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CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

EXECUTIVE SUMMARY

2025-2027 Needs Assessment

EXECUTIVE SUMMARY

Contents

List of tables 3
List of figures 3
Introduction 5
Health issues 5
Health of specific populations 5
Access and Coordination 5
Central and Eastern Sydney region 6
Demographic profile 7
Population growth 8
Health status 9
Life expectancy 10
Potentially avoidable deaths 10
Child mortality 11
Premature mortality 12
Psychological distress 13
Primary care landscape 14
Future directions and priorities 14
Methodology 15
Strategic alignment 17
Stakeholder engagement and consultation process 18
Analysis, triangulation, and prioritisation of community needs and service gaps 20
Approach to data analysis 20
Approach to data triangulation and prioritisation and insights 20
Data limitations 20
Health Needs analysis 22
Service Needs Analysis 34
Priorities and opportunities 36
Checklist 49
References 50

List of tables

Table 1: Estimated resident population (ERP) in the CESPHN region by SA3, 2023 8
Table 2: Housing targets by LGA, 2024 8
Table 3: Population projections by age groups, CESPHN region, 2024-2041 9
Table 4: Premature mortality per 100,000 people by cause and by SA3, 2018-22 13
Table 5: Proportion of psychological distress experienced, CESPHN and NSW, 2013, 2023 14
Table 6 Stakeholder engagement process 18

List of figures

Figure 1: Population projections by sex and five-year age groups, CESPHN region, 2024-2041 9
Figure 2: Life expectancy, CESPHN and NSW, 2010-2022 10
Figure 3: Potentially avoidable deaths in the CESPHN region (ASR per 100,000) by SA3, 2022 11

EXECUTIVE SUMMARY

In this document we have used the terms Aboriginal, Aboriginal person and Aboriginal people/s when referring to Aboriginal and Torres Strait Islander peoples. We chose Aboriginal because it is inclusive of different language groups and areas within the CESPHN region. There will be some instances where the terminology will be different to our preferred terms, as we use the terminology of the data set being used.

EXECUTIVE SUMMARY

Introduction

The purpose of this Needs Assessment is to identify community health and wellbeing needs, gaps in service delivery and to work with partners across the region to address these.

Central and Eastern Sydney Primary Health Network (CESPHN) will use the Needs Assessment to:

- Better meet the health and wellbeing needs of residents
- Inform CESPHN's strategic direction
- Plan for commissioning services and programs
- Prioritise work with partners
- Share insights and data with services and the community
- Build relationships and engage with the community around joint initiatives.

Stakeholder engagement and insights, combined with the rigorous analysis of public datasets, such as Census data and other relevant information, provide us with a comprehensive picture of appropriate and fit-for-purpose responses that support, strengthen, and shape a person-centred primary healthcare system.

CESPHN conducted consultations to gather community and service provider input to identify the health needs of the community as well as the service gaps that exist. This, along with data analysis and a triangulation process has led to the identification of 13 priority needs and two overarching service needs.

These are:

Health issues

- Chronic conditions
- Suicide prevention
- Mental Health
- Use of alcohol and other drugs
- Sexual health

Health of specific populations

- Aboriginal and Torres Strait Islander peoples' health and wellbeing
- Health and wellbeing of people from multicultural communities
- Older individuals' health and wellbeing
- Health and wellbeing of children in the first five years
- Health and wellbeing of people living with a disability
- Health and wellbeing of people affected by domestic, family and sexual violence
- Health and wellbeing of LGBTIQ+ people
- Health and wellbeing of people impacted by homelessness
-

Access and Coordination

- Access to primary health care
- Coordinated care.

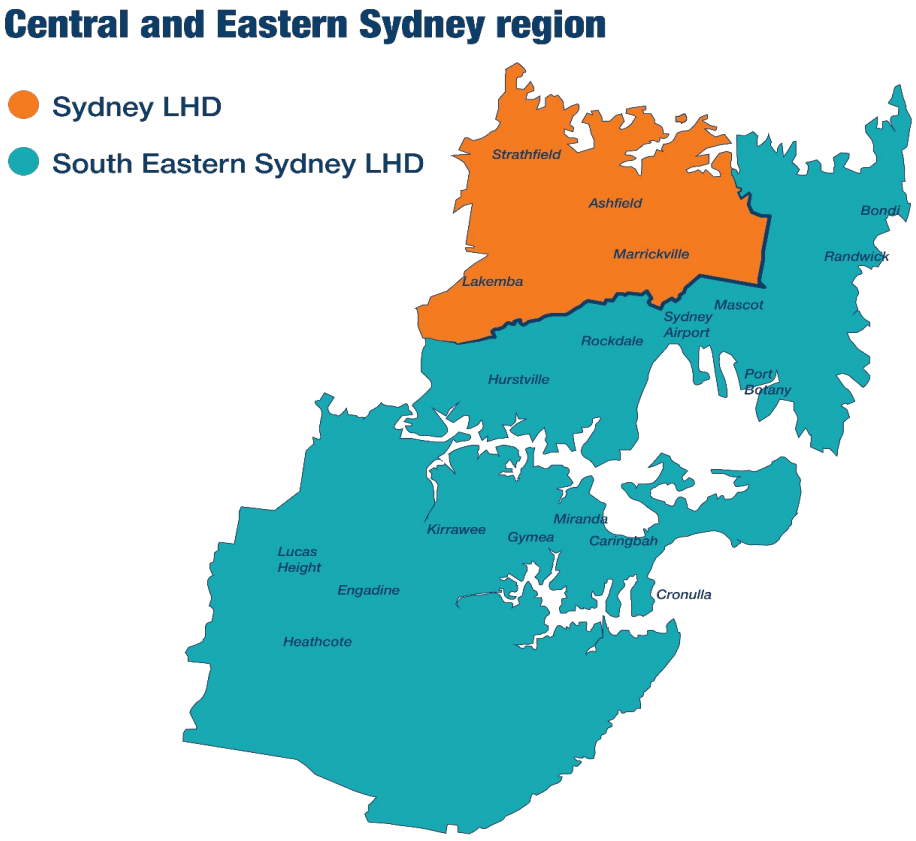
Each priority need and service gap is outlined in a chapter showing the data and outcomes of consultations. Within each chapter priority needs are outlined and service gaps specific to that need are also identified.

Central and Eastern Sydney region

The Central and Eastern Sydney region covers the area of Sydney, south of the Harbour Bridge along the coast as far as the Royal National Park, the city of Sydney itself, extending to the inner western suburbs of Lakemba and Strathfield.

The catchment area includes 12 Local Government Areas (and Lord Howe Island). The region includes the Central Business District.

The region corresponds with the two Local Health Districts of Sydney and South Eastern Sydney as shown in the image below. The Central and Eastern Sydney region is often referred to as the CESPHN region throughout this document.



Demographic profile

The estimated resident population of the central and eastern Sydney region is 1,624,881 in 2024 (approximately 20% of NSW's population) (1). This makes CESPHN one of the largest PHNs by population, comprising 6% of Australia's population (1).

Most areas have urban densities above 4,000 persons per square kilometre, but the region also includes Lord Howe Island with a total population of 452 people. At 9,489.87 people per sq km, Sydney Inner City is the most densely populated SA3 in the central and eastern Sydney region. Other highly dense areas include Leichhardt (5,387.37), Eastern Suburbs – North (5,014.65) and Strathfield-Burwood-Ashfield (4,938.83).

As a major employment, education and entertainment hub for the larger Sydney population, this region also has a large non-resident population with 350,761 people entering the region each day (2021 Census). This non-resident population also make use of the range of health services on offer.

The region contains communities of great wealth and areas of disadvantage. Woollahra is the most advantaged area in Australia. The Canterbury and Hurstville SA3s have the lowest Socio-Economic Indexes for Areas (SEIFA) values in the region, at 914 and 995 respectively and contain 281,130 (17.4%) of people in the region according to the 2023 ERP. The 2021 Census data recorded a high number of people experiencing homelessness or at risk of homelessness in the region (12,799 people). These 12,799 people represent:

- 35% of the NSW homeless population
- 66.2% of the NSW boarding house residents
- 20.8% of NSW social housing residential dwellings and long waitlists for general applicants.

There is significant cultural diversity across the CESPHN region, with the 2021 Census data showing that 40.7% of CESPHN residents were born overseas. The SA3 areas of Canterbury, Sydney Inner City, Strathfield-Burwood-Ashfield, Botany and Kogarah-Rockdale have more than 50% of their population born overseas and Hurstville has 50% of residents born overseas. Overall. 46.8% of the population speak a language other than English at home and 6.3% do not speak English well or at all. (Census, 2021).

The areas with the highest proportions of people who do not speak English well or not at all are Canterbury (14.5%), Hurstville (11.3%), Strathfield-Burwood-Ashfield (10.0%) and Kogarah-Rockdale (8.7%) and Botany (6.3%), compared to the NSW average of 4.5%. The top four languages other than English spoken at home are Mandarin (17.2%), Cantonese (Greek 8.7%) and Arabic (8.2%).

There are 16,265 Aboriginal people living in the region, representing 1.0% of the total population. The Sutherland Shire has the largest Aboriginal population with 3,273 residents (20.1% of Aboriginal population) who identify as Aboriginal or Torres Strait Islander, then Sydney City has 3,009 (18.5%) and Randwick-La Perouse has 2,354 residents (14.5%). (2021 Census). The region is home to 11,382 same sex couples, representing 14.5% of same sex couples living together in Australia. For comparison, the region comprises 6% of the total Australian population.

Table 1: Estimated resident population (ERP) in the CESPHN region by SA3, 2023

SA3	Total Persons	Density (per sq. km)
Botany	61,999	2,230.36
Canada Bay	88,731	4,493.37
Canterbury	144,858	4,834.30
Cronulla-Miranda-Caringbah	121,298	2,180.91
Eastern Suburbs - North	131,308	5,014.65
Eastern Suburbs - South	141,831	4,495.71
Hurstville	136,272	4,013.28
Kogarah-Rockdale	151,988	4,848.43
Leichhardt	57,417	5,387.37
Lord Howe Island	452	27.74
Marrickville-Sydenham-Petersham	56,334	4,446.29
Strathfield-Burwood-Ashfield	168,628	4,938.83
Sutherland-Menai-Heathcote	113,160	471.02
Sydney Inner City	237,855	9,489.87
CESPHN	1,612,131	2,708.38

Source: ABS, 2024

Population growth

There are increased planned housing targets in all LGAs in the CESPHN region over the next five years. This increased housing will allow for more people to live in the region requiring more services.

Table 2: Housing targets by LGA, 2024

LGA	2029 New Housing Target
Bayside	10,100
Burwood	3,300
Canada Bay	5,000
Canterbury-Bankstown	14,500
Georges River	6,300
Inner West	7,800
Randwick	4,000
Strathfield	3,500
Sutherland	6,000
Sydney	18,900
Waverley	2,400
Woollahra	1,900

Source: NSW Department of Planning, Housing and Infrastructure, 2024

Between 2024 and 2041, the population in the CESPHN region is expected to increase by 9.3% to 1,866,105 residents. The greatest population growth is expected in the 85 years and over age group

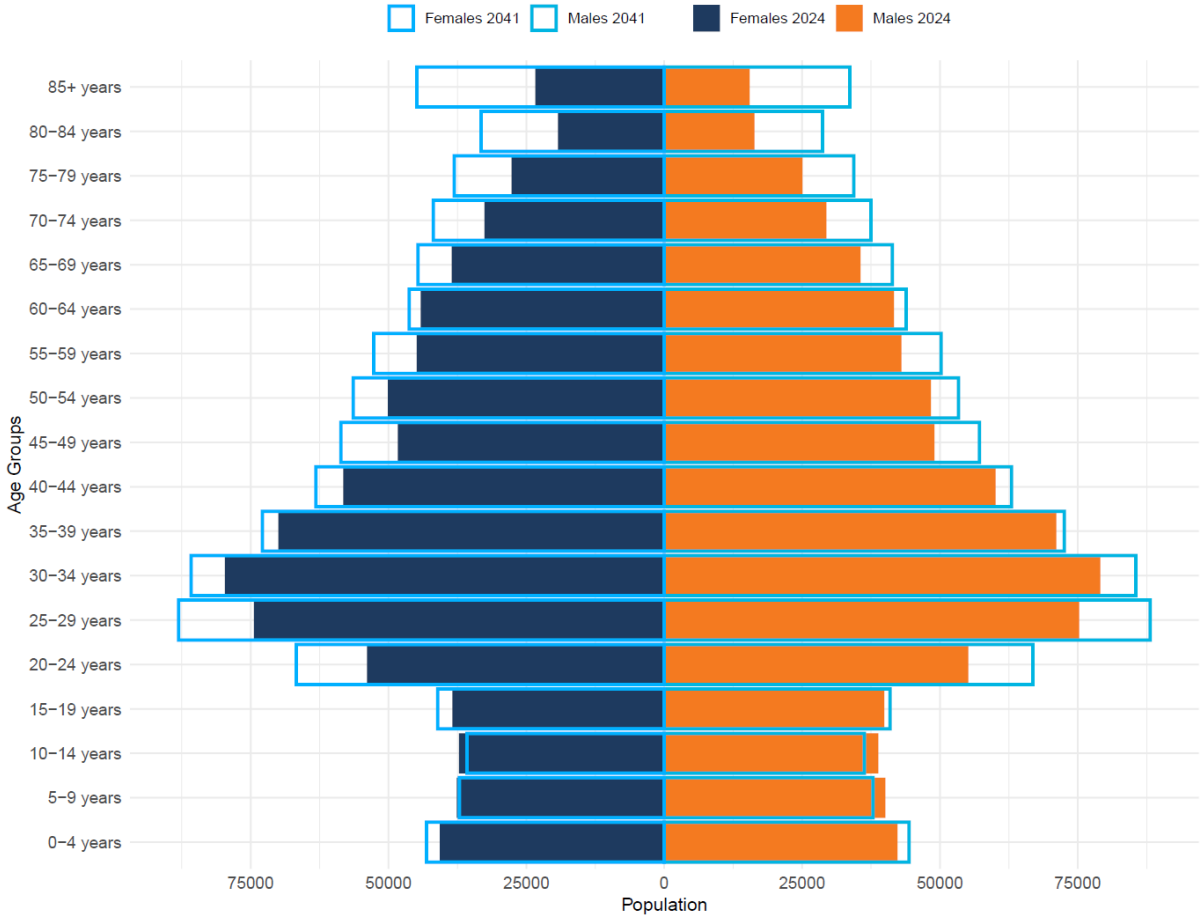
(120.4% increase). These projections are based on assumptions about future trends in fertility, mortality and migration (1).

Table 3: Population projections by age groups, CESPHN region, 2024-2041

Age group	2024	2041	% change	Compound annual growth rate (CAGR)
0-14 years	236,771	234,580	-0.93	-0.05%
15-64 years	1,124,744	1,253,317	11.43	0.64%
65+ years	346,348	378,208	9.20	0.52%
Total	1,707,863	1,866,105	9.27	0.52%

Source: HealthStats NSW, 2024

Figure 1: Population projections by sex and five-year age groups, CESPHN region, 2024-2041



Source: HealthStats NSW, 2024

Health status

The CESPHN region overall has a generally better health profile than the rest of Australia. Obesity and smoking rates are lower, people drink fewer standard drinks per day than in the rest of Australia, exercise more and suffer less mental health distress. There are less avoidable deaths and less

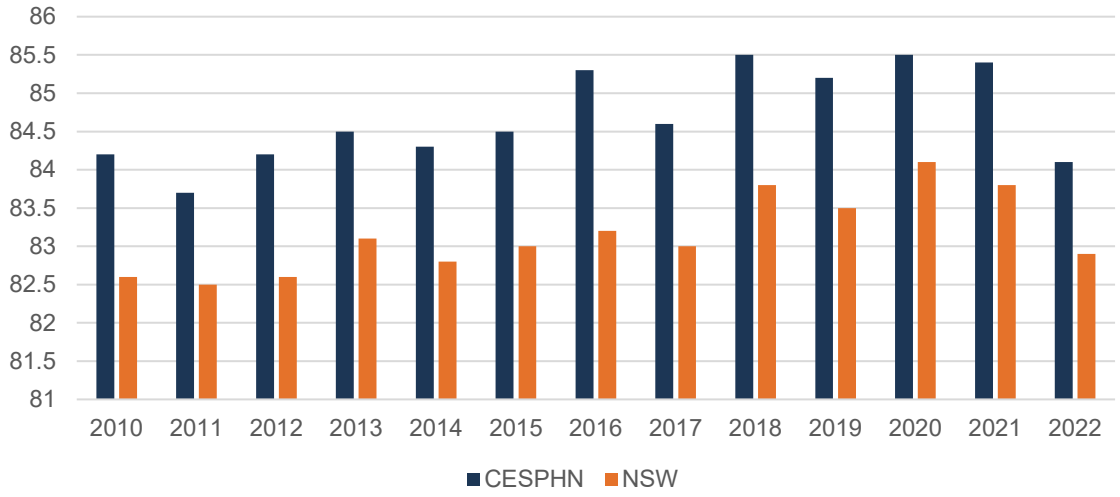
cancer diagnoses. However, there are many areas where there is room for improvement. These include immunisation rates, rates of cancer screening and rates of sexually transmissible infections.

Life expectancy

In 2022, the life expectancy at birth for those living in the CESPHN region was 84.1 years, which was higher than that of NSW by 1.2 years (2).

Life expectancy in both CESPHN and NSW have been generally trending upwards over the past 10 years, however a marked decline was seen between 2020 and 2022. (2) This decline was observed Australia wide and could be attributed to the increase in deaths in 2022, of which close to half were due to COVID-19 (3).

Figure 2: Life expectancy, CESPHN and NSW, 2010-2022



Source: HealthStats, 2024

Within the CESPHN region the female life expectancy is slightly higher (86.1 years) than male life expectancy (82.2 years). This is higher than the NSW life expectancy of 84.9 for females and 80.9 for males (2).

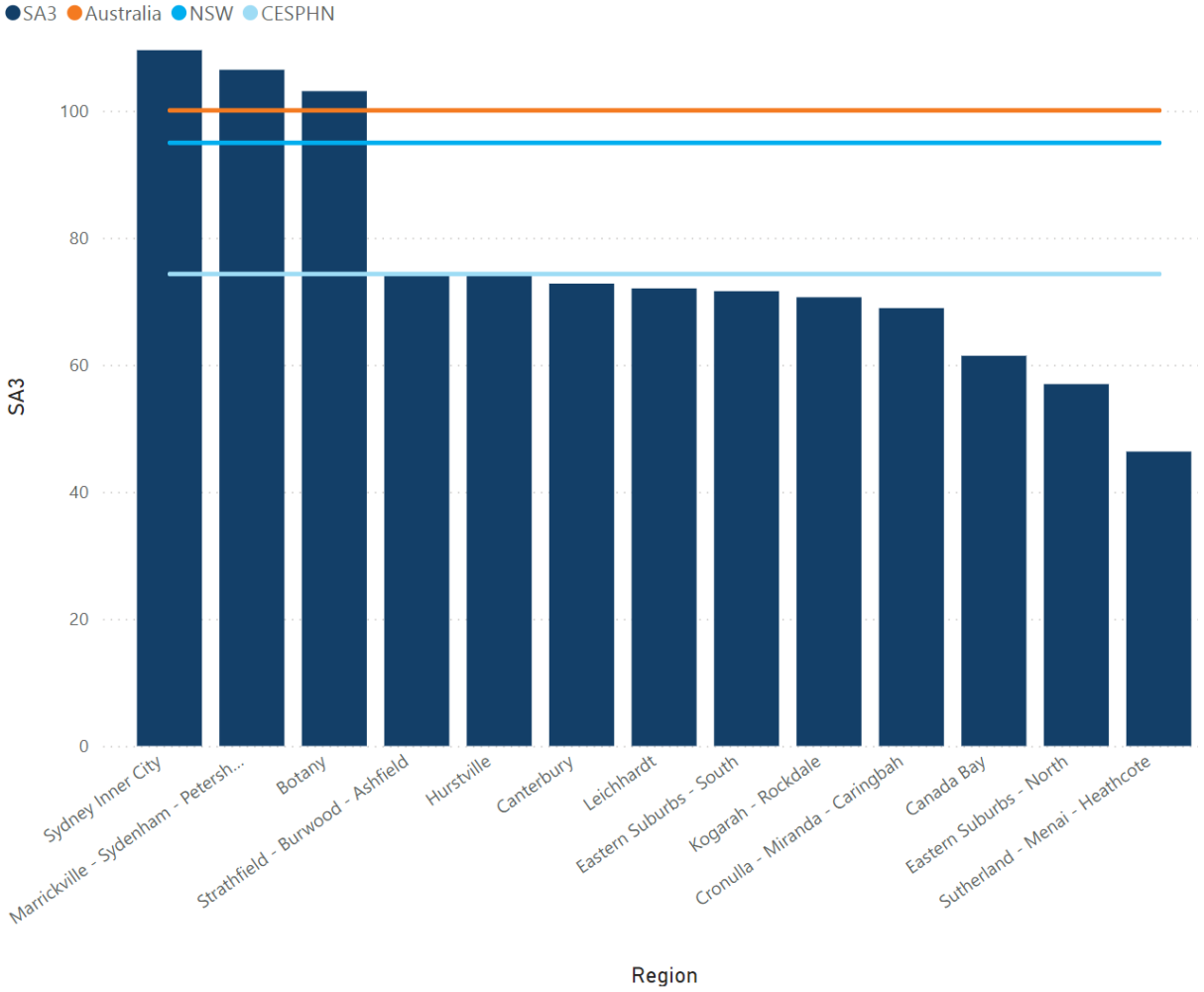
Potentially avoidable deaths

Potentially avoidable deaths are deaths below the age of 75 years from conditions that are potentially preventable through primary or hospital care.

In 2022, the age-standardised rate (ASR) of potentially avoidable deaths for males in the CESPHN region was 97.64 per 100,000 people which was significantly higher than that of the female ASR of 52.04 per 100,000 people. This is reflective of the national rates with the avoidable death rate in males and females accounting for 129.76 per 100,000 and 71.50 per 100,000, respectively.

Sydney (Inner city), Marrickville-Sydenham-Petersham, and Botany had the highest rate of potentially avoidable deaths, exceeding that of the CESPHN, NSW and Australia averages.

Figure 3: Potentially avoidable deaths in the CESPHN region (ASR per 100,000) by SA3, 2022



Source: AIHW, 2023
***Lord Howe Island is not included as there is no published data available.*

Child mortality

Perinatal deaths have stayed relatively constant across both the CESPHN region and NSW from 2012 to 2022, with CESPHN perinatal deaths accounting for 17.11% of the total NSW perinatal deaths. (4)

Across 2013 to 2022, there were on average approximately 474 deaths each year among NSW infants and children aged 0 to 16 years. Most child deaths occurred in those aged under 1 year, accounting for 65% of all these deaths in NSW over the 10-year period of 2013-2022 (4).

The leading cause of death for children aged under 1 year over this period was maternal, neonatal and congenital causes (80% of deaths). In older children, the leading cause of death was injury and poisoning (59% for those aged 15 years and 54% for those aged 16 years) (5).

Premature mortality

Premature mortality refers to deaths that occur among people aged under 75 years. In 2016-20, premature mortality rates in the CESPHN region (188.5 per 100,000 people) were lower than both NSW (235.1 per 100,000 people) and national rates (236.1 per 100,000 people) (6).

The male rate (236.3 per 100,000 people) was much higher than the female rate (140.7 per 100,000 people) in the CESPHN region. Botany SA3 (226.4 per 100,0000 people) had the highest rate of premature mortality for both genders (6).

The three highest causes of premature mortality were cancer (82.6 per 100,000), circulatory system diseases (32.4 per 100,000) and external causes (20.3 per 100,000). Canterbury SA3 has higher premature mortality rates for circulatory disease (45.6 per 100,000), ischaemic heart disease (21.8 per 100,000) and cerebrovascular disease (7.0 per 100,000) than state and national rates (6).

Table 4: Premature mortality per 100,000 people by cause and by SA3, 2018-22

SA3	Cancer	Cerebrovascular disease	Circulatory disease	COPD	Diabetes	External causes	Ischaemic heart disease	Respiratory system disease	Road traffic	Suicide
Botany	93.6	8.3	39.8	11.4	8.8	24.3	22.0	15.1	3.5	9.4
Canada Bay	79.5	5.0	22.4	4.0	3.7	19.2	8.7	6.3	1.9	8.2
Canterbury	85.8	7.5	40.2	5.6	5.1	17.9	19.4	12.1	1.3	5.1
Cronulla - Miranda - Caringbah	80.9	5.1	27.0	4.4	3.7	18.7	11.9	10.1	0.9	8.6
Eastern Suburbs - North	70.5	5.8	23.0	2.3	2.8	21.0	9.6	5.4	2.7	8.9
Eastern Suburbs - South	86.7	8.6	34.9	6.8	5.1	23.4	16.6	9.4	0.7	8.5
Hurstville	79.6	7.4	29.1	3.9	5.4	16.9	11.9	8.7	2.5	7.2
Kogarah - Rockdale	86.2	7.1	33.5	4.3	7.3	16.5	13.6	9.4	1.1	6.3
Leichhardt	84.9	9.1	34.0	9.1	5.3	22.6	14.3	15.6		11.3
Marrickville - Sydenham - Petersham	91.6	9.2	44.7	8.4	8.3	26.7	19.7	14.0	1.8	11.7
Strathfield - Burwood - Ashfield	81.9	7.2	34.4	6.4	3.0	20.2	17.2	13.8	1.8	7.1
Sutherland - Menai - Heathcote	88.1	4.7	29.9	4.7	4.9	21.0	15.8	9.4	2.9	8.8
Sydney Inner City	93.7	6.7	38.5	11.7	6.6	32.7	18.3	17.2	0.9	12.8
CESPHN	84.3	6.8	32.5	6.0	5.1	22.1	15.0	10.9	1.6	8.8
NSW	98.4	8.0	41.6	10.2	7.4	26.7	19.2	16.3	3.4	11.2
Australia	96.5	7.9	42.8	9.7	7.1	30.4	21.6	15.3	4.2	12.6

Source: PHIDU 2022

** Lord Howe Island is not included as there is no published data available.

Psychological distress

Rates of psychological distress in NSW have grown significantly since 2013 as well as the severity of psychological distress. In 2013, 72% of people experienced low levels of distress in 2023, 26.8% of people experienced low levels of distress with a corresponding increase in the population experiencing moderate levels of distress. Similarly, the levels of high or very high psychological distress increased in the same period (7).

Table 5: Proportion of psychological distress experienced, CESPHN and NSW, 2013, 2023

Psychological distress	2013 NSW Proportion	2013 CESPHN Proportion	2023 NSW Proportion	2023 CESPHN Proportion
Very high levels	3.10%	2.5%	4.20%	4.2%
High levels	7.0%	6.3%	11.0%	11.0%
Moderate levels	17.9%	17.8%	58.0%	26.8%
Low levels	72.0%	73.4%	26.8%	58.0%

Source: HealthStats NSW, 2024

In 2021-2023, 15.8% of persons aged 18 years and over in the CESPHN region reported experiencing high or very high psychological distress compared to 16.9% in NSW. (8)

Primary care landscape

As of September 2024, the central and eastern Sydney region has 564 general practices, of which 69.5% are accredited or registered for accreditation (CESPHN CRM). The region has 2,166 general practitioners, giving a rate of 138.7 fulltime equivalent (FTE) per 100,000 population (9). In 2023, the region had 238 Australian General Practice Training (AGPT) registrars. In 2022, central and eastern Sydney had 515 primary care nurses.

In 2022, there were 13,604 Australian Health Practitioner Regulation Agency (AHPRA) registered allied health professionals (AHPs) working in the central and eastern Sydney region (12,565.9 FTE), giving a rate of 895.8 per 100,000 population (827.3 FTE per 100,000 population). This is made up of the following:

- 581 Chinese medicine practitioners
- 436 chiropractors
- 1,790 dental practitioners
- 1,055 medical radiation practitioners
- 1,216 occupational therapists
- 502 optometrists
- 114 osteopaths
- 697 paramedicine practitioners
- 1,785 pharmacists
- 2,334 physiotherapists
- 380 podiatrists
- 2,777 psychologists.

In 2023-24, CESPHN commissioned 93 programs and services, delivering 229,206 occasions of service to 62,070 people.

Future directions and priorities

There is a range of national reforms in the planning that will impact the delivery of care and create disruptions to the usual way of doing business for primary and social care providers over the next five years. The Commonwealth has flagged primary health care's key role in prevention and early intervention. Changes to the way health care is funded will impact primary health and consumers.

With an aging population and the resultant increase in health needs, there is increased focus on healthy ageing. Additionally, there is an increased push for strengthened collaboration between primary care and other parts of the system, as well as collaboration with all arms of government.

In primary health care, ongoing digital health developments should improve continuity of care through system interoperability and the incentivisation of system integration. At the state level, the Single Digital Patient Record (SDPR), which is currently in development, will replace the numerous electronic medical record, patient administration and laboratory systems in use across the state public health system with a single source of clinical information. The implementation of cloud-based health systems is also a priority. Efforts are also being made to enhance communication between state and commonwealth systems, ensuring more cohesive healthcare delivery.

The cost of primary health care for consumers has been a key issue raised in the consultations. Community service survey responses identified that people are struggling to afford to live in the Sydney region and health and wellbeing costs are expenses they will forgo if possible. Delaying or foregoing treatment has implications for the longer term health of the population given that early intervention and prevention lead to the best outcomes. Differential access to care also leads to increasing disparities in health between those who can afford to pay for services and those who cannot.

Methodology

The 2025-2027 Needs Assessment development process involved four key phases. It involved a more comprehensive approach to gathering qualitative and quantitative evidence from broader sources and identifying key priorities. We considered feedback from our staff and stakeholders involved in consultations on the current use of the Needs Assessment and opportunities for improvement. We focused on increasing stakeholder engagement throughout the process and providing more of opportunities for consultation.

Planning and design

- Feedback from CESPHN staff and leadership on the previous Needs Assessment process and report
- Documentation review of key national and regional guides, strategies and policies
- Review of 2022-2024 CESPHN Needs Assessment and Strategy (includes other CESPHN strategies on key areas since 2021)
- Review of Needs Assessments from other PHNs and organisations
- Engagement with Local Health Districts ad Networks (LHDs/LHNs)
- Engagement with local Councils
- Project plan developed to include key timeframes, deliverables, processes, roles and responsibilities
- Market analysis
- Revised Needs Assessment structure to guide writing during the reporting phase

Data collection and engagement

- Quantitative data collection/updates e.g., ABS, AIHW, Population-level statistics, health indicators, etc.,
- Primary care level data through POLAR, LUMOS, NADA (AOD) and primary mental health data
- Qualitative data collection
- Service mapping
- Use of academic articles
- Use of reports from other organisations

Analysis and triangulation

- Initial analysis of quantitative and qualitative data to identify key themes and trends
- Internal sensemaking analysis sessions triangulate data and prioritise needs/gaps identified
- Sense check priorities with CESPHN leadership, staff and key stakeholders
- Confirm priorities

Reporting feedback and submission

- Draft Needs Assessment report and executive summary
- Feedback from relevant CESPHN staff and leadership
- Updated Needs Assessment based on feedback
- Prepare and submit Needs Assessment to the Department
- Develop 2-3 page snapshots on priorities and for different audiences post submission and approval
- Update CESPHN website to make it more interactive

EXECUTIVE SUMMARY

A mixed methods approach was used to capture, analyse and triangulate data to obtain an understanding of the health needs and services gaps for the region. Quantitative data were derived from internal, administrative, primary care data, and census-based sources, while qualitative data collected from stakeholder consultations and engagement was considered and, where contextually relevant, included in the data synthesis. Additionally, progress made since the last needs assessment has been considered, together with new data, emerging literature, policies, and plans to provide contextual information and insights not obvious from quantitative data sources.

Both quantitative and qualitative methods were used to both gather data and then to cross check. The table below provides an overview of the quantitative and qualitative data gathered during the data collection phase of the Needs Assessment process.

The **quantitative data** gathered and assessed included demographic and epidemiological data predominantly from the following sources: • Australian Bureau of Statistics (ABS) • Australian Institute of Health and Welfare (AIHW) • Public Health Information Development Unit (PHIDU) • HealthStats • Department of Health • National Disability Insurance Scheme (NDIS) • Lumos dataset on emergency department presentations • Primary Mental Health Care Minimum Data Set • headspace Tableau We also used data and insights from internal databases used across our steams, including: • Salesforce, CESPHN's CRM • The Network of Alcohol and Drugs Agencies (NADA) • POLAR primary care data from over 381 GP clinics in the region •	The **qualitative data** gathered and assessed included: • Survey of 32 community service organisations • Consultations with CESPHN staff • Roundtable disability discussions • Consultations with selected subject matter experts across priority areas • Consultations with CESPHN advisory committees including the Aboriginal advisory committee and alcohol and other drugs advisory committee • Insights from 11 in-language focus groups conducted with recently arrived immigrants • Consultations with the Clinical Leaders Network, Clinical Council, Community Council and Member Chairs • Strategy workshop with 60 health and community stakeholders • Insights from local council reports on the overall wellbeing of their population and reports of consultations with community members run by community organisations • Document review of academic articles on key topics • Priority areas summary distributed to South Eastern Sydney Local Health District, Sydney Local Health District and St Vincent's Health Network for review and final input

Strategic alignment

Alongside development of the Needs Assessment 2025-2027, CESPHN has developed a strategic plan that aligns with the broader Department of Health and Aged Care direction and priorities.

Key strategies that have an increased emphasis in the strategic plan:

- Be a data-driven organisation

- Improve the way we show our impact
- Actively promote CESPHN in the community and the work we do
- Increase our reach with more stakeholders
- Address health needs more holistically, such as domestic and family violence, gambling harm and social isolation and loneliness
- Increase community involvement in the planning and delivery of services to address needs
- Increase focus on navigation to assist multicultural communities
- Use commissioning to improve equity.

Stakeholder engagement and consultation process

Table 6 Stakeholder engagement process

Stakeholder Engagement	Process
Consultation with CESPHN staff and board	All staff and separately all of the CESPHN board and member networks were involved in initial consultation to identify health needs and service gaps. CESPHN teams working across these priority areas provided insights from strategy-level discussions, and an initial exploration of quantitative data.
Service mapping	Salesforce, CESPHN's CRM, was used to report on data pertaining to the region's general practices, including size, accreditation status and digital health capability. Health Workforce Data (HWD) was used to determine the number and distribution of key primary care services, in particular general practices and general practitioner (GP), GP registrar, practice nurse and allied health professional data. Service mapping undertaken by program teams as part of their program activities has also been utilised.
Market analysis	As part of CEPHN's Strategic Planning process that was also being conducted at the same time, a market analysis, including SWOT and PESTLE analysis were conducted to understand internal and external driving forces for the needs assessment and future strategic directions for our work.
Consultations with experts in specific priorities	Nine paid in-person/online group consultations were held in June and July 2024, consisting of a mix of established stakeholders and stakeholders new to CESPHN. The individual consultations targeted the following: • LGBTIQ+ • Homelessness • Aged care • Domestic and family violence • Sexual health • Maternal and child health • Mental health • AOD • Disability

	The consultations followed a semi-structured approach that included both general questions and questions specific to each area. Deductive thematic analysis was then applied on key points of discussion.
Community Services survey	A 19-question electronic survey was distributed to Community Services in the region in June 2024. The aim of the survey was to gather insights on the health and social needs, as well as services gaps in the community's they work. There were 32 responses, and this information has informed the development of the priority areas addressed.
Aboriginal Consultation	Rather than over consult the community, the writers of this needs assessment attended a consultation held by South Eastern Sydney Local Health District with the Aboriginal community in March with 25 people consulted and gathered the insights from that session to apply to the needs assessment. CESPHN's Aboriginal Advisory Group were consulted throughout this process and members were invited to the Strategy Workshop.
LHD/LHN and Council engagement insights and reports	Invited to subject matter expert consultations, involved in councils and committees, and additional meetings on certain topics, such as LGBTIQ+. An extensive summary of health needs and service gaps was shared with LHDs and LHNs for input.
Consultations with LHDs, Community and Clinical Councils, Clinical Leaders Network, Member Chairs, Multicultural Advisory Group	212 stakeholders were involved in consultations, semi-structured questions designed to gather insights on what community needs and service gaps stakeholders see in their work and engagement with the community they work with, and where the opportunities for improvement are. We used these engagements as an opportunity to gather qualitative and quantitative data that people were using to make statements on community needs and service gaps.
Strategy workshop	A strategy workshop was held in July 2024 with 60 stakeholders from health and community services across the region as a sense checking opportunity. During the workshop, the draft priorities from stakeholder engagements and an initial analysis of quantitative data were put forward to stakeholders, who were then asked to discuss if they agreed with the draft priorities and what priorities, if any, were missing.
In-language focus groups with newly arrived immigrants	Data were collected between 22 June 2024 and 20 July 2024 via 11 in-person, in-language focus groups (125 participants). The focus groups were conducted in: Arabic (2x), Mandarin (2x), Nepali (2x), Bengali (2x), Urdu, Mongolian (women) and one focus group run in English for Indian speaking participants. A report was prepared for each focus group which summarised the conversations and observations for each question outlined in the discussion guide and included translated quotes from the participants. The data were then analysed using a deductive approach, in line with the research questions identified. Quotations from these focus groups are incorporated into the needs assessment.
Consultation with Local Health District Executives	Local Health Districts and Local Health Networks were invited and involved at every consultation. The executives from the Local Health Districts and St Vincent's Hospital received a detailed summary of the Needs Assessment in October and provided feedback.

Analysis, triangulation, and prioritisation of community needs and service gaps

Once data collection ended, CESPHN began the analysis, triangulation, and prioritisation phase of the Needs Assessment process. This involved, using a robust analysis process to identify key community needs and service gaps appearing across both quantitative and qualitative data and insights.

Approach to data analysis

Quantitative data was updated as data became available to use. For most public datasets, data was downloaded, cleaned and then connected to Power BI for transformation, analysis and interpretation. Qualitative data that was gained through consultation was collected with prior informed consent from participants. A CESPHN staff member also took notes. Both recordings and notes were used to summarise key points and conduct an initial thematic analysis of the discussion.

Approach to data triangulation and prioritisation and insights

The writers of this document looked at themes across multiple sources of data and considered.

- Is the key need/gap mentioned across more than one data source?
- If an issue was raised during consultations – is there robust data to back it up and confirm its importance?

Data limitations

Whilst every effort to include all relevant and up-to-date data as part of the analysis of the needs assessment, there are a number of data limitations that need to be acknowledged. These limitations are both around new data sources used and the way previously used data sources have changed.

- Introduction of general practice level data collected through the data extraction tools. CESPHN currently use two data extraction tools, POLAR and CAT4, with POLAR having the highest usage rate of 40.7% of practices. For the Needs Assessment, POLAR and CAT4 were only used to identify Aboriginal and/or Torres Strait Islander patients.
- Utilisation of POLAR for chronic disease, cancer screening and other statistics were investigated, however the following limitations were encountered:
- Lack of consistent data on ethnicity data, making analysis difficult
- Limited pickup of free text information, which as a result underreports diagnoses and other figures
- Reduced functionality when linking with Power BI compared with calculations, free text translation, etc. built into the Qlik portal
- The ability to use data linkage insights though Lumos:
- There is low frequency of data refreshes (six monthly)
- There is no breakdown of ethnicity level data
- Not all general practices in the region participate in Lumos so the numbers may not be 100% representative
- Not possible to perform state or national comparison analysis because CESPHN only receives data for patients within its catchment.
- Changes in AIHW reporting levels from SA3 to SA4 across some datasets, has reduced the ability to compare across time periods and identify smaller geographic areas of higher need
- Previously available MBS data is no longer consistently available across most priority areas
- PBS data only available for mental health related prescriptions and granularity has changed
- Slow adoption of the ABS Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables demographics questions across surveys and datasets This impacts the ability to identify the health needs of trans and gender diverse people.

- Continued limited availability of recent local level data for Aboriginal peoples including:
    - Lifestyle risk factors
    - Infant and child mortality
    - Cancer screening participation
    - Mental health and suicide prevention
- Ongoing limited usage of the National Mental Health Service Planning Framework tool (limited access and cannot publish findings)
- Local level data on dementia and palliative care – local dementia data is still being developed in AIHW
- GEN Aged Care Data is available at LHD level and not at SA3 level.

Health Needs analysis

Identified need	Key issue	Description of evidence
Chronic conditions	**Key issues** • Increased usage of vaping • Prevalence of hepatitis B virus is the fourth highest in Australia • Prevalence of chronic hepatitis C is above the national average. • High burden of chronic disease in the region • Higher age-standardised rates of melanoma in Sutherland, Woollahra and Waverley LGAs when compared with NSW • High prevalence of behavioural risk factors for chronic disease highlighting the need for risk reduction strategies • Low uptake of cancer screening. **Key gaps** • Early detection and prevention of Type II diabetes • Strategies to address increased rates of liver cancer • Variability in prevention and screening behaviours and need to work specifically with multicultural and Aboriginal populations to increase uptake. • Scaled up local lifestyle programs that are effective in reducing risk factors for chronic disease • Engagement with priority population groups that have low health literacy regards chronic disease • Effective monitoring of cerebrovascular risk factors such as hypertension • Need for increased focus on preventive factors and early intervention strategies in primary care	• Quantitative sources include AIHW, NDS and Cancer Institute NSW • Qualitative sources include stakeholder consultation and surveys on cancer management
Mental health	**Key issues**	• Quantitative sources include AIHW, Mental Health MDS, RACGP and headspace

Identified need	Key issue	Description of evidence
	• 71% of GPs report psychological issues in their top 3 reasons for patient presentation • There is an increase in severity of mental health related issues • Self-reported prevalence of a mental health condition varies across the region from 11.7% in Marrickville-Sydenham-Petersham SA3 to 5.0% in Hurstville SA3 • There are a number of vulnerable population groups who experience a higher prevalence of mental health concerns. These include Aboriginal people, children and young people, LGBTIQ+ peoples, older people, veterans, people experiencing social isolation and people engaging in harmful levels of gambling • In 2021-21 there were 106 mental health related emergency department presentations per 10,000 population and 102.4 overnight admitted mental health-related hospitalisations per 10,000 population **Key gaps** • Access to child mental health services (including a multidisciplinary approach) • Access to psychiatrists across all speciality areas including children, older people, ADHD and autism • Availability of psychological therapies for people experiencing severe and complex mental illness • Affordable access to services for eating disorders • Availability of longer-term therapy for eye movement desensitisation and reprocessing (EMDR) therapy and dialectical behavioural therapy (DBT) • Therapy for children who have experienced Domestic and Family Violence and people who have left a relationship that experienced Domestic and Family Violence • Access to therapy in language	• Qualitative sources include Community Services survey, Strategy Workshop, mental health provider and GP consultations

EXECUTIVE SUMMARY

Identified need	Key issue	Description of evidence
Suicide prevention	**Key issues** • Modelled rates of suicidal thoughts and behaviours in the last 12 months are highest in young people aged 16-24 years (5.4 per 100 population) • Individuals in the 25-44 year age group had the highest proportion of individual self-harm hospitalisations in the CESPHN region (39.4%), followed by 0-24 year-olds (30.6%) • High rates per 100,000 of suicide in older people aged 80+ **Key gaps** • Primary care professionals identified a lack of appropriate services, including barriers to accessing acute services, to support/refer individuals at risk of attempting suicide • Primary care professionals face challenges in identifying individuals at risk of attempting suicide.	• Quantitative sources include AIHW, Mental Health MDS • Qualitative sources include consultations with expert panel

Use of alcohol and other drugs	**Key issues**
	• Within the CESPHN region, the primary drugs of concern are methamphetamines, alcohol, cannabinoids, and heroin.
	• The populations most impacted by AOD use include:
	  ○ Aboriginal and Torres Strait Islander people
	  ○ Multicultural communities
	  ○ Young people
	  ○ LGBTQI+ communities
	  ○ People experiencing homelessness
	  ○ Individuals in contact with the criminal justice system
		• Quantitative sources include Health Stats NSW, AIHW, NSW Ministry of Health, CESPHN survey and IDRS
		• Qualitative sources include consultations with internal staff and an expert panel of Local Health District and local service providers

Identified need	Key issue	Description of evidence
	Key gaps • Limited access to holistic support and care coordination, as well as a lack of pathways for patients navigating AOD services. • A need for additional prescribers to transition patients from public Opioid Treatment Programs (OTP) to private care. • Insufficient services for priority populations, particularly women and multicultural communities. • A shortage of residential rehabilitation beds. • High prevalence of co-occurring mental health and substance use concerns, with a need for further capacity-building initiatives. • Limited access to culturally appropriate rehabilitation for Aboriginal participants. • Workforce shortages and the need for ongoing training and development.	
Sexual health	• From October 2023 to October 2024, the CESPHN region recorded the highest number of notifications in NSW for chlamydia (11,812), gonorrhoea (565) and non-congenital syphilis (2652). The region accounted for 36.7% of chlamydia NSW notifications, over half (51.2%) of gonorrhoea notifications and 46.3% of non-congenital syphilis notifications. Notification rates in males for syphilis and gonorrhoea are the highest in NSW. **Key issues** • Early identification of cases and liaison with general practitioners • Engagement with local at-risk populations to encourage uptake of preventive strategies and promotion of testing • Knowledge of antimicrobial resistance in the treatment of gonorrhoea • Low health literacy that limits access to sexual and reproductive health services	• Quantitative sources include NSW Health, Department of Health and Aged Care, and National Viral Hepatitis Mapping Project • Qualitative sources include stakeholder consultation

Identified need	Key issue	Description of evidence
	Key gaps • Level of general practitioner confidence in diagnosing, testing and treatment prescription • Stronger active identification of cases and engagement with general practitioners • Antenatal screening for syphilis twice for each pregnancy • Promotion of vaccination to increase protection against Mpox • Stigma-free health care provision • Improved accessibility of sexual and reproductive health services.	
Aboriginal and Torres Strait Islander peoples' health and wellbeing	• There were an estimated 16,265 Aboriginal people within the Central and Eastern Sydney PHN (CESPHN) region in 2021, accounting for 1.05% of the total population. **Key issues** • The impact of past traumas, injustices and the effects of intergenerational trauma • Aboriginal children in NSW are significantly over-represented in the child protection system • Aboriginal adults in NSW are over-represented in the criminal justice system and the youth justice system • Suicide is 3 times more prevalent in this population than the general population in the region • High rates of ED presentations for mental and behavioural disorders • 30% of all Aboriginal people in the CESPHN region, had at least one long term health condition • High rates of smoking at some time during pregnancy • High rates of domestic violence • Low uptake of preventative health measures such as 715 assessments, cancer screening	• Quantitative sources include AIHW, ED data, HD Australia, MBS data, PHIDU, HWA, NDIS, POLAR, PenCS, Cancer Institute NSW, HealthStats NSW, National Aboriginal and Torres Strait Islander Health Survey, the Aboriginal and Torres Strait Islander Health Performance Framework, and GEN • Qualitative sources included members of the CESPHN Aboriginal Advisory Committee

Identified need	Key issue	Description of evidence
	• The percentage of Aboriginal people living with overweight or obesity increased from 57% in 2014 to 72% in 2023 • Pressures on unpaid carers of people with disabilities and older people due to reluctance to access support services. **Key gaps** • Continuity of healthcare transition from correctional facilities to general practice and other primary care services • Reducing disparities in preventable health measures and trying to improve health outcomes • Promote better use of Urgent Care Centres and primary care to the community to avoid ED and hospital admissions • Appropriate culturally safe care throughout the health system that is tailored to the needs of this community.	
Health and wellbeing of people from multicultural communities	• 40.7% of residents were born overseas, 46.8% speak a language other than English at home, and 6.3% do not speak English well or at all **Key issues** • People from CALD backgrounds don't access CESPHN commissioned mental health services at the same rate as non-CALD community. • People from CALD backgrounds attend services later, resulting in more involuntary admissions • Less likely to access preventable screening for breast cancer • International students in the CESPHN region needing support for health and wellbeing issues • Impact of global events on local communities (Gaza conflict) **Key gaps** • There is a need to understand better the experiences shaping health outcomes for multicultural communities	• Quantitative sources include ABS, AIHW, Department of Education, Skills and Employment, Cancer Institute NSW, and Diabetes Australia • Qualitative data includes CESPHN consultations and in-language focus groups

Identified need	Key issue	Description of evidence
	• Health navigation assistance can assist people to understand and access the complex health and social support system • Need for culturally responsive care	

Older individuals' health and wellbeing	• In 2022, 14.9% of the estimated resident population (ERP) in the CESPHN region were aged 65+, and 7.1% were aged 75+
	• The number of people aged 65 years and over is expected to increase by 56% between 2021 and 2041.
	
	Key issues
	• Lower uptake of all recommended vaccines - COVID-19, pneumococcal and shingles (herpes zoster) as well as flu
	• Older individuals (65+ and 85+) experience a range of health issues, including:
	  ○ Higher rates of fall-related hospitalisations
	  ○ Mental health issues
	  ○ Higher use of health care services for those living with dementia and living in the community
	  ○ Chronic conditions and comorbidities
	  ○ Higher levels of disability (2 in 5 people aged 65+)
	  ○ Growing levels of elder abuse by family members/carers
	
	Key gaps
	• Better coordination of primary care and other services in the community to ensure timely access to care and continued/seamless support
	• Reduced access to affordable primary care and aged care services (cost of primary care and aged care services, and long wait times for home care packages and Commonwealth Home Support Program services)
	• Difficulties in service navigation with poor awareness of available support services
		• Quantitative sources include AIHW, HealthStats NSW, ABS, DSS, POLAR, DOH and GEN
		• Qualitative sources include stakeholder and subject matter individual consultations

Identified need	Key issue	Description of evidence
	• Social isolation, exacerbated by language and cultural barriers. • Underutilisation of general practice preventative health services (health checks, CDM care plans, vaccination) • Residential age care places are reducing against increasing number of people (many of whom will have dementia) with social dislocation occurring as older people have to move out of their locality and social networks to access residential aged care. • Meeting ageing needs of people with a disability in group homes • Older people report barriers to accessing mental health support • Diagnosis and services are limited for people living with dementia, and services vary across the CESPHN region • Increasing difficulties for older people in residential aged care being able to access GPs.	
Health and wellbeing of children in the first five years	**Key issues** • In some parts of the CESPHN region there are high levels of socio-economic disadvantage • Child immunisation rates are less than the national target • Some SA3s with the highest developmental vulnerability in one or more domains • The proportion of women with their first antenatal visit recorded during the first 14 weeks of gestation is below the NSW average • Aboriginal babies are less likely to be born within a healthy weight range compared with Non-Aboriginal babies (88% versus 95%) **Key gaps** • Immunisation rates in children in several regions within CESPHN have fallen below 90% • Treatment delays for children newly diagnosed with a disability • Access to affordable paediatric care.	• Quantitative sources include ABS, Department of Health and Aged Care, HealthStats NSW, CESPHN internal database, and Department of Social Services • Qualitative sources include stakeholder and subject matter individual consultations

EXECUTIVE SUMMARY

Identified need	Key issue	Description of evidence
Health and wellbeing of people living with a disability	• High numbers of people living with a disability in the CESPHN region • Approximately 2 in 5 people aged 65 years and over living within the CESPHN region have some level of disability • NDIS participant numbers across service districts within the CESPHN region increased from 16,950 in December 2020 to 19,715 on 30 June 2023 • The rate of psychosocial disability within the Sydney service district is 1.7 times the national rate • 7-to-14-year age band made up the highest proportion of NDIS participants across the CESPHN region **Key issues** • Access to well-coordinated care between primary, secondary and tertiary for those with a disability • Timely participation in preventive health and screening services for those with a disability • Inadequate Medicare funding models can deter extended consultations for complex medical and psychosocial care. GPs may be financially disincentivised to provide long consults, home visits to group homes, and prepare care plans which are paid at a lower rate or unbillable. • Knowledge of primary care providers and provision of tools and resources to engage in conversations about disability. • Those from priority population groups with a disability are particularly vulnerable because of low health literacy and economic disadvantage • Intersection between aged care and disability. For example, there is a lack of palliative care support for those in group homes. People receiving NDIS who transfer to residential aged care after age 65 will lose access to the NDIS. • Lack of support for teenagers living with a disability experiencing poor mental health e.g. suicidal thoughts and tendencies.	• Quantitative sources include AIHW, ABS, NDIA and Department of Social Services • Qualitative sources include stakeholder and subject matter individual consultations, and round table discussions with disability specialists

Identified need	Key issue	Description of evidence
	Key gaps • Lack of service navigation support tailored to the needs of those with intellectual disability • Lack of support for people with a disability when they receive dental care • Lack of community-based child behavioural management programs for those with ADHD and autism • Provision of support for carers to manage their own health needs • Need for ongoing patient-centred, multidisciplinary and integrated models of care • Support general practices to help address financial barriers to optimal care for people with a disability • Development of tailored strategies to address health inequity • Limited mental health services available for people with intellectual disability with poor mental health • Lack of access to NDIS and psychosocial services for people experiencing severe mental ill health • People with a disability leaving incarceration lose support and access to care and are at high risk of reoffending	
Health and wellbeing of people affected by domestic, family and sexual violence	• Domestic, Family and Sexual Violence (DFSV) has increased over the 12-month period to March 2024 across NSW. • In CESPHN, 5,936 domestic violence related assault incidents were recorded between April 2022 and March 2023, with the Canterbury-Bankstown LGA reporting the highest number of incidents. • Domestic violence-related murders:16 adult women in NSW (12 months to March 2024) • People with disabilities, older people, Aboriginal and Torres Strait Islander peoples, and LGBTIQ+ people experience increased risk, severity and frequency of DFSV and other types of abuse. **Key issues** • Need for continuous DFSV education and support for primary care	• Quantitative sources include BOSCAR

Identified need	Key issue	Description of evidence
	• Service design and delivery needs to prioritise children and young people **Key gaps** • Fragmented support for the intersecting issues of sexual violence and child sexual abuse. • Support for children impacted by DFSV • Wider range of service options that reduce DFSV.	
Health and wellbeing of LGBTIQ+ people	The Central and Eastern Sydney PHN region has a high number of same sex couples living together (n=11,382), representing 14.5% of same sex couples living together in Australia. By comparison, this region comprises 6% of the total Australian population **Key issues** • LGBTIQ+ people experience higher levels of mental distress and poor mental health • LGBTIQ+ people drink more alcohol and use illegal drugs at higher levels than non-LGBTIQ+ people • Can have higher instances of sexually transmitted diseases, though PReP use remains high amongst gay men • High levels of loneliness and social isolation, especially amongst older adults (see mental health chapter of this Needs Assessment) • The community can experience stigma harassment and discrimination in their daily lives **Key gaps** • Easy access to gender affirming care for transgender patients • Specific services for intersex people • Delivery of trauma-informed care and sexual diversity training for clinical staff and community services	• Quantitative sources include ABS and Rainbow Realities Report • Qualitative sources include consultation with internal staff and local service providers

EXECUTIVE SUMMARY

Identified need	Key issue	Description of evidence
Health and wellbeing of people impacted by homelessness	• In the CESPHN region in 2022-23, 8,084 people experienced homelessness (a slight increase from 7,627) **Key issues** • Further investment in access to affordable primary health care services for people experiencing, or at risk of homelessness. • Upskilling of the primary care workforce; refinement of assessment processes, raised awareness of pathways out of homelessness for people at risk of homelessness • Enhanced data management; improved technological solutions and frameworks for capturing and prioritising and referring clients • Strengthening collaboration between housing providers, specialist homelessness service providers and health service providers based around a housing first approach • Embedding of primary health care services with other health, housing, and homelessness support services • Improving coordination between primary mental health and domestic violence support services • Need for more innovative localised responses to priority cohorts including Aboriginal people and those leaving correctional centres and mental health services. **Key gaps** • Integration of the health, housing and homelessness service system • Access to primary care homelessness friendly GPs, pharmacists, allied health, dentistry, mental health, and drug and alcohol detox and support services) • Access to post-crisis support (mental health and drug and alcohol detox and support services) • Capacity of workforce to deliver respectful and person-centred care • Geographic location and reach of specialist homelessness services with most providers choosing to work in the inner-city regions. • Access to coordinated chronic care management	• Quantitative sources include ABS, AIHW and Department of Communities and Justice and SLHD • Qualitative sources include subject matter expert consultations

Identified need	Key issue	Description of evidence
	• Innovative models that deliver flexible integrated care.	

Service Needs Analysis

Identified Need	Key Issue	Description of Evidence
Access to primary health care	• GP workforce will reduce as many GPs are retiring and yet there will be more demand for services with an ageing population and predicted population growth • The GP FTE in the CESPHN region has decreased despite the increase in population. Analysis of FTE between 2021 and 2023 shows a peak of 1,903.9 FTE in 2021 and a reduction to 1,730.4 FTE in 2023, a decrease of 9.1% • In 2022 an average of 27% of GPs intending to work only another five years in the region • Reduction in the number of registrars, with a 34.8% decrease in AGPT registrars between 2018 and 2023 • Rising out-of-pocket costs for individuals accessing GP services: $78,244,065 (2022-23) across CESPHN, a 69% year-on-year increase • Lack of affordability for GP care, dental care and mental health care was the major concern raised in CESPHN consultations held • Access to psychiatry for a diagnosis for ADHD or other conditions is difficult to get and expensive. • Long waiting lists for public outpatient services. **Key gaps** • Expected ongoing reduction in GP workforce when measured against numbers, FTE and years intending to work against the	• Quantitative sources include ABS, NSW Health stats and DoH statistics, MBS data • Quantitative sources include UNSW research and stakeholder consultation

	expected increase in health service needs as the population increases and ages • Reduction in number of GP registrars • Rising out of pocket costs for individuals accessing GP services and subsequent lack of affordability	
Coordinated care	**Key issues** • Limited communication between providers due to lack of integration across primary care system, attributed to limited increase in uptake of My Health Record registration, fragmented allied health professional software landscape and limited health system interoperability • Low interoperability across platforms used by primary and acute care providers • Need to improve transitions for people moving between systems i.e. the justice system to primary care, Defence Force personnel becoming veterans, paediatric to adult services, community to residential care, disability and primary care services • Need for more integrated approach to disaster management. • Low health literacy particularly among vulnerable and priority groups • Provider and consumer challenges with identifying and navigating services **Key gaps** • Improved engagement of primary care in disaster management • Supporting care transitions across the lifecycle • Need for increased focus on multidisciplinary team work • More effective communication and information sharing among healthcare providers including system interoperability that enables continuity of care • Utilisation of My Health Record.	• Quantitative sources include ADHA Collaborate data, CESPHN's CRM and Lumos

Priorities and opportunities

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
Stepped care	Mental Health	Access	• Consumers have streamlined access to the most appropriate services to support individuals at the stage they are at	• CESPHN to work with partners of the Mental Health and Suicide Prevention Regional Plan to ensure clear and accessible pathways to care at all levels of intensity/acuity, in which consumers, referrers and service providers understand how to navigate, refer to and provide services using a stepped care approach • CESPHN to work with our LHD and LHN partners to fulfill the requirements of the bilateral schedule regarding the promotion of the Initial Assessment and Referral Decision Support Tool. • Promote the use of the Mental Health Services Directory to referrers and service providers to further promote services that are offered in our region across all levels of care.
Workforce Development	Mental Health	Access	• Built a sustainable workforce that is skilled, well distributed and supported to deliver mental health treatment, care and support that meets the current and future population needs	• CESPHN to work with our LHD and LHN partners to fulfill the requirements of the bilateral schedule regarding the actions relating to workforce planning and development, focusing on priorities such as bilingual mental health clinicians, Aboriginal workforce and lived experience workforce.

EXECUTIVE SUMMARY

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
Low intensity mental health services	Mental Health	Access	• Increased proportion of population receiving Nationally funded low intensity services and successful promotion of these services	• CESPHN to work with referrers and community members to promote access to low intensity mental health services, including the newly established national low intensity service, other online services, and resources
Child and youth mental health services	Mental Health	Access	• Increase proportion of population receiving PHN-commissioned youth specific services	• CESPHN to continue to commission headspace centres to provide youth mental health services in line with the headspace model integrity framework (hMIF) and within a stepped care approach • CESPHN to continue to commission early intervention services for young people with or at risk of severe mental illness (e.g., psychosis, major depression, severe anxiety, eating disorders and personality disorders) in the primary care setting • CESPHN to support commissioned providers to use telehealth and other technologies to facilitate access to services • CESPHN to work with our LHD and LHN partners to fulfill the bilateral schedule regarding the headspace enhancement initiatives, and child mental health and social and emotional wellbeing commitments. • CESPHN to commit to actions from the joint Mental Health Regional Plan

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
				relating to child mental health and emotional wellbeing.
Psychological therapies for priority populations	Mental Health	Access	• Increase proportion of population receiving PHN-commissioned psychological therapies and have improved clinical outcomes	• CESPHN to continue to commission services to ensure access to a range of evidence based psychological therapies for priority groups in the CESPHN region
Severe and complex mental illness	Mental Health	Access	• Increase proportion of population receiving PHN-commissioned care coordination services and have improved functional and clinical outcomes	• CESPHN and LHDs to implement learnings from the evaluation of the Mental Health Shared Care program to improve service access and provision. • Commit to actions from the joint Mental Health Regional Plan relating to the development of the mental health workforce, including increasing the peer workforce • CESPHN to continue to commission care coordination services and other services aimed at supporting the physical and mental health and wellbeing of individuals with severe and/or complex mental illness.
Suicide prevention	Mental Health	Access	• Increase number of people who are supported by PHN-commissioned services following a recent suicide attempt and during a crisis.	• CESPHN to commission universal aftercare services in line with the requirements of the bilateral schedule regarding Universal aftercare. • CESPHN to commission suicide prevention services, and training to increase workforce and community capacity.

EXECUTIVE SUMMARY

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
				• Support the promotion and awareness of prevention and postvention support services.
Access to alcohol and other drug treatment services	Alcohol and Other Drugs	Access	• Increase access to treatment services	• CESPHN to commission drug and alcohol treatment services that address gaps, are evidence based and accessible to our priority populations • CESPHN to work with service providers to ensure services are accessible and meet the needs of priority populations
Access to alcohol and other drug treatment in the primary care setting	Alcohol and Other Drugs	Care Coordination	• Increase engagement of GPs in responding to AOD problems and shared care arrangements between specialist AOD services and GPs • Increase numbers of GPs prescribing and pharmacy engagement in OTP	• CESPHN to provide support, resources and education to GPs • CESPHN to work with LHD/LHNs to implement the GLAD shared care project with GPs across the region • CESPHN to partner with PHNs to co-fund Primary Care Telehealth Alcohol Withdrawal and Recovery Service Proof of Concept
Capacity to address high need populations and clinical complexity	Alcohol and Other Drugs	Vulnerable Population (Non-Aboriginal Specific)	• Services meet the needs of priority populations and address co-occurring mental health in the context of AOD use	• CESPHN to work with peak bodies and champions to develop effective service models to meet the needs of multicultural communities, gender and sexuality diverse communities, individuals recently released from prison and individuals with co-occurring mental health needs
Sexual health	Population Health	Early Intervention and Prevention	• Increase number of GP prescribers for HVB, HIV S100 medications, HCV and PrEP S85 medications	• CESPHN to support primary care providers to address STIs and other blood borne (HIV and Viral Hepatitis) conditions by building confidence in

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
			• Enhance GP capability to deliver hepatitis B and C, syphilis and Mpox treatment	diagnosing, testing and treatment prescription • CESPHN to support engagement with local at-risk populations to encourage uptake of preventive strategies and promotion of testing • Promotion of vaccination to increase protection against Mpox
Chronic conditions	Population Health	Chronic Conditions	• Increase cancer screening rates • Reduce prevalence of risk factors • Increase number of patients with chronic diseases managed under GP Management Plan and/or Team Care Arrangements • Reduce potentially preventable hospitalisations for chronic conditions • Increase the number of practices sharing data for quality improvement • Increase the number of practices participating in quality improvement activities •	• Improving the uptake of evidence-based cancer screening programs, specifically, breast, cervical and colorectal cancers where rates are low in the region. Work with LHDs to review availability of mobile screening units across the region. • From July 1, 2025, a National Lung Cancer Screening Program will be launched targeting high risk smokers or ex-smokers accessed through general practice and Aboriginal Health Services. • Promote new smoking and vaping cessation clinic at Concord Hospital. • Continue supporting general practices to connect to the National Cancer Screening Registry and promoting share care and quality improvement activities for cancer screening and prevention. • Work with LHDs to address lifestyle risk factors such as excessive intake of alcohol, lack of physical exercise and poor diet.

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
Older individuals' health and wellbeing	Aged Care	Chronic Conditions, Care Coordination, Workforce	• Increase MBS services provided by primary care providers in residential aged care facilities • Increase rate of people aged 75 and over with a GP health assessment • Improve communication, coordination and integration of services within the health system and at the interface of the health and aged care systems • More informed consumers and carers • Build primary health care workforce capacity and capability to address the health needs of older people	• CESPHN to commission community-based options for palliative care and to support healthy ageing, social connection and people living at home for longer • CESPHN to work with social interaction models of service • CESPHN to support GPs to complete MBS health checks and medication reviews in the community and in aged care • CESPHN to work with GPs to develop local dementia care and frailty pathways • CESPHN to commission community care finders to assist older Australians accessing and navigating the aged care system. • CESPHN to work with the Department of Health and Aged Care and LHD/ LHNs to identify gaps in system accessibility and opportunities for improved coordination, integration and reform across the aged care and health systems • CESPHN to support GPs and RACF staff with digital technologies including telehealth care for aged care residents, MyHR adoption, and sharing Advance Care Directives and care plans for transitions between health and aged care systems • CESPHN to support Geriatric Flying Squads/E Health programs to enable

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
				deteriorating older people to stay at home and out of hospital • CESPHN to provide/ commission training for general practice, allied health and RACF staff on local clinical and service pathways, dementia care, palliative care, mental health, and medication and wound management
Health and wellbeing of people affected by domestic, family and sexual violence	Population Health	Vulnerable Population (Non-Aboriginal specific)	• Primary care providers are better able to identify and respond to DFV presentations • DFV victims receive appropriate services	• CESPHN to provide training to primary care providers to identify and appropriately respond to DFV presentations from patients or colleagues • CESPHN to link primary care providers with appropriate DFV services and secondary consultations to assist health professionals to support their patients
Aboriginal and Torres Strait Islander peoples' health and wellbeing	Aboriginal and Torres Strait Islander Health	Vulnerable Population (Aboriginal specific)	• Increase general practice IHI PIP uptake • Increase rate of patient records with Aboriginal status recorded • Increase rate of Aboriginal population receiving health assessments and follow-ups • Increase rates of service use for: maternal and child services, chronic disease, mental health and AOD services • Increase proportion of PHN-commissioned services delivered to the regional	• CESPHN to support general practice to enrol in the IHI PIP, identify Aboriginal patients and provide health checks • CESPHN to work with the Aboriginal community and LHD/LHNs to address access issues to culturally appropriate maternal and child health, chronic disease, mental health and AOD services • CESPHN to work with commissioned providers to ensure the workforce is culturally competent and continues to upskill in this area • CESPHN to continue providing education to GPs to promote cultural safety and

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
			Aboriginal population that are culturally appropriate • Increase cultural awareness training participation rates among the primary care workforce • Increase support for the Aboriginal workforce	understanding of intergenerational trauma and ongoing impacts • CESPHN to support the Aboriginal workforce through the Aboriginal workers circle and training opportunities • CESPHN to promote urgent care as an alternative to attending Emergency departments for non-urgent care • CESPHN to work with partners to deliver community education on accessing relevant health care, domestic violence and sexual abuse resources, mental health and antenatal care
Health and wellbeing of people from multicultural communities	Population Health	Vulnerable Population (Non-Aboriginal Specific)	• Culturally appropriate commissioned services • Increase access to services among multicultural communities	• CESPHN to work with community organisations to build health literacy among consumers and their carers so they can be actively involved in decisions about their health • CESPHN to ensure translation and interpreting services are available to allied health professionals and promote TIS National interpreting services to medical practitioners and pharmacies • CESPHN to work with its commissioned service providers to co-design culturally appropriate services, employment of staff from multicultural backgrounds and providing cultural competency training for service providers • CESPHN to commission multicultural health navigators to increase access to health care

EXECUTIVE SUMMARY

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
Health and wellbeing of people impacted by homelessness	Population Health	Vulnerable Population (Non-Aboriginal Specific)	Improve health outcomes and access to health care among people experiencing homelessness or at risk of homelessness	• CESPHN to work with partners to implement the Intersectoral Homelessness Health Strategy 2020-2025 • CESPHN to support general practices and allied health professionals working with people experiencing homelessness • CESPHN to work with registered training organisations to enable and support GP registrars to work in homelessness health clinics during their training • CESPHN to provide training to general practices and allied health professionals on the skills and knowledge required to engage and care for people at risk of, or experiencing, homelessness • CESPHN to explore with the primary care sector the feasibility of new models of primary care in key locations to improve service navigation
Health and wellbeing of people living with a disability	Population Health	Vulnerable Population (Non-Aboriginal Specific)	• Primary care providers are better able to provide best practice care for people with a disability • People with an intellectual disability receive appropriate specialist services • Improved access to behavioural interventions for children with ADHD •	• CESPHN to provide training to primary care providers on best practice care for people with a disability, including annual Medicare assessments and access to NDIS care plan • CESPHN to link primary care providers with the most appropriate specialist services for their patients with intellectual disability • CESPHN to work with LHDs to increase the availability and capacity of mental health services for people with

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
				intellectual disability with poor mental health • CESPHN to advocate for disability needs during development of the Single Digital Patient Record • CESPHN to lead an annual disability roundtable to bring together key stakeholders in health and primary care and the broader disability sector to showcase progress and highlight areas for further intervention • CESPHN to develop strategies to address needs of people living with a disability who are older, members of multicultural communities, impacted by alcohol and other drugs or exiting the Justice system.
Health and wellbeing of LGBTIQ+ people	Population Health	Vulnerable Population (Non-Aboriginal Specific)	• Increase access to LGBTQI inclusive primary care • Distinction between specific LGBTIQ+ sub-groups as priority populations within CESPHN program areas	• CESPHN to arrange provision of training and education for primary care and mental health workforce on LGBTQI+ inclusive care • CESPHN to support upskilling of aged care workforce and adoption of LGBTQI+ person-centred approaches • CESPHN to promote gender affirming care • CESPHN and partners to work on provision of greater support for transgender children and adolescents • Support adoption of trauma informed care approach

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
				• CESPHN to support ACON in the development of an integrated general practice specializing in LGBTIQ+ health • Promotion of LGBTIQ+ services in CESPHN service directories and HealthPathways • CESPHN to ensure commissioned services are accessible for LGBTQI+ people.
Health and wellbeing of children in the first five years	Population Health	Early Intervention and Prevention	• Reduce percentage of children with childhood developmental delays • Increase percentage of women attending antenatal visits	• CESPHN to improve collaborations, pathways and partnerships with child and family health services • CESPHN with work with LHD/ LHNs to maintain access to maternal primary care services, including the GP antenatal shared care program • CESPHN to commission activities to address developmental delay, particularly for multicultural communities • CESPHN to work with LHD/LHNs, Department of Communities and Justice, Department of Education, local government and community providers on implementation of First 2000 days framework
Access to primary health care	Health Workforce	Other	• Increased number of general practices receiving the after hours PIP • Reduce low urgency care emergency department presentations	• CESPHN to support general practice to participate in the after hours PIP • CESPHN to commission services to ensure an appropriate use, mix and distribution of after hours services for the population, including enhanced out of hours support for residential aged care

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
			• Increase the number of unique health professionals accessing professional development opportunities • Increase in number of accredited general practices • Increase the number of practices sharing data for quality improvement • Increase the number of practices participating in quality improvement activities	• CESPHN to work with key stakeholders to identify and implement relevant professional development opportunities for GPs, practice nurses, practice staff, mental health and AOD workforce and allied health professionals • CESPHN to commission, deliver and promote training and education to the primary care workforce specific to our priority areas and priority populations • CESPHN to collaborate with universities to train the health workforce • CESPHN to support general practices with accreditation and continuous quality improvement activities (e.g., PIP QI, Lumos) • CESPHN to implement health promotion strategies to improve awareness of after hours services (including HealthDirect helplines), appropriate use of emergency departments/urgent care and options for after hours services, particularly frequent users such as people aged 65 years and over, families with young children and priority populations such as people experiencing homelessness
Coordinated care	Population Health	Care Coordination	• Increase rate of regular uploads to My health Record • HealthPathways sessions of use, unique page views, different users	• CESPHN to support increased uptake of digital health systems (smart forms, e-referrals, eprescribing, telehealth) • CESPHN to work with LHD/LHNs and medical specialists to improve the integration of care through the

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
			• Increase rate of discharge summaries uploaded to My Health Record • Increase rate of health care providers using specific digital health systems (smart forms, ereferrals, telehealth) • Improved identification and support of veterans	meaningful use of MyHR (e.g., electronic discharge summaries and e-referrals) in the hospital sector and access to Single Digital Patient Record • CESPHN to work with LHD/LHNs and general practice on virtual care models and management of patients following discharge to prevent readmissions • CESPHN to promote improved identification and support of veterans in primary care • CESPHN to work with partners on implementation of a centralised mental health intake and assessment model to combine intake, assessment and referral services • CESPHN to commission program to support smaller general practices to connect to local allied health providers through a multidisciplinary approach • Promotion of service directories and HealthDirect • Re-engage general practice, allied health and specialists on use of My Health Record • Work with partners to improve engagement of primary care in disaster management

Checklist

Requirement	✓
Provide a brief description of the PHN's Needs Assessment development process and the key issues discovered.	✓
Outline the process for utilising techniques for service mapping, triangulation and prioritisation	✓
Provide specific details on stakeholder consultation processes.	✓
Provide an outline of the mechanisms used for evaluating the Needs Assessment process.	✓
Provide a summary of the PHN region's health needs.	✓
Provide a summary of the PHN region's service needs.	✓
Summarise the priorities arising from Needs Assessment analysis and opportunities for how they will be addressed.	✓
Appropriately cite all statistics and claims using the Australian Government Style Manual author-date system.	✓
Include a comprehensive reference list using the Australian Government Style Manual.	✓
Use terminology that is clearly defined and consistent with broader use.	✓
Ensure that development of the Needs Assessment aligns with information included in the PHN Needs Assessment Policy Guide.	✓

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