

WENTWORTH HEALTHCARE
NEPEAN BLUE MOUNTAINS PRIMARY HEALTH NETWORK



ANNUAL REPORT 2025

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



**Wentworth
Healthcare**

Blue Mountains | Hawkesbury | Lithgow | Penrith

CONTENTS

2	MESSAGE FROM THE CEO
3	MESSAGE FROM THE CHAIR
4	CELEBRATING 10 YEARS TIMELINE
6	OUR BOARD
8	GOVERNANCE FRAMEWORK AND STRUCTURES
11	OUR VISION, OUR MISSION, OUR VALUES
12	OUR STRATEGIC PLAN
13	BOARD ADVISORY COMMITTEES
16	OUR PRIORITY AREAS
16	FUNDING BY PRIORITY AREA
17	A SNAPSHOT OF OUR COMMUNITY AND PRIMARY CARE IN OUR REGION
18	OUR PEOPLE
19	OUR WORKPLACE
20	SERVICES WE FUND FOR THE COMMUNITY
22	Priority Area: ABORIGINAL HEALTH
23	Priority Area: ALCOHOL AND OTHER DRUGS
28	Priority Area: HEALTHY AGEING
30	Priority Area: MENTAL HEALTH AND SUICIDE PREVENTION
43	Priority Area: POPULATION HEALTH
45	Priority Area: VULNERABLE COMMUNITIES
50	SUPPORTING PRIMARY HEALTHCARE
52	Priority Area: HEALTH WORKFORCE
58	Priority Area: DIGITAL HEALTH
62	Priority Area: DISASTER AND EMERGENCY MANAGEMENT
64	Priority Area: HEALTHY AGEING
69	Priority Area: POPULATION HEALTH
76	INTEGRATING CARE
78	Priority Area: ABORIGINAL HEALTH
80	Priority Area: DISASTER AND EMERGENCY MANAGEMENT
82	Priority Area: HEALTHY AGEING
88	Priority Area: MENTAL HEALTH AND SUICIDE PREVENTION
94	Priority Area: POPULATION HEALTH

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

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

COVER:

This year Wentworth Healthcare celebrates 10 years of providing the Nepean Blue Mountains Primary Health Network. By funding services for the community, supporting primary healthcare, and connecting local health systems, our staff are committed to building healthier communities.

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

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

Initially trading as the Nepean-Blue Mountains Medicare Local, we became the provider of the Nepean Blue Mountains Primary Health Network (NBMPHN) on 1 July 2015, when the Primary Health Network (PHN) program was established. This year, we are proud to celebrate 10 years of providing the NBMPHN and helping build healthier communities.

The PHN program is funded by the Australian Government with the key objectives of increasing the efficiency and effectiveness of health services for patients, and improving the coordination of care to ensure patients receive the right care, in the right place, at the right time.

MESSAGE FROM THE CEO MS LIZZ REAY

This year marks my tenth annual report as CEO and our tenth year of providing the Nepean Blue Mountains Primary Health Network.



In 2015, the Commonwealth Government established Primary Health Networks (PHN) to strengthen and improve the healthcare system. PHNs were set up as regional organisations with a strong local focus. One of our key roles is to identify our community's needs and advocate for funding where it is needed most, particularly in areas where local priorities may not be visible at the state or national level. I am proud of what we have been able to achieve over the past 10 years and of the services and programs we have delivered to our community.

When we launched our PHN, we had an annual budget of approximately \$15m, which has now grown to approximately \$50m. We now have multiple funding sources and significantly more contracts, program areas and activities, and have introduced over 20 additional community-based services to our region. We now have four headspace Centres, two Medicare Mental Health Centres, four after-hours services, two Urgent Care services and a community-based alcohol and other drug service in each local government area.

We provide outreach services to schools and residential aged care homes, specialist clinics and telehealth services for priority populations, such as Aboriginal and Torres Strait Islander peoples and those with chronic conditions. We have implemented social connection initiatives, care navigation services, a domestic family and sexual violence program and much more. Some of these services and programs would not have been funded in our region without our strong advocacy efforts and knowledge of our local needs.

We have also built collaborative partnerships with primary care and key stakeholders to better integrate our local health system to increase efficiency, deliver economic value and improve health outcomes. We have worked closely with general practices, supporting them with data driven quality improvement initiatives for priority areas, which has seen positive and sustaining results. We have helped drive digital adoption and provided vital support during the pandemic.

I am particularly proud of our efforts in disaster management. Our region has experienced more natural disasters than most in the last 10 years including drought, bushfires and multiple floods. We have played a leading role in helping PHNs prepare for disasters by sharing our learnings, developing state-based Disaster HealthPathways and advocating to have primary care and PHNs formally recognised in state and national disaster plans.

We are deeply committed to Aboriginal and Torres Strait Islander reconciliation. We formalised this in 2018 by developing and implementing the first of our three Reconciliation Action Plans (RAP). Our RAPs have provided us with the opportunity to learn, grow and mature as an organisation, building our staff's respect for culture and understanding of the important role it plays in the health and wellbeing of Aboriginal peoples.

The face of healthcare is changing. Since establishment, the role of PHNs has expanded and evolved and as we look to the future, I am confident in the contribution PHNs can continue to make in helping to shape a better healthcare system for our community. Our significant local knowledge, together with the relationships we have built with our communities, service providers and others, means that we can bring people together to find innovative solutions to local health needs.

Finally, I would like to thank our staff and Board Directors, both past and present, for their contributions towards the success of our organisation over the last 10 years. Now and into the future, we remain committed to building the capability of our people, providers and partners to help us deliver on our vision of better health and wellbeing for the people living in our region.

MESSAGE FROM THE CHAIR MR GARY SMITH AM

I am pleased to present the 2024-2025 Annual Report, that not only highlights our achievements during the year but reflects on some of our achievements over the last decade.



In the context of the broader health system, Primary Health Networks (PHNs) are still relatively new. Yet, we have proven our value to the national health system through our capacity to develop, trial, evaluate and refine new innovations and our ability to be agile during times of crisis. As a result, in just a short period, the scope, breadth and complexity of PHNs have evolved, and our responsibilities and priorities have grown, along with our funding.

Our role in health system reform is an area that has significantly progressed, with PHNs acting as a bridge between national health policy and regional needs, bringing a local focus to national goals. The strong relationships we have developed with general practice, that have been built through local engagement, are not typically accessible to state and national organisations. This means we are uniquely placed to support the delivery of systematic change.

At the 2025 Federal Election, the Commonwealth's Strengthening Medicare policies took centre stage as the Government continued to push reforms from their 10 Year Primary Health Care Plan 2022-2032. We have played a vital role in supporting the implementation of many of these national initiatives, such as Urgent Care Clinics and Medicare Mental Health Centres. This year, there has been a focus on preparing general practice and other providers for the roll-out of MyMedicare and driving the adoption of digital health initiatives. While we receive limited funding for GP workforce support, it continues to be a significant area of focus for us, as we navigate the national health agenda and advocate for the health workforce needs of our region.

One of the core functions of PHNs is to support the coordination and integration of our local healthcare systems. We are passionate about cultivating a 'one health system' mindset and this year, we reaffirmed our strong partnership with Nepean Blue Mountains Local Health District by renewing our Memorandum of Understanding. This agreement is a platform to reinforce our shared priorities, and outlines our common vision to deliver integrated, patient-centred care that is accessible to all people living in our region. Together, through our strategic collaboration and shared leadership, our two organisations will continue to work on a wide range of projects to strengthen coordination across the local health system.

Fostering strong stakeholder engagement remains a key focus for the Board. Building collaborative relationships with key stakeholders is embedded in our Strategic Plan and formal stakeholder engagement is part of our Governance Framework. This year, the Board developed specific engagement action plans for key stakeholders with the Governance and Nominations Committee providing oversight of the implementation of these plans. Our Board Advisory Committees remain an integral part of our Governance Structure, and we thank our committee members for their continued involvement and meaningful contributions, which help shape our priorities.

Lastly, I would like to take this opportunity to acknowledge Mr Jeffery Jenkins, who resigned from the Board in September 2024 for health reasons. We are grateful to Jeffery for sharing his skills and expertise with us and thank him for his valuable contributions to our organisation.

In 2015 we successfully won the tender to provide the Nepean Blue Mountains Primary Health Network.

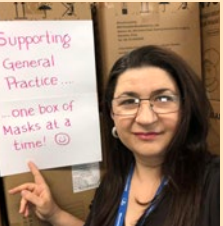
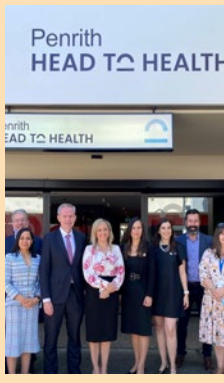
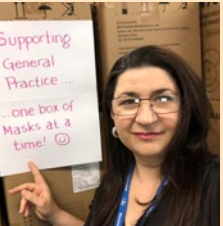
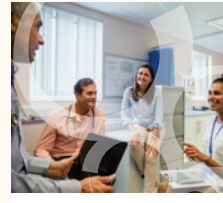
NBMPHN launch in 2015 (L to R) Dr Andrew Knight – Board Chair 2015-2018, Lizz Reay – CEO, Louise Markus – Federal Member for Macquarie 2010-2016, Peter Gooley – Community Advisory Committee Member.



In 2025 we celebrate 10 years of providing the Nepean Blue Mountains Primary Health Network.

NBMPHN 10 Year Anniversary Staff Celebration – Lizz Reay – CEO and Gary Smith AM – Board Chair.



2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Established Windsor Diabetes Clinic in Hawkesbury and Healthy Ears, Better Hearing, Better Listening school-based speech pathology service in Lithgow through Rural Doctors Network funding. Both services are still running in 2025. Launched MentalHealthHelp.com.au website co-designed with community to provide information about locally available mental health services. Over 250 services are now listed. One of two PHNs involved in the My Health Record Opt-out Trial. We reached 106,000 community members during trial period. 	Played a lead role in the national My Health Record Expansion by coordinating regional communications for NSW and ACT that reached over 775,000 community members. Launched Dianella Cottage Lithgow providing non-residential treatment for adults experiencing alcohol and other drug concerns. Launched HealthPathways with Nepean Blue Mountains Local Health District, a clinical decision and referral tool, helping integrate care across the local health system. Over 600 pathways are now listed. 	Launched first Innovate Reconciliation Action Plan (RAP) cementing our commitment to reconciliation. Launched our second Innovate RAP in 2021 and our third, a Stretch RAP, in 2025.  Launched NDIS Support Calculator, the first free tool of its kind nationally. This initiative won the Innovation Award at the Western Sydney Awards for Business Excellence. 	Launched headspace Lithgow after years of advocacy together with the community. A total of 1,337 young people were assisted since opening.  Launched Empowering our Communities distributing over \$1.2 million in grass-roots community grants that supported the wellbeing of drought-affected farming communities. 	Launched Bushfire Community Wellbeing Grants distributing \$350,000 to 78 grass-roots community initiatives that supported wellbeing and fostered resilience in bushfire-affected communities. Finalist in the Western Sydney Awards for Business Excellence in the Arts and Culture category for our Breath of Fresh Air anti-smoking campaign, co-designed with Aboriginal community.  Formed the Integrated Health and Wellbeing Joint Boards Sub-Committee together with Nepean Blue Mountains Local Health District. One of two PHNs funded to pilot a Social Connectedness Program. Starting in Hawkesbury, it has now expanded across the region delivering six components as part of the program. This includes the MyHealthConnector.com.au website, co-designed with community, that lists over 900 local health, lifestyle and social support services. 	Launched Joint Regional Suicide Prevention Plan 2021-2026 with Nepean Blue Mountains Local Health District, focused on an integrated and holistic approach to suicide prevention across the region. Launched the first Head to Health Centre nationally in Penrith, now known as Penrith Medicare Mental Health Centre. A total of 1,922 clients assisted since opening. In 2023, successfully advocated for funding to transition the Hawkesbury Pop Up site into a permanent Centre.  Responding to COVID-19: Throughout 2020 and 2021 we opened three GP-led Respiratory Clinics, supported 91 practices to deliver vaccinations, distributed over 170,000 masks, provided 4,654 practice support activities, sent 312 newsletters and expanded access to mental health support. 	Launched Wellbeing and Resilience Flood Grants. A total of \$420,000 was distributed to 71 grass-roots community initiatives that supported wellbeing and fostered resilience in communities affected by multiple floods in 2022.  Disaster Grants were launched to support vaccine providers. A total of \$352,000 was distributed across 86 grants to help general practices and community pharmacies delivering COVID-19 vaccinations prepare for future natural disasters. 	Launched headspace Hawkesbury after seven years of advocacy. A total of 568 young people were assisted since launch. Hawkesbury became the fourth headspace to open in our region adding to Katoomba (opened in 2020), Lithgow and Penrith.  Launched The Street University Katoomba, an early intervention alcohol and other drugs service that uses music, art, dance and culture to reach young people. We were the first PHN to fund this innovative service when we opened the Penrith centre in 2020. 	Expanded Care and Connect domestic and family violence program (launched in 2020) to include sexual violence and child sexual abuse. Care and Connect has trained 898 health professionals and assisted 258 clients since 2020.  Contributed to a review leading to formal recognition of PHNs and primary care in the NSW HEALTHPLAN. This outcome followed years of advocacy, beginning with the 2013 bushfires and included a formal response to the 2020 Royal Commission into National Disaster Arrangements among other actions.	Launched Diabetes Multidisciplinary Team Pilot, co-designed with clinicians, in eastern Penrith providing patients access to diabetes education and dietetics services within their general practice.  Supported general practice to navigate Strengthening Medicare Reforms such as MyMedicare, including the General Practice in Aged Care Incentive, resulting in 97% of eligible practices being registered for MyMedicare.

OUR BOARD

Our Board consists of nine directors who are appointed based on the Board of Directors Skills Matrix and Diversity Policy.

Our Directors must all complete the Australian Institute of Company Directors (AICD) graduate course and a Cultural Competency Course through the Centre for Cultural Competency Australia. They also participate in formal training annually on topics such as conflicts of interest, ethics, governance and more. This year they received governance training regarding artificial intelligence.

Find out more:

nbmphn.com.au/About/Governance

Mr Gary Smith AM

Director since November 2018
Appointed Chair November 2021

Member: Governance and Nominations Committee

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



Ms Janja Bojanic

Director since 2025

Member: Clinical Governance Committee

Ms Bojanic is an accomplished registered psychologist, manager and Board Approved Supervisor with over 10 years of clinical and leadership experience. She has extensive experience working across various sectors including the corporate, private and hospital settings. Ms Bojanic is driven by a passion for excellence and a commitment to improving mental health and wellbeing for those in the community. Throughout her career, Ms Bojanic has worked with complex clinical presentations, facilitating both inpatient and outpatient programs. She has a passion for working with military and first responder communities, as well as those affected by occupational trauma. Ms Bojanic has provided expert training and supervision, facilitated master classes, podcasts and consultations, and is also actively involved in research and academic tutoring. She is a regular guest presenter at a wide variety of conferences to further the advancement of the field.



Mrs Fleur Hannen

Director since November 2020
Chair: Clinical Governance Committee

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



Dr Nicole Langsford

Director since November 2021
Member: Finance, Audit and Risk Management Committee

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



Professor Andy Marks

Director since November 2020
Member: Finance, Audit and Risk Management Committee

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



Ms Heather Nesbitt

Director since November 2019
Chair: Governance and Nominations Committee

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



Dr Madhu Tamilarasan

Director since November 2020
Member: Clinical Governance Committee

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



Mr Bruce Turner AM

Director since November 2017
Chair: Finance, Audit and Risk Management Committee

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



Mr John Yealland

Director since November 2018
Member: Governance and Nominations Committee

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



Mr Jeffery Jenkins

Director since November 2022
Resigned September 2024

We would like to acknowledge the work and contributions of Mr Jeffery Jenkins who served on the Board for almost two years and resigned for health reasons. We extend our deepest thanks and gratitude to Mr Jenkins for his valuable contribution to the Board and to our organisation during his time with us and send our best wishes to him and his family.



GOVERNANCE FRAMEWORK AND STRUCTURES

Strong Governance Foundations

Good governance is essential to ensuring our organisation is effective and accountable in our work. Our governance processes and behaviours help us achieve our vision and mission, comply with all applicable laws and standards, and uphold the community’s expectations for ethical practice, accountability and transparency. Our Governance Framework provides our staff with a clear direction and sense of purpose, shaping how we interact with one another, our commissioned providers and with our external stakeholders.

We have a comprehensive range of governance policies and procedures in place to support our operations. We also adopt a continuous quality improvement approach to ensure our corporate governance practices remain contemporary and appropriate. Our governance practices are based on the Australian Securities Exchange (ASX) Corporate Governance Principles and Recommendations (4th edition) where relevant for a not-for-profit.

Our Governance Structure

Our organisation has a well-defined governance structure. The Board of Directors is the principal governing body and is supported by the CEO and the Executive Team. There are three Board Committees that assist the Board to carry out its role and three Advisory Committees that provide recommendations to the Board to support the direction of our work.

In addition, together with the Nepean Blue Mountains Local Health District (NBMLHD), we have an Integrated Health and Wellbeing Joint Boards Sub-Committee which serves to strengthen our ‘one system mindset’ in the region by encouraging the development and delivery of models of care that support integration across acute, community and primary care.

Our Executive Management Team are further supported by multiple program specific stakeholder advisory committees and internal staff advisory committees.

Clinical Governance

Our Clinical Governance Framework was developed specifically to meet the needs of our organisation as a commissioner and contractor of services. Our Clinical Governance Committee (CGC) monitors external complaints, clinical incidents and critical incidents, supported by a range of clinical governance policies and procedures. Clinical program audits of our commissioned and delivered services are undertaken on a scheduled basis. These audits are presented to CGC, and the progress of any recommendations is monitored. We also employ a Clinical Advisor for our mental health and integrating care work. Contracts for clinical services require the providers to have appropriate clinical governance systems as per our due diligence checklist, with annual reviews and improvements.

Commissioning

Our robust commissioning process is evident throughout every step of the commissioning cycle. We consistently ensure our procurement and contracting processes are of high probity in terms of transparency and fairness, facilitating the involvement of the broadest range of suppliers. Moreover, we have developed environments high in trust through collaborative governance and due diligence, shared decision-making and collective performance

management. Finally, we effectively monitor and evaluate through regular performance reports, consumer, clinician, community and provider feedback, and independent evaluation.

Conflict of Interest and Related Parties

We have a clear process for assessing and reporting related parties and managing conflicts of interests, which is outlined in our Conflict of Interest and Related Parties Policy. A Conflict of Interest Declaration and Register is in place for the Board and all staff, and the Conflict of Interest Declaration is a requirement for commissioning assessment panels and included in all tenders. This year, we engaged Lower Russell and Farr to undertake an internal audit on conflicts of interest to identify any areas we can strengthen, with the report findings delivered in 2025-26 financial year. Two minor recommendations were made, which will be implemented.

Cultural Competency and Diversity

Respect is one of our five values. All staff are required to complete cultural competency training and opportunities to increase cultural awareness are provided annually. The Board has a Diversity Policy and we have an internal Strength in Diversity Working Group to assist the organisation implement strategies to support diversity and inclusion.

Our Commitment to Reconciliation

We commenced our formal journey towards reconciliation in 2018, with our first Innovate RAP. In 2024 we completed our second Innovate RAP and started development of our Stretch RAP, which was endorsed by Reconciliation Australia in July 2025. We are proud to have reached this next stage of our reconciliation journey and look forward to formally launching our Stretch RAP in November 2025.

Organisations who undertake a Stretch RAP need to have established strong approaches to advancing reconciliation internally and be willing to work with others in their sphere of influence externally to do the same. Our role through our Stretch RAP will be to cultivate relationships and form partnerships that foster collaborative healthcare practices. By working together, we seek to address the specific needs and priorities of Aboriginal and Torres Strait Islander communities in our region, ultimately improving health and wellbeing outcomes in ways that are defined by the communities themselves.

The development and implementation of our RAPs have been supported by our internal RAP Working Group. This year, we also appointed a Reconciliation Implementation Coordinator, who will assist with the implementation of our Stretch RAP.



Ethical Practice

Ethical Practice is one of our five values.

We foster a culture that instils ethical behaviour supported by a clear Code of Conduct for staff, and our Board Code of Conduct which is part of our Board Charter. In our independent annual staff survey, the Company rates highly (on or above the norm compared to other healthcare organisations and other PHNs) to questions of ethics, equity (gender and culture) and safety.

Our CEO reports to the Finance, Audit and Risk (FARM) committee annually on current mechanisms and processes to ensure services are provided ethically, including mechanisms to assess compliance with the organisation's Statement of Business Ethics which was first launched in 2019.

External and Internal Audits

Annually, we engage an external auditor to audit our financial position. Since incorporation, we have received unqualified financial audit reports.

Each year we conduct an internal audit with an area of focus determined by the FARM committee. This year, this focus was Conflicts of Interest. Implementation of recommendations from our internal and external audits are monitored by the FARM committee and the Board.

Feedback and Complaints

Continuous Improvement is one of our five values. We value feedback as a way to continuously improve our performance. We collect feedback internally from staff through our fortnightly anonymous Pulse Check questionnaire and through an independent whole-of-staff annual survey. The organisation has been identified through these annual staff surveys as having a culture of success (highest culture rating) consistently since 2019. Information on areas of improvement feeds into the development of our Annual Business Goals.

This year, we refreshed our Complaints Policy and procedures with training conducted for staff. The 'Have Your Say' page on our website allows people to provide feedback, compliments or complaints about our services, programs or staff. In addition, our commissioned providers are

required to have appropriate complaints policies and processes in place, and advise us of any critical incidents. We also collect good news stories from the services we commission.

Governance Reviews

Quality is one of our five values. We undertake annual Board performance and governance reviews. The recent independent Board Performance Review, undertaken by Sadhana Consulting, concluded that our Board operates in a highly effective manner. Some opportunities to strengthen Board stakeholder engagement were identified and have been implemented.

This year, the Board undertook the Australian Charities and Not-for-profit Commission (ACNC) Charity Self-Evaluation to assess the performance of the Board in meeting its obligations under the ACNC Governance Standards and other obligations. The Self-Evaluation showed that we are meeting our obligations under the ACNC Governance Standards, with a few minor administrative actions implemented.

Preventing, Detecting and Responding to Fraud and Corruption

We have no tolerance for fraud and corruption. We have a Fraud Policy, as well as a Fraud and Corruption Control Plan. The plan is reviewed every two years by the FARM Committee. In addition, our Whistleblower Policy outlines the process for staff to report fraud, corruption, and unethical behaviour. Our Compliance Management Framework monitors fraud, corruption, and unethical behaviour. It is reported to the FARM committee and the Board every six months via the Compliance Obligation Report.

Protecting Privacy

We are committed to protecting individual privacy and managing personal information in accordance with relevant legislation, as outlined in our Privacy Policy updated in May 2025. We participate in the Office of the Australian Information Commissioner's Privacy Awareness Week in May each year to encourage awareness within our organisation about privacy issues and the importance of protecting personal information. Our Data Breach Management Policy outlines our approach to managing data breaches.

Recognising and Monitoring Risks

Risk management is embedded within our strategic planning processes. Risks are assessed and managed in accordance with our Risk Management Framework, Risk Management Policy and Risk Appetite Statement. The Executive and the FARM committee regularly review our key business risks. The Board reviewed our Risk Appetite Statement (RAS) and Key Business Risks in June 2025 and a revised RAS will be implemented in the 2025-26 financial year.

Regulatory Compliance

We have numerous compliance obligations related to legislative requirements and contractual obligations. Our Compliance Management Framework and our Compliance Management System (which includes exhaustive regulatory compliance coverage via Folio and LexisNexis) ensure we meet our compliance obligations and is aligned to the ISO standards. Our Compliance Management Policy and Compliance Obligation Register support this work and a Compliance Report is provided to the FARM committee and the Board every six months.

Stakeholder Engagement

Collaboration is one of our five values. Building effective relationships and partnerships with our key stakeholders is embedded throughout our Strategic Plan. In addition to our Board Advisory Committees, our Stakeholder Engagement Framework, which was approved by the Board in July 2024, outlines our approach to stakeholder engagement. This year, action plans were developed by the Board for key stakeholders and the Governance and Nominations Committee provide oversight of the implementation of these plans. One new initiative was implementing an online forum for the Board and Company Members to share priorities and identify opportunities for strengthening work together. The inaugural forum was held in May 2025.

OUR VISION

Our community experiences better health and wellbeing.

OUR MISSION

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

OUR VALUES



Collaboration



Continuous Improvement



Ethical Practice



Respect



Quality

OUR STRATEGIC PLAN 2024-2029

In July, after extensive consultation with staff, community, health professionals and others, we were proud to launch our new 2024-2029 Strategic Plan which outlines our organisation’s strategic objectives and intended outcomes for the next five years.

Our new Strategic Plan focuses on the key objectives of excellence and impact, building a skilled and influential local primary care workforce, delivering integrated, quality-focused health services and engaging with, and empowering, the community. It builds on the strengths and outcomes of our 2019-2024 Strategic Plan and incorporates learnings from the last five years in health, that included unprecedented challenges.

The new Strategic Plan provides a roadmap for how the organisation will serve the region’s changing health needs into the future. It ensures that our collective energy as an organisation is focused on helping to deliver a more efficient, equitable, integrated and patient-centred health system that meets the needs of our growing community and that our work continues to be outcome-based and sustainable.

Find out more:
nbmphn.com.au/StrategicPlan

“We are proud of what we have achieved over the last five years and of the services we have been able to bring to the region, sometimes in difficult circumstances. Over the next five years, we remain committed to building the capability of our people, providers and partners to help us deliver on our vision of better health and wellbeing for the people living in our region.” Lizz Reay – Wentworth Healthcare CEO

“Our significant local knowledge, together with the relationships we have fostered with our community, service providers and partners, means that we understand the needs of our region and are well placed to provide innovative local health solutions, together with others in the sector. In 2024-2029, we look forward to building on these cross-sector relationships to provide more accessible and cohesive health services that deliver quality health outcomes for our community.” Mr Gary Smith – Wentworth Healthcare Board Chair

Strategic Objectives, Vision and Mission 2024–2029



BOARD ADVISORY COMMITTEES

Our Governance Framework includes three Board Advisory Committees that provide recommendations to the Board to support the direction of our work

Members come from our four local government areas of the Blue Mountains, Hawkesbury, Lithgow and Penrith, ensuring all areas have a voice to share their concerns and ideas. This framework plays a fundamental role in how we identify and commission health services and meet the health needs of our community.

Community Advisory Committee (CAC)

The committee is jointly operated in collaboration with the Nepean Blue Mountains Local Health District (NBMLHD). Members of CAC come from communities across our region and provide advice and insights to ensure that decisions, investments and innovations are person-centred, locally relevant and aligned to local care expectations. They provide advice on appropriate methods of community engagement and communicate important information into and from their networks.

- CAC met five times this year. In addition, CAC members attended a Board meeting in April 2025.

MEMBERS 2024-2025:

Belinda Leonard – Chair (Blue Mountains)
Caroline Allen (Hawkesbury)
Peter Gooley (Hawkesbury)
Simon Griffin (Hawkesbury)
Priya Jensen (Blue Mountains)
Joe Rzepecki (Penrith)
Andrew Wilson (Blue Mountains)
Colleen Winterburn (Lithgow)

KEY AREAS OF FOCUS in 2024-2025

Membership and recruitment review – including role, Terms of Reference, structure, membership and a skills matrix to support future recruitment, CAC’s purpose and how it can best represent our community.

- **Community Health Services** – NBMLHD consultation.
- **Disaster and emergency management** – our PHN works in this space, including the development of a Disaster and Emergency Framework.
- **North Richmond Urgent Care Service** – implementation of the service and the model of care.
- **Emergency Department avoidance** – the role of Urgent Care Centres/Services and After-Hours GP services.
- **Health Literacy Review Group** – MedicinesEd community education across all local government areas relating to medication management.
- **Domestic Family Violence** – in-depth discussion and consultation on this topic and the PHN and LHD programs are addressing this issue.



Belinda Leonard

MESSAGE FROM THE CHAIR – Belinda Leonard

“Our Community Advisory Committee thrives as a dynamic force for consumer advocacy, with members bringing diverse perspectives from across the PHN and LHD networks. This depth of experience generates informed, meaningful discussions that directly shape healthcare outcomes. CAC remains steadfast in advancing joint Board priorities while amplifying the consumer voice at every level. Our members have made tangible contributions to critical initiatives spanning HealthPathways development, palliative care improvements, mental health and suicide prevention programs, emergency department experience and the Nepean Hospital redevelopment. Looking ahead, we’re strategically expanding our membership base to reflect our updated Terms of Reference. This growth will strengthen both our diversity of perspectives and geographic reach, ensuring our community has representation in shaping their healthcare future.”

GP Clinical Council (GPCC)

Members of GPCC share valuable perspectives about the unique needs and concerns of their local areas, as well as broader issues for GPs. GPCC provides expertise and advice that informs our work across program areas and supports the integration of health services across the region, helping to improve healthcare for the community.

- GPCC met five times this year. In addition, a combined GPCC and Allied Health Clinical Council meeting was held in December, bringing together members to discuss shared priorities and strengthen collaboration.

KEY AREAS OF FOCUS in 2024-2025

- **Annual review and recruitment strategy for GPCC** – led to the appointment of two new members, enhancing the diversity of voices within GPCC. The recruitment of a GP Registrar brought a fresh perspective and strengthened our engagement with the next generation of healthcare professionals.
- **Homelessness Access Program** – including service implementation and GP education needs.
- **Disaster and Emergency Management** – discussion focused on the need for co-ordinated planning across general practices, allied health services, the broader community, and vulnerable patient groups.
- **HealthPathways** – including GP education needs for the implementation of individual logins.
- **Advocacy during the election cycle** – priorities included funding for obesity, alcohol and other services, speech pathology outreach programs, policies regarding GP workforce and for the development of a GP liaison model.
- **Upper Blue Mountains GP Workforce** – recognition of the workforce challenges. Discussion included GP registrar retention, attracting experienced Fellowed GPs to the area, bulk-billing and fee-for-service models of payment.
- **Residential Aged Care Homes (RACH)** – workforce issues and their potential current and future impacts.
- **PHN Resources** – feedback on a new GP PHN services guide and distribution suggestions.
- **Combined GPCC and Allied Health Clinical Council event** – brought together GPs and allied health professionals to explore key issues in disaster and emergency management. The meeting highlighted barriers and enablers, shaping our work in this area throughout 2025. This remains a continuing area of focus for GPCC in the coming year.



Dr Louise McDonnell

MESSAGE FROM THE CHAIR – Dr Louise McDonnell

“My role as chair of GPCC this year has been interesting and productive. We continue to provide valuable and insightful feedback to the PHN Executive and the Wentworth Healthcare Board on issues that affect general practice. We have had productive discussions around workforce issues including suggestions for recruitment of GPs and registrars to our area. Aged care continues to be a particularly challenging area regarding workforce, with a small number of GPs visiting the majority of RACHs. We have advised the PHN on ways to support these GPs and strategies to recruit new GPs into aged care. I warmly welcome our two new members, Dr Kamal Singh representing the Blue Mountains and Dr Roxanne Chenn representing Hawkesbury.

I would like to thank all the GPCC members for their commitment and their valuable input at these meetings. Finally, thank you to the fantastic team at the PHN who provide incredible support for this role.”

MEMBERS 2024-2025:
Dr Louise McDonnell – Chair (Blue Mountains)
Dr Anju Aggarwal (Penrith)
Dr Hilton Brown (Lithgow)
Dr Roxanne Chenn (Hawkesbury)
Dr Jialiang Chin (Blue Mountains)
Dr Thu Dang (Penrith)
Dr David Foley (Hawkesbury)
Dr Hany Gayed (Penrith)
Dr Ben Hanson (Lithgow)
Dr Simone Heiler (Blue Mountains)
Dr Kamal Singh (Blue Mountains)
Dr Alex Williams (Hawkesbury)

Allied Health Clinical Council (AHCC)

Members of AHCC are from various disciplines, providing valuable perspectives about the needs of their profession and patients within our local areas. AHCC provides expertise and advice on our program areas and on integration of health services across the region to ensure improved healthcare for the community.

AHCC met four times this year. In addition, a combined GPCC and Allied Health Clinical Council meeting was held in December, bringing together members to discuss shared priorities and strengthen collaboration.

KEY AREAS OF FOCUS in 2024-2025

- **Annual review and recruitment strategy for AHCC** – this led to the appointment of three new members, strengthening the diversity of voices within AHCC.
- **National Allied Health Practice Engagement Toolkit** – including service implementation and allied health education needs.
- **Multidisciplinary Team Care Pilot Project** – regular input sought regarding project planning, implementation and assessment.
- **Hospital Discharge** – seeking advocacy from PHN.
- **Communication** – between allied health professionals and other primary care professionals including GPs.
- **Changes to Chronic Condition MBS items numbers** – impact on allied health practice.
- **Dementia Training** – consultation in 2024 led to training opportunities for allied health in 2025.
- **AI impact on allied health** – special committee formed to discuss the development of an information evening provided for allied health professionals discussing AI and the impact on practice and health delivery.
- **Workforce pressures** and barriers to access allied healthcare services in our region.
- **Combined GPCC and Allied Health Clinical Council event** – brought together GPs and allied health professionals to explore key issues in disaster and emergency management. The meeting highlighted barriers and enablers, shaping our work in this area throughout 2025. This remains a continuing area of focus for AHCC in the coming year.

MEMBERS 2024-2025:
Jillian Harrington – Chair (Penrith) Clinical Psychologist
Cara Bourke (Hawkesbury) Podiatrist
Christine Colusso-Craig (Hawkesbury) Public Health Representative
Dr Rudi Crncec (Penrith) Clinical Psychologist
Rebecca Hannon (Hawkesbury) Exercise Physiologist
Rainy Johnston (Blue Mountains) Pharmacist
Dr Anne Lyell (Hawkesbury) Chiropractor
Gobika Srikanthan (Lithgow) Pharmacist
Sally Webb (Lithgow) Physiotherapist
Adam Wilkes (Penrith, Blue Mountains and Hawkesbury) Physiotherapist
Susan Williams (Blue Mountains) Dietitian



Jillian Harrington

MESSAGE FROM THE CHAIR – Jillian Harrington

“This year has been a busy and productive year. Discussion and consultation with AHCC has ensured that the Wentworth Healthcare Board and team are supported by a range of voices across different disciplines, work settings, geographical locations and career stages. The group has been a sounding board on a range of issues including disaster and emergency management and multidisciplinary team care (MDT) in our region, including the current Pilot Project in MDT approaches to diabetes.

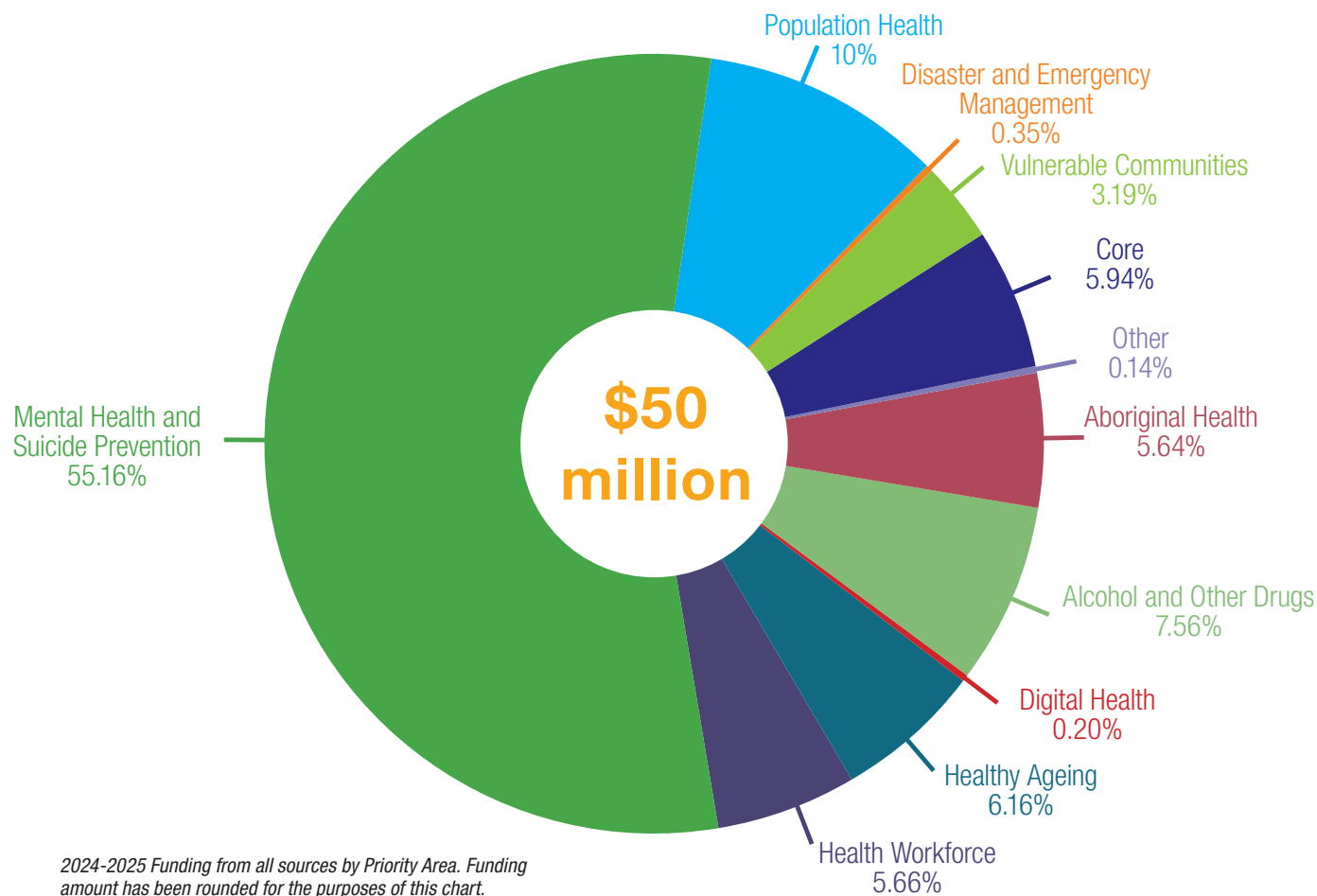
As clinicians who are passionate about our health system and the role of allied health, we've continued to discuss and to advise the Board on broader issues as they play out in our region, including workforce issues, the impact of the NDIS and medication short supply. Collaboration with Wentworth Healthcare's other committees ensures we keep our eye on our shared goals of supporting safe, high-quality and accessible care for the people of our region.”

OUR PRIORITY AREAS



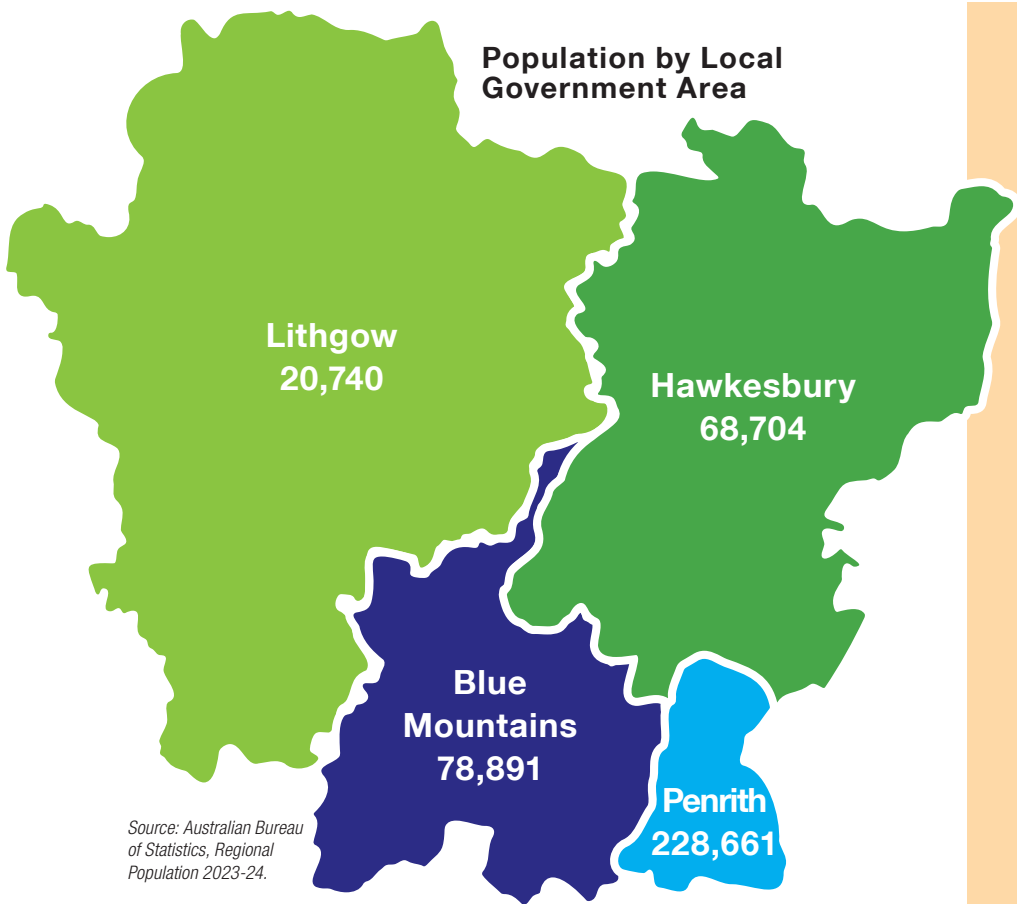
FUNDING BY PRIORITY AREAS

In 2024-2025, 96% of our funding came from the **Department of Health, Disability and Ageing**. The below graph shows funding from all sources.



2024-2025 Funding from all sources by Priority Area. Funding amount has been rounded for the purposes of this chart.

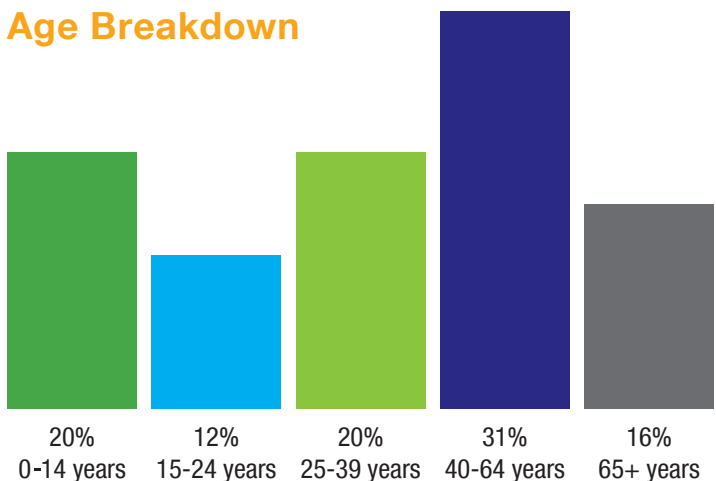
A SNAPSHOT OF OUR COMMUNITY AND PRIMARY CARE IN OUR REGION



4 local government areas across **9,063km²**

3 traditional lands of the Darug, Gundungurra and Wiradjuri peoples

Age Breakdown



Source: Australian Bureau of Statistics, Census

396,996+
total population

452,639
expected population increase by 2041
(an increase of 14% from 2024)

4.7% identify as Aboriginal and/or Torres Strait Islander

19.7%
born overseas

Source: idcommunity, Population Summary 2024

130
general practices

86 community pharmacies

29 residential aged care homes with places for **2599** residents

Source: AIHW, GEN Aged Care Data, 2025

543 GPs (including GP registrars)

495 full-time equivalent GPs (1.3 FTE per 1,000 people)

Source: HeadsUPP, 2025

131 GP registrars

236 practice nurses

1736 allied health professionals

Source: Wentworth Healthcare CRM, 2025

OUR PEOPLE

Our Executive Team



Lizz Reay BAppSc, MNutr&Diet, AdDipBusMgt, GAICD
Chief Executive Officer

Lizz has a proven track record of applying strategic and adaptive leadership to achieve outcomes. With a background in clinical and public health nutrition both in Australia and the UK, Lizz has over 27 years of experience in the healthcare sector.



Bobby Stefansen Acevski BBus (Acc and Fin), LLB (Hons), MTax&IntBus, CPA, CTA, Solicitor
Executive Manager Business Services

Bobby is a certified practising accountant, chartered tax advisor, barrister and solicitor with extensive experience in financial leadership and business strategy. With over 16 years experience in leading accounting and legal private practices, commerce and government entities, he has expertise in all aspects of business, risk, compliance and law.



Elisa Manley BNursing, MPubHlth
Executive Manager Strategy & Integration

Elisa has worked for over 40 years in health, government and not-for-profits. Her background in hospital nursing, occupational health and safety, and expertise in public health and primary care, supports commissioning, planning and integration of health services within the region. Elisa retired in July 2025.



Carolyn Townsend B.EC (Soc Sci), MBA
Executive Manager Corporate and Strategic Performance

Carolyn has more than 20 years of leadership experience, largely in financial services with a focus on stakeholder and project management and service delivery. She also brings experience from leadership roles in managing elections and work in an allied health service.



Kate Tye BHACS, GradCertCaseMgt, MHLM
Executive Manager Primary Care Development

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

OUR WORKPLACE

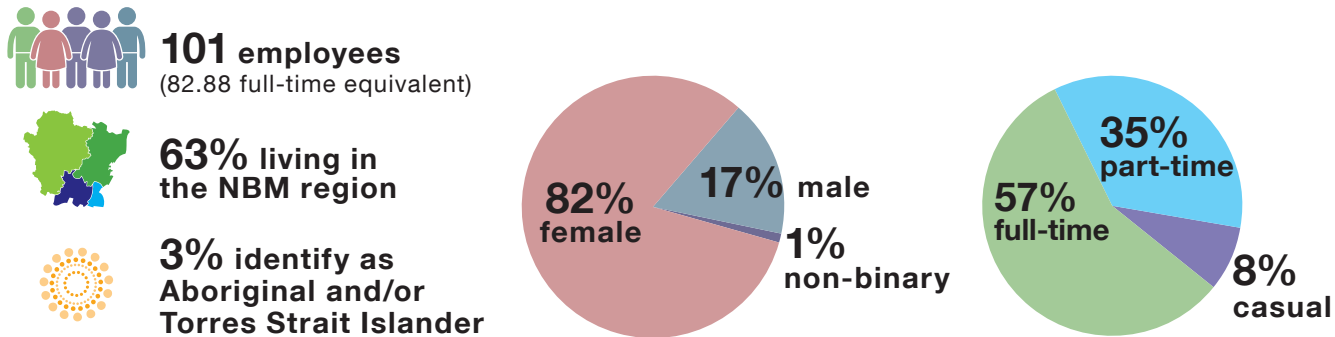
We are proud to foster a workplace culture that embraces diversity, inclusion and community connection. Many of our staff live in our region, strengthening our local ties and understanding of the communities we serve. Our staff span a mix of ages, educational and cultural backgrounds, and professional experiences – creating a vibrant, collaborative environment. For the past five years, independent staff surveys have consistently rated us as a “truly great” place to work.

We actively encourage employee input through participation in organisational working groups, regular staff development days and employee feedback opportunities. We celebrate employee contributions and success through our STAR Awards program and length of service awards.

Professional growth is a priority. We invest in training, support attendance at conferences and encourage participation in PHN network activities,

ensuring our people stay informed, build expertise and bring fresh insights back to the organisation.

This year, we launched our Career Development Framework to support our people in taking ownership of their career journeys. This initiative aligns personal aspirations with organisational goals, and we look forward to sharing its positive impact in the years ahead.



We work in three ways:

 We provide health services that meet the needs of our community.	 We support the delivery of high-quality healthcare to patients.	 We connect the local health system, so people don't get 'lost' between health services.
SERVICES WE FUND FOR THE COMMUNITY	SUPPORTING PRIMARY HEALTHCARE	INTEGRATING HEALTHCARE

➔ [Read more on page 20.](#)

➔ [Read more on page 50.](#)

➔ [Read more on page 76.](#)



SERVICES WE FUND FOR THE COMMUNITY

We help improve the health of our region by understanding local needs and advocating to fund services to meet those needs – when and where people need them. We use health data and work closely with GPs, allied health professionals, community stakeholders and other organisations, to make sure that the services we fund provide evidence-based high-quality care that improve the health outcomes of our community, while delivering value for money.

Susan Templeman MP (middle), Federal Member for Macquarie, visiting the Hawkesbury Medicare Mental Health Centre.

PRIORITY AREAS

ABORIGINAL HEALTH

Case-Management: Aboriginal and Torres Strait Islander Youth
Merana Fitness and Health Challenge
Deadly Dreaming
The Nepean Linker Project

ALCOHOL AND OTHER DRUGS

Aftercare and Relapse Prevention Program
Dianella Cottage
WHOS (We Help Ourselves)
The Street University

HEALTHY AGEING

WiseMind
Mobile Occupational Therapy in Lithgow
Health Literacy for Consumers

MENTAL HEALTH AND SUICIDE PREVENTION

Mental Health

Wellbeing Outreach Program
Medicare Mental Health Centres
headspace
headspace Lithgow Youth Plus
headspace Youth Early Psychosis Program
Youth Enhanced Support Service (YESS)
Commonwealth Psychosocial Support
Telepsychiatry Service
Live Life Get Active
Mental Health Nurse Incentive Program
Psychological Therapy Services
Bushfire and Flood Psychological Therapy Services
Dialectical Behaviour Therapy Skills Program
Expressive Therapy Programs

Suicide Prevention

Community-Led Suicide Prevention Program
Top Blokes
Suicide Prevention Training
Seek Out Support (SOS)
The Way Back Service Penrith

POPULATION HEALTH

After Hours Services
Urgent Care
Diabetes Multidisciplinary Team Pilot

VULNERABLE COMMUNITIES

Chronic Obstructive Pulmonary Disease Services
Chronic Pain Management Program
Domestic, Family and Sexual Violence Lithgow Outreach Speech
Therapy Program
Healthy Eating Active Lifestyle Program
Outreach Clinics

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

ABORIGINAL HEALTH

Case-Management: Aboriginal and Torres Strait Islander Youth

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

- 282 clients assisted

Find out more:

nbmphn.com.au/AODYouthCaseManagement

Merana Fitness and Health Challenge

We fund Merana Aboriginal Community Association to run the Merana Fitness and Health Challenge in the Hawkesbury area. This program encourages local Aboriginal and Torres Strait Islander peoples to participate in structured physical activity across 10 weeks. Participants have the opportunity to learn new skills from an exercise physiologist and engage with a dietitian.

- 12 participants
- 173 individual sessions delivered

Find out more:

gwahs.net.au

Deadly Dreaming

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

Deadly Dreaming Groups

- 8 schools participated
- 123 group programs conducted
- 283 young people were assisted

Cobham Juvenile Justice Centre

- 12 group programs conducted
- 23 young people were assisted

Find out more:

nbmphn.com.au/DeadlyDreaming

The Nepean Linker Project

An Aboriginal and Torres Strait Islander peoples' specific service delivered by Greater Western Aboriginal Health Services (GWAHS) providing equitable access to appropriate alcohol and other drug, and mental health services in the Penrith area. Services include direct service delivery, care coordination, linkages and referrals.

- 50 clients were assisted

Find out more:

nbmphn.com.au/NepeanLinker

Nepean Linker Project

An Aboriginal man engaged with GWAHS through the Nepean Linker Project, seeking support for multiple complex challenges. His history included substance dependence, childhood trauma, periods of incarceration and homelessness. At the time of referral, he was receiving monthly anti-psychotic medication and required assistance with transport to appointments.

The client expressed a strong desire to improve his physical health and address his alcohol and drug dependence. In a pivotal moment of self-advocacy, he requested morning appointments to help avoid the temptation of drinking beforehand. This proactive step marked a significant turning point in his care, demonstrating his commitment to recovery and his ability to identify strategies that worked for him.

During routine check-ins, it was noted that the client was rapidly losing weight. Further investigation revealed that this was due to inconsistent access to food. In response, a collaborative care plan was developed with his GP, which included regular weight monitoring and referrals to food support services such as Meals on Wheels and Foodbank. He was also connected with the Liver Clinic for further medical assessment.

With ongoing support from the Nepean Linker Project, the client successfully applied for the National Disability Insurance Scheme (NDIS), securing long-term assistance tailored to his needs.

ALCOHOL AND OTHER DRUGS (AOD)

Aftercare and Relapse Prevention Program

A support program to prevent AOD relapse that includes treatment planning and weekly self-management and recovery training (SMART) groups, over a period of six months. We fund WHOS in Hawkesbury and Penrith, and Lives Lived Well in the Blue Mountains and Lithgow areas to deliver the programs.

- 422 clients assisted

Find out more:

nbmphn.com.au/AODinformation

Dianella Cottage

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

- 507 clients assisted through 2,231 individual occasions of service
- 324 group sessions provided

Find out more:

nbmphn.com.au/DianellaCottage

Dianella Cottage Katoomba

A patient attending Dianella Cottage Katoomba was struggling with substance use and feeling disconnected from her future. Although she had experienced periods of abstinence before, she described this episode of care as her first experience of personal recovery. A key difference was her engagement with a peer support worker for the first time.

The peer worker's belief in her potential became a turning point. Together, they explored her strengths and passions, leading her to reconnect with art. She was invited to take creative control of a group project, designing and painting a street library for Dianella Cottage as part of a social art group.

Initially hesitant, the patient was unsure about contributing to such a public piece. With encouragement, she embraced the opportunity. Her involvement quickly became transformative. She painted vibrant designs symbolising hope and resilience, inspiring others in the program to participate.

Working alongside the peer worker, she found not just artistic expression but a renewed sense of purpose and connection. As the street library took shape, so did her confidence. She began to see herself as an artist, a mentor and a valued community member.

The completed street library now stands proudly outside Dianella Cottage Katoomba, serving as a symbol of recovery and creativity.

With continued encouragement, the patient enrolled in a community services course at TAFE. She has since completed her studies and now works part-time in the sector.



“Painting that library taught me that I’m capable of so much more than I thought. It gave me hope and showed me I could be part of something bigger.”

WHOS (We Help Ourselves)

WHOS delivers a non-residential AOD day rehabilitation service in Hawkesbury and Penrith, structured for people at different stages of their recovery journey. The program offers assessment, treatment planning, counselling, case management and Aboriginal specific support and programs.

WHOS Hawkesbury

- 1,880 individual occasions of service
- 260 individual clients
- 551 group sessions providing 1,361 occasions of service

WHOS Hub Penrith

- 3,183 individual occasions of service
- 542 individual clients
- 653 group sessions providing 3,201 occasions of service

Find out more:
nbmaphn.com.au/WHOSHUB



L to R: Scott Hassett – Service Supervisor WHOS Hawkesbury and Penrith, Kirsty McLeod – Wentworth Healthcare Clinical Services Manager, Mental Health, Lizz Reay – Wentworth Healthcare CEO, Kylie Barbaschow – Community Services Worker, WHOS, Anne Rogers – Wentworth Healthcare Commissioning and Contracts Officer, Mental Health and Alcohol and Other Drugs, Wentworth Healthcare, Melissa O'Sullivan – Community Services Worker, WHOS, Gerard Byrne – Operations Manager WHOS Treatment Services, and Susan Templeman MP, Federal Member for Macquarie.

This year we officially launched WHOS Hawkesbury, a free alcohol and other drug service funded through the Federal Government's Community Health and Hospitals Program.

When it comes to supporting people with AOD issues, residential rehabilitation services aren't always the best fit for everyone. Some people can't commit to a residential program and this can act as a barrier to seeking help. That is why community-based support is so important.

The service plays a crucial role in supporting people to get well within their own community. AOD issues don't discriminate, and anyone can be impacted. There has been a lack of permanent and accessible services offering affordable or free community-based support in Hawkesbury – this service is now available to address this need.

A client was referred to WHOS Hawkesbury day rehabilitation program from the Hawkesbury Community Health team, after being admitted to the detox unit for daily drug and alcohol use over the past seven years.

WHOS Hawkesbury worked with the client to provide relapse prevention support, assistance with referrals to mental health services and help to find stable, affordable accommodation. They supported the client to identify and set goals to reduce alcohol and drug use, and continue to attend support groups and services, including a psychologist to stabilise their mental health diagnoses.

The client attends groups and case management sessions, weekly psychology appointments and has achieved their initial goals, but requires ongoing support. They have secured part-time employment through the Flourish program, stable public housing accommodation, and remain active with WHOS Hawkesbury to maintain routine and AOD support.

The client has not consumed any alcohol or other drugs for over two months, and stated that they feel safe, stable and motivated to continue building a healthy lifestyle – continuing to improve in official assessment scores since admission with WHOS.

“I find coming to WHOS Hawkesbury a positive experience, it aligns well with my schedule and needs. I have learnt so much. I still get cravings, but I’m able to manage them. I look forward to continued growth in managing challenges and remaining connected.”

Client



The Street University

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

Katoomba:

- 4,731 occasions of service
- 793 workshops delivered

Find out more:
nbmphn.com.au/TSUKatoomba

“I just want to let you know how grateful we are to the Noffs team for all their hard work with one of our students. They are really making a difference with this student, who is going through such a difficult time, and the practical support they are providing for her is invaluable.” Leigh Mclean, Deadly Dreaming Outreach Program, Deputy Principal, Portland Central School

“Thanks to you and your team for the support in 2024. I really appreciate how you and the team have worked with us and our students.” Andrew Finlay, Deputy Principal, Katoomba High School

Penrith:

- 4,506 individual occasions of service
- 684 workshops were delivered

Find out more:
nbmphn.com.au/TSUPenrith

“Just a quick email to say that the youth support workers are doing great work and wanted to let you know that their effort and collaboration with youth justice is greatly appreciated. Time and time again they show their commitment and drive to work with a complex group of young people and support my staff and convenors wholeheartedly. Their dedication is noted and appreciated.” Gaston Bonnet, Assistant Manager, Youth Justice Penrith



The Street University Katoomba (TSU)

An older teenager presented with ongoing cannabis use, nicotine dependence and binge drinking, having recently ceased methamphetamine use after a history of poly-substance use. Diagnosed with complex PTSD, depression, anxiety, bipolar and borderline personality disorder, the client was prescribed multiple medications and had experienced recent suicidal thoughts. The client's living situation was unstable, volatile and not conducive to recovery.

Initially hesitant to engage with external support, the client connected with TSU Katoomba, where they participated in workshops and later engaged in face-to-face counselling. Their goals included managing cannabis withdrawal, improving mental health stability and building self-confidence. Counsellors focused on psychoeducation, emotional regulation and communication skills.

Through therapy, the client developed a safety plan, learned various strategies and created a Cognitive Behavioural Therapy-based relapse prevention plan. They gained insight into the impact of substance use, nutrition, sleep and medication on their wellbeing. The client abstained from methamphetamine and cannabis during treatment, reconnected with their values and pursued goals such as regaining their driver's license, employment and independent housing.

The client identified and distanced themselves from unhealthy relationships, began a healthier relationship and developed a passion for cooking and exercise. The client accepted referrals to youth homelessness and employment services and despite challenges at work, continues to engage in healthy behaviours.

The client's treatment outcome scores improved consistently and they reported feeling safer, more stable and confident.

HEALTHY AGEING

WiseMind

Our WiseMind program assists residents of residential aged care homes (RACHs) with mild to moderate symptoms of mental illness, or who are experiencing early symptoms and are assessed as 'at risk' of developing a diagnosable mental illness. Services are delivered by mental health professionals including psychologists and mental health nurses. This year, the WiseMind program expanded from 26 to 27 RACHs.

- 389 people assisted
- 2,325 occasions of service

Find out more:

nbmphn.com.au/WiseMind

Mobile Occupational Therapy in Lithgow

We funded Tablelands Sports & Spinal Physiotherapy to provide a free occupational therapy (OT) service for older people living at home in Lithgow. This service includes an initial home visit by an OT to identify patient needs and develop a personalised intervention plan.

- 72 clients were assisted with in-home assessments
- 65 equipment requests
- 30 home modifications
- 56 additional home modification requests

Find out more:

nbmphn.com.au/MobileOT

"To have access to the WiseMind program and be able to talk was like having a weight lifted from my shoulders." Participant

"I have received a lot of positive feedback about the program. Residents have reported that it was great to have someone to listen to them." Senior RACH nurse

"A family recently requested that their mother (a resident) be re-referred to me as they had noticed the improvement in her mood when previously participating in the program." WiseMind clinician

"It took some time for Lithgow to get an occupational therapist. I was lucky the OT came into my life when she did. She cared about me. She made decisions that would help keep me safe. And she followed up to see that the home modifications worked." Client

"Extremely satisfied. Suggestions and issues were treated quickly and compassionately." Client

"Every aspect of my concerns were dealt with clearly and compassionately and follow up was always available." Client

"I feel much safer at home now with the changes 'OT' suggested and have been made. Also, the things she arranged for me are really helpful." Client



Kurrajong workshop.

Health Literacy for Consumers

We engaged MedicinesEd to deliver the Consumer Medicines Health Literacy workshops, empowers older people to improve their health literacy and proactively manage their own health with confidence.

- 10 workshops delivered
- 137 participants

Participants reported that the most useful topics included keeping a list of medicines, side effects and interactions, where to find good information and how to ask questions.

- 99% would recommend the workshop
- 46% improvement in correct label interpretation
- 77% reported improved confidence in where to find trusted information
- 61% felt more confident asking health professionals about medicines
- 73% felt they could now understand a pharmacy label

Overall, participants reported improved health literacy:

- 79% checked expiry dates when they previously wouldn't have
- 74% were more likely to ask about medicines
- 98% updated their medicine list
- 45% made a medicine list when they otherwise wouldn't have
- 30% shared their list with a trusted person

"Great delivery. Presenters were very knowledgeable and engaging, helping to make the topic fun and understandable." Participant

"I thought the workshop was outstanding. The information was fantastic and very helpful." Participant

"I think it is a great initiative for elderly people to have a good knowledge of the medicines they are consuming." Participant

"The workshop opened my eyes about medicines. More people need to go. It is so important." Participant

"This workshop was the most informative, practical and helpful session I have attended in recent times. Great, practical and well-presented handouts. Thank you so much." Participant



St Clair workshop.

Mental Health

Wellbeing Outreach Program

Following the success of the model used to support bushfire-affected communities after the Black Summer bushfires, Peppercorn Services delivered the Wellbeing Outreach Program to provide flexible, community-based wellbeing support in the Hawkesbury and Penrith for flood-affected residents. Services included individual and group assistance in informal settings.

The final six months of the program, which concluded in December 2024, focused on the Hawkesbury as a priority area.

- 50 clients assisted
- 631 individual support sessions provided
- 57 hours of community engagement conducted
- 22 organised groups and events attended

“As the Peppercorn Recovery Support Service approaches its conclusion, our team would like to take a moment to extend our heartfelt gratitude for the invaluable contribution and steadfast support you have provided to our service and the flood-impacted communities across the Hawkesbury-Nepean Valley over the past few years.

Since 2021, we have worked closely to support flood-affected communities across the region, with NBMPHN providing consistent advocacy, funding and on-the-ground engagement.

A pivotal moment in this partnership was the activation of the Wellbeing Outreach Program. This initiative addressed a critical gap in mental health support for clients hesitant to engage with external services due to stigma, mistrust and limited access. By embedding mental health professionals within Peppercorn’s trusted environment, the service facilitated seamless transitions, enabling immediate and familiar support.

The results were transformative. Clients previously resistant to mental health referrals began engaging, including some of the most difficult-to-reach individuals. This breakthrough not only improved client outcomes but also empowered Peppercorn staff to focus on broader recovery needs.

This partnership exemplifies how responsive, community-integrated mental health support can accelerate recovery and foster resilience.” Peppercorn Recovery Support Service

“You are one of the only people in my life I can talk to about my grief and feel truly heard.” Client

“Thank you for today, it helped me understand why I lie as I do, and that maybe I don’t need to do it anymore.” Client



Medicare Mental Health Centres

In February 2025, existing Head to Health Centres were rebranded as Medicare Mental Health Centres. Both the Hawkesbury and Penrith Centres offer free, walk-in mental health support, without the need for an appointment, referral or Medicare card. Delivered by Neami National, they provide access to trained mental health professionals and peer workers who can assist with short-term support or finding other services. The Hawkesbury Centre is open six days a week, including public holidays (except Sundays), and the Penrith Centre is open seven days a week, 365 days a year.

Hawkesbury Medicare Mental Health Centre

- 362 individuals assisted through 376 episodes of care and 3,553 service contacts
- Almost one-third of episodes of care closed due to treatment being completed with a pre- and post-treatment evaluation showing significant improvement

Penrith Medicare Mental Health Centre

- 899 individuals assisted through 987 episodes of care and 11,817 service contacts
- Over 50% of all episodes of care closed due to treatment being completed with a pre- and post-treatment evaluation showing significant improvement

Find out more:

nbmphn.com.au/HawkesburyMedicareMentalHealthCentre

nbmphn.com.au/PenrithMedicareMentalHealthCentre

► Read about the Medicare Mental Health Phone Service in the **Integrating Care** section on page 88.

Hawkesbury Medicare Mental Health Centre.



Support for when you're feeling down.

Call for mental health advice and to connect to a local service that is right for you.

medicare Mental Health
1800 595 212



Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

A client arrived at the Penrith Medicare Mental Health Centre in urgent need of support after being repeatedly turned away from hospital services. They disclosed experiencing strong urges to use drugs, auditory hallucinations, homelessness and a lack of access to a phone.

Upon arrival, they were welcomed into a safe, non-judgemental space where they connected with the clinical lead and mental health clinician. The team built rapport and provided immediate emotional support. They were given the opportunity to call their immediate family who lived out of state and who they hadn't contacted for a significant length of time.

Staff at the Centre also contacted the local Aboriginal health service to secure a same-day appointment and walked the client to the service due to their heightened anxiety. The clinician briefed the admin team to ensure continuity of care. The client, who had not been able to take their medication for a week, was later supported by a nurse practitioner at the Centre to access a prescription and begin a long-term psychiatric care plan. They were also connected with a service to access for housing support.



headspace

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

- In Hawkesbury, 424 young people assisted through 1,538 sessions
- In Katoomba, 227 young people assisted through 896 sessions
- In Lithgow, 417 young people assisted through 1,698 sessions
- In Penrith, 905 young people assisted through 3,831 sessions

headspace Hawkesbury

“A young person self-referred to headspace, seeking support for low mood, anxiety, suicidal thoughts and self-harming behaviours. These challenges were significantly affecting their day-to-day life and emotional wellbeing. Over the course of four months, the young person engaged in eight early treatment sessions with a youth access team clinician. The therapeutic approach focused on identifying and building on the young person's strengths, while introducing practical strategies such as urge surfing and emotional regulation techniques to help manage distressing thoughts and behaviours.

Throughout the treatment period, the young person showed steady improvement, both in their clinical presentation and in measurable outcomes. This progress was reflected in their 'My Life Tracker' score increasing from 55 at intake to 93 after eight sessions.

In the final sessions, the young person reported a noticeable uplift in mood and a reduction in anxiety. Most significantly, they shared that they had not engaged in self-harming behaviours for three consecutive months – which is a milestone that underscored the effectiveness of the intervention and the resilience they had developed. This case demonstrates the value of early intervention and personalised care in supporting young people through complex mental health challenges, and the potential for meaningful, sustained change when the right support is in place.” Portland High School



headspace Penrith

A young person was referred to headspace by her medical officer after experiencing severe bullying at school. The young person did not feel the school had adequately addressed her concerns and expressed that she no longer felt safe returning to the environment.

The young person completed two early treatment sessions and is now receiving ongoing support under a mental health treatment plan with a private practitioner. She has managed to attend school more, which is a significant achievement given the severity of her previous distress and avoidance. The collaborative efforts between clinicians, external services and the family have laid the foundation for continued engagement and recovery.



(fourth from left) The Hon Emma McBride – Assistant Minister for Mental Health and Suicide Prevention Assistant and Minister for Rural and Regional Health visiting headspace Lithgow.

headspace Lithgow

The Rainbow Group visits from headspace have played a vital role in fostering a positive and inclusive atmosphere at Portland Central School. Their presence has significantly enhanced the wellbeing of the school community by offering students a broader perspective and reinforcing the values of diversity, acceptance and inclusivity. For a school known for its isolation and disadvantage, these interactions have been especially meaningful. They help bridge the gap for students by providing opportunities to engage with people from diverse backgrounds and lived experiences, which many may not otherwise encounter.

These visits serve as a powerful reminder to students that they are not alone and that safe, supportive spaces exist within their school environment. The involvement of headspace helps ensure that students know where to turn for help and that resources are available to support their mental health and wellbeing. The impact of these visits goes beyond the classroom, contributing to a culture of care and connection. Portland Central is deeply grateful for the ongoing support from headspace, which continues to make a lasting difference in the lives of its students.

headspace Katoomba

A young person presented to headspace experiencing symptoms of depression and feeling quite low. At the beginning of his engagement, the young person expressed feelings of stigma and shame surrounding the challenges he was facing, which made it difficult for him to open up during sessions. To help normalise his experience and create a more comfortable environment, the young person was referred to a peer support worker who attended the initial sessions. This approach helped the young person feel less alone and more understood, gradually building his confidence to speak about his emotions and experiences.

By the sixth session, the young person had become noticeably more comfortable discussing his mental health and was able to express his emotions more freely. He shared that simply having someone to talk to had been incredibly beneficial and had contributed to an improvement in his overall wellbeing. Through psychoeducation, the young person gained a deeper understanding of his mental health and learned how to sit with and process his emotions more effectively.

In addition to clinical support, the young person began attending group activities, where he discovered new hobbies. These activities provided a positive outlet and a coping mechanism during difficult times, offering both entertainment and emotional relief.

headspace Lithgow Youth Plus

A brief intervention service available in the Lithgow area offering young people aged 12-25 who are in crisis. A set of specific individual appointments in which a clinician will help the young person navigate their situation and link them with further services as needed.

- 25 young people assisted through 261 occasions of service

Find out more:
nbmphn.com.au/YouthPlus

headspace Youth Early Psychosis Program

This early intervention program supports young people aged 12-25 in the Blue Mountains, Hawkesbury and Penrith areas who are experiencing, or at high risk of, a first episode of psychosis, by offering co-ordinated care from a multidisciplinary team. The program offers a comprehensive recovery-oriented service to meet the needs of this group.

- 381 young people assisted through 10,198 occasions of service

Find out more:
nbmphn.com.au/hYEPP

Youth Enhanced Support Service (YESS)

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

- 247 young people assisted through 2,832 occasions of service

Find out more:
nbmphn.com.au/YESS

headspace Youth Early Psychosis Program (hYEPP)

A young person presented with voice hearing, self-harm and challenges stemming from developmental trauma, which contributed to low self-esteem and difficulties in relationships. His parents separated during childhood and he was raised by his mother, whose drinking and behaviour impacted his sense of attachment and belonging. The young person felt emotionally neglected due to high expectations and a lack of support, compounded by abuse from his brother and the absence of parental intervention, which undermined his ability to trust others.

Throughout his year with hYEPP, the young person attended weekly sessions and engaged with other professionals, including a dietician. Treatment focused on psychoeducation, stress management and self-care to improve emotional regulation. His commitment to the program led to significant progress. He developed stronger coping skills, gained insight into his mental health and built a sense of self-worth, enabling him to set healthy boundaries and navigate relationships more confidently.

Commonwealth Psychosocial Support (CPS)

We fund Flourish Australia to provide CPS across the region to those aged 16 years and over, living with severe episodic mental health illness with psychosocial supports. This program works with individuals to build connections with community through group sessions as well as one-on-one support to encourage skill development relating to increased independence. Support also includes assisting those eligible for NDIS Access Requests.

- 504 individuals over 653 episodes of care and 10,877 service contacts
- 33% of episode and treatment conclusions reporting significant improvement
- 60 individuals assisted with NDIS applications
- 52% increase in number of individuals assisted compared to last financial year

Find out more:
nbmphn.com.au/CPS

CPS Lithgow

A client from Lithgow and their child had been living with a friend. This living arrangement was ending abruptly, putting them at imminent risk of homelessness.

The client had challenges trying to find appropriate housing that suited their budget and allowed them to bring their pet. They also needed time off to find their new home, and the stress of their situation was beginning to impact on their health. The situation prompted the client to analyse their income with the help of their CPS support worker and begin to search for rental properties in Lithgow within their budget. The CPS support worker also connected the client with potential financial support options so they could save or augment their savings towards the initial rental bond deposit.

Referrals to other organisations for food goods and basic furnishings were made by the CPS worker, who provided transport when needed and negotiated rental agreements on their behalf, enabling them to move into their own pet-friendly rental space with adequate furnishing for them and their child. Exit interview notes reported them as describing the services received as “a timely life saver.”

YESS Program

A young person who had recently been finding it difficult to engage in therapeutic sessions showed meaningful progress after being linked with a peer support coach. Historically, the young person struggled to remain in sessions for more than 30 minutes. However, in their first session with the peer support coach, the young person remained engaged for a full 50 minutes, which is a significant milestone that marked a shift in their ability to connect with support services.

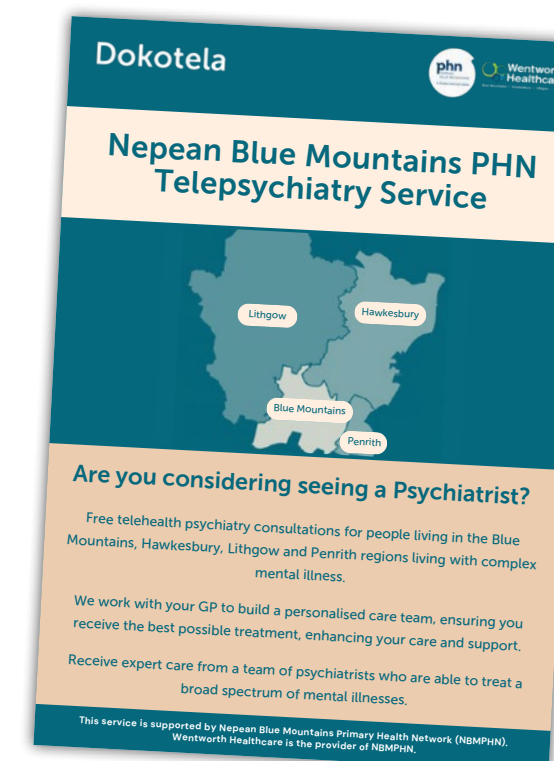
The presence of the peer support coach provided an additional layer of care, helping the young person to feel safe and supported while sharing their experiences. Feedback from both the peer support coach and the young person’s mother has been positive, highlighting the impact of peer-led support in enhancing engagement and emotional safety.

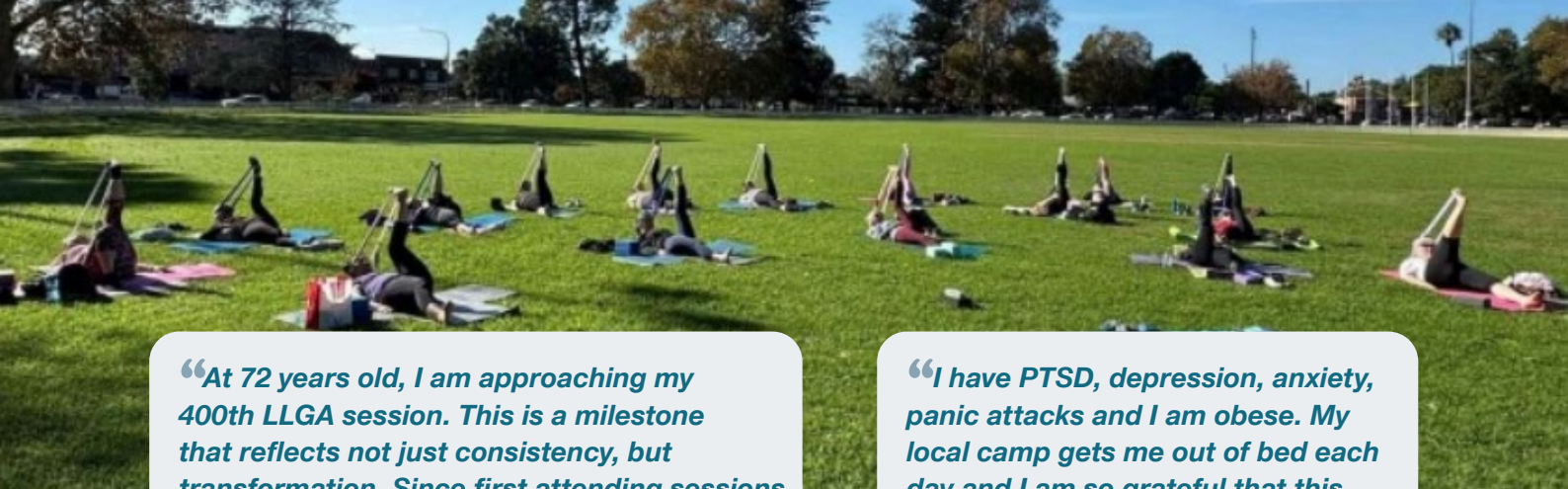
Telepsychiatry Service

We fund Dokotela to provide telepsychiatry services with no cost to the patient. The service provides access to over 40 experienced psychiatrists, with a range of different specialities, who work collaboratively within a multidisciplinary team of mental health professionals. Appointments are delivered via telehealth at the patient’s home, office of a support service or their nominated GP practice.

- 554 people assisted across 1,179 occasions of service
- 647 referrals

Find out more:
nbmphn.com.au/Telepsychiatry





“At 72 years old, I am approaching my 400th LLGA session. This is a milestone that reflects not just consistency, but transformation. Since first attending sessions in Penrith and now regularly at St Marys, my fitness, confidence, wellbeing and mental health are the best they’ve ever been, even compared to my younger years.” *Live Life, Get Active participant*

“I have PTSD, depression, anxiety, panic attacks and I am obese. My local camp gets me out of bed each day and I am so grateful that this camp is free with online support including nutrition, wellness, online training and more.” *Live Life, Get Active participant*



Mental Health Nurse Incentive Program

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

- 9 mental health nurses assisted in the program
- Assisted 144 people across 4,410 sessions

Find out more:
nbmphn.com.au/MHNIP

Live Life Get Active

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

- 7 locations – two in Blue Mountains, two in Hawkesbury, one in Lithgow and two in Penrith
- 654 active clients across 13,811 occasions of service

Find out more:
nbmphn.com.au/LiveLifeGetActiveProgram

Psychological Therapy Services

This program provides low-cost short term psychological support for people experiencing mild to moderate mental health issues. The program improves access for people who face additional barriers such as financial hardship and geographical disadvantage.

- 2,478 patients resulted in 17,011 occasions of service (including people at low to moderate risk of suicide or self-harm)
- 79 local providers
- 394 suicide prevention referrals (SOS)

Find out more:
nbmphn.com.au/PTS

Bushfire and Flood Psychological Therapy Services

The Bushfire and Flood streams delivered a final 12-month extension to the program, concluding in June 2025. This extension provided trauma-informed mental health support to individuals affected by prolonged exposure to adverse weather events and natural disasters across the region. This program did not require a GP referral or mental health treatment plan.

- 115 new referrals were accepted
- 142 patients
- 950 individual therapy sessions
- 31 trauma trained mental health professionals

Expressive Therapy Programs

We funded several short-term grants to deliver therapeutic programs that used artistic and expressive activities to help people with low intensity mental health needs improve their overall wellbeing.

- 7 grants
- 233 group sessions
- 315 individual participants
- 235 individual therapy sessions

“We feel incredibly fortunate to have the KidsXpress program. For many of our students, accessing off-site services just isn’t possible and our families face real challenges in getting the support they need. KidsXpress has truly been a vital resource for our community.” *Principal, Kingswood Park Public School*

“We didn’t anticipate such a significant change in such a short time. Behaviours have noticeably settled, and we’ve seen remarkable transformations in individual students. One child who was once overwhelmed with anxiety is now calm and prepared for high school – a transition we were concerned she would not manage. Parents are also seeing these positive changes at home. We only wish we could keep the KidsXpress program here forever.” *Assistant Principal and School Wellbeing Leader, Kingwood Park Public School*

Noro Music Therapy

One participant demonstrated significant therapeutic progress, transitioning from initial reservation to confident musical expression. This individual progressed to planning a performance for family members, representing substantial personal growth and therapeutic breakthrough.

“Music has done so much for me. This group has done so much for me.” *Noro Music Therapy participant*

“You’ve helped me realise I can sing and given me hope that I can bring all of me together.” *Noro Music Therapy participant*

“Music is the highlight of my week.” *Noro Music Therapy participant*



STARTTS Participants.

Suicide Prevention

“My life took a dark turn as I lost direction and returned to unhealthy habits such as excessive drinking. I attended a workshop called 5 ways to wellbeing. It was there that I was moved to reflect and focus on my mental health. They have made an astronomical difference to my days. I’ve found a sense of structure and purpose that I’d been missing and for the first time in years, I can genuinely say I feel happy.”

STARTTS participant

Community-Led Suicide Prevention Program

We fund the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) to provide culturally sensitive programs for the refugee community. The program runs throughout the Blue Mountains, Hawkesbury and Penrith areas, and provides the South Sudanese and Arabic speaking communities with health literacy and suicide prevention training by building the capacity and knowledge of local leaders.

Through a series of formal training in language, community discussions across generations and wellbeing groups, the effect upon these communities has been overwhelming.

- 735 participants

Top Blokes

Top Blokes empowers young men aged 10 to 24 through programs focused on mental health, leadership and positive decision-making. These programs foster healthy masculinities, build respectful friendships and redefine what it means to be a ‘top bloke’. The program equips young men to lead with purpose, empathy and strength in today’s evolving world. It has also led to noticeable improvements in physical wellbeing, social behaviour and school attendance.

- 80 participants

“It helped me with leadership, teamwork, resilience, and communication.” Top Blokes participant

“That drugs can affect more than just you.” Top Blokes participant

“It has made me realise more of what leadership is and how to treat people.” Top Blokes participant

“Helped me with relationships and friendship.” Top Blokes participant

“Talking about your emotions doesn’t make you less of a man.” Top Blokes participant

“Top Blokes Foundation would like to thank NBMPHN for their support and investment through the community-led suicide prevention programs. We are pleased with the level of outcome and impact achieved in the program and would like to thank our participants for all their hard work and dedication.

We would also like to thank our school partners for all their support throughout the program which has helped create a safer and more cohesive environment for all. We hope the outcomes achieved during the program will continue to grow into stronger outcomes for both the young men and the wider community.”

Suicide Prevention Training

Suicidal distress is a human response to overwhelming suffering and we all have a role in offering immediate help. Tragically, suicide rates in our region exceed the state average and signs of distress are often missed.

Building on community-led training rolled out in response to the 2019/2020 bushfires, we funded several organisations to assist people in the community to recognise and support those in distress. We also conducted a Suicide Prevention Community Training Survey to ascertain what training the community needed, receiving 160 engaged responses.

LivingWorks Australia were funded to deliver Assisted Suicide Intervention Skills Training (ASIST) and SafeTALK training, including SafeTALK LGBTQIA+ and I-ASIST (Indigenous ASIST) for a total of:

- 9 community events with 182 attendees

Further workshops included:

- SafeTALK, ASIST, Mental Health First Aid, Teen Mental Health First Aid delivered by Regional Counselling (formerly Lifeline Central West)
- Advanced Training in Suicide Prevention and Talking About Suicide in Practice delivered by Black Dog Institute
- Touch Points and Lived Experience Informed Suicide Literacy Workshops delivered by Roses in the Ocean

Delivering a total of:

- 29 workshops with 631 participants

“When members of our team seek further training, it enriches the collective knowledge base of our peer workforce and the safety of our Blue Mountains community.”

Blue Mountains Safe Space for Suicide Prevention Inc.

“Thank you for bringing together community to support each other... and those struggling or burdened with mental health or other battles. I feel privileged to be in the presence of such amazing people.”

Roses in the Ocean Lived Experience Information Suicide Literacy Training participant

“Awesome support that made me feel safe and enjoy the workshop.”

Roses in the Ocean Lived Experience Information Suicide Literacy Training participant

Teen Mental Health First Aid

High school staff in the Blue Mountains and Lithgow areas identified that students were experiencing mental health challenges due to recent traumatic events. Teen Mental Health First Aid workshops were delivered to local high schools in the Blue Mountains, Lithgow and Penrith areas by Mountains Youth Services Inc (MYST). Across three schools, approximately 285 students participated in this training.

Additionally, MYST invited six teachers from Nepean Creative and Performing Arts High School to participate in Youth Mental Health First Aid training, enabling staff to continue supporting students as needed. Staff reported an increase in students seeking additional support, engaging in content and improved relationships with peers and friendship groups.

“At first I wasn’t interested but I ended up learning a lot.” Teen Mental Health First Aid participant

“It has been good to learn how other people feel with mental health issues.” Teen Mental Health First Aid participant

Suicide Prevention Survey Results

Building community capacity to support those in distress is key to suicide prevention. We asked the community what training they needed, with strong interest shown in supporting young people, people with disabilities and older adults. We are now exploring tailored training to better equip communities to help these identified groups.

- 160 responses

“The community desperately needs more mental health support and wellbeing training. This is a fantastic initiative. Too many people fall through the gaps, too many services have staff that are not trauma or mental health informed when it shapes their every day without them realising.”
Blue Mountains survey responder

“I’m mainly interested due to a family member suffering with depression, I want to be able to help.”
Lithgow survey responder

“I just need an effective method to identify when there’s a real risk of suicide and then the basic first steps.”
Hawkesbury survey responder

Seek Out Support (SOS)

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

- 41 mental health professionals
- 394 new referrals
- 446 clients assisted through 2,634 occasions of service

Find out more:
nbmphn.com.au/SOS

► Read about other Suicide Prevention initiatives in our **Integrating Care** section from page 88.

“A person I have been supporting through The Way Back program has been improving their mental health by building a great support network. They do this by continuously showing up for appointments and using the time with The Way Back to suit their needs.

They actively communicate what is a priority and what could wait according to their current situation. This person has shared that their confidence has grown and as a result, they are actively bettering themselves through community programs or self-help programs. During the time with The Way Back they have had their ups and downs with suicidal thoughts, feelings and behaviours, however as of recently, they are having next to no suicidal ideation.

This can be seen in the outcome measures we have used together. This person expressed feeling proud of their choices which I can happily agree with.”
Peer Support Coordinator

The Way Back Service Penrith

This program is a vital component of the Universal Aftercare initiative delivered by Stride Mental Health. The program offers non-clinical psychological support services to individuals who have recently been discharged from hospital following a suicide attempt or crisis for up to three months. This dedicated program focuses on providing a supportive environment where healing and growth takes place.

- 65 new clients were supported
- From the 65 clients, 9 individuals identified as Aboriginal and 7 individuals identified as members of the LGBTQI+ community

► Read about other Suicide Prevention initiatives in our **Integrating Care** section from page 88.



POPULATION HEALTH

After Hours Services

We fund a variety of services across the region to facilitate access to primary healthcare services and resources outside of the normal business hours when regular GPs are unavailable. This helps prevent people from unnecessarily presenting at hospital emergency rooms.

- 4 services funded, including after hours clinics in Lithgow and Penrith, a home visiting doctor service for the lower Blue Mountains and a 24 hour pharmacy in Penrith
- 32,648 consultations provided by after-hours GP services
- 781 consultations by National Home Doctor
- 21,158 people used Penrith 24 Hour Pharmacy in the after-hours period

We developed and continue to maintain the Doctors Closed website to help community members locate available GP services when their regular practice is closed.

- 21,613 visits to Doctor Closed website
- 434,874 people reached through Doctor Closed Facebook advertising

Urgent Care

Urgent care services improve access to primary care services, offering an alternative to emergency departments for urgent but non-life-threatening issues when a GP isn't available.

Penrith Medicare Urgent Care Clinic (MUCC)

Funded by the Department of Health, Disability and Ageing, the clinic is open 8am to 8pm, seven days a week, 365 days a year. Walk-ins are welcome and services are free for Medicare cardholders.

- 7,488 occasions of service
- 5,890 patients were treated and referred home
- 5,522 patients were seen by a clinician with less than a 20 minute wait
- Without the MUCC 44% of patients would have attended the Emergency Department
- 25-44 year-olds were the most frequent patients seen
- Main reasons for overall attendance were injury, laceration and pain

North Richmond Urgent Care Service (UCS)

Funded by NSW Health, the service is open 8am to 8pm, seven days a week, 365 days a year. Access via healthdirect on 1800 022 222.

- 837 unique patients attended the UCS
- 98% of patients expressed their satisfaction level with care at the UCS as 'good' or 'very good'
- 93% of respondents would be 'likely' or 'very likely' to call healthdirect again

Find out more:

nbmphn.com.au/UrgentCare

► Read about other Population Health initiatives in our **Integrating Care** section on page 94 and the **Supporting Primary Healthcare** section on page 69

“I had ‘redness’ that had developed along the suture line from my recent pacemaker implant. The medication you provided did its job and the redness has gone. Thank you! Equally importantly though, I wanted to say thank you for your empathetic and caring manner. You are a credit to your profession and I consider myself very fortunate to have been cared by you.”
Penrith MUCC patient

“As a mechanic, it’s easy to injure yourself. I have been here twice for injuries and have received professional care promptly each time. I’m so glad I found your Urgent Care Clinic! This place is unlike any other medical centre around.”
Penrith MUCC patient

- Over 70% of patients were seen by a clinician either 'on time or early' or in 'less than 30-minutes'
- 84% of patients with urgent, but non-life-threatening issues were treated at the UCS and referred home, while 10% were referred to the emergency department



Diabetes Multidisciplinary Team Pilot Project Handbook



Diabetes Multidisciplinary Team (MDT) Pilot

The Diabetes MDT Pilot commenced in May 2025, offering individuals with type 2 diabetes in eastern Penrith complimentary access to diabetes education and dietetics services delivered in their general practice setting.

The pilot demonstrated what is required for multidisciplinary team care to work in small general practice settings, while improving collaboration between primary care health professionals involved in caring for people with type 2 diabetes.

- 4 general practitioners involved and referring patients
- 4 practice administrators/managers actively involved
- 3 allied health providers commissioned to provide services
- 4 practice orientations provided before service commencement
- 64 patients have accessed the service for an initial consultation with allied health providers

Read more:
nbmphn.com.au/MDT-Handbook

“I applied a continuous glucose monitor (CGM) on a patient who has had type 2 diabetes for more than 20 years. This patient was very low on motivation and did not test blood glucose levels at all. The client was taking insulin twice per day. Their most recent haemoglobin A1c (HbA1c) was 11%. Since wearing the trial CGM, the client has continued to purchase ongoing sensors to monitor blood glucose levels. From one month of data so far, the client’s estimated HBA1C is now 7.7%. Continuing this form of management will significantly improve the client’s diabetes and further slow the progress of diabetes complications currently being impacted. The client’s behaviour has changed, and they are more open to learning about their diabetes and what is impacting glucose level fluctuations.” *Commissioned provider*

“Patient feedback has been positive. A few patients who have previously seen other dietitians still find this service useful as it updates them on the latest dietary knowledge. They often have forgotten the previous information, not found it useful or have received lots of misinformation since then. The positive feedback has been reflected from their direct feedback to the clinic and doctors.” *Commissioned provider*

“Collaborating with a GP and a dietitian to manage people living with type 2 diabetes has been a highly rewarding experience that has significantly enhanced my job satisfaction. Working as part of a MDT allows us to take a holistic approach, combining medical management, nutritional guidance and lifestyle interventions to support the participant’s health goals. For example, being able to see each other’s notes and reinforce advice of the MDT shows the patient we are all on the same page and helps support the intervention. The open communication and shared decision-making among professionals have led to noticeable improvements in patient’s blood sugar levels, energy and confidence in managing their condition. Seeing these positive outcomes and knowing that our collaborative efforts contributed to meaningful change has reinforced my passion for providing person-centred, integrated care.” *Commissioned provider*



VULNERABLE COMMUNITIES

Chronic Obstructive Pulmonary Disease Services

CALM Program

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

- 29 people completed the program with 4 programs completed within the year
- 247 people have completed the program since 2018

Find out more:
nbmphn.com.au/COPD

Lungs in Action

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

- 101 groups were held with an average of 15 participants in each group
- 20 participants completed the participant survey

Post-program survey results:

- 100% of participants reported that the program had a positive effect on their mood, enabled them to remain independent and increased their confidence in managing their COPD and knowing when they need to see their GP

Find out more:
nbmphn.com.au/LungHealth

“All the staff were helpful and good natured. Very encouraging!” *CALM Program participant*

“The overall education gave me a better understanding of my condition and the means of improving. The talks and literature are very helpful.” *CALM Program participant*

“I would like the program to continue as it is a good exercise and for COPD and is very helpful for COPD by keeping my lungs moving.” *CALM Program participant*

“I have better strategies for managing breathlessness. I will continue to exercise.” *CALM Program participant*

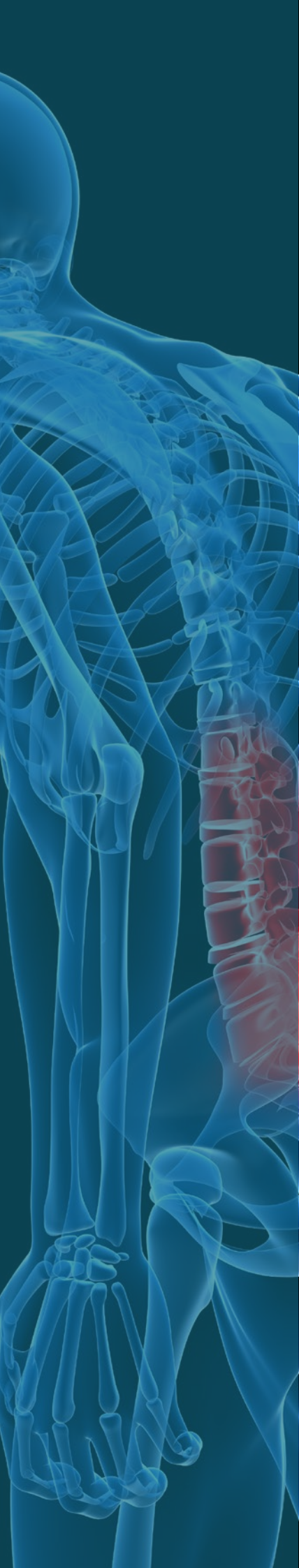
“My lungs would be a lot worse without your program.” *Lungs in Action program participant*

“This program has increased my fitness.” *Lungs in Action program participant*

“Lungs in Action is fantastic, it helps me so much.” *Lungs in Action program participant*

“The classes I attend are amazing with great instructors.” *Lungs in Action program participant*





Chronic Pain Management Program

Chronic pain affects more than 3.6 million Australians and remains the leading cause of disability nationwide. This six-week small group program in Lithgow combines exercise with practical education to help participants living with low to moderate chronic pain. Through guided self-management strategies, the program improves functional capacity, builds confidence and enhances quality of life.

- 4 programs
- 31 participants
- 85% of program participants completing the program reported an improvement in each of the patient outcome measures
- 83% of participants who completed the program reported a reduction in their pain levels and ability to re-engage in social activities that previously they could not participate in due to their pain

Find out more:
nbmphn.com.au/chronic-pain

“Liz was wonderful, came away with lots of tools to use and she was great to talk to.” Chronic Pain Management Program participant

“The program has helped me come to the realisation that my pain won’t vanish, but I am learning what to do to manage it better.” Chronic Pain Management Program participant

Chronic Pain Management Program

At the start of the program, participants were reporting regular pain flare ups. During week one, pacing is discussed in relation to the ‘boom-bust’ cycle (in a ‘boom’ phase participants feel relatively good, with reduced pain and increased energy levels, in a ‘bust’ phase, participants feel increased pain and fatigue and need to reduce activity levels). This phase can last for hours, days or weeks.

Participants were able to recognise that their pain flare ups were related to the boom-bust cycle. Through the program, participants learn how to pace their activity levels, and break down activities into smaller, more manageable steps to enable them to manage their pain better.

By implementing pacing, participants reported feeling more empowered to be gradually work towards the longer-term goals including packing up and de-cluttering their houses, engaging in home-based cleaning activities and engaging in regular physical/ social engagement activities. After covering this theory in week one, participants did not report any major pain flare ups throughout the duration of the program.

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

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

- 20 children assisted across 29 occasions of service

Find out more:
nbmphn.com.au/OutreachSpeechTherapist

Lithgow Outreach Speech Therapy Program

Since beginning speech therapy, a five-year-old participant has made significant progress in both communication and confidence. Now attending Kindergarten, he continues his therapy journey with support from his school, which has incorporated some of his exercises into the classroom routine.

His ability to engage in conversation has noticeably improved, he now answers questions and interacts more freely, reflecting a growing sense of self-assurance. As his speech develops, the positive impact on his self-esteem is becoming increasingly evident.

Before therapy, his mother often acted as his interpreter during social interactions due to his limited verbal skills. Now, she’s able to take a step back, allowing him space to find his own words and express himself. While he still has a way to go, the combination of ongoing therapy, supportive schooling and opportunities to build social skills is helping him grow into a more confident communicator.

Healthy Eating Active Lifestyle (HEAL) Program

The HEAL program is an evidence-based lifestyle program helping adults to make life-long changes to their health. It supports participants to move more, eat better and feel more confident managing their health and wellbeing.

The HEAL program is suitable for people at risk of cardiovascular disease or type 2 diabetes. Participants are empowered to improve their nutrition knowledge and reduce sedentary behaviours through a series of weekly education, individual goal-setting and supervised education classes over an 8-week period.

- 3 programs run
- 31 participants with a waitlist of 38
- 100% of program participants reported an improvement in their overall fitness levels at the end of the 8-week program, with many reporting that the program was beneficial to creating lifestyle changes and a gentle way to commence low impact exercise suitable for their starting point

Find out more:
nbmphn.com.au/HEAL



Outreach Clinics

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

- 1,662 service occasions across all three clinics

Healthy Ears, Better Hearing, Better Listening

- 258 individual consultations over 40 clinic days
- 94 consultations with Aboriginal patients

Paediatric Outreach Clinic

- 419 individual consultations over 42 clinic days
- 326 consultations with Aboriginal patients
- 90 telehealth consultations

Endocrinology Outreach Clinic

- 867 individual consultations over 25 clinic days
- 59 consultations with Aboriginal patients

Find out more:

nbmphn.com.au/OutreachServices



SUPPORTING PRIMARY HEALTHCARE

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

Wentworth Healthcare's Primary Care Engagement Team.

PRIORITY AREAS

HEALTH WORKFORCE

- Supporting General Practice
- MyMedicare
- General Practice Satisfaction Survey
- Quality Improvement in General Practice
- Practice Nurse Engagement
- Online Peer-to-Peer Networking
- Workforce Support
- Workforce Planning and Prioritisation Program
- Continuing Professional Development
- Suicide Prevention Training

DIGITAL HEALTH

- Supporting the Uptake of Digital Health
- Digital Health Maturity Assessment Project
- Data Analysis Support
- My Health Record
- ePrescribing and SafeScript
- Secure Messaging
- LUMOS

DISASTER AND EMERGENCY

- Disaster and Emergency Management
- Working with RACGP

HEALTHY AGEING

- General Practice in Aged Care Incentive
- Aged Care Telehealth and After-Hours Support
- RACH Disaster Preparedness
- Supporting Residential Aged Care
- Healthy Ageing Quality Improvement Collaborative
- Healthy Ageing Quality Improvement – Mobility

POPULATION HEALTH

- Childhood Immunisation Quality Improvement Program
- Be Your Own Health Hero Campaign
- Winter Strategy Quality Improvement Program
- Nurse Immunisation Scholarships
- Diabetes Management Quality Improvement Collaborative
- Advance Care Planning
- Palliative Care GP Education
- Aboriginal Health
- Aboriginal Cultural Awareness Training

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

HEALTH WORKFORCE

Supporting General Practice

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

- 2,747 support activities including 814 practice visits across 132 practices
- 5 practices were assisted to obtain accreditation for the first time
- 82% of total practices are accredited
- 97% of Accredited practices share de-identified data with us

MyMedicare

As part of the Strengthening Medicare reforms, the Australian Government MyMedicare initiative was designed to formalise the continuity of care between patients and their preferred general practice. We played a pivotal role in supporting general practices to register for, and understand the requirements of, participating in the MyMedicare program.

The PCEOs provided targeted support to general practices navigating the process, particularly for those undertaking accreditation for the first time. This included tailored guidance, resource sharing and connecting practices with relevant accreditation bodies to ensure they met the necessary standards to participate in MyMedicare.

The PCEO team provided support to practices with patient registrations and rollout, including the General Practice in Aged Care Incentive (GPACI) program, to improve patient outcomes and foster collaborative healthcare delivery.

- 108 practice visits, 66 phone calls and 116 correspondences provided by the PCEO team
- 97% of eligible practices registered
- 82% of total practices are registered

We implemented a new fortnightly email newsletter to support primary care to understand the changes with MyMedicare. This publication focused on the 'why' of MyMedicare and provided practical steps for practices to take, to support change within their practice. Topics included the General Practice in Aged Care Incentive (GPACI) and preparing your practice for chronic condition management changes.

- Commenced in April 2025, with 7 editions sent
- 4,609 total emails sent
- 55% average email open rate (average open rate for primary healthcare emails in Australia is around 28%)

Find out more:
nbmphn.com.au/MyMedicare



Responding to Continuing Professional Development (CPD) Needs in General Practice

The General Practice Satisfaction Survey identified a diverse range of CPD and education priorities, including updated approaches to chronic condition management, immunisation, operational training such as MBS billing, triage, cardiopulmonary resuscitation (CPR) and accreditation, as well as emerging focus areas like digital health and cybersecurity. We delivered several initiatives:

- **CPR Training:** delivered to clinical and non-clinical staff, focusing on basic and advanced life support. Reinforced emergency response protocols within practices.
- **Triage in general practice:** tailored sessions for reception and administration staff. Covered patient prioritisation, communication strategies and escalation pathways, improving confidence and consistency in front-line patient interactions.
- **Cybersecurity awareness:** addressed growing concerns around data privacy and digital threats, including practical guidance on secure systems, password hygiene and breach response for both clinical and administrative teams.
- **Childhood Immunisation Quality Improvement (QI):** focused on improving vaccination rates and cold chain management, including updates on immunisation schedules and reporting requirements. Supported by data-driven QI tools and peer discussion.

We saw increased engagement from practice staff across disciplines, with positive feedback on relevance and applicability of training. With the strengthened alignment between CPD offerings and practice needs, practices were more prepared for accreditation and quality improvement activities.

Our PCEO team continues to monitor CPD needs, with expanded offerings to include mental health, billing workshops and nurse-specific modules, as well as collaborative CPD models involving GPs and allied health.

General Practice Satisfaction Survey

As part of our ongoing commitment to improving support for general practices, we undertook a comprehensive redesign of our General Practice Satisfaction Survey. The survey asked respondents to indicate their likelihood of promoting our services to other practices.

Since the launch of the revised survey in October 2024:

- 72 responses were received
- Overwhelmingly positive results, with a Net Promoter Score of 82, exceeding the benchmark score of 70, indicating a strong level of satisfaction and endorsement from participating practices

Responses highlighted the need for more educational opportunities specifically tailored to practice administration staff. In response, we organised and delivered a series of targeted training events including three triage workshops, aimed at enhancing front-line decision-making and patient flow management, and two CPR training sessions to ensure administrative staff are equipped with essential life-saving skills.



Quality Improvement in General Practice

The Quality Improvement Practice Incentive Program (PIP QI) supported accredited practices that commit to improving the care they provide to their patients.

- 98 practices registered for PIP QI

The PCEO team initiated a quality improvement (QI) initiative to support eligible general practices in integrating their clinical information systems with the National Cancer Screening Register (NCSR).

- 11 practices integrated their systems, a 23.9% increase

Integrating clinical systems with the NCSR gave GPs real-time access to patients' complete screening histories for bowel and cervical cancer. This streamlined practice workflows allowing actions to be completed directly within clinical software. With immediate access to screening status during consultations, GPs had timely, personalised conversations to encourage life-saving screening programs. The team will continue collaborating with general practices to support further integrations with the NCSR, including lung cancer screening.

We also offered QI programs to practices, including diabetes, healthy ageing and winter strategy. These programs provided practices the opportunity for peer-to-peer learning with like-minded practices with the added support and structure associated with a defined approach.

Practice Nurse Engagement

Primary care nurses played a vital role in delivering safe, efficient and high-quality care across our region. We observed a steady increase in the number of nurses joining local practices. To support this growing workforce, our nurse orientation sessions offered new practice nurses tailored local guidance, practical resources and the support needed to quickly integrate into general practice.

- 238 practice nurses employed in the region
- 22 practice nurse orientations completed
- 39 practice nurse support sessions delivered

Read more:
nbmphn.com.au/PracticeNurseSupport

Online Peer-to-Peer Networking

To support information sharing and peer support amongst health professionals in our region, we administer and moderate closed Facebook groups for GP registrars, practice managers, health professionals, and practice nurses. The Practice Nurse Network is highly engaged, with members regularly posting questions and advice and sharing resources and information about nursing in general practice.

- 235 Health Professionals Group members
- 189 Practice Nurse Network members
- 106 Practice Managers Group members
- 42 GP Registrars Group members

Supporting Practice Nurses Through Orientation and Education

Recognising the unique challenges faced by nurses transitioning from hospital settings into general practice and newly graduated nurses, our PCEOs delivered a structured orientation and support program across our region. They conducted 22 nurse orientation visits that provided tailored support to help nurses adapt to the general practice environment.

The visits focused on equipping nurses with practical knowledge and tools, including updates on chronic condition management, immunisation schedules (both National Immunisation Program and state-based) and guidance on accessing the Australian Immunisation Register (AIR) through clinical software. Cold chain management was also a key focus, with nurses supported to complete the required Health Education and Training Institute (HETI) training and understand protocols for vaccine storage and handling.

Each nurse received comprehensive orientation resources including a chronic disease guidelines booklet – a valuable reference guide covering clinical tasks, infection control, digital health and quality improvement. Feedback from participants highlighted the usefulness of this resource, with several nurses expressing surprise and appreciation for the depth of support and the quality of the interaction provided by the nurse-led mentor during their orientation.

This initiative has not only enhanced the confidence and capability of new practice nurses but has also strengthened the overall capacity of general practices to deliver safe, high-quality and patient-centred care.

“Thanks for the PHN session your staff ran recently for our clinic, it was very helpful! We are trying to put together a practice nurse folder with resources for our clinic.”

Practice staff

Workforce Support

We continue to develop a sustainable and skilled primary healthcare workforce through initiatives that attract, recruit and retain primary health professionals. We coordinate a job matching service by advertising local primary healthcare positions, receiving applications from healthcare job seekers, and connecting local practices with potential, suitable candidates, delivering substantial results in supporting and strengthening general practice across the region.

- 501 support consultations
- 64 job vacancies advertised across 30 practices
- 131 GP registrars per year maintained
- 32 face-to-face orientation sessions provided to 61 GP registrars and new GPs in the region

Health professionals recruited:

- 6 GPs, 7 practice nurses and 9 practice staff

Read more:

nbmphn.com.au/workforce

Workforce Planning and Prioritisation (WPP) Program

The GP WPP consortiums advise on GP workforce needs across Australia. As a member of the NSW and ACT consortium, led by Capital Health Network, our Workforce team engaged with key stakeholders to provide evidence-based recommendations to the Department of Health, Disability and Ageing (DHDA). These engagements helped guide the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) in registrar placement and training decisions. Our engagement included collecting feedback through consultations, focus group discussions and networking events to increase and strengthen the professional connections among registrars, supervisors and teaching practices. Our advocacy efforts through the WPP program have helped maintain a steady supply of registrars in the region.

- 131 GP registrars maintained this year

GP registrar orientation evenings were held in August 2024 and February 2025 with around 90 attendees across the events. These events welcomed new GP registrars to the region and provided them with the chance to network with local stakeholders, other practices and our staff.

The orientation evenings were well received among practice managers, GP supervisors and GP registrars as they could discuss the services we provide and gain local knowledge to support their term in practice.

NSW and ACT PHNs are leading GP workforce planning under the Australian General Practice Training (AGPT) Workforce Planning and Prioritisation (GP WPP) program, shaping registrar placements through stakeholder engagement and evidence-based insights. As part of the consortium, we were recently recognised at Australian National University (ANU) for being dependable, detail-focused, timely and closely aligned with the evidence base driving national GP training priorities.

Learn more:

nbmphn.com.au/Workforce

“Thank you sincerely for taking the time to meet with me. I truly appreciate your invaluable advice and insights regarding my pathway in Australia. Your guidance has given me a clearer perspective, making me more confident in following the steps. Please know that I will keep you updated on every advancement in my career journey here in Australia. Your support and insights have been instrumental in shaping my approach. Thank you once again for your time and generosity.”

Overseas trained doctor

“It’s my pleasure to see you all and thanks for organising such a great networking event. I’m looking forward to the next event.” Registrar

“It is so kind of you to welcome me in this way. I am really excited to start training as a GP.” Registrar

“Great format! It’s great to talk to colleagues.” GP Supervisor



Continuing Professional Development

We supported the continuing professional development (CPD) of GPs, practice nurses, practice managers, allied health professionals and their teams throughout our region, with most being free to access. As an accredited CPD education provider under the RACGP CPD Program, we are committed to delivering high-quality education.

To enhance our CPD activities, we collaborated with training organisations, professional bodies, Nepean Blue Mountains Local Health District (NBMLHD), universities and local clinicians. Our online learning management system, Your Practice Portal, hosted a range of CPD education.

We delivered an extensive calendar of educational activities, including full-day events such as the annual Clinical Paediatric Conference, Navigating Women's Health in Primary Care and Healthy Ageing Conference.

- 105 CPD events with 1,149 health professional attendances
- 100% of attendees who provided feedback reported that it improved their knowledge and/or skills

Find out more:

nbmphn.com.au/CPD

“Very enjoyable day. Very informative. Great venue and well organised engaging speakers.”

Attendee – Clinical Paediatric Conference 2024

“Very well spent Saturday. Thank you PHN, sponsors and all Nepean Women and Children’s Health specialists who participated. The venue was good and service was excellent. I would like to attend more meetings like this.”

Attendee – Navigating Women's Health in Primary Care

Suicide Prevention Training

We partnered with the Black Dog Institute to deliver a multi-disciplinary suite of suicide prevention training programs targeted towards GPs, allied health professionals, psychologists and social workers. The training increases the knowledge and skill of health professionals in managing suicide risk and aftercare, along with developing safety plans and supporting families experiencing suicide bereavement. Workshops were facilitated by experienced clinicians and covered advanced training in suicide prevention, talking about suicide in practice and case discussions.

- 8 workshops
- 54 participants

Find out more:
nbmphn.com.au/SuicidePreventionTraining

“I would highly encourage all professionals to engage with the Black Dog Institute’s free suicide prevention coaching sessions. One of the most valuable aspects is the opportunity to present real-life scenarios from our work and gain input from experienced facilitators and peers. The sessions are a timely reminder of the common risk factors we often see, such as loneliness, financial stress, trauma and lack of sleep. It’s powerful to be reminded of the value in slowing down and having meaningful conversations that can potentially save lives. Participating in these courses, including the burnout modules, not only reinforces the skills and knowledge we already have, but also offers fresh insights and practical strategies. Thank you to the Black Dog Institute for creating a supportive, practical and accessible space for learning and growth. I truly appreciate every opportunity to take part in these coaching sessions.” Health professional

DIGITAL HEALTH

Supporting the Uptake of Digital Health

Through the Australian Digital Health Agency (ADHA), we continued driving the adoption of digital health initiatives across primary care in our region. This included delivering face-to-face and virtual sessions on the importance and benefits of My Health Record, engaging GPs and pharmacists to scope the utilisation of electronic prescribing and the Active Script List, and promoting Provider Connect Australia (PCA) as the preferred platform for accurate business-to-business information sharing.

- 176 digital health support activities across 132 practices and 10 RACHs

From March 2025 to July 2025, engagement activities were conducted with primary healthcare providers on electronic prescribing and Active Script List, reporting on GP promotion strategies, barriers to adoption, consumer engagement insights, and recommended educational materials to support uptake and facilitate clinician-patient discussions.

We promoted the Digital Health Maturity Assessment and completed ad-hoc pharmacist interviews during site visits that contributed to broader digital health engagement across the region.

Interviews with healthcare providers offered valuable insights into the use of electronic prescribing and Active Script List.

Find out more:
nbmphn.com.au/DigitalHealth



Digital Health Maturity Assessment Project

We undertook a Digital Health Maturity Assessment across four key primary healthcare provider groups in the region: general practice, residential aged care homes (RACH), pharmacy and allied health.

This strategic initiative provided a comprehensive snapshot of current digital health infrastructure, encompassing technology, workforce capacity and organisational processes. It enabled us to identify strengths, gaps and opportunities for improvement, as well as areas with the greatest potential impact. It highlighted potential barriers to digital transformation, such as limited training, resistance to change and infrastructure challenges.

Each participating primary healthcare provider received a tailored Digital Health Action Plan based on the survey findings. The plan served as a strategic roadmap, outlining the provider’s current level of digital health maturity. It provided a clear overview of existing digital health resources, capabilities and infrastructure, identifying specific areas for improvement.

The action plan included targeted recommendations designed to support the provider’s progression along the digital maturity spectrum. These recommendations may address technology adoption, workforce

development, process optimisation and integration of digital tools into clinical workflows. By aligning recommendations with the provider’s unique situation and readiness, the plan facilitated a more effective and sustainable approach to digital transformation.

Importantly, the Digital Health Action Plan also supported ongoing quality improvement by helping providers prioritise initiatives, allocate resources efficiently and overcome common barriers such as limited training or resistance to change. It empowered healthcare providers to make informed decisions and take proactive steps toward enhancing patient care through digital innovation.

This project marked a significant milestone in our commitment to advancing digital health across the region. It promoted equitable access to technology-enabled care and supporting providers in their journey toward digital excellence. In 2026 we look forward to launching a Digital Health Strategy for our region.

Assessment completion rates:

- general practice – 32%
- residential aged care homes – 37%

Completion rates for pharmacy and allied health are still in progress and will be reported in the next financial year.

Data Analysis Support

As part of our population health, general practice engagement and digital health strategies, we offered practices free access to Primary Sense – a clinical audit tool. We assisted practices to use the tool effectively to enhance patient care through data-driven quality improvement. To encourage adoption, we hosted monthly ‘Lunch and Learn’ webinars focusing on specific health topics and conditions, promoting greater use of Primary Sense. These sessions helped practices build confidence in applying data insights to improve patient care and support quality improvement initiatives.

- 91% of eligible practices have Primary Sense
- 10 Primary Sense ‘Lunch and Learn’ sessions delivered with 85 participants

Find out more:
nbmphn.com.au/Primary-Sense



My Health Record

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

- 110 digital practices are registered to use MHR
- 33,386 Shared Health Summaries uploaded
- 49,861 documents were viewed, which were uploaded by other healthcare organisations, a 6.2% increase from last financial year
- 19,586 documents were uploaded by general practices, which were viewed by other healthcare organisations, a 23.9% increase from last financial year

Our Digital Health Officer actively supported education and engagement within RACHs, including participation in a one-hour train-the-trainer session on the electronic National Residential Medication Chart (eNRM) conducted by the Australian Digital Health Agency Education team. Face-to-face training sessions on My Health Record in RACHs promoted use of digital health tools and improved clinical workflows.

Find out more:
nbmphn.com.au/GP/MyHealthRecord

ePrescribing and SafeScript

Electronic prescribing (ePrescribing) offers prescribers and patients the convenience of receiving an electronic prescription (eScript), serving as a digital alternative to traditional paper prescriptions. SafeScript NSW is a real-time prescription monitoring system that provides prescribers with access to their patients' history of certain high-risk medications. This system supports safer clinical decision-making and helps reduce the misuse of monitored medicines. We assisted practices in adopting both ePrescribing and SafeScript NSW to enhance patient safety and streamline prescribing workflows.

- 95% of pharmacies are eScript ready
- 382 GPs (88%) registered for SafeScript NSW
- 289 pharmacists (82%) registered for SafeScript NSW
- 545 other health practitioners (eg. nurse practitioners, specialists etc.) (45%) registered for SafeScript NSW

Find out more:
nbmphn.com.au/ePrescribing



Secure Messaging

We assisted practices to implement and use secure messaging. It enabled healthcare providers to send and receive sensitive and confidential clinical information like eReferrals, reports, pathology and radiology requests, results and electronic discharge summaries in a secure and encrypted environment.

- 55 general practices used the SR Specialists and Referrals platform to send a total of 4,373 eReferrals to specialists, an 8.5% increase from last financial year
- General practices sent 61,052 messages and received 604,428 messages through secure messaging (via HealthLink)
- 51.5% increase in total messages sent and received, compared to last financial year

Find out more:
nbmphn.com.au/SecureMessaging

LUMOS

LUMOS is a collaborative initiative between NSW Health and Primary Health Networks that helps general practices gain deeper insights into their patients' journey across the health system. It securely links de-identified data from general practices to other health data in NSW, including hospital, emergency department, mortality ambulatory and other data. By connecting information about the care patients receive, LUMOS gives GPs visibility of where, when and how care is accessed, supporting more informed decisions in both individual patient management and population health planning.

- 43 practices shared de-identified data for LUMOS
- 6.6% increase (from 35.7% to 42.3%) in the first half of 2025, second in NSW for LUMOS practice participation growth

Find out more:
nbmphn.com.au/LUMOS

DISASTER AND EMERGENCY MANAGEMENT

Disaster and Emergency Management is a key priority in our region due to the high risk for multiple hazards, the high frequency of events and our vulnerable populations. This is reflective of national trends but is particularly evident in our region with the Blue Mountains area being the highest bushfire hazard and the Hawkesbury area being the highest flood hazard in the state. The Penrith area experiences extreme heat with the frequency of events higher than other parts of Greater Sydney, often surpassing 50 degrees in summer in built areas.

We continued to support general practice, allied health and residential aged care homes with their planning for disasters and emergencies, including extreme heat and power outage, focusing on maintaining continuity of care. A highlight of this was the combined Clinical Council event in December, which was solely focused on Disaster and Emergency Management. This significant engagement, along with input from the Community Advisory Committee, informed the development of further training, resources and support.

Find out more:
nbmphn.com.au/Disaster-Planning-and-Recovery

This year saw the development and roll out of the 'What Ifs?' campaign to 132 general practices and 12 pharmacies in our region. This two-part campaign provided resources to support general practice and pharmacy in localising their plans and identifying local risks and connections. As part of this work, we provided training and support to practice managers, pharmacy, general practitioners and registrars to understand the new Australian Warning System, and to help them find and identify accurate information in emergency situations.

The second part of the 'What Ifs?' campaign provided resources for patients to support their connection to person-centred emergency planning and local services through general practice, community engagement and pharmacy connector points. Over 3,000 resources have been distributed to the community.

We have also produced tailored resources for primary care to use to support at-risk patients in preparing for disasters, particularly those with chronic health conditions, disabilities or who are reliant on life support equipment. Additionally, we are working closely with the social connection programs, acknowledging the importance of social connection in emergencies.



Liz Murphy and Monique Pryce from Wentworth Healthcare at Penrith Seniors Festival Penrith City Council March 2025.

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

“Thank you so much for all your guidance so far in developing such a useful, comprehensive resource for practice teams.” Participant

“Thank you so much Liz for such wonderful feedback and contributions. Incredibly helpful!” Participant

“When delivering the disaster resources to Wallerawang – there was a patient in the waiting area, the staff were so impressed by the magnets and the Lithgow Council ‘go envelope’ that they gave one to the patient then and there as he lived on a large property.” Participating practice

Do you have a plan for an emergency?
People who have a plan:

- KNOW THEIR RISKS
- ARE PREPARED
- STAY INFORMED
- RECOVER BETTER

How to prepare and stay informed in the **Hawkesbury**:

State Emergency Service (SES)	132 500
NSW Rural Fire Service (NSW RFS)	1800 679 737
Fire and Rescue Home Safety Visits	4588 4581
For assistance to make an Emergency Plan	Peppercorn Services 4587 0225
For assistance with your Mental Health	Head to Health 1800 595 212

Be prepared for the WHAT IFs!

For online links and more resources, visit nbmphn.com.au/DisastersAndEmergencies

phn Wentworth Healthcare

Do you have a plan for an emergency?
People who have a plan:

- KNOW THEIR RISKS
- ARE PREPARED
- STAY INFORMED
- RECOVER BETTER

How to prepare and stay informed in the **Blue Mountains**:

State Emergency Service (SES)	132 500
NSW Rural Fire Service (NSW RFS)	1800 679 737
Fire and Rescue Home Safety Visits	4784 8343
For assistance to make an Emergency Plan	Belong Blue Mountains 4759 2592
For assistance with your Mental Health	Head to Health 1800 595 212

Be prepared for the WHAT IFs!

For online links and more resources, visit nbmphn.com.au/DisastersAndEmergencies

phn Wentworth Healthcare

Do you have a plan for an emergency?
People who have a plan:

- KNOW THEIR RISKS
- ARE PREPARED
- STAY INFORMED
- RECOVER BETTER

How to prepare and stay informed in **Lithgow**:

State Emergency Service (SES)	132 500
NSW Rural Fire Service (NSW RFS)	1800 679 737
Fire and Rescue Home Safety Visits	6339 8563
For assistance to make an Emergency Plan	Red Cross 1800 733 276
For assistance with your Mental Health	Head to Health 1800 595 212

Be prepared for the WHAT IFs!

For online links and more resources, visit nbmphn.com.au/DisastersAndEmergencies

phn Wentworth Healthcare

Do you have a plan for an emergency?
People who have a plan:

- KNOW THEIR RISKS
- ARE PREPARED
- STAY INFORMED
- RECOVER BETTER

How to prepare and stay informed in **Penrith**:

State Emergency Service (SES)	132 500
NSW Rural Fire Service (NSW RFS)	1800 679 737
Fire and Rescue Home Safety Visits	4784 8386
For assistance to make an Emergency Plan	Red Cross 1800 733 276
For assistance with your Mental Health	Head to Health 1800 595 212

Be prepared for the WHAT IFs!

For online links and more resources, visit nbmphn.com.au/DisastersAndEmergencies

phn Wentworth Healthcare

Working with RACGP

We were invited to work closely with RACGP to update the National Managing Emergencies in Disasters in General Practice resources. This resource supports general practices to identify risks, develop comprehensive response plans and be better prepared for disasters and emergencies. The new resource is linked on our website and Disaster HealthPathways.

Find out more:
nbm.communityhealthpathways.org

General Practice in Aged Care Incentive

Since the commencement of the General Practice in Aged Care Incentive (GPACI), we have been actively supporting residential aged care homes (RACHs) across the region. We have kept the homes informed through regularly sharing departmental resources, updates on our website and our monthly RACH newsletter.

- We met with 93% of homes in the region to increase awareness and engagement with the incentive

We worked with general practitioners across the region to understand GPACI and supported the implementation of this new initiative. We worked with general practitioners and residential aged care homes to develop an orientation package to improve communication between health professionals.

- 1,028 registered patients for GPACI amongst 2,658 RACH beds (38.7%)
- 75 general practitioners providing clinical care to the 29 RACHs in our region

Find out more:

nbmphn.com.au/GPACI

Aged Care Telehealth and After-Hours Support

Residential Aged Care Homes (RACHs) received support to purchase telehealth equipment – including laptops, tablets, and mobile carts – to help residents connect with primary care providers remotely.

- 16 homes were provided with grants to purchase telehealth equipment
- RACHs reported that the purchased equipment met their needs and supported them to assist residents in undertaking telehealth appointments with their health professionals

Supporting Residential Aged Care

RACHs were supported to complete a Digital Health Maturity Assessment (DHMA) to identify gaps in their use of digital health technology and to support increasing the digital maturity of the home.

- 12 RACH managers and clinical staff were provided with training on My Health Record
- 11 RACHs completed the DHMA and all were provided with a Digital Health Action Plan
- RACH management and staff trained reported they felt more confident in their use of My Health Record
- Digital Health Action Plans are being used to inform our future work including telehealth and allied health training

The Digital Health Action Plan includes tailored recommendations for each RACH to support improving their digital health maturity. This includes providing factsheets on how the RACH can improve cyber-security, disaster recovery, My Health Record, secure messaging, communication and telehealth topics.

Find out more:

nbmphn.com.au/RAC

RACH Disaster Preparedness

We held a disaster preparedness event in collaboration with the Nepean Blue Mountains Local Health District (NBMLHD). The event brought together a range of representatives from RACHs, emergency services, Department of Health, Disability and Ageing (DHDA) staff, NBMLHD staff, community organisations and disaster preparedness experts, to share vital knowledge and guidance on preparing for and responding to disasters.

- 67 attendees
- 83% of attendees indicated that they were very satisfied with the event

Attending RACH staff found the event to be informative and practical. Many of the RACHs in attendance have made changes to their Emergency Plans and connected with other services that were at the forum. One RACH has installed a generator to further assist them to "shelter in place" in an emergency situation if there is extended power outage.

Find out more:

nbmphn.com.au/PrepareYourRACH



Attendees at the RACH Disaster Preparedness event.





Healthy Ageing Conference

We hosted our inaugural Healthy Ageing Conference in April, with 115 health professionals in attendance including general practitioners, nurses and allied health professionals.

Dr Norman Swan*, physician, broadcaster and author, was the keynote speaker and MC for the day. The event was opened by Senator Tony Sheldon, Senator for NSW, and provided a platform to highlight and acknowledge the crucial role that primary healthcare plays in keeping people healthy and happy as they age, so that they can remain at home for as long as possible.

The critical importance of social connections and agency for older people as they age was a key theme. Our social prescribing initiatives were introduced as important early intervention programs to improve older people's social networks and by extension, their physical and mental wellbeing, allowing them to stay healthier for longer. Of the 57 participants that completed the evaluation form:

- 100% said they would likely recommend this conference to a colleague
- 82% said they would likely change something in their practice because of the conference
- 98% said that participation improved their knowledge and/or skills
- 100% said the overall quality of the education component as a learning experience was good/very good
- 89% said the opportunity to ask questions for clarification was good/very good

Read more:

nbmphn.com.au/healthyageingconference

* Arrangements were made through Celebrity Speakers
www.celebrityspeakers.com.au



Janice Peterson – Manager, Healthy Ageing & Palliative Care Wentworth Healthcare, Kate Tye – Exec Manager Primary Care Development Wentworth Healthcare, Senator Tony Sheldon – Senator for NSW, Lizz Reay – CEO Wentworth Healthcare and Dr Norman Swan.

“Thank you for organising such a valuable and insightful conference on proactive approaches to healthy ageing. I truly appreciated the comprehensive focus on key areas such as cognitive health, post-diagnosis dementia care, falls prevention, social connection, and chronic disease management through nutrition. The emphasis on practical, person-centred strategies – “every patient, every encounter, every time” is now my daily mantra - was particularly impactful and resonated deeply with the kind of practitioner I aspire to be. Supporting independence and enhancing quality of life in older adults was at the heart of every session, with evidence-based insights that were highly relevant and directly applicable to clinical practice.”

Participant



Wentworth Healthcare staff at the Healthy Ageing Conference.

Healthy Ageing Quality Improvement Collaborative

The Healthy Ageing Quality Improvement (HAQI) Collaborative supported older people to live at home for longer through the commissioning of early intervention initiatives that promoted healthy ageing, supporting the ongoing management of chronic conditions, reducing functional decline.

We engaged Dr Paresh Dawda from Prestantia Health and an Expert Reference Panel consisting of primary care and allied health professionals, to determine the measures of the program.

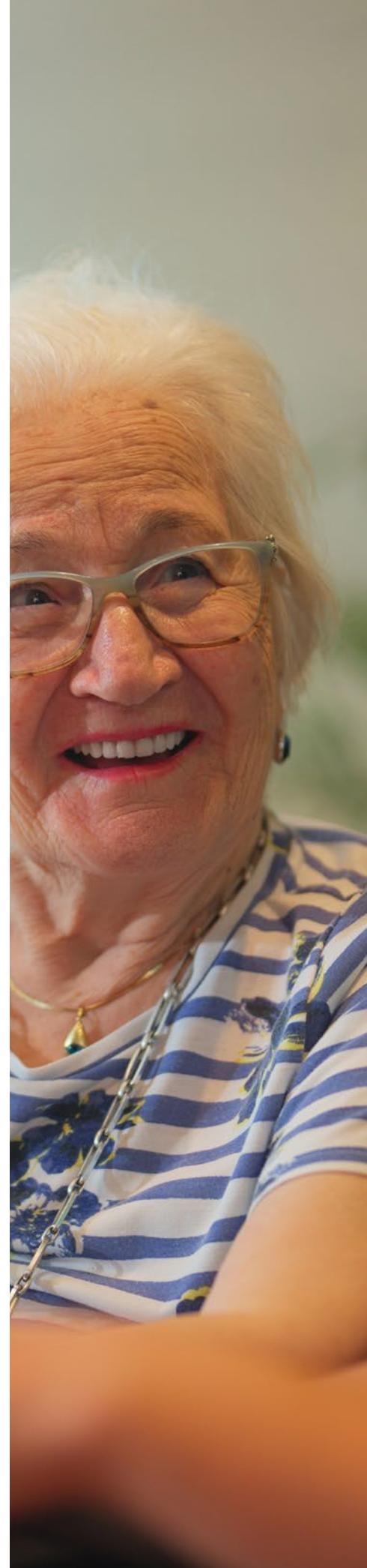
HAQI supported general practice to improve the management of patients with chronic conditions by implementing important preventative care measures to minimise their risk of hospitalisation. Patients were encouraged to be equal partners with their care team to better manage their chronic conditions, medications and avoid preventable hospitalisation. It also improved the care of older people living in the community, guided by the 5M framework utilised by participating general practices across our region. The 5M framework is a simple, powerful and evidence-based framework that measures outcomes based on What Matters to the patient, Medication, Mobility, Mentation and Malnutrition.

Practices participated in peer learning and collaborative improvement with other practices. The program achieved significant improvements in the assessment and management of older patients, with a marked increase in the use of wellbeing and function screening tools (PROMIS 10 and WHO-5), medication reviews and care planning.

- 7 general practices each registered 20 eligible patients
- 51 patients reported improved quality of life, almost 40% of patients
- 67% of practitioners reported meeting all program learning outcomes to a high degree
- 83% of practitioners reported significant learning in the ‘reflecting of data and using learnings to inform future QI activities’
- 83% of practitioners reported the learning workshops met their expectations to a high degree

“The participation in the Healthy Ageing QI has been informative and interesting, showing us that it takes considerable effort, time and communication with patients, other staff members and other healthcare providers to achieve the goals aimed for. Participation in this collaborative has been positively enriching to the quality of care we provide for our older adult cohort, above and beyond our 20 selected participants. Connected patients with other allied health professionals and services to promote optimal physical health, mental health and wellbeing (Health Connector Program, HMR, Exercise Programs). Above all, opportunity to drive change and support increased quality of care and improved satisfaction of our patients.”

Participating practice



Healthy Ageing Quality Improvement – Mobility

The Healthy Ageing Quality Improvement – Mobility (HAQI-M) program was implemented in 2025. It supported general practices to improve the management of older patients with age-related chronic conditions like frailty or mobility issues, who were experiencing social isolation and at risk of hospitalisation or entering a residential aged care home. Through this program, patients stayed as well as possible, were assisted in better managing their chronic conditions, to remain out of hospital and feel socially connected and supported.

- 7 practices enrolled 70 patients to participate in the mobility program

How has your involvement in this program benefited your patients or influenced your clinical practice?	What aspects of the program did you find most enjoyable or valuable?	What worked well for you during this program? What were your key takeaways?
It helped streamline our approach to chronic disease management in older adults. Patients received more timely care plans and relevant health assessments, and many became more engaged in their care due to clearer communication and structured follow-up.	Seeing measurable improvements in patient engagement and outcomes, and the ease of integrating the changes into existing systems.	Flagging eligible patients at booking improved efficiency, Ongoing staff engagement was key to sustainability
Mobility and maintaining strength in older adults are such key aspects of daily living and promoting quality of life. I feel the opportunity to focus a small group and outcome has had a follow-on effect to my clinical practice that will continue to have benefits to our patients now and in the future.	As a part of the research I conducted at the commencement of the program, I became more familiar with local exercise programs using the My Health Connector website and received feedback from participants of some of the local activities they enjoy. Gaining this knowledge, I feel more confident in supporting others to join an activity.	This project has reinforced my commitment to ensuring and encouraging safe mobility and promoting regular physical activity for the physical, mental and social benefits in older adults and the broader patient population.

The creation of a healthy ageing information station within one of our local clinics has been a key initiative. This inspirational practice nurse set up a dedicated Healthy Ageing room. Patients can browse the materials at their own pace, select what’s most relevant to them, and place it into a personalised take-home ‘Healthy Ageing Goodie Bag’.



POPULATION HEALTH

Childhood Immunisation Quality Improvement Program

We invited practices in the Blue Mountains, Hawkesbury and Penrith local government areas to express their interest in participating in a three-month Quality Improvement (QI) program aimed at enhancing childhood immunisation rates by at least 2%, over three months, as part of our ongoing commitment to improving the health and wellbeing of children in our community.

The program was designed to support general practices in implementing evidence-based strategies to improve immunisation coverage, targeting paediatric patients aged two years who had missed their scheduled 18-month immunisations.

The national aspirational target for childhood immunisations is 95%. Our goal is to increase our region’s immunisation rate above 95% and the QI focus will allow us to collectively achieve this.

- National rolling annualised percentage of all children fully immunised by 24 months of age is 90.4%.
- NSW rolling annualised percentage of all children fully immunised is 90.5%

Vaccination rate for two-year-olds

- **March 2024:** Nepean Blue Mountains 92% | NSW 91%
- **March 2025:** Nepean Blue Mountains 89.0% | NSW 89.4%

Children fully immunised at 5 years of age

- **June 2025:** Nepean Blue Mountains 94.9% | NSW 93.2%

We provided the group with a resource pack that included:

- Buzzy Bee, which uses a combination of cold and vibration to help block sharp sensations on the body. It has been shown to decrease needle pain by 50-80%.
- What to expect and what to do after vaccination tear-off pad
- Immunisation schedule
- Comprehensive QI Childhood immunisation Guide, including ideas on how to identify patients, how to access AIR via practice software, how to update the patient file for immunisation given elsewhere, patient reminders and catch-up calculator.
- Links to service Australia, immunisation handbook, catch-up calculator online
- Posters
- Opportunity for nurse scholarship entry to upskill the nurse workforce

Find out more:
nbmphn.com.au/immunisationprogram

We are so happy to have the Buzzy Bee, it’s really helpful for patients when they are scared of needles. My unforgettable encounter with a child having the Buzzy Bee while she’s having the needle is “I can have needle everyday because it’s not painful at all.”
Practice feedback



Photo from www.buzzy4shots.com.au



Be Your Own Health Hero Campaign

Over winter, we ran our Be Your Own Health Hero community awareness campaign to encourage COVID-19, influenza and pneumococcal vaccinations in vulnerable groups, including children, 70+, those with chronic conditions and Aboriginal and Torres Strait Islander peoples. The campaign was promoted through retail, washroom, print and social media advertising over three months.

- 821,532 foot traffic reached across retail advertising
- 470,000+ Google Ad impressions
- Facebook ads 943,502 impressions and 269,323 reach
- 783,600 audience reach through local newspaper advertising

Find out more:

nbmphn.com.au/healthhero

► Read about other Population Health initiatives in our [Services We Fund for the Community](#) section on page 43 and [Integrating Care](#) section on page 94.

Winter Strategy Quality Improvement Program

This quality improvement program supported practices in implementing processes to assist patients at risk of hospitalisation during the winter period.

- 14 general practices participated in the program

By the end of the Winter Strategy Quality Improvement Program, general practices had achieved the following measures, tracked against 187 patients who met the patient eligibility criteria:

- 85% of patients had an influenza immunisation recorded, an increase of 83%
- 75% had an up-to-date GP Management Plan, an increase of 43%
- 73% had an up-to-date Team Care Arrangement, an increase of 48%
- 64% had an up-to-date pneumococcal immunisation, an increase of 37%
- 54% of patients had a Shared Health Summary uploaded in the last six months
- 20% received a medication review

Find out more:

nbmphn.com.au/WinterStrategyQI

Nurse Immunisation Scholarships

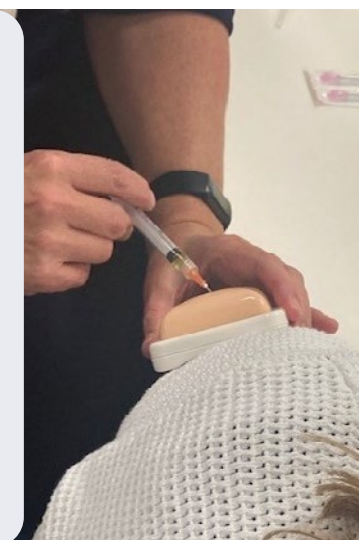
We provided practice nurses in primary care, Aboriginal and Torres Strait Islander health practitioners and registered nurses in aged care the opportunity to become accredited as authorised nurse immunisers, enabling them to provide vaccinations for their patients or residents. Nurses were awarded scholarships to complete accreditation via Benchmark Group's Immunisation Course for Health Professionals.

- 30 nurses were awarded scholarships and commenced training
- 6 immunisation scholarships were provided to RACH nurses

Upon successful completion of the Immunisation Course for Healthcare Professionals, participants will be equipped with the knowledge and skills required to practise as approved immunisation providers in accordance with national legislative requirements and the National Immunisation Education Framework.

Graduates will be qualified to deliver safe, evidence-based immunisation services across a range of healthcare settings. They will be able to apply both national and state-specific immunisation protocols, contributing to improved public health outcomes through increased vaccination coverage.

“The immunisation course was very informative and valuable, especially for me as a registered nurse working in aged care. It provided a comprehensive understanding of immunisation across different age groups. The online modules were clear, well-structured and easy to understand, making the learning process smooth and accessible. However, the highlight for me was the face-to-face session.” RACH nurse



Diabetes Management Quality Improvement Collaborative

The purpose of the Diabetes Management Quality Improvement Collaborative (DMQIC) was to address the capacity, capability and coordination barriers to optimal diabetes care for patients in the region by:

- Improving the management of patients living with diabetes
- Improving the quality of life of people living with diabetes
- Increasing confidence of primary care teams to look after people with diabetes, with support as needed from the public health system
- Increasing awareness amongst general practice staff and consumers of access to public health services, private allied health and other services available to people living with diabetes
- Enhancing self-management and care capabilities of people living with diabetes
- Strengthening coordinated, integrated and multidisciplinary team care

Fourteen general practices across the region participated in the DMQIC, by creating a register of their adult Diabetic patients. A total of 736 patients were enrolled into the program across the 14 general practices.

The aim of the DMQIC was to “improve the optimal care of adult patients living with diabetes by 20% by the end of June 2025”. This was informed by an Expert Reference Panel held in June 2024, including representatives from general practice, NBMLHD, allied health and community.

The DMQIC embraced a bundled indicator set of clinical management goals for optimal care that included the proportion of patients in the last 12 months with:

- blood glucose (sugar) level recorded
- total cholesterol recorded
- blood pressure recorded
- COVID vaccination recorded
- influenza vaccination recorded

Progress against these individual goals was reported, with the measure of optimal care being the proportion of patients who had all five goals met.

Recording of blood glucose (sugar) level, cholesterol and blood pressure all increased, with cholesterol recording showing the greatest improvement from 71% to 83% (an 18% relative increase), while blood pressure recording improved slightly from 82% to 84%.

When combined, the proportion of patients with blood glucose (sugar) level, cholesterol and blood pressure results recorded grew substantially from 58% to 79% (a 37% relative increase).

Vaccination indicators showed mixed results: up-to-date influenza vaccination remained almost unchanged at 56%, whereas up-to-date COVID-19 vaccination rose from 30% to 39%, (a 30% relative increase).

The proportion of patients with all five measures recorded improved from 16% to 24% (a 47% relative increase).

General practice staff also participated in a series of learning workshops to deepen their knowledge and understanding of the quality improvement methodology and hear from experts in the field about managing diabetic patients in general practice. Guest speakers included Dr Kathryn Williams (Endocrinologist) and her team from the Nepean Family Metabolic Health Service, as well Daniel Nasri (consultant pharmacist), local diabetes nurse educators, dietitians and a psychologist.

By the end of the program, the general practices participating in the DMQIC achieved an impressive 47% relative improvement in the optimal care of adult patients living with diabetes, surpassing the 20% target.

Find out more:
nbmphn.com.au/QualityImprovement

Advance Care Planning

We supported practices by providing information and resources to encourage conversations with patients on advance care planning. The Advance Care Directive form was converted and made available for import into general practice software, making it more personalised and easier for patients to complete. Conversations with practices commenced, where we provided practice and patient resources to facilitate conversation about advance care planning.

- 4 practices downloaded the Advance Care Directive form into their software
- 7 practices participated in the Healthy Ageing Quality Improvement Collaborative and enrolled 20 patients each to support a range of initiatives.
- 17.8% of participating patients have an up-to-date Advance Care Directive, a 15.3% increase
- 12.8% of participating patients had their Advance Care Directive uploaded to My Health Record, a 12% increase

Practice nurses started conversations with patients on advance care planning and some are planning to hold advance care planning awareness and information days for their patients.

Find out more:
nbmphn.com.au/AdvanceCarePlanning

Palliative Care GP Education

We hosted a GP education event on Enhancing Palliative Care, focusing on prescribing palliative care medication, where to refer patients for supportive and palliative care, and navigating HealthPathways.

- 100% of attendees reported an increased confidence and knowledge of when to start and stop regular medications for palliative care patients
- 100% of attendees were able to navigate HealthPathways’ Palliative Care pages and know the systems in the hospital for referring patients to services
- 100% of attendees improved their knowledge and skills and will likely recommend this education event to their colleagues
- 100% stated that the education was practical and relevant to their work





'Healing Country' by Janelle Randall-Court, historic commissioned artwork for Wentworth Healthcare.

Aboriginal Health

We provide support to primary healthcare providers to deliver culturally safe care. This includes training and providing information to practices about services and programs available for Aboriginal peoples in our region. Our Aboriginal Health Lead, Mitchell Beggs Mowczan, has worked with many stakeholders across the region and supported practices to deliver culturally safe care.

Mitch has connected with many practices across our region. He has met with hundreds of health professionals in general practice to discuss a wide range of topics such as cultural sensitivity, 715 Aboriginal Health Checks, Integrated Team Care Program, effective patient

recall systems, the physical environment of the practice, effective engagement in a healthcare setting, health systems and more.

We have had amazing connection with practices who are interested in learning more about how to effectively engage with our local Aboriginal and Torres Strait Islander community. Our hope is that this leads to better health outcomes and a positive uptake of Aboriginal programs and Aboriginal specific item numbers.

- 2,864 Aboriginal Health Checks (715) have been delivered by practices across the region

Find out more:
nbmphn.com.au/AboriginalHealth

► Read about other Aboriginal Health initiatives in our **Services We Fund for the Community** section on page 22.

Aboriginal Cultural Awareness Training

We have delivered a targeted and practical program to support the increase in cultural safety within primary healthcare in our region. Some of the topics discussed in this training included how to effectively engage with Aboriginal peoples in a healthcare setting, different perspectives on health, the physical practice environment, local programs and initiatives.

- 25 attendees across three training sessions



Mitchell Beggs Mowczan – Wentworth Healthcare Aboriginal Health Lead.



INTEGRATING CARE

One of our guiding principles is a ‘one health system mindset’, working to improve the integration of care across the primary, hospital, community and social sectors. This improves access and continuity of care for people, minimises service duplication and leads to better health outcomes.

We place a strong emphasis on connecting services and systems to support our region’s most vulnerable populations, including individuals with multiple and complex health conditions.

PRIORITY AREAS

ABORIGINAL HEALTH

Aboriginal Health Lead
Integrated Team Care – Closing the Gap
Village Café

DISASTER AND EMERGENCY MANAGEMENT

Disaster Planning and Response
Disaster and Emergency Coordinator

HEALTHY AGEING

Care Finder
Dementia – National Consumer Support Pathways
Compassionate Communities
– Connector Points
– Pharmacy Connector Points
– Health Connectors
– My Health Connector Website
– Intergenerational Connections
– Wellbeing Connector Service

MENTAL HEALTH AND SUICIDE PREVENTION

Initial Assessment and Referral Decision Support Tool
Medicare Mental Health Phone Service
Mental Health Help Website
Suicide Prevention Coordinators
Suicide Prevention Collaborative
Joint Regional Mental Health Suicide Prevention Plan
Right Care, First Time, Where You Live
New Aboriginal Wellbeing Commissioning Process
Postvention Community Response Coordination
Lived Experience Representation
Suicide Prevention Bursaries Program – Indigenous Suicide Prevention Forum 2025

POPULATION HEALTH

HealthPathways
Care and Connect Program
Western Sydney Health Alliance

Below are examples of **INTEGRATING CARE** through our **Priority Areas**.

ABORIGINAL HEALTH

Aboriginal Health Lead

Mitchell Beggs Mowczan, is a Wiradjuri man who was born and raised on Darug land with 14 years' experience in Aboriginal Health. He supports our organisation and regional stakeholders with training and cultural guidance while working with practices to promote the 715 Aboriginal Health Assessment and Integrated Team Care program.

Integrated Team Care – Closing the Gap

We commission Nepean Community & Neighbourhood Services to facilitate care coordination and multidisciplinary care to support Aboriginal and Torres Strait Islander peoples with chronic health conditions access the services they need. Support includes assistance with medical appointments, transport and accessing medical equipment.

- 4 care coordinators assisted 256 new patients
- 18,672 occasions of service delivered

The team behind the Integrated Team Care program worked tirelessly this year to support local Aboriginal and Torres Strait Islander peoples in our region to access the appropriate healthcare and services needed. Staff go above and beyond to ensure patients are supported and practices achieve the best outcomes. Part of this work is being able to build connections with community and general practice staff, to ensure there are no barriers to accessing the appropriate care.

Find out more:

nbmphn.com.au/ClosingtheGap

Integrated Team Care

Our Aboriginal outreach worker had been working with a client that had trouble navigating the health system and fell through the gaps. The client had been diagnosed with breast cancer, coronary artery disease and other chronic illnesses. She was feeling fed up, frustrated and beside herself, and she did not know who she could turn to for support. The Aboriginal outreach worker built a relationship with the client and attended appointments to work with her breast care nurse on a weekly basis. The client is now in remission and continues to work with specialists to address other chronic conditions.



Village Café St Marys. Photo from facebook.com/PenrithNR

Village Café

Village Café in Kingswood, North St Marys and Llandilo fosters community connections and wellbeing. It has a number of supporting partners, including Penrith City Council, Nepean Blue Mountains Local Health District (NBMLHD) and Community Junction. The Café offers coffee, conversation and connection with local community members and service providers. Since 2017, we have seen a growth in the number of people utilising the service in each community, helping to prevent social isolation and maintain connections.

- 27 Village Cafés attended by our Aboriginal Health Lead

At these events, our Aboriginal Health Lead engaged with local communities helping to build health literacy, and support access and integration with local services. Other programs we fund attended Village Café to promote services, which included the delivery of vaccinations and education on advance care planning.

Over the years, Village Café has grown in each community location and is an important service for strengthening connections in the community and providing key health messages. We have seen many successful outcomes from events, including linking people with key services and addressing health needs by bringing resources to a place where they feel comfortable and safe.

► Read about other Aboriginal initiatives in our **Services We Fund for the Community** section on page 22 and the **Supporting Primary Healthcare** section on page 74.

A man has been attending Village Café for many years and has a big distrust of services and other people. We developed a great relationship with this man and broke down barriers to the point where he allowed the podiatrist to look at his feet for the first time in his life. This was a massive achievement for him and was a key example of how this model builds connections and breaks down barriers.



Jessica Savill, Gabe Treble and Mitch Beggs Mowczan at a NAIDOC event.



DISASTER AND EMERGENCY MANAGEMENT

Disaster Planning and Response

We actively contributed to a range of collaborative initiatives to support disaster and emergency preparedness, particularly targeting at-risk community members living with chronic and complex conditions. In close partnership with government, health, community and emergency service sectors, we worked across national, state and local levels to deliver key outcomes.

Our continued partnership with the NBMLHD and regional networks plays a vital role in delivering a coordinated and effective approach to disaster and emergency planning in our region. We are focused on improving preparedness for vulnerable communities through key initiatives, including:

- NSW/ACT PHNs Disaster Management Network
- Western Sydney Health Alliance – Health Planning Disaster Handbook Group (cross regional)
- Culturally and Linguistically Diverse (CALD) Disaster and Emergency Reference Group (Greater Sydney)
- Recovery/Resilience on Wheels Network (regional)

These collaborative activities have delivered some great outcomes including the launch of a suite of resources for life support users in partnership with Endeavour Energy and local councils, including the Check. Plan. Do. Power Outage Plan.



Liz Murphy – Wentworth Healthcare, Tony Baerwinkel – Endeavour Energy, Bec Jolly – The Energy Charter.

“We are proud to have worked alongside Wentworth Healthcare through two of our critical #BetterTogether initiatives. These initiatives have been instrumental in building national capacity to enhance disaster preparedness and response with a focus on power outage planning. We have deepened our understanding of the significant risks that certain communities face.” The Energy Charter

We are a pivotal member of the cross-sector Recovery/Resilience on Wheels Network since its foundation in response to the 2019 bushfires in the region. The Network’s focus this year has been on fostering strong and ongoing relationships, and building resilience in preparation for future events.

The Network was included as a case study of best practice in the Resilient Sydney Strategy 2025-2030 released this year.



Recovery/Resilience on Wheels Network Planning at Wentworth Healthcare office.



Liz Murphy – Disaster and Emergency Coordinator, Wentworth Healthcare.

Disaster and Emergency Coordinator

Our Disaster and Recovery Coordinator, Liz Murphy, supports primary care providers and their patients to plan and prepare for disasters.

“You have been an incredible advocate in the disaster recovery space, both for our organisation and the wider community. Your dedication and passion for the community, along with your efforts to engage with individuals and connect them to recovery services, have greatly improved the recovery of hundreds across our community.”

Recovery Service – Hawkesbury

“Since 2021, our two organisations have worked together to address the needs of the Hawkesbury-Nepean Valley communities hardest hit by floods. Nepean Blue Mountains PHN staff have been in regular contact with our service and have consistently supported our initiatives and events within the community. Your organisation has played a critical role in advocating for improvements and changes to the community recovery process.”

Recovery Service – Hawkesbury

Find out more:

nbmphn.com.au/NBMPHN-Library/Disaster-Planning

Care Finder

The care finder service provides specialist and intensive assistance to help vulnerable older people access aged care services and connect them with other relevant supports in the community. We have commissioned three organisations to provide our care finder service, with a total of seven individual care finders covering our region.

- 358 new clients have been assisted
- 97% of the care finder clients surveyed reported an improved understanding of aged care services and felt the care finder successfully assisted them to access appropriate aged care supports
- 100% of care finder clients surveyed reported they would recommend the care finder service to others

Find out more:

nbmphn.com.au/CareFinders

▶ youtu.be/YFibWwsDfnY

Dementia – National Consumer Support Pathways

We facilitated dementia events in the community, bringing together service providers and community members to share information and provide connection to local services to support those living with dementia. Subject matter experts in occupational therapy and advance care planning from the NBMLHD presented these community workshops.

- 5 sessions were held in Hawkesbury and Penrith
- 59 community members attended

During the sessions, community members were connected with appropriate services. As needed, services referred people on to other providers in our region.

Find out more:

nbmphn.com.au/DementiaSupport

An older person living alone in a public housing unit struggled with daily tasks due to chronic pain from a past physical and brain injury. With no family nearby to support them, the idea of navigating aged care services was daunting and they were unsure of where to begin. After connecting with the care finder service, they received personalised support that helped them register with My Aged Care to begin accessing vital services including domestic assistance, community transport and physiotherapy. Through this support, they were approved for a Level 1 Home Care Package and residential respite care, giving them greater flexibility and peace of mind. This journey highlights the importance of accessible, compassionate support for older people who may otherwise struggle to connect with the services they need.

“I learn something new each time I attend an education. Excellent session. Fantastic, thank you.” Participant

“Very helpful and user friendly – practically helpful. Very informative. Advance Care Directive will be most useful.” Participant

“Good information on Advance Care Directive, dementia and where to get support.” Participant

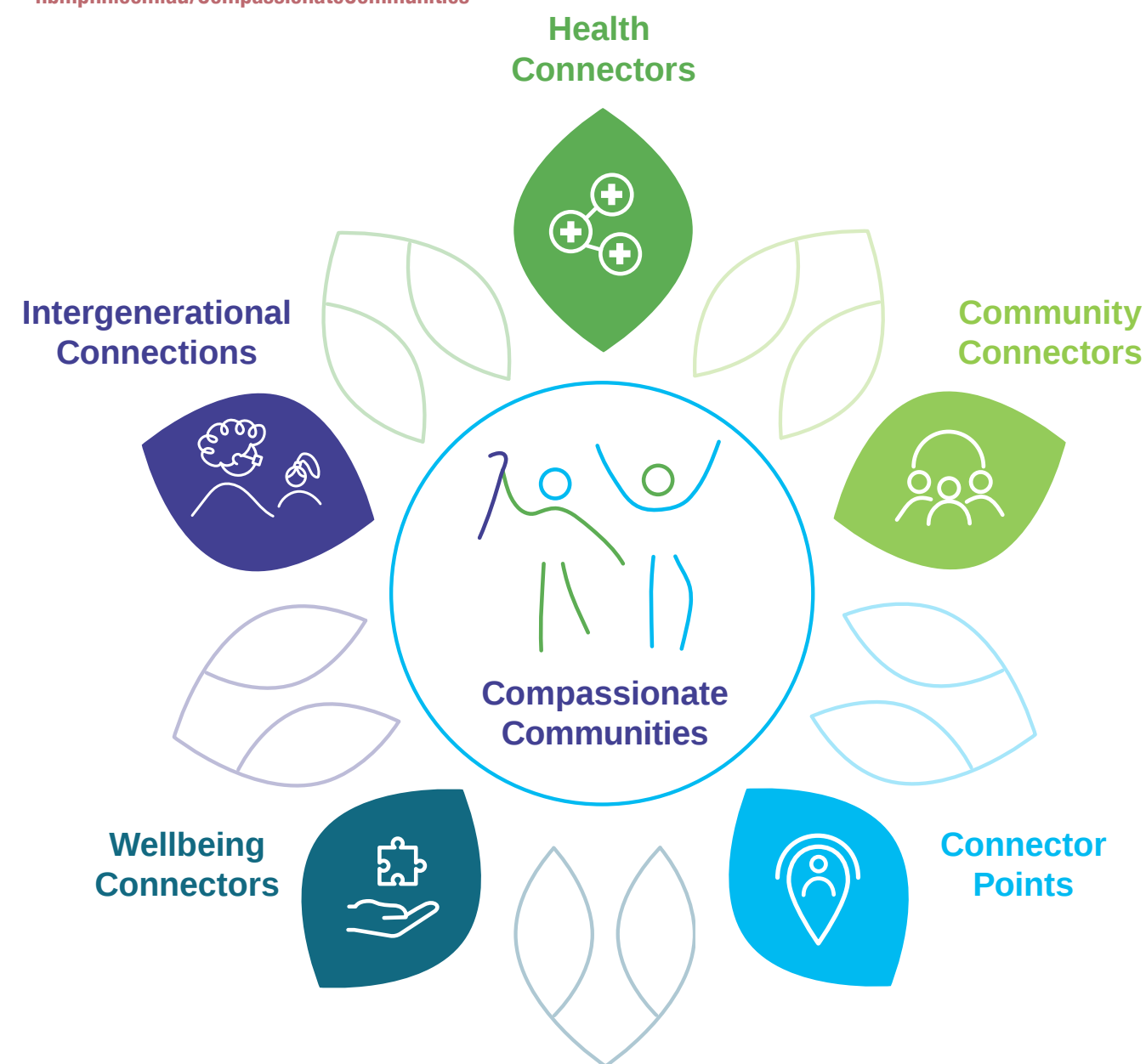
“Great session with lots of valuable information. The speakers were informative...” Participant

Compassionate Communities

Older people without adequate social connections have an increased risk of poorer health and wellbeing outcomes. Based on a Compassionate Communities approach we fund a range of social connection programs.

Find out more:

nbmphn.com.au/CompassionateCommunities



Connector Points

Connector Points are community organisations and services that provide face-to-face or telephone assistance for improving social connections and reducing social isolation in older people, particularly those without internet access. We fund a range of Connector Points that recognise the importance of human connection, kindness and compassion.

- 7 new Connector Points established
- 22 Connector Points across our region





Daniel Nasri – consultant pharmacist.



Veronica Nou – community pharmacist.



“One older person who was living at home with family expressed that they were experiencing loneliness and social isolation because for most of the day their family were out working. The Pharmacy Connector was able to connect them with a community centre and it was really life-changing because now every week they go to the community centre to have morning tea with others in the group. A story of renewed hope and reconnection and people feeling part of the community again.”

Consultant Pharmacist – Daniel Nasri

“I attended a Biggest Morning Tea at one of the pharmacies involved in this program. The pharmacy had invited specific patients who they identified as possibly needing some connections. The event was attended by over 20 community members. Toward the end of the event, three older people were exchanging numbers to have a coffee later in the week.”

Pharmacy Connector program participant

Pharmacy Connector Points

During the year we engaged nine community pharmacies as connector points. The pharmacists and staff undertook the Pharmacists Addressing Loneliness and Social Isolation (PALS) training by the Pharmaceutical Society Australia (PSA). Through this initiative, pharmacists conducted social prescribing, connecting patients with services, social groups or lifestyle activities. It was used to address a range of health issues including both physical and mental health conditions.



- 9 pharmacy connector points
- 99 conversations from December 2024 to June 2025
- 5 patients assisted to attend activities or groups

Find out more:

nbmphn.com.au/ConnectorPoints

► youtu.be/yjeeG8kU_JY

Health Connectors

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



- 7 practice nurses trained as health connectors in five practices
- 98 clients assisted through 274 occasions of service
- 31 trained health connectors in total

Find out more:

nbmphn.com.au/HealthConnectors

My Health Connector Website

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

- 985 services listed
- 10,259 visits/sessions
- 21,900 page views
- 7,424 active users

Find out more:

MyHealthConnector.com.au

► youtu.be/WKNGbtI0PU?si=Y-bE60Go8hQcUzS4

An elderly patient was calling and attending a general practice several times a week. The staff had noted that the patient wanted to chat and did not need medical assistance. The practice is involved in the Health Connector program where practice nurses find out what’s important to a patient and try to connect them to non-clinical social activities and groups. They spoke to the patient and referred them to the dementia day centre. The patient attends several times a week and the husband’s carer is also happier as he can go to activities he enjoys. The patient no longer rings or attends the general practice several times a week.

An older person had recently moved to the Blue Mountains to be closer to their daughter. They have no friends in the area and were feeling quite isolated. They are now happily part of our current intergenerational program (where they have made some friends) and will also start volunteering as a home visitor soon.
Lower Blue Mountains Wellbeing Connector

An older person who described themselves to their referrer and again to the Wellbeing Connector during their first phone call as someone 'not overly outgoing', attended their first Village Café yesterday with their Wellbeing Connector and thoroughly enjoyed it and actually exclaimed 'oh no' when it finished. They are going to come to the Village Café next week!
Penrith Wellbeing Connector

Intergenerational Connections

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



- 97 clients were assisted through 110 group sessions
- 79 participants (82%) reported sustained or improved quality of life based on the WHO-5 Wellbeing Index, which was administered at the first and last sessions of each program

Facilitators conducting structured observations with the Leuven Scale reported consistently high levels of wellbeing and involvement throughout the sessions, with older participants offering overwhelmingly positive feedback.

Find out more:

nbmphn.com.au/Intergenerational-Programs

► youtu.be/hTKgcIV-EFw

Wellbeing Connector Service

The Wellbeing Connector Service provides free support to connect older adults with social or lifestyle activities in their community, including:



- Physical activity programs such as walking groups
- Arts and recreational activities like bush clubs, music programs and book clubs
- Social activities such as intergenerational programs, coffee clubs and men's sheds
- Volunteering opportunities

Since the service commenced in August 2024:

- 116 people participated
- 48 participants have completed their 12-week and/or 26-week follow-ups
- 32 participants (67%) reported sustained or improved quality of life

Find out more:

nbmphn.com.au/WellbeingConnectors



Intergenerational programs.

MENTAL HEALTH AND SUICIDE PREVENTION

Initial Assessment and Referral Decision Support Tool (IAR-DST)

The IAR-DST is a clinically informed online tool designed to support GPs and allied health professionals choose the most appropriate mental healthcare treatment for their patients. The tool offers a standardised, evidence-based and objective approach to make recommendations in a primary care setting. We have conducted training sessions with GPs and other clinicians to enable them to learn about, meaningfully use, and embed the IAR-DST into their clinical practice.

- 56 IAR-DST training workshops were conducted both online and face-to-face
- Over 25% of GPs in our region have been trained

▶ youtu.be/orc1pT7iy1I

Find out more:

nbmphn.com.au/IAR

Medicare Mental Health Phone Service

Medicare Mental Health (phone service) is available nationally to people of all ages. Clinicians will help people find the most appropriate local mental health support that meets their individual needs. This may include referring them to the Hawkesbury or Penrith Medicare Mental Health Centres, or to other services. In our region, the Medicare Mental Health clinicians work directly for our organisation. Having clinicians who work or live locally means they have a good understanding of the challenges and concerns people experience in our area, what local services are available and what service would be the best fit.

- 3,561 calls taken to assist people with mental health service navigation and referral
- We received 13% of all calls in NSW, despite our region representing 4.8% of the NSW population

Find out more:

nbmphn.com.au/MedicareMentalHealth

Mental Health Help Website

This free online directory helps the community and health professionals search over 200 local mental health services. Providers in our region can add their services to the website for free and manage their own listings.

- 32,259 page views
- 14,420 sessions
- 11,170 users
- 38 new services were approved

Find out more:

MentalHealthHelp.com.au



Simon Griffin and Joshua Stojanovic at the Roses in the Ocean Lived Experience Summit.

Suicide Prevention Coordinators

Our Regional Suicide Prevention Coordinators use the Black Dog Institute's nine strategy Lifespan Model, which is an evidence-based, integrated systems approach to suicide prevention. Working on community-led initiatives, stakeholder engagement is a primary focus to understand emerging themes and trends across priority populations at risk.

- Facilitated the presentation of mental health services at the NSW Police Nepean Principal's Forum, Hawkesbury School Partnerships Meeting and attended events including Hawkesbury Wellness and Suicide Prevention (HWASP), the Hope Walk, Meet your Neighbour Blue Mountains and Lithgow's She Is Not Your Rehab
- 186 engagement activities undertaken including events, meetings, panels, communities of practices, consultations and presentations

The coordinators have created and facilitated meaningful connections across the community, health and education sectors. This has resulted in a greater understanding of the community-led suicide prevention opportunities available to the community.

Find out more:

nbmphn.com.au/SuicideSupport

"I just wanted to reach out individually to say thank you for your hard work. It is people like yourself who are willing to go above and beyond that will help make a difference in the suicide prevention space."

University
Stakeholder



Lived Experience of Suicide Summit 2025.

Suicide Prevention Collaborative

The Nepean Blue Mountains Suicide Prevention Collaborative unites individuals and organisations committed to suicide prevention across the region. Through funding from the Australian Government's Targeted Regional Initiatives for Suicide Prevention program, we provide backbone support for administration, governance and capacity building and remunerate people with lived experience who contribute to the collaborative. Members include those with lived and living experience of suicide, as well as representatives from government and non-government organisations, community groups, volunteers, the public and local businesses.

Through the Black Dog Institute's Capacity Building Program, participants achieved personal and professional growth, enhanced cross-sector collaboration, championed lived experience engagement and developed the skills to support people in distress or who have been bereaved by suicide.

- 22 members representing each local government area in our region
- 8 members representing their lived or living experience of suicide
- 11 meetings held

We see the Collaborative's longevity as an essential part of a system that helps prevent suicide. Members value the nine strategy Lifespan Model as a practical roadmap for local impact. With 42 proposed activities, working groups are now implementing three key strategies and six priority initiatives. Key strategies include:

- Training the community to recognise and respond to suicidality
- Engaging community, involving them in awareness campaigns and local forums
- Improving the skills and confidence of front-line workers, educators and first responders to deal with suicidal crisis

Find out more:

nbmphn.com.au/SuicideSupport

“I believe great effort goes to making every voice and opinion heard and considered and they [the Wentworth Healthcare team] truly put the voice of community and stakeholders at the centre of the group. It is a powerful experience watching people feel safe enough to express their opinions, show their vulnerability, and know there is never a wrong answer, just at times different, and that together we can work towards making a vital difference to the lives of those who experience suicidality, those bereaved by suicide, and those that wish to end what is an unacceptable rate of unnecessary lives lost within the community by working together on ways to bring awareness, understanding and support.” Stephanie Robinson, CEO of Lifeline Central West



Joint Regional Mental Health Suicide Prevention Plan

Together with NBMLHD, we have released version 3 of the Joint Regional Mental Health and Suicide Prevention Strategic Plan 2021-2026. Since the inception of the Strategic Plan, we have increased access to free mental health services and suicide support services eg. universal aftercare, the embedding of Medicare Mental Health Centres, the establishment of headspace Hawkesbury and ongoing support of Safe Haven integration within the Penrith Medicare Mental Health Centre.

The Bilateral Agreement between NSW Health and the Federal Government Department of Health, Disability and Ageing provides funding that enables us to expand existing services and commission new services with an integrated approach to address local, specific needs.

- Continuation of the Medicare Mental Health Centres in Hawkesbury and Penrith and the phone service
- Investing in child mental health and social and emotional wellbeing
- Enhancement and integration of youth mental health services through headspace including additional clinicians

- Universal aftercare services – implementation of the NSW Way Back Service in Penrith from July 2024, with expansion plans to encompass additional LGAs in 2026
- Postvention support – Youturn providing the Standby Support After Suicide program across the region
- Establishment of the Suicide Prevention Collaborative, ensuring that the perspectives of lived experience remain central to decision making
- Mental health workforce and regional planning and commissioning – ongoing commitment of Commonwealth and state to work collaboratively
- Update our Joint Regional Mental Health and Suicide Prevention Plan by July 2026 and implement recommendations

Find out more:

nbmphn.com.au/JRMHSP

Right Care, First Time, Where You Live

We worked closely with the University of Sydney's Brain and Mind Centre on the Right Care, First Time, Where You Live program to develop and implement a local system modelling tool. This tool can be used to help decision-making regarding youth mental health interventions in our local area.

The program co-created a dynamic systems model that can provide a bird's-eye perspective on what is happening in our region's youth mental health system.

The model can be used by decision makers to test 'what-if' scenarios. For example, "What if we increased mental health education programs in schools? Would that reduce the number of young people going to emergency departments in acute psychological distress?" From these scenarios, the system can help determine the types of programs and services that will have the most impact and benefit for young people.

- Over 60 stakeholders, including local community organisations, young people with lived experience of mental health concerns, and various government and health sector representatives, including the Nepean Blue Mountains Local Health District
- 11 of our young people attended advocacy and health economics training along with 26 other stakeholders

We will utilise this tool to support our commissioning and advocacy work moving forward. It will also be accessible to those involved in the workshops to support their program and advocacy work.

Find out more:

nbmphn.com.au/RightCare

“I think it sounds wonderful, the technique can be applied without bias from different services. Including lived experience is so important and they've done a wonderful job of that, getting all these young people in the room.”
headspace Lithgow youth representative

New Aboriginal Wellbeing Commissioning Process

After recognising a gap in suicide prevention programs in the Aboriginal community, we took a new approach to sourcing community-led programs. Drawing on insights from other PHNs, a commissioned report by Ochre and Salt and research into Aboriginal mental health programs, we adopted a more flexible and culturally sensitive process.

The Aboriginal Wellness, Healing and Suicide Prevention Program reshaped its communication approach, simplifying content, using familiar language, incorporating Aboriginal artwork and iconography and supporting potential collaborations between organisations. Applicants could present their projects on Country and access pitch coaching to strengthen their presentations.

The program received highly positive feedback, with many highlighting the valuable opportunity it offered to community organisations to present their projects in a different light. The evaluation team also observed that the environment fostered a shared cultural space for all participants.

Find out more:

nbmphn.com.au/SuicideSupport

Postvention Community Response Coordination

Providing dedicated support to people who are bereaved by suicide is a form of suicide prevention, as those impacted can be at a higher risk of suicide themselves. Community organisations working with government and non-profits can be best placed to identify groups of people who have been impacted and provide assistance.

We engaged Youturn, providers of the StandBy program, to enhance and strengthen collaboration, activate and integrate available services and supports, and assist the community to build suicide prevention capacity.

StandBy will establish and coordinate an ongoing Postvention Community Action Group from which stakeholders can form localised Postvention Community Response Groups. The aim is to prevent, identify, contain and reduce the risk of suicide during each response to one or more specific suicides, where the incident is likely to increase exposure and risk in the community. Coordination of a Postvention Community Action Group will increase community resilience, knowledge, awareness and skills in the postvention space and they will work in conjunction with our Suicide Prevention Collaborative for holistic planning.

Find out more:

nbmphn.com.au/SuicideSupport

Lived Experience Representation

We have expanded opportunities for people with lived experience of suicide to actively contribute. These include roles on evaluation panels, such as the Aboriginal Wellness and Suicide Prevention EOI Panel and the Postvention Community Response Coordination Panel. They also involve providing advice and guidance through the Suicide Prevention Collaborative and the Mental Health Consumer and Carers Group. Bursaries to the Lived Experience of Suicide Summit and Indigenous Suicide Prevention Forum further supported community knowledge and expertise.

A lived experience of suicide is having experienced suicidal thoughts, survived a suicide attempt, supported a loved one through suicidal crisis, or been bereaved by suicide. Roses in the Ocean

Suicide Prevention Bursaries Program – Lived Experience of Suicide Summit

To support and encourage participation of people in our region with lived and living experience of suicide in national conversations, we funded five bursaries to attend Roses in the Ocean’s Lived Experience of Suicide Summit. The Summit is an innovative, interactive, workshop-style forum to find new ways of reducing distress and preventing suicide.

“I will use my learning to continue to push and advocate for positive change, to challenge systems and unhelpful help and I will use my lived experience where it’s most powerful and raise the voices of those who aren’t heard enough.” Bursary recipient

Suicide Prevention Bursaries Program – Indigenous Suicide Prevention Forum 2025

To support and encourage participation from local Aboriginal and Torres Strait Islander peoples in national conversations to prevent Aboriginal suicide, we funded bursaries to attend the Indigenous Suicide Prevention Forum. The forum provided a platform for experts, community leaders and practitioners to come together to share their insights, learn from one another and form partnerships that will strengthen the collective approach to suicide prevention.

Bursaries were awarded to six local Aboriginal staff members from: Merana Aboriginal Community Association for the Hawkesbury Inc, Muru Mittigar Ltd, Sydney Region Aboriginal Corporation and Nepean Community Neighbourhood Services. Several of our staff were also funded to attend this event to represent our organisation and support the bursary recipients.

Find out more:

nbmphn.com.au/SuicideSupport



“Trauma exposure is nothing new for community workers but it catches up with you and exposure to suicidal ideation is daily for our Aboriginal workers. A big piece of the puzzle is strengthening our workforce because if we’re not strong we can’t help our people.” Bursary recipient



POPULATION HEALTH

HealthPathways

HealthPathways is an online tool that supports health professionals with clinical and referral information at the point of consultation. Developed collaboratively by GPs, hospital clinicians, and other health professionals, it reflects strong cross-sector collaboration to produce locally relevant, practical pathways of care. HealthPathways continues to adapt to local needs, supporting clinicians in providing timely, community-based care.

- 76 pages were localised and another 78 pages were reviewed
- A total of 626 pathways have been localised for our region
- 86,711 page views
- Rollout of Phase 1a and 1b of the Statewide Referral Criteria, a joint priority with NBMLHD
- Continued strong engagement from GPs seeing HealthPathways as a trusted resource

Our HealthPathways program has evolved from a growth phase into a mature phase, with a strong focus on continuous improvement. This includes enhancing processes, embedding health equity, sustainability and consumer engagement while continuing to support primary healthcare professionals at the point of care.

The individual login account project continues into next year and presents an opportunity to re-engage health practitioners with the HealthPathways program through enhanced user experience.

Find out more:

nbm.communityhealthpathways.org

“Our practice recently used HealthPathways for gynaecological review of a patient who needed help after a miscarriage. The information we found from the HealthPathways search was great; we found a clinic to send our patient to.” Practice feedback via practice support immunisation webinar

Domestic, Family and Sexual Violence (DFSV) Care and Connect Program

The Care and Connect program supports primary care to recognise the signs of DFSV, respond appropriately to that person's needs, and make referrals to relevant agencies. The program offers targeted training and access to Care and Connect Linkers, who support practices with system navigation and service integration.

Linkers are co-located at six general practices across the region, assisting staff with DFSV-related cases and available to see patients directly. This year, we were proud to launch the expansion of the program to include sexual violence and child sexual abuse.

- 18 Care and Connect training sessions were delivered to primary care and allied health professionals with two sessions delivered to Western Sydney University medical students
- 183 attendees including 42 GPs, 53 primary care staff, 18 allied health professionals, 17 Aboriginal health workers and 51 medical students
- 110 referrals to Care and Connect Linkers
- Over 345 other engagements (case consults, support in completing forms and/or information on DFSV)
- We held a Care and Connect event, which brought together professionals and people with lived experience to spotlight the urgency of addressing DFSV, including child sexual abuse, within primary care

Find out more:

nbmphn.com.au/CareAndConnect

CARE and CONNECT

DOMESTIC, FAMILY and SEXUAL VIOLENCE PROGRAM

A patient presented at one of the co-location sites to see their GP. During the consultation, the GP suspected possible abuse and gently asked some general questions. The patient disclosed that they were incredibly frightened of their partner. As the Care and Connect Linker was onsite that day, the patient agreed to meet with her.

A risk assessment was conducted, and the patient was assessed as being at high risk. The Linker immediately coordinated with additional DFSV services. As a result, a safety plan was implemented and the patient was connected with ongoing support, ensuring their safety and access to appropriate care, which resulted in the patient moving away.



Western Sydney Health Alliance

The Western Sydney Health Alliance is a partnership across federal, state and local governments, established to improve health outcomes and design healthier, more liveable neighbourhoods in the Western Parkland City. The region is already home to more than 1.1 million people, with population expected to grow by another 500,000 by 2036.

We are proud to be one of 12 members, including the Nepean Blue Mountains and South Western Sydney health districts, PHNs, and Blue Mountains, Hawkesbury and Penrith local councils. Our involvement keeps us connected, strengthens advocacy for our communities and ensures insights from the Alliance inform our planning and projects.

We contributed to the development of a Domestic and Family Violence (DFV) Toolkit designed to support the early identification of DFV in community and primary care settings. The toolkit will be distributed to community workers, library staff and other non-clinical professionals, to enhance their capacity to recognise and respond to DFV.

We are also contributing to a project focused on developing a Disaster Preparedness Handbook, a culturally and linguistically tailored resource aimed at enhancing community awareness and readiness for heatwaves, bushfires and other emergencies. The handbook has been translated and distributed through local councils and community organisations to ensure broad accessibility.

Find out more:
wshealthalliance.nsw.gov.au

► Read about other Population Health initiatives in our **Services We Fund for the Community** section on page 43 and the **Supporting Primary Healthcare** section on page 69.

We proudly acknowledge these employees who have been with Wentworth Healthcare throughout our entire 10 years as a PHN.

- | | |
|------------------------|------------------|
| Mitchell Beggs Mowczan | Nicole Parsons |
| Tina Calarco | Rakesh Patel |
| Saskia Creed | Janice Peterson |
| Claudia Grab | Lizz Reay |
| Jackie Janosi | Julie Rigelsford |
| Elisa Manley | Kerrie Roche |
| Vicky Ogden | Jessica Savill |

Wentworth Healthcare

Level 1, Suite 1, Werrington Park Corporate Centre,
14 Great Western Highway
Kingswood NSW 2747

T (02) 4708 8100

POSTAL ADDRESS

Wentworth Healthcare,
Building BR, Level 1, Suite 1,
Locked Bag 1797,
Penrith NSW 2751

For more information about Wentworth Healthcare
or Nepean Blue Mountains PHN visit
nbmphn.com.au

808_0425

While the Australian Government contributed funding for this material, it has not reviewed the content and is not responsible for any injury, loss or damage however arising from the use of or reliance on the information provided herein.

Some imagery in this document from www.flaticon.com and www.freepik.com