Comprehensive Needs Assessment Report 2014-15

Executive Summary

Nepean-Blue Mountains Medicare Local (NBMML) is a not for profit organisation that works to improve health for the communities of Blue Mountains, Hawkesbury, Lithgow and Penrith. The organisation does this by working with and providing support to general practice, other primary health care providers and the many health and non-health stakeholders across the Nepean-Blue Mountains (NBM) region. The mission of NBMML is to Improve the health of the region through patient centred health care and primary care integration.

Needs assessment has become an integral part of the process by which NBMML sets its strategic direction and ensures it responds to localised primary health needs of providers and consumers. This document is a result of cumulative work conducted over an 18 month period during which time the NBMML collected data from a variety of sources on health needs across the region. This included consultations with consumers via a series of community forums held in each of the NBM region's 4 LGAs plus an online survey and a telephone survey of consumers. Consultations were also conducted with GPs and Allied Health Providers, including a survey concerning the needs of 90 GPs and 157 Allied Health Professionals, and other stakeholders. In addition, an extensive desk top review of published data was conducted with the formation of a population profile.

An assessment of this data was undertaken using the triangulation process to produce a list of health needs. These were considered by the NBMML Comprehensive Needs Assessment Steering Committee who met face to face on two occasions in 2014 and communicated electronically to assist in the prioritisation of these health needs and strategic activities. The CNA Steering Committee consisted of representatives from Allied Health, General Practice, the University Sector, the NBM Local Health District, consumers, and the NBMML including the health planner. The results from the CNA Steering Committee were presented for consideration and approval by the NBMML Board.

The core needs in the NBM region identified by the CNA process were: obesity/diabetes/cardiovascular disease; mental health; cancer; aged healthcare; access needs; and cultural/demographic needs.

In response to these identified needs NBMML has put forward a suite of strategies and activities to action (see Table 6, pages 24-28). The NBMML will Increase coordination, collaboration and communication between primary health care providers across the primary, acute, community and aged care sectors to improve care and increase capacity of providers and services. NBMML will coordinate, deliver or advocate for services where there are gaps such as General Practice after hours services, chronic disease and self-management programs, mental health services, pain management programs for elderly.

Another focus area will be to improve access to primary health care for particular population groups such as older people and Aboriginal and Torres Strait Islander people and work with primary health care providers to increase rates of immunisation and cervical screening in regions and/or population groups where rates are low. NBMML will work with the NBM LHD to identify opportunities for value add via involvement of primary care in illness prevention strategies.

Over the next twelve months, NBMML will Identify and respond to primary health care workforce gaps across the region and develop and promote referral pathways, particularly where there is identified service capacity, and continue to develop as a centralised information point for primary care services for health professionals, consumers and their carers. NBMML will work with others to address issues that impact on access to health care specific to the NBMML region e.g. transport and natural disasters.

A number of needs were identified as part of the CNA process that were shortlisted but were excluded as priorities for the NBMML. Strategies were excluded if it was felt there was a duplication of services or if the activity/service was the core business of another organisation, There were also some strategies that were considered not cost effective in light of available health funds e.g. a program of Dialectical Behaviour Therapy. Needs were also considered in light of the mandate given to Medicare Locals and the 2014-17 NBMML Strategic Plan. Some needs were considered outside the remit or level of influence of the NBMML and primary care. In some cases it was thought best to advocate for others to address these needs (see Excluded Needs/Issues on page 32).

The needs identified as part of the CNA process fit with the strategic directions of the NBMML as outlined in the NBMML 2014-17 Strategic Plan. The needs will be addressed over this three year period. The resources required to implement strategies identified as part of the CNA were considered as part of the annual planning process and needs were further prioritised to identify those that could be addressed in the upcoming 2014-15 year considering available resources. The resources required to implement these strategies over the next 12 months are outlined in the 2014-15 Annual Plans and Budgets.

NBMML will evaluate the performance of the activities and programs which have been generated by the needs assessment process on an on-going basis each year and the results will feed into the development of future needs assessments.

Section 1 – Planning (Phase 1)

Table 1 - Phase 1 Selected Gate Review Items

Item Title	Complete?
Phase 1	
Governance established (Strategic Leadership Group (or similar) appointed).	✓
Stakeholder mapping has been completed and analysed – appropriate partnering and engagement plans developed.	✓
Data sources (secondary and primary) identified (including existing reports and relevant background information from partners).	✓
Resourcing (with appropriate capacity and capability either internal or external) has been acquired, and are aware of their involvement and commitment.	✓
Project Plan (including schedule, resourcing capacity and capability, methodology, measures of success and a risk management strategy) completed & approved.	✓
Project Plan is in alignment with the CNA Reporting Template and describes how final outputs are expected to be published and distributed.	✓

Section 2 – Assessing Needs (Phase 2)

Table 2 - Phase 2 Selected Gate Review Items

Item Title	Complete?
Phase 2	
Part A – Compiled and reviewed data on health inequity, key demographic trends and decided on special needs groups (or sub-regions) where issues/needs may exist based on evidence.	✓
Part B - Compiled and reviewed data on health outcomes, health status and health utilisation as well as considered available information on patient experience or consumer satisfaction.	✓
Part C - Compiled and reviewed data/information on service provision including mapping service capacity and considering gaps in access for vulnerable and marginalised populations.	✓
Part D - Findings from the community profile completed in A, B and C informed the scope of and approach to community engagement and health professional and service provider consultations.	✓
Part D1 **-** The community has been appropriately consulted (considering the most appropriate engagement methods) including consultations with special needs groups where identified and deemed important.	✓
Part D2 **-** Health professionals and service providers have been appropriately consulted (considering the most appropriate engagement methods) including consultations with special needs groups where identified and deemed important.	✓
Part E **-** Data and information from Parts A, B, C and D has been compiled and a final population health profile has been completed, including consideration of normative, comparative, expressed and felt needs. The Strategic Leadership Group (or similar) has approved the final population profile.	✓
Part E **-** A shortlist of needs, using that profile as a key input, has been generated. The Strategic Leadership Group (or similar) has approved the final shortlist of issues/ needs.	✓

NBMML Comprehensive Needs Assessment 2014-15
Table 3: Population Profile
Available on request

Comprehensive Needs Assessment – Table 4

Nepean-Blue Mountains Medicare Local	Issue/Need	Brief description of issue/need	Population group(s) affected and inequities identified	Summary of key evidence	Links to Table 6 Priorities for 2014-15 (i.e., is the issue/need established as a priority for 2014-15?)	If answered 'No' - will the issue/need be funded and/or implemented by another organisation?	If answered 'Yes' or 'In Partnership' - describe the organisation's type
	Diabetes/Obesity and Cardiovascular	* High rate of obesity * Pockets of higher diabetes prevalence * Relatively high mortality rate from cardiovascular disease	All population groups affected. Greater rate of illness among lower socio-economics	* 64% of adults are overweight or obese * Pockets of higher diabetes prevalence in Lithgow (7.1%) and Nepean (6%) compared to NSW (5.7%) * Highest mortality rate from CVD of the 8 metropolitan LHDs	Yes	Partnership with NBMLHD	NBMLHD. [1] Australian Diabetes Council National Heart Foundation

[1] A joint Board planning group of the ML and the Local Health District has been formed to fully scope this issue and develop an action plan to be rolled out later this year. First deliverable is a Board paper

	Mental Health	Relatively high rate of mental distress in the community	All population groups affected. Certain groups such as the young, the homeless, the unemployed or those with substance abuse problems are particularly vulnerable	* 29670 people reported high psychological distress over a 12 month period * Region ranked 2nd highest in self rated high to very high psychological distress in population aged 16 and over in 2011 * 3rd highest mental disorder death rate 2010-11 out of eight metropolitan LHDs	Yes	Partnership with NBMLHD	NBMLHD. [2] St John of God After Care UnitingCare Mental Health Richmond PRA Family and Community Services (NSW)
	Aged Healthcare	Growing need for aged care services due to the aging population in line with demographic trend nation-wide	N/A	Region ranked 3rd highest in proportion of population to be aged 70 and over by 2033, out of 8 metropolitan LHDs	Yes	In Partnership	Working in partnership with Residential Aged Care Facilities across the region.
	Cancer	* Relatively high smoking rate * Relatively low participation in cancer prevention schemes * Relatively high rate of mortality from cancer	All population groups affected. Greater rate of illness among lower socio-economics	* Responsible for 30.2% of all deaths (NSW: 29.1%) * Cancer death rate is 3rd highest of all the metropolitan LHDs in NSW	Yes	In Partnership	Local Health District Blue Mountains Cancer Help Cancer Institute NSW

[2] A joint Board planning group of the ML and the Local Health District has been formed to fully scope this issue and develop an action plan to be rolled out later this year. First deliverable is a Board paper

	Access Needs	* Access needs relating to some remote settlement * Access needs relating to some pockets of economic hardship	Those in remote communities, those from lower socio-economic groups, etc.	* Number of patients presenting to ED at hospitals in the region over a 12 month period: 103582. * 10,438 people reported often having difficulty or being unable to travel to places due to lack of transport over a 12 month period * Lithgow and areas of Blue Mountains classified as rural (RA2) * 23% of adults reported delaying or not seeing a dentist or dental hygienist due to cost over a 12 month period	Yes	In Partnership	Nepean Blue Mountains Local Health District Peppercorn Transport Great Community Transport Lithgow Community Transport Contracted general practices across the region Deputising service (Family Care Medical Services) Hawkesbury District Health Service (Catholic Healthcare)

	Cultural Needs/Demographic	* Cultural needs mainly relating to relatively high proportion of population being of indigenous origin * Cultural needs relating to increasing settlement of refugees * Demographic needs relating to relatively youthful population	Indigenous groups and those from CALD communities, homeless people and youth.	* Approximately 3% of the population in the region report themselves as being of indigenous origin. * There were 24,293 persons aged 5 years and under in the region	Yes	In Partnership	NBMLHD Blue Mountains Aboriginal Health Coalition Headspace (UnitingCare Mental Health)

Triangulation Process

Triangulation is the process that combines the findings from the community and stakeholder consultations and data analyses and compares and crosschecks the results. Triangulation enabled the CNA Steering Committee and the project team to identify and confirm the major needs and key issues that have emerged for the NBM region and communities. Qualitative and quantitative analyses were undertaken concurrently, the information integrated and results compared to identify key issues and confirm the overall findings. Consumer, community and professional views were treated the same, depending on the quality of the evidence.

A basic thematic shortlist of issues was developed for each sub-region and the NBM region based on the population profile and cross-checked to see which issues were identified and raised in the data analyses, community or special needs group consultations and by health professionals or service providers.

NBMML utilised a triangulation matrix to perform the triangulation. Issues were listed on the triangulation matrix and allotted a score to indicate how issues raised in community or stakeholder consultations compared with the findings of the data analyses on health status, social determinants of health, service usage or prevalence of risk factors.

Data was compiled from such sources as the Australian Bureau of Statistics, NSW Ministry of Health, Australian Medicare Local Alliance, Australian Institute of Health and Welfare, Public Health Information Development Unit and NBMML Consumer Engagement Reports. An online survey of service providers together with a separate survey of GPs and Allied Health Providers relating to their needs was used as the data representing the views on service providers in the region.

The results of focus groups on consumer opinions was used as the basis of input from consumers. This was supplemented by the results of an online survey of consumers which was available for consumers who did not attend the consumer forums. NBMML also conducted a further telephone survey researching the attitudes and behaviours of 260 health consumers in the NBM region.

Data was assigned a score, or weighting, which was shown by either a four star rating indicating ‘raised frequently as a high priority issue or concern needing action’; a three star rating indicating ‘raised frequently as an important issue/concern evident in data’; a two star rating indicating ‘raised as an issue/somewhat evident in data’; or a one star rating indicating ‘rarely raised as an issue/not evident in data’. Where issues or needs arose consistently or rank highly in two to three of the domains they are likely to represent a need which warrants serious attention in the region.

The triangulation matrix was cross-checked to determine if issues raised by stakeholders and communities were reflected in the data on health status/outcomes, utilisation of health services and primary care system capacity. Issues identified in the data were compared and cross-checked with the views and issues identified in consultations with the community, priority population groups, health professionals and other partners. This includes confirming which social determinants of health may impact on the health outcomes of concern identified in consultations. Additional data analyses were undertaken and extra information gathered from key informants and stakeholder groups where needed to further validate and confirm the issues/needs to be considered for review in the next stage. Finally, the CNA Steering Committee was convened to assess and shortlist key issues/needs.

Issues/Needs identified

Triangulation commenced with a list of some twenty five possible needs: the high rate of diabetes, low fruit and vegetable consumption; low rate of breastfeeding, high rate of cardiovascular mortality; the increase in the aged population; pain management; high rate of poisoning from accidental use of medications; mental health service availability; drug and alcohol abuse; high rate of homelessness; need for a Dialectical Behaviour Therapy; low rate of participation in breast and cervical cancer screening programs, high smoking rate; high rate of mortality from respiratory illness; the need for after-hours healthcare; the need for health transport; insufficient knowledge of health services; insufficient access to specialists and allied health; insufficient access to dental services; lack of accommodation for consumers from more remote areas and their families; aboriginal health; low participation in immunisation programs by some consumers in the Blue Mountains; multicultural health; increase in population; and youth health.

Several identified needs were excluded by a process of evaluating the weight of evidence for the need. Remaining needs were grouped along logical lines into related needs and a pattern of six core groups of health needs were shortlisted as follows:

- Obesity/Diabetes/Cardiovascular
- Mental Health
- Cancer
- Aged Healthcare
- Access Needs
- Cultural/Demographic Needs.

Section 3 – Establish priorities (Phase 3)

Table 5 - Phase 3 Selected Gate Review Items

Item Title	Complete?
Phase 3	
Assessed the impact, evidence, changeability, acceptability and resource feasibility of each issue/need.	✓
Considered and assessed strategies to address issues/needs and documented an indicative Scoping Paper for discussion in selecting priorities.	✓
Engaged with relevant stakeholders to ensure they have bought into the set of prioritised problems or factors.	✓
Validated priority setting criteria and ratings and rankings of each strategy/proposal/initiative.	✓
Prepared recommendations and received formal comment from the Strategic Leadership Group (or similar) and other stakeholders identified in *Phase 1* through stakeholder mapping.	✓
Validated and agreed the final list of priorities including those that will be progressed by the ML and those that will be progressed by other stakeholders (if applicable).	✓

Table 6: Summary of Issues/Needs and Strategies to Address

Issue/Need	Strategy	Description of Strategy Activities	Justification	Expected Outcome
Obesity / Diabetes / CV	Strengthen networks and Communication	Strengthen networks and communication b/w service providers who support care of patients with chronic disease	Feedback from service providers and consumers emphasised that there was a lack of knowledge of available services in the area and improved coordination of services supporting patients with chronic diseases needed	Remove bottlenecks from referral pathways and increase satisfaction for both consumers and providers.
	Delivery of chronic disease management and prevention programs	Support GPs' management of patients with chronic disease including through the delivery and promotion of chronic disease management, prevention and early intervention programs	Very high rate of obesity, diabetes and CVD and trend towards increasing rates and the capacity of acute sector to manage the problem. Primary care play important role in improving outcomes and slowing progression of chronic disease and its long term complications particularly with earlier identification and management	A greater proportion of patients will be identified as at risk of chronic disease at an earlier stage allowing for better impact of early intervention programs and reduced pressure on hospitals.
	Work with LHD	Work with the LHD to identify and implement strategies to address the high obesity rates within the NBM region and implement illness prevention and wellbeing programs through primary care via joint planning between the ML and LHD	The complexity of the problem of obesity and related chronic diseases requires a more thorough scoping of the current services and barriers, particularly as management of these conditions require input from both the primary and acute care sectors.	In 2015 as a result of this scoping a joint ML/LHD program of work will be designed and implemented throughout the ML
Mental Health	Improve access	Improve access to appropriate mental health services for patients with differing levels of severity and facilitate networking between mental health providers	There is currently limited capacity for the provision of acute mental health services, minimal capacity for inpatient/residential subacute mental health provision and no capacity for non-acute inpatient/residential mental health service provision within NBMLHD	Increased proportion of patients accessing the most appropriate service stream for their particular problem(s)
	Work with LHD	Work with LHD to better support primary care in the management of mental health and drug and alcohol co-morbidities	The complexity of mental health requires a more thorough scoping of the current services and barriers, particularly as management of these conditions require input from both the primary and acute care sectors.	In 2015 as a result of this scoping a joint ML/LHD program of work will be designed and implemented throughout the ML

Aged Health Care	Pain Management	Community based pain management program for elderly experiencing chronic pain	Highlighted as priority at both the State and Federal government level due to the Australia wide high rate of incidence of chronic pain, particularly in the elderly. Also highlighted by local GPs in their elderly practice population.	Better management of chronic pain for the elderly, particularly those waiting for services
	Map and Promote Pharmacists	Map and promote pharmacists that are able to conduct home medicine reviews for older patients	Identified high rate of accidental injury and poisoning resulting from the incorrect use of medication	Decreased rate of hospitalisations due to misuse of medicine
	Increase collaboration and communication	Increase collaboration and communication between General Practice and other Primary Care providers and the aged care sector and support services and advocate on issues that will improve the care of older people including provision and access to services	Service providers have expressed the need for improved communication between primary care and other sectors	Improved outcomes in aged care programs through better co-ordination and collaboration
Cancer	Address Low Cervical Cancer Screening Rates in Nepean LGA	Develop strategies to address the low rates of cervical screening in the Penrith LGA, particularly in St Marys, including promotion of the recommendations from the new cervical cancer screening renewal program	Low screening rates in Penrith LGA, particularly in St Marys. Need to ensure GPs are familiar with any new screening recommendations	Greater consistency in screening practices across the primary health care sector and increase screening rates in the Penrith LGA
	Work with LHD	Work with LHD to identify value add via involvement of primary care in smoking cessation strategies they currently undertake	Health promotion and smoking prevention material is not always accessed via GP practices. Need to ensure LHD based programs penetrate the GP and allied health network where consumers can easily access information	Greater uptake of LHD created health promotion and smoking cessation programs to support the health promotion efforts of primary care
Access	After Hours	Establish, manage and promote After Hours Primary Care services across the region	Need to ensure after-hours access across the entire ML	Reduced after hours emergency department presentations for non-urgent health problems

	Workforce	Map, monitor and support a strong primary health care workforce for the NBM region. This includes recruitment and retention strategies for primary care and advocating for specialist and private dentistry services where there are gaps	Need to ensure that an adequate primary health workforce is available across all LGAs to meet current needs and future projections of increasing population generally, and increasing ageing and youth populations. Service providers and consumers identified a lack of specialists and dentistry services especially in remote areas. Innovative solutions such as tele-health can be promoted for specialist consultation, case conference, planning and management and follow up/review post-discharge from hospital	Greater equity of access for all consumers to receive of care commensurate to their needs regardless of residential location. Continuity of primary health care access across the lifespan of individuals and reduced reliance on acute sector
	Centralised Information Point	Continue to develop as a centralised information point for primary care services for health professionals, consumers and their carers and identify responsibility for management, checking and updating of information	Consumers and health and non-health stakeholders consistently tell us they need support to navigate the health system and to know what services are available with the need for a centralised hub of information about primary care services. Current NBMML Veterans health program promotes health services available to the Veteran community, through *Homefront Assessments*	More consistent and accurate information available in one place which increases access to services by consumers and those supporting consumers
	Improved Co-ordination of Services	Work with primary health care providers, the Local Health District, community health, consumers and other stakeholders to improve the coordination of services and programs across the primary, community and acute health sectors	Service providers and consumers have identified the need for a smoother journey between primary, community and acute care with better communication between services and providers	Improved communication between providers and services and increased uptake and utilisation of available programs

	Pathways	Promote pathways through GPs to primary allied health service providers where there is capacity to reduce waiting times for access to services and develop, enhance and implement referral pathways to and from primary care to improve patient care e.g. ante-natal shared care	Need to develop and implement new models of care to better fit the demands on services	Better coordination of service delivery across sectors
	Best Practice	Promote best practice in screening in accordance with the Green Book (includes screening for STIs)	Service providers have indicated that screening practices are inconsistent and not conducted as often as recommended by best practice	Reduced rate of preventable illness
Cultural / Demographic	Indigenous Health	Continue to implement Closing the Gap, the Healthy for Life program and other indigenous health initiatives and ensure Aboriginal and Torres Strait Islander community has a voice into the work of the NBMML	Large health inequality between indigenous and non-indigenous people. In line with government health initiatives	Better health outcomes for Aboriginal and Torres Strait islander populations
	Youth	Identify and address barriers to primary health care for young people; map and promote youth-specific services and programs to health care providers	Lack of youth specific services and lack of awareness by primary health care practitioners of the availability of these services	Improved access and better outcomes through prevention
	Immunisation	Work with General Practice, the NBMLHD and the Aboriginal liaison officer to promote immunisation of children and provide information and updates to General Practice on immunisation	Pockets of low immunisation rates in some population groups and regions particularly in areas of the Blue Mountains	Improved protection from illness and securing of herd immunity

	Inequities	Work in primary care to reduce inequities in the provision of services and outcomes to those in remote areas, those with transport difficulties and to disadvantaged groups such as people experiencing homelessness, low income earners and those from CALD communities	Need for equity in access to health services.	Better primary care access for people from disadvantaged groups
	Disaster Planning	Formalise Primary Care role in disaster planning	Raised by consumers. Geography of area is prone to natural disaster such as bushfires and flooding	Efficient response to various problems associated with natural disasters including psychological issues

Excluded Needs/Issues

The relatively low rate of breastfeeding by new mothers was identified under the need of obesity/diabetes/cardiovascular disease. Many new mothers do not have the time in hospital necessary to develop breastfeeding skills after giving birth. It was suggested that more could be done to support new mothers through pre-natal education on breastfeeding and other means.

The NBMLHD is currently undertaking a review of community health and out-patient services. Until the findings of the review are provided by Price Waterhouse Coopers, it is not possible to undertake this activity so as to avoid duplication of services.

Mental Health was identified as a clear need during the Comprehensive Needs Assessment process. Those suffering from Borderline Personality Disorder were noted to draw a large amount of resources from the mental health system. To address this need and to reduce the amount of resources consumed by this particular part of the mental health community, establishment of a program offering Dialectical Behaviour Therapy was considered. There is evidence that Dialectical Behaviour Therapy is effective in patients suffering from Borderline Personality Disorder.

Dialectical behavioural therapy, although effective for treatment of Borderline Personality Disorder, was determined to be prohibitively expensive considering the relatively low rate of incidence of BPD and the large resource investment required to set up and run the program.

The long distances that some patients have to travel was identified as a factor impacting on access to health services for some patients needing intensive or frequent services. The establishment of accommodation services for patients and their families was identified by consumers as a possible means of increasing access for these consumers.

The LHD has an accommodation services for consumers and their families and the need for NBMML to establish such a service would result in duplication of this service. Accommodation services for patients and their families was excluded as a priority.

As stated above, the NBMLHD is currently undertaking a review of community health and out-patient services which will also look into patient transport and accommodation. Again, until the findings of the review are provided by Price Waterhouse Coopers, the NBMML will not be planning any activities in relation to the NBMLHD services which require accommodation.

Low access to dental health services was also identified as a need, with some consumers having to wait for substantial periods of time to see a dentist.

The NSW Ministry of Health has funded the NBMLHD to broaden dental service provision in the region. The new and expanded service has been addressing waiting lists. It was agreed the NBMML was better placed to take on an advocacy role if needed.

Section 4 – Confirm priorities for action (Phase 4)

Table 7 - Phase 4 Selected Gate Review Items

Item Title	Complete?
Phase 4	
Presented the recommendation to the ML Board and gained endorsement.	✓
Developed action plans for each initiative and implemented a stakeholder communication. strategy	✓
Set up the post-CNA evaluation review process.	✓

Board Approval

An assessment of the accumulated data was undertaken to produce a list of health needs. These were considered by the NBMML Comprehensive Needs Assessment Steering Committee who met face to face on two occasions in 2014 and communicated electronically to assist in the prioritisation of these health needs and strategic activities. The NBMML Board have received the resulting CNA document which has been scheduled in the Board calendar for approval. The NBMML Board have approved the Annual and Strategic Plan and Budgets which were informed by the CNA.

Feedback to Stakeholders

The CNA is a valuable document that informs the Strategic Plan. Both documents will be made available to our key stakeholders with whom we work in partnership to achieve outcomes in key priority areas. In addition, information collected as part of the ongoing identification of needs has been made available. For example the needs identified as part of the consumer forums and surveys have been documented and published as consumer reports for each of the four LGAs within the NBM region. These are available on the NBMML website.

CNA Review

NBMML will set in place a process and timeline for CNA review. An ongoing mechanism of consultation and feedback will be established with stakeholders. The CNA process will be evaluated through feedback from CNA Steering Committee members on process, role, composition, etc.

The NBMML has also contracted with the University of Western Sydney to develop the NBMML evaluation framework for evaluation of programs. This framework is based on a Program Logic Model (PLM) and has been developed in close collaboration with a Project Reference Group convened by the NBMML. The model assess programs against five key areas as well as indicators and measures recommended for evaluation. These have been aligned with the NBMML Strategic Plan 2014-17.

The key components of the PLM based model of evaluation are: Inputs, Activities, Outputs, Outcomes and Impacts:

Inputs includes the human, financial, organisational and community resources a program has available to direct toward doing the work. This area assesses such indicators as funding, management/governance structures, staff resources at NBMML and at key stakeholders, community, consumer stakeholders, research evaluation expertise, technology and others.

Activities refers to the way resources are utilised. Activities are the processes, tools, events, technology and actions that are an intentional part of the program implementation. These interventions are used to bring about the intended program changes or results.

Outputs are the direct products of activities and may include new resources and/or types, levels and targets of services and programs delivered by the NBMML. This area assesses such indicators as program implementation and program evaluation itself.

Outcomes are the specific changes in program participants' behaviour, knowledge, skills, status and level of functioning. This area assesses such indicators as the level of stakeholder knowledge or programs, consumer access to programs and achievement against stated outcomes.

Impacts are the fundamental intended or unintended change occurring in organisations, communities or systems as a result of program activities. This area assesses such indicators as enhanced local community health and wellbeing and integrated and coordinated health services.

Economic Evaluation of activities and programs will also be carried out by NBMML. Analysis on the cost effectiveness of programs will be conducted throughout the year to ensure that value for money is being had from programs.

The NBMML now has the following key documents to inform the roll out of health services and programs:

- Comprehensive Needs Assessment
- 2014-17 Strategic Plan
- 2014-15 Annual Plan and Budget
- NBMML Evaluation Framework

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