, population health planning, service commissioning and services to support local and national priorities. Our **advisory groups** provide input and advice regarding specific issues.

Our **seven member networks** include five general practice companies, one allied health network and a community network. They use their combined expertise to advocate for and support general practice, allied health and the community to improve health outcomes in our region.

This section also describes our internal **planning processes** that support the delivery of this Strategic Plan.

What we want to see within the next three years

- Timely and constructive communication within and between the governance structures.
- Efficient use of internal plans to drive better practice.

Enablers
E1. Governance

E1.1	**Maintain our governance structure:**
	■ Support the board, board committees, Community and Clinical Councils, member networks and advisory groups.
	■ Provide regular opportunities for the members of these governance groups to provide feedback on our culture, strategic directions and practice.
E1.2	**Implement this Strategic Plan:**
	■ Develop an annual process to review the Strategic Plan and report on progress in delivering it, including indicators from the PHN Program Performance and Quality Framework[4] plus local and operational indicators (see p24).
	■ Develop and implement an annual operational plan.
E1.3	**Develop additional supporting plans as required:**
	■ Develop, implement and report against annual activity work plans for each funding schedule.
	■ Develop, implement and report against additional organisational plans as required, such as our *Reconciliation Action Plan, Communications Plan, Information Technology Strategy, Stakeholder Engagement Strategy, General Practice Engagement Strategy and Learning* and *Development Plan*.

E2. Operations

Our PHN workforce is our greatest asset. A well-trained and well-supported workforce delivers to a high standard, meeting the needs of the organisation, stakeholders and region. Workforce priorities identified by our staff include:

- Culture, values and behaviour
- Leadership and management
- People practices
- Professional development
- Teamwork.

Our workforce is supported operationally by **PHN corporate systems, policies and processes** including procurement and contract management, human resources, finances, information technology and management, marketing and communications. A customer focus is an important element of these operations.

These provide the essential foundation through which to deliver this Strategic Plan in an efficient and effective manner.

What we want to see within the next three years

- A culture that fosters learning and growth.
- A culture that promotes collaboration, inclusion and diversity.
- Organisational practices that reinforce the strengths we wish to maintain and build those we aspire to achieve.
- An engaged workforce providing feedback on operational matters.
- More effective and efficient corporate operations.

Enablers
E2. Operations
E2.1   Provide regular opportunities for our PHN workforce to provide feedback on workplace culture, learning and directions.
E2.2   Develop and implement "people and culture" frameworks and practices that encourage staff engagement and retention, positive performance and a culture of collaboration, including: ■ Human resource policies and procedures ■ Performance planning, review and development framework and management training ■ Workforce development including developing leaders and champions for the future ■ Collaboration and teamwork across the PHN ■ Supporting equity and diversity within the PHN ■ Implementing Activity Based Working.
E2.3   Implement policies and procedures to support the operations of the business, such as: ■ Procurement and contract management ■ Human resources ■ Finances ■ Information technology and management ■ Marketing and communications.
E2.4   Develop and track practical operational indicators to ensure that we are doing what we set out to do.

E3. Partnerships

Engagement and partnerships underpin the way we work. We are committed to the concept of **co-design**, which recognises that there is a difference between delivering services *for* people and doing so *with* them. It acknowledges that consumers, carers, families, and communities know what works best for them. Drawing on their lived experiences is gaining recognition as a best practice approach to transform the way that health services are designed and delivered[9, 10]. This links strongly back to the key concepts of improving health literacy to empower people to understand, navigate and manage their own health journeys, and taking a person-centred, person-led approach[6].

Partnerships are an important component of this. **Our partners** include GPs, allied health professionals, nurses, local health districts, specialty health networks, professional associations, social service, non-government and community-managed organisations, other PHNs and other health and human services. Our **Community and Clinical Councils** and **member networks** play an important role in fostering these partnerships.

What we want to see within the next three years

- A cultural shift across our organisation towards person-led practice, with co-design and partnerships being central to the way we work.
- Evidence that not only has engagement occurred, but that these voices have been properly heard and understood, and that action/change has occurred as a result.
- Recognising and measuring what matters to consumers and carers.
- Better engagement with general practices and allied health professionals.

Enablers
E3. Partnerships

E3.1	**Work with our Community and Clinical Councils and member networks to foster and facilitate effective partnerships.**
E3.2	**Provide opportunities for consumers, carers, GPs, allied health professionals, nurses, local health districts, specialty health networks, non-government organisations, community-managed organisations, universities and other health and community organisations to:** ■ Identify the major issues where primary health care can make a real difference to health outcomes. ■ Have input to the co-design of PHN services, particularly towards more person-led practice.
E3.3	**Continue engagement throughout the whole process, not just at the commencement of new work.**
E3.4	**Embed indicators for co-design, partnerships and participation into relevant PHN governance, planning and service delivery to demonstrate that consumers, carers, service partners and community organisations have been genuinely engaged, properly heard, and that action/change has occurred as a result of their input.**
E3.5	**Participate in key partnership forums across the region.**

E4. Evidence

We are committed to **evidence-based practice**. Evidence guides our work in many ways, including:

- Using evidence to guide strategic planning
- Using evidence to inform the development of services
- Collecting evidence through service evaluation
- Using evidence from evaluation to inform future planning
- Disseminating evidence and learnings from our work.

Evidence therefore informs a complete and ongoing **cycle of improvement**. For example, our needs assessments inform planning, feed into activity work plans and provide a process through which to monitor changes in health and wellbeing across our region over time.

Where evidence is lacking, we advocate for and/or participate in the conduct of **research** to fill these gaps. We are located in one of the heaviest concentrations of academia and research in Australia. We have the opportunity to make greater investments in collaborative research and local data sharing. Translational research that bridges the gap from research into policy and practice can help us to improve the experience of consumers and carers, the experience of service providers, and value for money.

What we want to see within the next three years

- Better use of evidence in service planning.
- A stronger focus on outcomes in service evaluation.
- Identification of gaps and opportunities for research.
- Stronger partnerships with researchers and research organisations.
- Greater investments in research, particularly translational research.

Enablers
E4. Evidence

E4.1 Undertake well-informed needs assessments:
- To inform strategic planning and activity work plans.
- To identify opportunities for collaboration with local partners.
- As part of ongoing monitoring.

E4.2 Use evidence throughout the program management cycle:
- Ensure that evidence is used appropriately in the planning of all services.
- Include robust evaluation plans with a focus on outcomes.
- Improve the use of evidence in commissioning, including better data collection using standardised tools and indicators to build a collective picture of access, effectiveness, appropriateness and value for money.

E4.3 Invest more in strategic, collaborative research:
- Build and enhance partnerships with research organisations and researchers.
- Identify gaps and opportunities for research.
- Increase data sharing and data analytics to improve quality, value for money and to inform change.

E4.4 Collect relevant quantitative and qualitative data to monitor and report on the implementation of this plan.

Headline Strategic Plan indicators

A review of the plan and our progress in delivering it will be undertaken and reported annually.

Headline Assessment Indicators for the Central and Eastern Sydney PHN Strategic Plan 2019-2021			
Strategic planning element	**Scope**	**Indicators**	
Vision	**Better health and wellbeing** (see page 15)	**Population health indicators:** ■ Rates of preventable deaths and hospitalisations ■ Rates of health risk behaviours (eg smoking, alcohol and drug use and overweight/obesity) ■ Rates of prevention behaviours (eg immunisation, cancer screening) ■ Health inequities as measured by differences in the above indicators by population group (eg Aboriginal and Torres Strait Islander peoples) and/or place (eg disadvantaged suburbs) NB this is a long term vision, and changes may not be apparent within the life of this plan.	**Alignment with the QUADRUPLE AIM[3]** ↓ **Population health**
Purpose	**Improve and transform care** (see page 16)	**PHN indicators** as described in PHN Program Performance and Quality Framework[4] including: ■ Assessing needs – relates to actions to address identified needs in our region, including an equity focus ■ Quality care – relates to support for GPs and other health care providers to improve quality ■ Improving access – relates to actions to improve consumer/carer access to primary health care ■ Coordinate care – relates to improving coordination of care and integration of health services ■ Capable organisations – relates to actions that support the successful delivery of PHN initiatives Additional local indicators will be developed as required to reflect our local priorities.	**Patient experience** **Provider experience** **Value for money**
What we will do...	**Improve practice** **Integrate systems** **Commission services** (see page 18-20)		
How we will make that happen...	**Governance** **Operations** **Partnerships** **Evidence** (see page 22-25)	Internal **operational indicators** will be developed. These will have a focus on our processes and will be supplemented by qualitative feedback from staff/partners/consumers as appropriate to fully understand our practice and drive future improvements. Indicators addressing each of these areas will be included in our annual report.	

References

1. Australian Government Department of Health. Fact sheet: Primary Health Networks. 2018 19 July 2018 [cited 2018; Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/Fact-Sheet-Primary-Health-Networks+

2. Standing Council on Health. National Primary Health Care Strategic Framework. Canberra: Commonwealth of Australia; 2013.

3. Sikka R, Morath JM, Leape L. The Quadruple Aim: care, health, cost and meaning in work. BMJ Qual Saf. 2015 Oct;24(10):608-10.

4. Australian Government Department of Health. PHN Performance and Quality Framework. Canberra: Communication Branch, Department of Health, Australian Government; 2018.

5. Australian Government Department of Health. Fact sheet: PHN practice support. 2018 18 June 2018 [cited 2018; Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/Fact+Sheet-PHN-Practice-Support+

6. Australian Government Department of Health. Fact sheet: How PHNs integrate health services. 2018 18 June 2018 [cited 2018; Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/Fact-Sheet-How-PHNs-Integrate-Health-Services

7. Australian Government Department of Health. Fact sheet: PHNs: Commissioning Health Services. 2018 18 June 2018 [cited 2018; Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/Fact+Sheet-PHNs-Commissioning-Health-Services+

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9. Social Innovation Generation. Co-production. 2014 [cited 1/9/2015]; Available from: www.coproductionscotland.org.uk\about\what-is-co-production

10. Stephens L, Ryan-Collins J, Boyle D. Co-production: a manifesto for growing the core economy. London: New Economics Foundation; 2008.
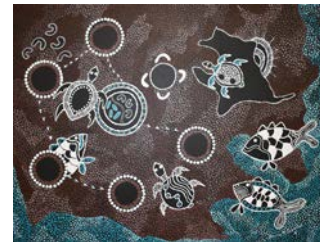
About the Artwork (back cover)

Artwork by Deanna Schreiber.

This painting was created to represent the Central and Eastern Sydney PHN area of work and local communities.

The earth colours represent the large land mass of the Sydney and Sydney basin area with the blues representing the surrounding salt water and traditional salt water Aboriginal communities and peoples who have inhabited this land for tens of thousands of years.

There is a circle almost central to the painting with a collection of inner circles and images which signifies the multiple teams, meetings and diverse areas of work conducted by the PHN.

The other circles surrounding that circle with earth and white coloured dots are reflective of the multiple Aboriginal and Torres Strait Islander pockets of communities in the CESPHN region. The feet joining the circles of community signify the travel between communities and exchanges of messaging and connections.

The image with the sun rising above it acknowledges the presence of The Royal National Park, a vast land area and natural habitat in the southern region of CESPHN.

The inclusion of the fish and turtle images identify some of the natural food sources which sustained the local communities throughout time immemorial.
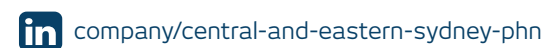
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Central and Eastern Sydney PHN is a business unit of EIS Health Ltd ABN 68 603 815 818

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