Australian Government
Department of Health

phn
An Australian Government Initiative

Central and Eastern Sydney Primary Health Network

Needs Assessment Report
(Nov 2016)

This template must be used to submit the Primary Health Network's (PHN's) Needs Assessment report to the Department of Health (the Department) by **15 November 2016** as required under Item E.5 of the Standard Funding Agreement with the Commonwealth.

Name of Primary Health Network

Central and Eastern Sydney PHN

When submitting this Needs Assessment Report to the Department of Health, the PHN must ensure that all internal clearances have been obtained and the Report has been endorsed by the CEO.

Instructions for using this template

Overview

This template is provided to assist PHNs to fulfil their reporting requirements for a Needs Assessment as required under Item E.5 of the Standard Funding Agreement (Funding Agreement) with the Department.

Further information for PHNs on the development of needs assessments is provided in the *Needs Assessment Guide*, available on the Department's website (www.health.gov.au/PHN).

The key output of needs assessment will be to inform the Activity Work Plan. In addition, the information provided by PHNs in this report may be used by the Department to inform programme and policy development.

Reporting

The Needs Assessment report template consists of the following:

Section 1 – Narrative

Section 2 – Outcomes of the health needs analysis

Section 3 – Outcomes of the service needs analysis

Section 4 – Opportunities, priorities and options

Section 5 – Checklist

PHN reports must be in a Word document and provide the information as specified in Sections 1-5.

Limited supplementary information may be provided in separate attachments if necessary. Attachments should not be used as a substitute for completing the necessary information as required in Sections 1-5.

While the PHN may include a range of material on their website, for the purposes of public reporting the PHN is required to make the tables in Section 2 and Section 3 publicly available on their website.

Submission Process

The Needs Assessment report must be lodged to the Grant Officer via email on or before 15 November 2016.

Reporting Period

This Needs Assessment report will cover the period of 1 July 2016 to 30 June 2018 and will be reviewed and updated as needed by 15 November 2016.

Section 1 – Narrative

This section provides PHNs with the opportunity to provide brief narratives on the process and key issues relating to the Needs Assessment.

Needs Assessment process and issues (500-600 words)
– in this section the PHN can provide a summary of the process undertaken; expand on any issues that may not be fully captured in the reporting tables; and identify areas where further developmental work may be required (expand this field as necessary)

The approach to this needs assessment built on the process undertaken for the BNA earlier this year. Given the relative recent submission of the BNA, priorities were carried through and emerging needs were highlighted. The BNA was reviewed for strengths and weaknesses and a gap analysis was undertaken to determine missing health and service data. Many areas requiring additional data and targeted work was identified, these included:

- Youth health
- Veterans
- Sexual Health
- Homelessness
- Domestic Violence
- CALD and refugees
- Immunisation
- Ageing
- Disability
- Rural health
- Chronic Disease Prevention and Management – inclusion of biomedical factors
- Mental Health changed to align with Departmental priorities

A range of data sources were used to refresh and refine the needs assessment, including: recently released data sets, needs assessments undertaken by stakeholder organisations such as the LHDs; emerging needs identified through consultations with existing committees the PHN is involved in and recent surveys undertaken by the PHN.

The Planning, Strategy and Evaluation team took the lead on the needs assessment and throughout the process consulted with a range of stakeholders, such as the planning units and specific departments of the SESLHD, SLHD and Specialty Health Networks; Clinical and Community Councils, the Chairs of the CESPHN member networks, Mental Health and Drug and Alcohol NGO peak bodies and internal CESPHN project staff. Advice and feedback was sought on priority health and service needs, data availability, opportunities and options in addressing the priorities and areas for further investigation.

Drug and Alcohol needs assessment
A consultant, David McGrath, was contracted to analyse additional data sets and feedback provided by the LHDs and SHN regarding the baseline Drug and Alcohol Needs Assessment.

We experienced limitations in engaging with local councils because of the Council amalgamations, this has impacted on partnership work and collaboration. As at October 2016, there are still two pending council amalgamations within the CESPHN region, two councils remained unchanged and four newly formed Councils. One of the newly formed Councils is now split across the CESPHN and SWSPHN.

Areas requiring further developmental work:
Due to the resource intensive nature of service mapping, the full range of services across our region are yet to be mapped. With the Brain and Mind Centre, the PHN has developed a mental health atlas and we anticipate using a similar systematic approach to map services for other health areas. Areas to look at include accessibility, acceptability, appropriateness and wait list.

Additional Data Needs and Gaps (max 400 words)
– in this section the PHN can outline any issues experienced in obtaining and using data for the needs assessment. In particular, the PHN can outline any gaps in the data available on the PHN website, and identify any additional data required. The PHN may also provide comment on data accessibility on the PHN website, including the secure access areas. (Expand field as necessary).

Gaps in Data available on PHN website:

- Limited updates from MBS data broken down into SA3 regions and/or age groups
- Unclear on the website which data sources have been updated, it would be useful to include a date with each data source to allow easy cross checking on when sources are updated
- Mental Health data sources are sparse and where possible should align with the key areas for mental health focus

General Data Gaps and Limitations:

- Several data limitations have been included throughout the health and service needs sections of the updated needs assessment. The main issues encountered were the lack of locally specific information for health areas, differing time periods/age groups/geographic breakdown (LGA, SA3 and Medicare Local) for data sources, making it difficult to compare across sources and small sample sizes
- Where data from only one LHD has been included, it is due to availability of plans. We are continuing to work with our two LHDs and SHNs to establish clear and comprehensive data sharing agreements to support ongoing joint planning across the region.
- Timeframe meant not all data sources had been updated since March submission of BNA
- Limited data by local regions for Aboriginal Health, Mental Health (suicide/self harm rates) data and limited reportable (publicly available) data for Lord Howe Island.
- Aboriginal – in this report, percentages are presented by total PHN population, not by LGA due to low numbers of Aboriginal people. Aboriginal data did not change alot due to the short timeframe between last update and this one.
- Awaiting 2016 Census publications including youth unemployment rate at SA3 / LGA level.
- CESPHN governance groups reported a need to focus on advance care planning under aged care, however with limited data available to support this as a need, it has not been included as a priority area.

Primary Health Care data gaps and limitations:

- Limited data available from general practices, despite use of PenCAT
- Data quality from general practice is variable
- Unable to map general practices and PIP registration due to internal data limitations

Additional comments or feedback (max 500 words)

– in this section the PHN can provide any other comments or feedback on the needs assessment process, including any suggestions that may improve the needs assessment process, outputs, or outcomes in future (expand field as necessary).

Section 2 – Outcomes of the health needs analysis

This section summarises the findings of the health needs analysis in the table below. For more information refer to Table 1 in '5. Summarising the Findings' in the Needs Assessment Guide on www.health.gov.au/PHN.

Additional rows may be added as required.

Outcomes of the health needs analysis		
Priority Area	Key Issue *(identified gap and needs with statistics or qualitative summary)*	Description of Evidence *(reference and limitations)*
Health Status	Life Expectancy The life expectancy at birth in NSW is 79.5 years for male and 82.9 years for female. The average expectancy for Sydney Local Health District and South Eastern Sydney Local Health District is 84.1 years and 85.1 years respectively, higher than the state average. The life expectancy at birth in NSW for Aboriginal and Torres Strait Islander people is 70.5 years for male and 74.6 years for female, significantly lower than their non-Aboriginal counterpart (79.8 years and 83.1 years respectively). Self-reported health status Central and Eastern Sydney PHN has a higher proportion of population (82.3% in 2015) with excellent, very good and good self rated health in adults over 16 years of age than the NSW average (80.0% in 2015). South Eastern Sydney Local Health District (83.7%) has a higher proportion of adults with excellent, very good and good self rated health than Sydney Local Health District (80.3%) Canterbury (21,269), Sutherland (19,594) and City of Sydney (17,924) LGA have the highest population (persons) aged 15 and over with fair or poor self-assessed health.	Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au Accessed (13 Sep 2016 and 29 Sep 2016). PHIDU Torrens University Australian. Social Health Atlas of Australian. Data by Local Government Area. New South Wales & Australian Capital Terriorty. http://phidu.torrens.edu.au assessed (13 Sep 2016) The Australian Bureau of Statistics. Personal Safety, Australia, 2012 (2013). Cat. No.:4906.0 http://www.abs.gov.au The Australian Bureau of Statistics. Population by Age and Sex, Regions of Australia 2015 (2016). Cat no.:3235.0 http://www.abs.gov.au The Australian Bureau of Statistic. Migration Australia 2014-15. Cat. No.: 3412 http://www.abs.gov.au Limitations: The dependency ratio also considers age as a factor of active employment, neglecting other contributing factors including

Outcomes of the health needs analysis		
	Canterbury (18.5), Botany Bay (16.1), Rockdale (16.0), Burwood (15.0), Hurstville (14.8) and Ashfield (14.7) has the highest rate (ASR per 100) of population aged 15 years and over with fair or poor self-assessed health compared to NSW average (14.3). Lord Howe Island (65.2), Cronulla-Miranda-Caringbah (55.5), Sutherland-Menai-Heathcote (51.5). Canterbury (51.3) and Hurstville (50.4) have the highest dependency ratio which places an economic strain on the working population. Dependency ratios Lord Howe Island (65.2), Cronulla-Miranda-Caringbah (55.5), Sutherland-Menai-Heathcote (51.5). Canterbury (51.3) and Hurstville (50.4) have the highest dependency ratio putting an economic strain on the working population. Sydney Inner City and Cronulla-Miranda-Caringbah have young dependency ratio lower than older age dependency ratio, reflecting less population entering the workforce than the population exiting. Comparing with 2011 ABS Census population data, Sydney Inner City (26.3% increase) and Marrickville-Sydenham-Petersham (3.9%) has the highest increase in the total dependency ratio, reflecting a growing ageing retired population Net Migration The largest annual net migration gain in 2014-2015 was found in Sydney Inner City (749 persons), predominately in the 15-24 years old age bracket and Botany (563 persons) predominately in the 25-44 years old bracket. The largest decrease in annual net migration in 2014-2015 was found in Canterbury (-3291 persons) predominately in the 0-14 and 15-24 year old age bracket followed by Strathfield-Burwood (-3116 persons) predominately in the 25-44 years old age bracket. The net migration of Lord Howe Island (4 persons), Leichhardt (-298 persons), Canada Bay (-330 persons) and Marrickville-Sydenham (-349 persons) in 2014-2015 remained reasonably static in 2014-15.	status as a student, illness or disability, stay at home parents, early retirement and the long term unemployed. Some people also continue to work beyond the age of 64 years.

Outcomes of the health needs analysis		
Aboriginal and Torres Strait Islander Health	15,466 people (1% of the population) in the CESPHN region are of Aboriginal and Torres Strait Islander descent. The local government areas of Botany Bay (1.9%), Marrickville (1.8%), Randwick (1.8%), Sydney (1.7%) and Leichhardt (1.2%) all have an Aboriginal and Torres Strait Islander population above our region's average. In CESPHN, the Aboriginal population has a considerably younger age profile than the non-Aboriginal population, however, CESPHN has the highest proportion of Aboriginal and Torres Strait Islanders people aged 50-54 years in comparison to all 31 PHNs (Australia). Socioeconomic disadvantage impacts upon the Aboriginal population who are vulnerable to poor lifestyle choices and diseases. The local government area of Botany Bay has an Index of Relative Socioeconomic Advantage and Disadvantage below the Australian average, which is also home to our largest Aboriginal and Torres Strait Islander population. Aboriginal people have lower participation rates in cancer screening programs and poorer antenatal, infant and child health. The largest proportion of Aboriginal and Torres Strait Islanders in the CESPHN region live in Botany Bay LGA, which has an Index of Relative Socioeconomic Advantage and Disadvantage below the Australian average and a higher proportion of children who are vulnerable on one or more domains (22.2%) (2015) in comparison to NSW (20.5%). It is estimated that differences in access to the social determinants of health between Aboriginal and non-Aboriginal people explain between a third to a half of the mortality gap. Locally, there is an over representation of dwellings rented by Aboriginal people (almost 45%) for the Indigenous areas of Sydney City. Twice the national rate of 21.5%. Whilst rates of Aboriginal homelessness is a priority issue for SLHD with estimates of 556 per 10,000 Aboriginal people in Sydney, Leichhardt and Marrickville LGAs (compared to 125 per 10,000 on non-Aboriginal people in the same area. At the State and National levels, Aboriginal and Torres Strait Islander people experience higher rates of chronic disease such as diabetes, chronic kidney disease, heart/circulatory and respiratory problems and mental health and higher rates of behavioural risk factors such as overweight and obesity, lack of physical activity, smoking and sexual health.	PHIDU. Social Health Atlas of Australia, Data by Primary Health Network. Indigenous status 2015 ERP (non-ABS), August 2016. Booth, A & Carroll, N 2005, *The health status of Indigenous and non-Indigenous Australians*, Centre for Economic Policy Research, Australian National University, Canberra; DSI Consulting Pty Ltd & Benham, D 2009, An investigation of the effect of socio-economic factors on the Indigenous life expectancy gap, DSI Consulting Pty Ltd. Sydney Metropolitan Local Aboriginal Health Partnership Agreement. Social Determinants of Health Forum Report and Recommendations, 2015. Cancer screening Australian Aboriginal and Torres Strait Islander Health Performance Framework, 2014. Early detection and early treatment. AIHW, Canberra Cancer in Aboriginal and Torres Strait Islander peoples of Australia: an overview. October 2013. AIHW, Canberra Cancer Institute NSW, 2016. Reporting for Better Cancer Outcomes Performance Report. Central and Eastern Sydney Primary Health Network. Child and Maternal NSW Perinatal Data Collection (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health Accessed 9 November 2016

Outcomes of the health needs analysis		
	Sexually Transmissible Infections have been identified as a priority area for Aboriginal and Torres Strait Islanders at the State level for HIV, Hepatitis B and Hepatitis C. There are no local rates for new diagnosis among this population group but nationally they are all reported higher than the non-Aboriginal rate. Nationally, Gonorrhoea rates was 18 times that of the non-Aboriginal population and Hepatitis C was over four times greater than the non-Aboriginal population. An additional area of concern is the overrepresentation of Aboriginal and Torres Strait Islanders in the Justice Health system (32.5% of men and 26.6% of women are Aboriginal and Torres Strait Islander compared to 2.5% in community) across NSW. Inmates are more likely to have multiple health needs such as mental health.	National Health Performance Authority 2014, Healthy Communities: Child and Maternal Health in 2009–2012 Australian Early Development Census Data (AEDC), 2015. Commonwealth of Australia 2014-15. Hearing loss Australian Aboriginal and Torres Strait Islander Health Performance Framework, 2014. AIHW, Canberra Consultation with Local Health District and Specialty Health Networks Planning Departments, 2016 Chronic Disease Australian Aboriginal and Torres Strait Islander Health Performance Framework, 2014. Circulatory disease. AIHW, Canberra Aboriginal and Torres Strait Islander Health Performance Framework, Respiratory Disease; Kidney Disease. AIHW June 2015 Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au Accessed 9 November 2016. Diabetes Australia, National Diabetes Service Scheme, Australian Government, Canberra http://www.diabetesmap.com.au/#/ Accessed 9 November 2016 Justice Health Indig, D., Topp, L., Ross, B., Mamoon, H., Border, B., Kumar, S. & McNamara, M. (2010) 2009 NSW Inmate Health Survey: Key Findings Report. Justice Health. Sydney 2009 Young People in Custody Report, Australian Institute for Health & Welfare,

Outcomes of the health needs analysis		
		Mental Health Review Tribunal, Australian Bureau of Statistics, Patient Administration System, CS NSW Inmate Census, 2011 Annual Patient Snapshot Survey as cited in the Justice and Forensic Mental Health Network Strategic Plan 2013-17. http://www.justicehealth.nsw.gov.au/publications/jfmhn-strat-plan-2013-17 Mental health NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health Accessed 9 November 2016 Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au Accessed 9 November 2016 Obesity and PA PHIDU. Aboriginal and Torres Strait Islander Social Health Atlas of Australia, 2015 ABS. Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia 2012-13. Canberra Smoking Cancer Institute NSW, 2016. Reporting for Better Cancer Outcomes Performance Report. Central and Eastern Sydney Primary Health Network. STIs Ministry of Health NSW Sexually Transmissible Infections Strategy 2016-2020. http://www0.health.nsw.gov.au/policies/ib/2016/pdf/IB2016_005.pdf

Outcomes of the health needs analysis		
		The Kirby Institute. Bloodborne viral and sexually transmissible infections in Aboriginal and Torres Strait Islander people: Surveillance and Evaluation Report 2015. The Kirby Institute, UNSW Sydney Kidney Health Australia. State of the nation: Chronic Kidney Disease in Australia, 2016 www.kidney.org.au Limitations: Datasets not available at the PHN level – cervical and bowel cancer screening participation rates, obesity, overweight, physical activity levels, smoking status, sexually transmissible infections, prevalence of CVD, diabetes, respiratory diseases and mental health. Whilst these data sets were available at a state or national level, they are presented by age groupings that are not consistent with available demographic age groupings, therefore, extrapolated data is unable to be presented. For example, State data is presented as 16 years and over, whilst ABS data age group starts at 15 years. Premature mortality by cause - despite recently released data (August 2016), the numbers are very small and in some cases not available, therefore no analysis was presented.
Ageing	People aged 65 and over constitute 13.5% of the CESPHN population, with the SA3 of Lord Howe Island, Cronulla-Miranda and Hurstville having higher rates than NSW (15.2%) and higher numbers of people aged 65 years and over reside in the Kogarah-Rockdale and Hurstville SA3s. The CESPHN population will increase over the next ten years by an estimated 12.5%, but this rate is significantly higher for the 85 and over age group, with an estimated increase of 20% by 2026. As this cohort are high users of healthcare and aged care services, this could present challenges if aged care service supply cannot meet the increasing demand.	Australian Bureau of Statistics (2015), Estimated population by age and sex. Available at http://www.abs.gov.au/Population (Accessed 20 Sept 16) Source: 3235.0 Population by Age and Sex, Regions of Australia. Table 6. Estimated Resident Population by Age, NSW, Persons – June 30 2015

Outcomes of the health needs analysis

	Nationally, there are more than 353,800 people living with dementia, which equates to three in 10 people over the age of 85, and almost one in ten people over the age of 65. These rates are predicted to increase by 40% by 2050 due to an ageing population. Dementia is currently the second leading cause of death in Australia, and the single greatest cause of disability in people aged 65 and over. Aboriginal and Torres Strait Islanders are using dementia services at a younger age, with incidence rates 5 times higher than the non- Aboriginal population. With the increasing rate of dementia, primary health care has an important role in dementia prevention, early and timely diagnosis, and providing access to health and aged care services and support as the need presents for those living in community and in residential aged care facilities. Frailty, is a common condition among the elderly, this increased vulnerability means that frail older people readily become deconditioned in hospital and are at increased risk of falls. The incidence of falls increases with age with 42% of those aged 90 and over in the Sax Institute's 45 and Up study reporting a fall in the last 12 months. Falls can lead to serious injury including hip fractures with lengthy hospital stays and long term disability. According to the National Heart Foundation (2013) the prevalence of CCF among Australians aged 65 years and over is at least 10%; this equates to approximately 20,000 people across the PHN. The Australian Health Survey (2011-12) reported the prevalence of COPD in Australians aged 55 and over was 5.7%, equating to approximately 20,000 people across the PHN. The prevalence of COPD increases with age, mostly occurring in people aged 55 years and over. There are groups of older people who are more at risk of depression and anxiety including people in residential aged care facilities, older people with comorbidities and older people with dementia. The risk of suicide increases for older people with depression and anxiety, with the 85 and over age group having the highest age-specific suicide rates of males. Within CESPHN, mental health in older people was identified as a major health need. Antipsychotic dispensing rates for 65 years and over indicate	Centre for Epidemiology and Research (CER) 2016, HealthStats NSW, Population growth by Local Health District, Available at: http://www.healthstats.nsw.gov.au/indicator/dem_pop_lhnmap (Accessed 13 November 2016) Australian Institute of Health and Welfare, 2012, Dementia in Australia, Cat. no. AGE 70, Australian Government: Canberra. Australian Bureau of Statistics (2015) Causes of Death, Australia, 2013: Cat no. 3303.0. Available at: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2014~Main%20Features~Leading%20Causes%20of%20Death~10001 (Accessed 20.09.16) Access Economics, 2009, Keeping Dementia Front of Mind: Incidence and prevalence 2009-2050. Report for Alzheimer's Australia AIHW, Healthy Communities: Hospitalisations for mental health conditions and intentional self harm in 2013-14. Available at: http://www.myhealthycommunities.gov.au/our-reports/mental-health-and-intentional-self-harm/september-2016/media-resources/media-release (Accessed September 2016) Australian Institute of Health and Welfare, 2012, Residential aged care in Australia 2010-2011: A statistical overview. Cat. No. Age 68. Canberra, Available at: http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737422896 (Accessed 13 November 2016)

Outcomes of the health needs analysis		
	there are areas of high usage including Sydney Inner City, Marrickville-Sydenham- Petersham, Strathfield-Burwood-Ashfield, Canterbury and Kogarah-Rockdale. Medication management is an important factor in reducing adverse health events in older people such as falls and preventable hospitalisations. Nationally it is reported that half of all 65–74 year olds and two-thirds of people aged 75 and over report taking 5 or more medicines daily. Priority areas identified by the LHDs in working across the region include improving linkages and coordination between GPs and hospital based services to reduce avoidable admissions and ensuring effective discharge planning from hospitals ensuring appropriate services are available, supporting residential aged care facilities, work across sectors to systematise end of life pathways and advance care planning and develop health pathways across primary and secondary health providers in developing sustainable, clear, concise localised pathways	Arkles, R.S., Jackson Pulver, L.R., Robertson, H., Draper, B., Chalkley, S., Broe, G.A., 2010. Ageing, cognition and dementia in Australian Aboriginal and Torres Strait Islander peoples: a life cycle approach. A review of the literature. Sydney: Neuroscience research Australia and Muru Marri Indigenous Health Unit, University of New South Wales. Centre for Epidemiology and Research (CER) 2016. HealthStatistics NSW. Sydney. Ministry of Health. Available at http://www.healthstats.nsw.gov.au/ (Accessed 20 Sept 16) Comino, E., Harris, E., Islam, F., Harris, M., Centre for Primary Health Care and Equity University of NSW, 2016, Aged Care Cohort in Central and Eastern Sydney: Factors Associated with Report of Fall in the Last 12 Months, A Preliminary Analysis. Department of Health, Chronic Disease: Musculoskeletal conditions – arthritis and osteoporosis and back pain. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/pq-arthritis (Accessed 14 November 2016) ABS (Australian Bureau of Statistics) 2012. Australian Health Survey: First Results, 2011–12. ABS. Table 3 Long-term conditions by age then sex—Australia. ABS cat. no. 4364.0.55.001 Canberra: ABS. Australian Bureau of Statistics, (2013), Cat. 3303.0 Causes of Death, Australia. Available at: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2013~Main%20Features~Suicide%20by%20Age~10010 (Accessed 29 Sept 2016).

Outcomes of the health needs analysis		
		Almeida, O.P., McCaul, K., Hankey, G.J., Yeap, B.B., et. At., Suicide in Older Men: The Health in Men Cohort Study (HIMS). Preventative Medicine 20 Sept 2016. Available at: http://www.journals.elsevier.com/preventive-medicine/ (Accessed 28 Sept 2016) National Health Performance Authority. Australian Commission on Safety and Quality in Health Care, 2015, Australian Atlas of Healthcare Variation, Antipsychotic medicines dispensing 65 years and over. CESPHN Local Health Needs Survey, February 2016 Dept. Of Human Services, Medicare Australia Statistics, Medical Local Statistics Report, Available at: http://medicarestatistics.humanservices.gov.au/statistics/med_locals.jsp (Accessed 10 Nov 2016) National Heart Foundation of Australia. A systematic approach to chronic heart failure care: a consensus statement. Melbourne: National Heart Foundation of Australia, 2013. SESLHD Aged Care Services Plan 2015-2018. April 2015. Available at: http://www.seslhd.health.nsw.gov.au/Planning_and_Population_Health/documents/HealthPlans/FinalAgedCarePlan_22%20April_2015.pdf (Accessed November 2016) SLHD Aged Health Care, Rehabilitation, General Medicine, Chronic and Ambulatory Care and General Practice Clinical Stream paper 2013-2018. Available at:

Outcomes of the health needs analysis		
		https://www.slhd.nsw.gov.au/planning/pdf/ACCR_Clinical_Stream_Position_Paper.pdf (Accessed November 2016) CESPHN Local Health Needs Survey, January 2016 Johnstone, T., Broome, R., Clenaghan, P., Martin, R., 2016, The demographic profile and health needs of those attending the Exodus Foundation's lunch service. Morgan TK, Williamson M, Pirotta M, et al. A national census of medicines use: a 24-hour snapshot of Australians aged 50 years and older. Med J Aust 2012;196:50–3.[PubMed] cited in NPS Medicinewise at: http://www.nps.org.au/topics/ages-life-stages/for-individuals/older-people-and-medicines/for-health-professionals/polypharmacy (Accessed 8/11/2016) Hilmer SN, Gnjidic D. The effects of polypharmacy in older adults. Clin Pharmacol Ther 2009;85:86–8.[PubMed] cited in NPS Medicinewise at: http://www.nps.org.au/topics/ages-life-stages/for-individuals/older-people-and-medicines/for-health-professionals/polypharmacy (Accessed 8/11/2016) Roughhead L, Semple S, Rosenfeld E, Literature Review: Medication Safety in Australia (2013). Australian Commission on Safety and Quality in Health Care, Sydney." Available at: https://safetyandquality.gov.au/wp-content/uploads/2013/08/Literature-Review-Medication-Safety-in-Australia-2013.pdf (Accessed 07 November 2016) Data Limitations: Dementia rates only at national level CCF rates are only available at NSW level

Outcomes of the health needs analysis		
Alcohol & Other Drugs	There has been a decline over the past 10 years in the proportion of the CESPHN population aged 16 years and over who consume alcohol at levels posing long term health risks. Patterns of consumption for men and women in our region have also changed, with reduction in rates of daily drinking, a reduction in the proportion of men drinking weekly (although this is still higher than for women), and increases in the rates of people drinking less than weekly or never. Prevalence predictions suggest that within the CESPHN population aged 12 years and over: • 104,000 people will have an alcohol use disorder • 7,600 people will have a methamphetamine use disorder • 5,500 people will have a benzodiazepine use disorder • 27,000 people will have a cannabis use disorder • 9,500 people will have a non-medical opiate use disorder 2.5% of headspace services in CESPHN region in 2015/16 were for alcohol and/or drug specific interventions; compared to 1.2% across headspace centres Nationally Almost 80% of clients using NGO Alcohol and other drug services in the PHN region in 2015/16 were aged between 19-49 years; males made up approximately 55% of clients and females 45%; 14% of AOD NGO clients identified as Aboriginal but not Torres Strait Islander; this is disproportionate to the representation in the CESPHN population. Amphetamines, alcohol, cannabinoids, heroin and methamphetamines were the principal drug of concern for over 75% of NGO clients. Some population groups are disproportionately represented in AOD services including: LGBTIQ, those involved in criminal justice system, Aboriginal population, CALD communities, homeless population and young people. It is anticipated that areas within the CESPHN region will have higher prevalence rates where there are higher concentrations of homeless people, LGBTIQ communities and/or people who have been recently released from prison. Over the past 5 years, we have seen an upward trend in the incidents of use/possession of amphetamines, cannabis, cocaine, ecstasy and narcotics; use and rates vary across the CESPHN	PHIDU Torrens University Australian. Social Health Atlas of Australian. Data by Primary Health Network http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au Accessed (22 September 2016). Central and Eastern Sydney PHN (2016). Alcohol and Other Drugs Prevention Needs Assessment, April 2016. Central and Eastern Sydney PHN, Kogarah NSW Headspace National Youth Mental Health Foundation headspace centres Central and Eastern Sydney PHN Financial Year 2016/17 (Quarter 1) NADAbase, 2015/16 Financial year report Bureau of Crime Statistics and Research, Crime Mapping Tool http://crimetool.bocsar.nsw.gov.au/bocsar/ National Health Performance Authority analysis of Pharmaceutical Benefits Scheme (PBS) statistics 2013–14 (data supplied 11/02/2015) and Australian Bureau of Statistics Estimated Resident Population 30 June 2013. Full data specifications at http://meteor.aihw.gov.au/content/index.phtml/itemId/623427 accessed 13 September 2016 Consultation with CRC staff, October 2016

Outcomes of the health needs analysis		
	catchment. Botany Bay, Marrickville, Sutherland Shire and Sydney LGAs all have seen upward trends in more than one drug. This may impact on the number of court diversion referrals to local services if trends continue to increase (refer to service needs). It is noted that approximately 70% of prisoners require support regarding AOD use, with more than 70% reporting that their offending was directly related to drug use. Opioid prescribing rates across the PHN differ to National trends, with four of the five highest rates in our region for areas with high socioeconomic status; National trends show dispensing rates were highest in areas of low socioeconomic status and decreased with areas of increasing socioeconomic status Unsafe use of needles in drug use contributes to other health issues such as Hepatitis C	Australian recommendations for the management of hepatitis C virus infection: a consensus statement 2016
CALD (Culturally and Linguistically Diverse) and Refugee	The population of the CESPHN region is diverse with over a third of the population born overseas, which is almost 10% higher than the NSW rate. Almost half of the people residing in the Burwood, Strathfield and Canterbury LGAs were born overseas. The most commonly spoken languages spoken at home other than English in the region are Mandarin, Greek, Cantonese, Arabic and Italian. The top countries of birth of humanitarian arrivals from 2008 to 2013 were from China, Burma, Iran, Iraq, Sri Lanka, Bangladesh, and Egypt. A SESLHD needs and assets analysis of the CALD population identified three communities most in need, these were Bangladeshi, Nepalese and Chinese grandparents. The identified areas of concern included impact of torture and trauma, isolation, overcrowding particularly in areas of Wolli Creek and Rockdale, homelessness, movement of children 0-5 to and from a family's country of origin and how this impacts children's development and readiness for school, vulnerability to issues related to domestic and family violence women and children from China, Nepal and Thailand. SLHD is currently undertaking a consultation process for their multicultural health plan and CESPHN will be involved to identify priorities that are in line with our strategic priorities. Recent Syrian refugee migration to the region are currently small in numbers, but require an immediate health check, which will predominately be completed by their families local GP.	Social Health Atlas of Australia: Data by Primary Health Network, 2014 ABS, 2011 Language spoken at home by LGA 2011 Available at: http://stat.abs.gov.au/Index.aspx?DataSetCode=ABS_CENSUS2011_B13_LGA (Accessed Feb 2016) Consultation with nurse from NSW Refugee Health Service Department of Immigration and Border Protection, Settlement Reporting. Available at: http://www.immi.gov.au/settlement/ (Accessed 13 November 2016) Diverse werks, Needs and Assets Assessment: New and Emerging Communities, August 2016. Limitations:

Outcomes of the health needs analysis		
		Have interpreting service utilisation data for part of the region only, therefore it was not presented.
Child and Maternal	Births: Almost one third of births in the CESPHN region in the past year have been under the GP Antenatal Shared Care model of care; approximately 40% of births at the Royal Prince Alfred Hospital and Royal Hospital for Women are under the ANSC model of care, with close to 30% of all births at Canterbury and St George Hospitals under this model. The Sutherland Shire LGA has for the past 15 years had the highest number of births in the CESPHN region, accounting for 14.2% of all births in 2015 (n=2,798). Canterbury and Sydney LGAs followed with 11.9% (n= 2,331) and 11% (n=2,151). Developmental Vulnerability: Across CESPHN, Hurstville is the only LGA to have seen a significant increase in the percentage of developmentally vulnerable children in two or more of the domains of AEDC between 2009 and 2015. When comparing rates between 2012 and 2015, both Hurstville and Leichhardt LGAs show significant increases in the percentage of developmentally vulnerable children in two or more domains of the AEDC Across the CESPHN region, several areas are of note in regards to child and maternal health: • The Canterbury area has high number of births yearly, higher than NSW rate of NDSS registrants with gestational diabetes, low immunisation rates, high rates of risk factors for perinatal depression (low SES, high overweight rates, lower rates of higher education), high rates of smoking in pregnancy, significantly low rates of % pregnant women having first antenatal visit by 14 weeks of gestation • The Sutherland Shire region highest number of births each year, risk factors for perinatal depression (high smoking rates, high proportion of residents born in Australia, English as main language, high rates of overweight/obesity), significantly low rates of % pregnant women having first antenatal visit by 14 weeks of gestation	CESPHN Twelve month report – ANSC update Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au Accessed 21 October 2016. Torrens University Australian. Social Health Atlas of Australian. Data by Primary Health Network http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks AEDC community compare tables, (http://www.aedc.gov.au/data) Accessed 15 September 2016 Source: NDSS Diabetes Map - Diabetes Australia, (http://www.diabetesmap.com.au/#/) Accessed 23 August 2016

Outcomes of the health needs analysis		
	• Eastern Suburbs – South area has high rates of perinatal depression risk factors (low rates of higher education, high smoking rates, low SES areas, higher than PHN rate of overweight and/obese females aged 18 years +) • Hurstville and Leichhardt areas both have high rates of registrants on NDSS with gestational diabetes mellitus and increasing developmental vulnerability rates under the AEDC	
Chronic Disease Prevention and Management	<u>Behavioural Risk Factors (SNAP)</u> We have seen a decline in smoking rates across the CESPHN region over the past 10 years; the most recent data suggests that the rates of smoking in the CESPHN population aged 18 years and over is lower than both the National and State rates of smoking. There continues to be low rates of fruit and vegetable consumption in the CESPHN population aged 16 years and over, rates have remained relatively stable over the past decade. In the past 10 years, we have seen an increase in the in the proportion of the CESPHN population aged 16 years and over who undertake adequate physical activity; this is in line with NSW rate changes <u>Biomedical Factors</u> Rates of high blood cholesterol across the CESPHN population are in line with State and National rates. CESPHN ranked 7th highest (out of 31 PHNs) in 2011-13 in terms of estimated population aged 2 years and over with hypertensive disease. Estimated rates of overweight and/or obesity have risen slightly between 2002 and 2015, however remain in line with or below State rates. <u>Cancer Screening</u> Uptake of bowel cancer screening programs in adults aged 50-74 years in the CESPHN region and breast cancer screening programs in females aged 50-74 years is lower than National and State rates. Between 1 January 2014 and 31 December 2015, CESPHN had the fifth lowest participation rate in both	**Behavioural Risk Factors** Smoking: *Torrens University Australian. Social Health Atlas of Australian. Data by Primary Health Network* http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au Accessed (22 September 2016). Nutrition: Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au Accessed (22 September 2016). Physical Activity: Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au Accessed (22 September 2016). **Biomedical Risk Factors** High blood cholesterol: *Torrens University Australian. Social Health Atlas of Australian. Data by Primary Health Network* http://phidu.torrens.edu.au/social-health-

Outcomes of the health needs analysis		
	the National Bowel Cancer Screening program and BreastScreen program. Areas within the CESPHN region have been identified as having participation rates lower than CESPHN rate. Participation rates in cervical screening programs for females aged 20-69 years is higher in the CESPHN region compared to National and State participation rates; CESPHN ranked twelfth highest for all PHNs between 1 January 2014 and 31 December 2015. Breast screening participation rates are lower in both CALD and Aboriginal population groups compared to the PHN population rates, however overall the 50-54 age group has the lowest participation rates across the CESPHN region. The 20-24 years' age group had the lowest participation rates in cervical screening programs across the PHN region. <u>Cancer Incidence:</u> CESPHN had areas with directly standardised incidence rates of bowel, breast, cervical and prostate cancer higher than the respective NSW rates. Of note was the incidence rate of breast and prostate cancers in Woollahra, with rates 1.4 and 1.2 times the NSW rates respectively. The Incidence of prostate cancer in the Sutherland Shire was 1.4 times the rate in NSW. The SESLHD portion of Sydney LGA had an incidence rate of cervical cancer which was 2 times the NSW rate and Botany Bay was higher than State rates for bowel, breast and cervical cancer. <u>Chronic Diseases:</u> Across the CESPHN region, the age standardised rates of circulatory system disease for the population aged 2 years and over was in line with State and National rates; with CESPHN ranking 15th highest out of 31 PHNs. LGAs with generally lower socioeconomic status (or pockets of low SES) had the highest rates in our region, including Canterbury, Botany Bay, Rockdale and Sydney. The former Inner West Sydney Medicare Local region has the second highest proportion of the adult population with biomedical signs of chronic kidney disease (16.7% of the adult population) in Australia; South Eastern Sydney Medicare Local region ranked 6th (14.2% of the adult population) and Eastern	atlases/data#social-health-atlas-of-australia-primary-health-networks Hypertension: *Torrens University Australian. Social Health Atlas of Australian. Data by Primary Health Network* http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks Overweight and Obesity: Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au Accessed 22 September 2016. **Chronic Disease** Cancer Screening: Bowel – AIHW http://www.aihw.gov.au/cancer-data/cancer-screening/ Accessed 4 November 2016 Breast - AIHW http://www.aihw.gov.au/cancer-data/cancer-screening/ Accessed 4 November 2016 Cervical - AIHW http://www.aihw.gov.au/cancer-data/cancer-screening/ Accessed 4 November 2016 Cancer Institute NSW Reporting for Better Cancer Outcomes Performance Report 2016: Central and Eastern Sydney PHN Cancer Incidence:

Outcomes of the health needs analysis		
	Sydney Medicare Local had 9.7%. This equates to an estimated 147,700 adults (approximately 10% of the CESPHN population. Over the past 5 years, we have seen an increase in the estimated proportion of the male population aged 16 years and over with diabetes or high blood glucose; the opposite has been seen for females. Within the CESPHN region, the Sydney LHD catchment has a highest estimated rate than SESLHD. Age standardised rates of musculoskeletal system disease and arthritis for the CESPHN population were both estimated to be below State and National rates. Pockets within in our catchment had rates higher than the PHN rate for each. Sutherland Shire LGA had higher than State and National rates for musculoskeletal system disease; Canterbury had higher than National rates for arthritis. CESPHN age standardised rate of the estimated population with respiratory system disease and/or asthma were lower than both State and National rates; rates of COPD were in line with State and National rates. Of note, the Sutherland Shire LGA had rates of respiratory system disease, asthma and COPD higher than the State and/or National rates for each condition.	Annual NSW cancer incidence and mortality data set, 2012 (sourced from the NSW Cancer Registry). Population data are sourced from the Epidemiology and Surveillance Branch, NSW Ministry of Health. Cardiovascular Disease: *Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au Accessed (27 September 2016). – Circulatory disease hospitalisations by LGA and disease type* Diabetes: *Torrens University Australian. Social Health Atlas of Australian. Data by Primary Health Network* http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks *accessed on 12 Sep 2016* *Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at:* www.healthstats.nsw.gov.au *Accessed (23 August 2016) – Diabetes prevalence by PHN* *Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at:* www.healthstats.nsw.gov.au *Accessed (23 August 2016) – Diabetes prevalence by LHD* Musculoskeletal Disease (including arthritis): *Torrens University Australian. Social Health Atlas of Australian. Data by Primary Health Network* http://phidu.torrens.edu.au/social-health-

Outcomes of the health needs analysis		
		atlases/data#social-health-atlas-of-australia-primary-health-networks Oral Health *Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au Accessed (27 September 2016). – Oral health hospitalisation by reason for hospitalisation by PHN* Respiratory Disease: *Torrens University Australian. Social Health Atlas of Australian. Data by Primary Health Network* http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks Chronic Kidney Disease *Kidney Health Australia. State of the Nation 2016 Kidney Health Week. Chronic Kidney Disease Hot Spot. Australia 2016.* Impaired fasting glucose: *Australian Institute of Health and Welfare. 'Impaired Fasting Glucose'. 2016(http://www.aihw.gov.au/risk-factors/impaired-fasting-glucose/) accessed 17 October 2016* The Australian Bureau of Statistics. 2015 Deaths, Australia, 2015 (2016). Cat. No.: 33020D005. http://www.abs.gov.au The Australian Bureau of Statistics. Causes of Death. New South Wales, 2015 (2016). Cat. No.: 3303.0 http://www.abs.gov.au

Outcomes of the health needs analysis		
		Limitations: Nutrition and Physical Activity data – small sample population Impaired fasting glucose and impaired glucose tolerance- only national data is available. Diabetes mellitus- this was not specified as type 1 or type 2 in the PHN and LHD data Death rate data are available at LGA level, however the cause of death is only available at state level.
Disability	Disability is emerging as a health priority due to the impending roll out of the NDIS in the CESPHN region in July 2017. With 4% of the CESPHN population requiring assistance with core activities and areas within CESPHN that report significant numbers and above NSW rates of people aged 65 and over with a profound or severe disability, in Canterbury (2.6%), Botany Bay (2.4%), Burwood (2.4%), Rockdale (2.3%), Ashfield (2.2%), Canada Bay (2.1%), Hurstville (2.1%) and Kogarah. Resulting in an increased reliance on primary health care providers to provide assistance with service navigation and care coordination for those disability services.	Primary Health Networks, Disability Report 2011. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Demographic_Data (Accessed 25 Sept 2016) Social Health Atlas of Australia, 2014. Available at: http://phidu.torrens.edu.au/social-health-atlases/data (Accessed 24 Sept 2016) Settlement Services Inc. Future Ability Data Cube. Available at: http://www.ssi.org.au/services/futureability/futureability-datacube (Accessed 7 November 2016) CESPHN Local Health Needs Community Survey, February 2016 Limitations: Profound or severe disability rates - LGA data only Disability by type data is only available for under age 65 Limited information on the SSI data cube

Outcomes of the health needs analysis		
Emerging Health Needs	Homelessness: Nationally, those who experience homelessness is an increasing issue at a rate of 49 per 10,000 persons (2011) whilst NSW has the highest rate of homelessness than any other state. The majority of those who are experiencing homelessness are under 35 years of age. The primary reason (33.8% of homelessness) for those who experience homelessness is domestic violence and relationship issues including time out from family, family breakdown, violence and assault, followed by accommodation issues (24.9% of homelessness) including housing crisis, inadequate or inappropriate dwellings. Thirty four percent of those experiencing homelessness are in overcrowded dwellings following by boarding houses (23%). Approximately 60% of people on reception to prison are homeless. Those who experience homelessness are affected by a range of chronic conditions and participate in risky health behaviours. Population groups who are particularly vulnerable to experiencing homelessness include Aboriginal and Torres Strait Islanders and youth (12-18 years). Boarding Houses: There are 418 general boarding houses (BH) in SLHD which accounts for 47% of the total number (885) of registered boarding houses in NSW. The highest numbers of BH are located in Marrickville (164) and City of Sydney (SLHD) (116) local government areas (LGA). The maximum number of residents in a single BH is approximately 118 in a BH in Ashfield (Inner West Council) LGA. Research participation rates depicted that the overwhelming boarding house population is male (82%). 59% of BHOS clients had been diagnosed with a mental health condition. An average of 12% are Indigenous. Domestic violence: Across Australia, both women and men experience different forms of domestic violence. 1 in 6 Australian women have experienced physical or sexual violence from a current or former partner since the age of 15 years, whilst 25% of women have experienced emotional abuse by a current or former partner since the age of 15 years. 1 in 19 Australian men have experienced physical or sexual violence from a current or former partner since the age of 15 years, whilst 14% of men have experienced emotional abuse by a currently or former partner since the age of 15 years. In NSW between July 2015 to June 2016, the PHN	Australian Bureau of Statistics, Census of Population and Housing: Estimating Homelessness 2011. Cat. No.: 2049.0 2012. http://www.abs.gov.au Australian Institute of Health and Welfare 2013. Specialist homelessness services:2012–2013. Cat. no. HOU 27. Canberra: AIHW. Homelessness NSW. Inner City Sydney Registry Week 2015 Report. February 2016. Consultation with the Corrective Services, 2016 Eastern Sydney and South Eastern Sydney PIR annual reports 2015/16 Domestic violence data are available only at a national level. Data limited to 2012 Population Census Report from Healthy Strong Communities service delivery reform in Central Sydney planning forum: general boarding houses in the Inner West of Sydney (2016). Bureau of Crime Statistics and Research. NSW Recorded Crime Statistics July 2015 to June 2015. http://www.bocsar.nsw.gov.au/Pages/bocsar_pages/Domestic-Violence.aspx (assessed 07 Nov 2016) Limitations: Only national and state homelessness data is available. Data is limited to 2012 population census.

Outcomes of the health needs analysis		
	region has six LGAs in the top 100 LGAs with recorded domestic violence, these are: City of Sydney (ranked 47), Rockdale (ranked 83), Hurstville (ranked 86), Canterbury (ranked 87), Kogarah (ranked 93) and Strathfield (ranked 96).	There is no single agreed definition of domestic violence. Considerations need to be given for whom domestic violence affect, whether the two people in an intimate relationship who live/don't live together and whether it extend to children and other family members. Consideration also need to include whether physical violence the only type of domestic violence or should it include psychological abuse or financial abuse.
Immunisation	<u>Child:</u> CESPHN child immunisation rates are generally in line with National and State rates as at 30 September 2016. Sydney Inner City, Canterbury and Eastern Suburbs-North SA3 areas all have low rates in two of the three child immunisation groups (12-<15months, 24-<27months and 60-<63months). Indigenous child immunisation rates across the CESPHN region are higher than the general population rates for all age groups. When compared to other PHN immunisation rates, CESPHN ranked 27th, 25th and 24th out of 31 PHNs for 12-<15months, 24-<27months and 60-<63months respectively. <u>Youth:</u> CESPHN ranked 2nd for females and 11th for males Nationally for HPV vaccine coverage, with 84.7% and 72.1% coverage rates respectively. Rates for females in Botany Bay (81.7%), Canada Bay (78.1%), Randwick (81.3%), Waverley (77.8%) and Woollahra (74.8%) LGAs are all below the NSW rate of 82.5% coverage; rates for males in Kogarah (69.1%), Rockdale (67.7%), Sydney (61.1%) and Woollahra (64.1%) LGAs are all below the NSW rate of 69.9% coverage <u>Adult:</u> Adult influenza and pneumococcal immunisation rates for persons aged 65 years+ in the CESPHN region are both below the State rate. Rates of immunisation are lower in the SLHD portion of our catchment for both vaccines.	*ACIR Report as at 30 September 2016, by SA3 region and PHN region. Available at:* http://immunise.health.gov.au/internet/immunise/publishing.nsf/Content/current-phn-immunisation-coverage-data *and* http://immunise.health.gov.au/internet/immunise/publishing.nsf/Content/current-data-SA3 Accessed 4 November 2016 *Torrens University Australian. Social Health Atlas of Australian. Data by Primary Health Network* http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks Accessed 02/09/2016 *Adult - Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at:* www.healthstats.nsw.gov.au Accessed 19 September 2016. <u>Limitation:</u> *The adult immunisation statistics may be underreported as there has been no central registry for collecting adult immunisation rates. From 1 November 2016, the Australian Childhood Immunisation Registry was expanded to the*

Outcomes of the health needs analysis		
		Australian Immunisation Registry and will collect all vaccinations, including influenza, given at general practice
Mental Health	For the CESPHN population, the estimated prevalence rates of mental illness each year is approximately: ○ 350,690 people with symptoms not warranting diagnosis ○ 138,150 people with mild mental illness ○ 69,834 people with a moderate mental illness ○ 47,062 people with a severe mental illness Approximately 10% of the CESPHN population aged 18 years and over reported high or very high levels of psychological distress; the highest rates were seen in Botany Bay, Canterbury and Burwood LGAs. Youth are accessing headspace sites in the CESPHN region for mental health services at rates higher than National rates; demographics in our region include twice the proportion of 'other' gender to National results, over one quarter identify as LGBTIQ which is higher than National proportion, higher proportion of clients 15 years + compared to National which supports community feedback re: need for additional support at transition periods of care, more than double the proportion of CALD clients than National results. CALD, Aboriginal, children and youth and those experiencing or at risk of homelessness have been identified as groups needing specific mental health supports and have therefore been included as priority groups under the new Psychological Support Services being delivered through CESPHN (formerly ATAPS). Eating disorders have been flagged as an issue across the CESPHN region with individuals more likely to attend primary health care for reasons other than their eating disorder. Individuals with severe and complex mental illness have an estimated life expectancy 25 years less than the general population and often live with multiple morbidities such as diabetes, arthritis, circulatory diseases.	*Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services (November 2015)* *Torrens University Australian. Social Health Atlas of Australian. Data by Primary Health Network* http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks *Headspace centres: Central and Eastern Sydney PHN Financial Year 2016/17 report* CESPHN Twelve month report National Health Performance Authority analysis of the National Hospital Morbidity Database 2013–14, data supplied March 2015 and Australian Bureau of Statistics Estimated Resident Population 30 June 2013. Accessed 22 September 2016 *Eating Disorder: Community Data and Primary Health Care Needs Assessment joint report from SLHD and SESLHD* Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au Accessed (21 September 2016). *Limitations:*

Outcomes of the health needs analysis		
	Suicide and self-harm have been identified as an issue within pockets of our population. Research shows that for every suicide, 10-135 people are affected. This equates to approximately 1,310 to 17,685 individuals affected by suicide in 2013; these individuals are then more likely to need mental health support themselves.	*Suicide and self-harm data based on LHD utilisation information; difficult to determine exact details for suicide rates* *Aboriginal MH data only available at State level*
Rural (Lord Howe and Norfolk Islands)	Lord Howe Island: There were 360 residents living on LHI in 2011, with 16.4% of children aged 0-14 years and 20% of the residents aged 65 years and over. Consultations with the GP and community nurse on LHI identified diabetes as a health need, and a lack of diabetes educator and dietician services available to residents. Norfolk Island: Refer to Norfolk Island BNA submitted 30 October 2016	Australian Bureau of Statistics, 2011, Census QuickStats Lord Howe Island. Available at: http://www.censusdata.abs.gov.au (Accessed 20 Sept 2016) Limitations There is limited health and service information available for LHI.
Sexual Health	Rates of sexually transmissible diseases are high across the CESPHN region, with chlamydia notifications the highest of them all (423 per 100,000 population) in 2015. Chlamydia notification rates are increasing and are three times higher for those aged 16-24 years. Sydney (1,146 per 100,000 population), Marrickville (558 per 100,000 population), Waverley (642 per 100,000 population) and Woollahra (474 per 100,000 population) LGAs have notification rates higher than the PHN rate. Sydney LGA and Marrickville LGA also have higher notification rates than the PHN for gonorrhoea and infectious syphilis. The gonorrhoea notification rate has increased across the region, with a higher notification rate in males. Of the blood borne viruses (Hepatitis B, Hepatitis C and HIV), Hepatitis B had a higher notification rate than for the PHN and had the highest number of people living with CHB (chronic hepatitis B) who were not engaged in care. CALD populations are a priority population for Hepatitis B across the State, particularly those born in the Asia-pacific region.	*Sydney Local Health District Sexually Transmitted Infections Report 2011-2015* *Sexually Transmissible Infections in South Eastern Sydney and Illawarra Shoalhaven Local Health Districts 2011-June 2016* *Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au Accessed 24th October 2016.* *Hepatitis B Mapping Project: Estimates of chronic hepatitis B prevalence, diagnosis, monitoring and treatment by Primary Health Network, 2014/15 - National Report* *Sydney Local Health District Hepatitis Report 2016* *South Eastern Sydney Public Health Unit Monthly Surveillance Report August 2016*

Outcomes of the health needs analysis		
	Whilst hepatitis C notification rates for the PHN were below the State, the rate has increased between 2012/13 and 2013/14 among all age groups. In Sydney LHD this increase was higher amongst males, whilst CALD was identified as a priority population for NSW. HIV notification rates are consistently high across the PHN region, with most NSW residents notified with newly diagnosed HIV infection residing in SESLHD (31.3%) and Sydney LHD (16.6%). South Eastern Sydney LHD consistently had the highest number and proportion of newly diagnosed NSW residents, followed by Sydney LHD. More than 90% of HIV infections are in males, with the highest proportion (19.9%) of newly diagnosed are in the 30-34 year age group. This holds true for SESLHD, with the average age of diagnosis being 32.08 years, however there is a slightly older cohort for SLHD with 37.8 years being the average age of diagnosis. The CALD population is a priority population across the State, locally there has been an increase in rates of new diagnosis among individuals born overseas between 2011-2015. The Sydney LGA had the highest number of newly diagnosed HIV infections across the CESPHN region (highest rate in each LHD respectively).	*South Eastern Sydney Local Health District – Overview of HIV Notifications 2011-15 Presentation* *Sydney Local Health District Newly acquired HIV notifications July 2015* *NSW Health: NSW HIV Strategy 2012-2015. 2015 Annual and Quarter 4 Data Report* *HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2015* Limitations: Data from multiple sources; variations in data reported/available publicly such as LHD and NSW Health Stats including different time periods and age groups. Often data only available at State or National level and need to extrapolate
Veterans	The total number of veterans reported by the Department of Veterans Affairs residing in the CESPHN region is 5169, with almost a quarter of these residing in the Sutherland Shire LGA. Veteran health has been identified as an emerging need in the CESPHN region by stakeholders including health professionals and service organisations. Health and wellbeing issues pertaining to Veterans include high prevalence of mental conditions including PTSD and anxiety disorders and those experiencing homelessness.	Department of Veteran Affairs, 2015, Social Health Strategy for the Veteran and Ex-Service Community. Available at: http://www.dva.gov.au/sites/default/files/files/publications/health/social_health_strategy.pdf (Accessed 09 November 2016) A. C. McFarlane, S. E. Hodson, M. Van Hooff & C. Davies (2011). Mental health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study: Full report, Department of Defence: Canberra. Diverse werks, One on One Consultations – Solider On, Summary Report, March 2016.

Outcomes of the health needs analysis		
		Department of Veteran Affairs, DVA Stats at a Glance, Available at: http://www.dva.gov.au/about-dva/statistics-about-veteran-population#treatmentpop (Accessed 19 Sept 2016) Homelessness NSW, Inner City Registry Week 2015 Report. Available at: http://www.cityofsydney.nsw.gov.au/community/community-support/homelessness (Accessed 20 October 2016) Limitations: Data on DVA clients is at LGA level only No data sources for veterans not receiving DVA benefits
Youth	The range of information available on youth health is limited, however, the PHN is participating in several initiatives that target youth such as: contributing to the consultation process on the Ministry of Health's Youth Health Policy; working in partnership with the SLHD, FACS and other key agencies to develop a youth health and wellbeing plan for the Inner West region and as part of the PHN mental health areas of work, a priority focus on youth mental health. Education The overall school retention rate to Year 12 in 2014 for NSW was 78.1%. LGAs with the lowest participation rate (percentage of population over 16 years old) of full time secondary school education are City of Sydney (70.7), Rockdale (79.8) and Canterbury (80.0), these are also lower than the NSW state average (80.1%). Youth unemployment Youth unemployment was 11.8% (August 2016), double the overall unemployment rate (5.0%) for the population aged over 15 years. The overall unemployment rate (15+ years old) was 5.0% in August 2016 for New South Wales. Marrickville (7.0% in June 2016), Canterbury (6.7%) and Botany Bay (6.4%) are LGAs with the highest unemployment rate and above the NSW State average.	Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au Accessed (19 Sep 2016). PHIDU Torrens University Australian. Social Health Atlas of Australian. Data by Local Government Area. New South Wales & Australian Capital Terriorty. http://phidu.torrens.edu.au assessed (19 Sep 2016) Department of Employment. Small Area Labour Markets publication. Available at: https://employment.gov.au/small-area-labour-markets-publication (assessed 26 Sep 2016) The Australian Bureau of Statistics. National Regional Profile, 2008-2012 (2014). Cat no.: 1379.0.55.001 . http://www.abs.gov.au. (accessed 27 Sep 2016)

Outcomes of the health needs analysis		
	Youth homelessness is a key area that may be under reported and requires further exploration. Refer to youth mental health under Mental Health	<u>Limitations:</u> Only NSW trend is available for school retention rate. Youth unemployment data is only available at a state level. Only 2011 census contains youth unemployment data at LGA level. Awaiting publications of 2016 census.

Section 3 – Outcomes of the service needs analysis

This section summarises the findings of the service needs analysis in the table below. For more information refer to Table 2 in '5. Summarising the Findings' in the Needs Assessment Guide on www.health.gov.au/PHN.

Additional rows may be added as required.

Outcomes of the service needs analysis		
Priority Area	Key Issue	Description of Evidence
Digital Health	CESPHN has the third highest MyHealth Record Registration in NSW, mostly amongst young people under 39 years of age. 99% of general practices in CESPHN region are registered for MyHealth with majority of users being GPs using the system to upload prescription records and for Shared Health Summary. Although almost all general practices are registered with MyHealth, only half of these practices are utilising the service. Approximately 76% of all general practices (520 practices) in the CESPHN area have access to secure messaging. However, only 68% of these practices are using secure messaging in practice.	Department of Health. My Health Record statistics by Primary Health Network (PHN) May 2016. http://www.health.gov.au (accessed 10 Oct 2016) Department of Human Services. Medicare Locals Statistics Reports. http://medicarestatistics.humanservices.gov.au/statistics/med_locals.jsp (accessed 10 Oct 2016) CESPHN Internal database, accessed 19 July 2016 <u>Limitations:</u> Information on ChiliDB were gathered from CESPHN census and therefore availability of data depends on voluntary response from census.
Workforce	In 2014, there were 1950 GPs actively working within the CESPHN region, with 50% of GPs aged 55 and over and 20% of GPs working in a solo private practice setting There were 450 practice nurses, 829 occupational therapists, 1,644 pharmacists, 1,671 physiotherapists, 2,172 psychologists, 249 podiatrists and 406 chiropractors working in the region. Overall, CESPHN had a higher rate of GPs and AHP per 1,000 populations than the NSW average, except	Health Workforce Data, http://data.hwa.gov.au Accessed 24th October 2016 CESPHN Health Needs Survey Findings, February 2016 Eastern Sydney Medicare Local, Lord Howe Island Project Plan, Version 3, 2013.

Outcomes of the service needs analysis		
	for practice nurses, where CESPHN had 0.3 practice nurses per 1,000 population, which is slightly less than the NSW rate (0.4 per 1,000 population). The LGAs within the CESPHN region with the highest proportions of GPs per 1,000 population were Sydney (2.3), Woollahra (1.9), Burwood (1.7), and Leichhardt (1.7). The LGAs within the CESPHN region with the lowest proportions of GPs per 1,000 were Kogarah (0.2), Botany Bay (0.6), and Marrickville (0.8). A survey of health professionals in the PHN region identified that of the 116 respondents, 20% are planning to retire, sell, or move their practice outside the region over the next five years. There is one GP servicing the 380 residents and tourists on LHI. The GP is currently 65, and must source and fund locums from the mainland when on leave. Fewer GPs are visiting RACFs, however are providing more MBS reportable services (2012/13-2014/15), resulting in an uneven distribution of workload.	Limitations: Information on CESPHN database was gathered from CESPHN census and therefore availability of data depends on voluntary response from census.
Aboriginal and Torres Strait Islander Health	In 2012/13, 5,406 Aboriginal and Torres Strait Islanders across the Indigenous Area Region (IARE), which covers a large portion of the PHN, were hospitalised, representing approximately one third of the CESPHN Aboriginal population. The highest rate of hospitalisations and ambulatory sensitive hospitalisations was for those living in the IARE Sydney -City area, both rates were higher than the State. Care involving dialysis accounts for the largest difference in hospitalisation rates between Aboriginal and non-Aboriginal people (3.5 times higher). This holds true locally, where in 2014/15, dialysis hospitalisation rates were highest for Aboriginal people (16285.4 per 100,000) compared to non-Aboriginal people (4427.7 per 100,000) and this rate has continued to climb over the last eight years. In 2014/15, hospitalisation for mental disorders was the second highest rate across the PHN (4004.6 per 100,000 population), this was substantially higher than the State (2908.5) and second highest among all NSW PHNs. This rate has continued to climb over the last eight years. Hospitalisations for	Centre for Epidemiology and Evidence. Health Statistics, New South Wales. Sydney: NSW Ministry of Health. Otitis media procedures by Aboriginality. Available at: www.healthstats.nsw.gov.au Accessed 13 November 2016. PHIDU 2016. Aboriginal and Torres Strait Islander Social Health Atlas of Australia. Data by Indigenous Area. Released Aug 2016. Admissions by selected principal diagnosis. PHIDU 2016. Aboriginal and Torres Strait Islander Social Health Atlas of Australia. Data by Indigenous Area. Released Aug 2016. Admissions by selected principal diagnosis and age. PHIDU 2016. Aboriginal and Torres Strait Islander Social Health Atlas of Australia. Data by Indigenous Area. Released Aug 2016. Ambulatory sensitive hospitalisations by age.

Outcomes of the service needs analysis		
	circulatory disease, respiratory diseases and injury and poisoning are at a higher rate than for non-Aboriginal people. Less than 8% of the practices in the CESPHN region are registered to the Indigenous Health incentive, which impacts upon access to primary health care services for Aboriginal people, particularly in areas with a high number of Aboriginal people. Lack of practices offering the health assessments and PBS entitlements ('CTG script') is an ongoing issue, particularly in areas with high number of Aboriginal population. In 2015/16, 1,379 MBS Item 715 were completed by up to 124 practitioners across the CESPHN region; this is an increase from 2014/15, where 989 MBS Item 715 were completed by up to 110 practitioners Several barriers in accessing health services were identified by community members, these included, cost, transport (particularly early morning and late afternoon appointments for dialysis treatment) and lack of culturally sensitive services. Access to more early intervention and prevention programs for Aboriginal youth, more outreach services – particularly a regular GP for the La Perouse community, more culturally appropriate initiatives, better transition services in child and youth and services for prisoners on release. Wide availability and knowledge of the Aboriginal health assessment and 'CTG' medication was noted as a barrier for Aboriginal people accessing services. Priority areas highlighted, included the need for better Aboriginal identification, easier navigation of health services and better communication and coordination between services.	*Community consultations February 2016* *La Perouse community consultation* *Co-design workshop with Aboriginal community members and Aboriginal service providers, Aug 2015* *Aboriginal and Torres Strait Islander Health Performance Framework 2014, AIHW*
Ageing	The ageing population are high users of the healthcare system and support services. There is a high need for primary care providers to coordinate care for individuals between other primary care providers, multiple inpatient and outpatient hospital services, home service providers, and residential aged care facilities (RACFs) to ensure appropriate care for this population. There are 161 RACFs (12,257 residential places) across the PHN region. There are fewer GPs visiting RACFs however they are providing more reportable MBS services, which has implications for GP	Department of Health PHN, MBS data by PHN & MBS Item. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-MBS_Data (Accessed 01 November 2016) National Health Performance Authority, Australian Commission on Safety and Quality in Health Care, Australian Atlas of Healthcare Variation, 2015.

Outcomes of the service needs analysis		
	workforce and aged care access to primary care services. A survey of RACFs (50% response rate) identified that 82% have a Registered Nurse on site at all times, 57% utilised a medical deputising services in the after hours period and 43% utilised geriatric flying squads/LHD outreach programs in the after hours period. There are 64 retirement villages across the PHN region, the majority (83%) housed people aged 75 years and over. There are variances in what services RV provided for residents, with some providing medical services and support services returning from hospital and those with dementia. All respondents stated they would benefit in further training to improve their skills to support their residents. Identified training subject areas included, dementia, falls prevention, mental health in older people, managing behaviours of concern, chronic disease and advance care planning. Of the 3,028 residents who received home care packages in 2015, 59% were 85 years and over. More than half (53%) of people receiving home care packages are people from a non-English speaking background whilst 55% of all Aboriginal and Torres Strait Islander Home Care Package recipients are aged under 65 years. Rates of hospitalisations among the elderly are high in pockets of the region for Dementia, falls and COPD. Dementia is currently the second leading cause of death in Australia, and the single greatest cause of disability in people aged 65 and over. Most areas within the PHN region reported higher than NSW rates of dementia hospitalisations, including Burwood, Rockdale, Strathfield and Randwick LGAs, with these rates increasing over the previous five years. Aboriginal and Torres Strait Islanders are using dementia services at a younger age, with incidence rates 5 times higher than the non- Aboriginal population. With the increasing rate of dementia, primary health care has an important role in dementia prevention, early and timely diagnosis, and providing access to health and aged care services and support as the need presents for those living in community and in residential aged care facilities. Within NSW, falls are responsible for 43.5% of injury-related hospitalisations, with falls related hospitalisations increasing in the PHN region by 20% over the last ten years. Certain areas with the region experience higher rates of falls related hospitalisations; Leichhardt, Marrickville, Randwick, Waverly and	Aged Care Service List – New South Wales as at June 2015, Department of Health, Ageing and Aged Care. Available at: https://agedcare.health.gov.au/ageing-and-aged-care-overview/about-aged-care/aged-care-service-list-new-south-wales (Accessed 20 September 2016) CESPHN RACF Census, February 2016 AIHW National Aged Care Data Clearinghouse, Residential aged care and home care 2014-15. Available at: http://ww.aihw.gov.au/national-aged-care-data-claeringhouse/racp/ (Accessed 20 September 2016) CESPHN Retirement Village Survey, October 2016 CESPHN Local Health/Service Needs – Individual Community Forum Summaries, February 2016 Department of Health PHN, MBS data by PHN & MBS Item. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-MBS_Data (Accessed 01 November 2016) Centre for Epidemiology and Research (CER) 2016, HealthStats NSW, Dementia as a principal diagnosis or as comordity hospitalisations. Available at: http://www.healthstats.nsw.gov.au/Indicator/bod_dementhos/bod_dementhos_lga_trend (Accessed 13 November 2016)

Outcomes of the service needs analysis		
	Sydney LGAs all had rates higher than the NSW average. Falls can lead to serious injury including hip fractures with lengthy hospital stays and long term disability. There are pockets of high hospitalisation rates due to Chronic Obstructive Pulmonary Disease (COPD) within the region, including Sydney LGA (562.2 per 100,000), which was double the rate of Canterbury LGA (282.4 per 100,000), which was the second highest LGA rate. Rates of CCF as a potentially preventable hospitalisation in the older population increase from the ages of 65-90. NSW hospitalisation rates for 2014-15 were highest among the 80-84 year age group with 2911 per 100,000 hospitalisations, equating to 795 hospitalisations in CESPHN region. It is important to note that pockets across the region identified as having high hospitalisation rates are not from the SA3s identified as having higher numbers and proportions of people aged 65 years and over. Service navigation portals such as My Aged Care, transitioned in July 2015, have presented issues for end users, such as the inability to access timely and appropriate information and support for those who need to access these services, their carers, and health professionals, and service providers; access for CALD populations are disadvantaged as the costs for interpreters are included in packages and hence lowering their overall service delivery level whilst there are reported barriers to accessing this for Aboriginal and Torres Strait Islander's. To address the gaps and improve services, it has been identified that higher priority must be given to increasing the coordination and service navigation between GPs and the aged care system.	Centre for Epidemiology and Research (CER) 2016. HealthStatistics NSW. Sydney. Ministry of Health. Available at http://www.healthstats.nsw.gov.au/ (Accessed 20 Sept 16) National Health Performance Authority Australian Commission on Safety and Quality in Health Care, 2015, Australian Atlas of Healthcare Variation, Hip fracture hospital admissions 65 years and over. HealthStats NSW, Dementia Hospitalisations. Available at: http://www.healthstats.nsw.gov.au/Indicator/bod_dementhos/bod_dementhos_atsi_trend Accessed 13 November 2016) Centre for Epidemiology and Research (CER) 2016, HealthStats NSW, Chronic Obstructive Pulmonary Disease hospitalisations. Available at: http://www.healthstats.nsw.gov.au/Indicator/res_copdhos/res_copdhos_aria_trend (accessed 13 November 2016) Centre for Epidemiology and Research (CER) 2016. HealthStatistics NSW. Sydney. Ministry of Health, Potentially preventable hospitalisations. Available at http://www.healthstats.nsw.gov.au/ (Accessed 12 November 2016) Roughhead L, Semple S, Rosenfeld E, Literature Review: Medication Safety in Australia (2013). Australian Commission on Safety and Quality in Health Care, Sydney." Available at: https://safetyandquality.gov.au/wp-content/uploads/2013/08/Literature-Review-Medication-Safety-in-Australia-2013.pdf (Accessed 07 November 2016) Limitations:

Outcomes of the service needs analysis		
		Lack of MyAgedCare related data including referrals for home care packages and services and residential aged care facility admissions; Local falls related hospitalisation data only available for all ages, not 65+; Rates of hip fracture hospital admissions for 65 years and over only available at SA4 level; COPD rates by LGA – only available at all ages CCF rates are only available at NSW level CCF rates are only available at NSW level
Alcohol and Other Drugs	Through initial mapping of services across the CESPHN region, we have identified many NGOs and LHD/SHN led Drug Health Services who offer a range of AOD services to different population groups, approximately 10% of pharmacies in our region are involved in OPT, we have a small number of private hospitals offering drug and alcohol services and AOD counsellors are available at each of the 5 headspace sites. Further detailed mapping of local AOD services in collaboration with LHDs, SHNs and NGOs needs to be completed to include service accessibility, service details, waitlists etc to assess, and where needed, improve referral pathways between levels of care. The main treatment types sought by clients of NGOs in our region are rehabilitation, assessment, detoxification and counselling; rates vary depending on principal drug for clients. There is a low referral rate from GPs to local NGO AOD services (2% of referrals); self-referral was the main referral source (46%), followed by residential alcohol and other drug services (13%), court diversion (8%), family member/friend (7%) and other criminal justice setting (7%). Almost one quarter of mental health hospitalisations in 2013/14 were for drug and alcohol use, with the proportion higher than Nationally (18.1%). High rates of age standardized overnight hospitalisations in specialized care compared to Nationally. Some SA3s in our region have approximately 3 times the rate of bed days to National comparator and 2.5 times the rate of hospitalisations.	*NADAbase, 2015/16 Financial year report* *Consultation with LHD and SHN drug health services* *National Health Performance Authority analysis of the National Hospital Morbidity Database 2013–14, data supplied March 2015 and Australian Bureau of Statistics Estimated Resident Population 30 June 2013. Accessed 22 September 2016* *Admitted Patient Services Data – PHN secure site* *Central and Eastern Sydney PHN (2016). Alcohol and Other Drugs Prevention Needs Assessment, April 2016. Central and Eastern Sydney PHN, Kogarah NSW*

Outcomes of the service needs analysis		
	Data shows that the CESPHN region had the highest relative utilisation across both public and private hospitals for 'Treatment for drug disorder, sameday'; approximately 2.5 times the average national utilisation. We have high hospital relative utilisation for alcohol withdrawal, drug intoxification and withdrawal, alcohol use disorder and dependence, opioid use disorder and dependence, other drug use disorder and dependence and treatment for alcohol disorders. Private hospital relative utilisation is highest across all PHNs for opioid use disorders and second highest for other drug use disorders and dependence and treatment for drug disorder, sameday.	
CALD	As the CESPHN population is diverse, better access to bilingual health care professionals can work to reduce the barriers that CALD communities face when accessing primary care and hospital based services. A number of GPs and allied health professionals across the region are bilingual, with Mandarin being the language most cited (423 AHPs and 158 GPs). Translating services currently provided by CESPHN to allied health professionals, recorded 58 occasions of service in the last 12 months, with Mandarin and Arabic as the most requested language service. The suburbs with the highest usage rates were Campsie and Homebush. This highlights the need to increase the uptake of these services in primary care. Consultations identified that people from CALD communities experience difficulties in accessing services as they have a general lack of understanding of the Australian health care system, resources and tools commonly used in within the system, concern for the cost of services, long waiting times for interpreting services, lengthy travel and wait times for preferred bilingual bulk billing GPs and the sensitivity and stigma associated with accessing services such as drug & alcohol and sexual health services. There was a general perceived need for more health information and types of services available.	CESPHN, Access to Interpreting Services for Allied Health Professionals Survey, 2016 CESPHN Database (Chili DB) – Accessed 01 November 2016 Consultation with nurse from NSW Refugee Health Service, November 2016 Diverse Werks, Needs and Assets Assessment: New and Emerging Communities, SESLHD. August 2016. SESLHD implementation plan for Health Culturally Diverse Communities 2014-16 Diverse werks, One on One Consultations, Summary Report, March 2016. Diversewerks, CESPHN Local Health/Service Needs – Individual Community Forum Summaries, February 2016

Outcomes of the service needs analysis		
		Limitations: The internal PHN database was in the process of being updated, therefore new data on primary care professionals speaking another language may not have been captured. Awaiting utilisation data from Sydney Health Care Interpreter Service who services SLHD, SESLHD, SVHN, SCHN
Child and Maternal Health	9 Hospitals in the CESPHN region have maternity services; 5 public (2 x Level 6 Maternity Service; 1 x Level 5 Maternity Service and 2 x Level 4 Maternity Service) and 4 private Sydney Children's Hospital Randwick is located within the CESPHN catchment 42 Child & Family Health centres across the CESPHN catchment A search of the CESPHN stakeholder database shows that 154 General Practitioners in the CESPHN region (approximately 8%) have a special interest in child and family health The July 2016 Evaluation of the Sydney HealthPathways program showed that Antenatal – First consult was the most viewed page both in recent time periods and across the life of the project Refer to Chronic Disease Prevention and Management regarding child asthma presentations	Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au Accessed 21 October 2016. *SLHD Child and Family Health Nursing, available at:* http://www.slhd.nsw.gov.au/communityhealth/EarlyChildhood/locations.html *SESLHD Child and Family Health Centres, available at:* http://www.seslhd.health.nsw.gov.au/SGSHHS_CFHN/stg_centres.asp *Sydney Health Pathways: SLHD HIV, STI & Viral Hepatitis Primary Care Advisory Group Evaluation report 18 July 2016*
Chronic Disease Prevention and Management	In 2014/15 UTIs were the most common potentially preventable hospitalisation across the CESPHN region, followed by cellulitis, dental conditions, congestive cardiac failure and COPD. Across NSW, asthma like presentations were the most common potentially preventable hospitalisation for children. Across the region, for all public hospital Emergency Department presentations in 2013/14, Sydney Children's Hospital had the highest percentage of triage category 4 presentations (69.12%), equating to 26,604 presentations. Whilst Sydney Hospital and Sydney Eye Hospital had the highest percentage of triage category 5 presentations (51.58%), equating to 19,305 presentations.	*Sydney Children's Hospital briefing 2016* Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au Accessed 21 October 2016. *NSW Health Stats. Asthma like presentations in 86 emergency departments by age and sex, NSW 2015*

Outcomes of the service needs analysis		
	MBS statistics show a relatively low uptake of chronic disease practice incentive payments (PIP), especially asthma cycles of care in the CESPHN region. We have seen a decline in most health assessment claims between 2013/14 and 2015/16, with a noted exception seen for Aboriginal and Torres Strait Islander Peoples Health Assessment (MBS item 715) which increased by 49% during this period. Similar trends have been seen in the uptake of case conferencing MBS item numbers, with there being only one item which has seen a significant increase in utilisation between 2013/14 and 2015/16 (MBS item 735 – organise and coordinate a GP case conference at least 15 minutes and less than 20 minutes). Conversely, increases have been seen in the uptake of multidisciplinary care plans processed between 2013/14 and 2015/16, primarily items relating to attendances for preparation and/or coordination of GPMPs and TCAs and review of the same. There is a low uptake by the community of the National Diabetes Service Scheme (NDSS), with data showing a lower proportion of our population registered with NDSS than National registrations, despite us having areas with greater prevalence of diabetes. This variation was seen for both Type I and Type II diabetes mellitus, however rates of registration for individuals with gestational diabetes was higher than National rates. Botany Bay and Sutherland Shire LGAs had significantly higher smoothed rates per 100,000 population than NSW, between 2013/14 and 2014/15, for high body mass attributable hospitalisations. Although UTIs have been identified as our most common potentially preventable hospitalisation, data from NSW Health shows that we have rates of potentially preventable hospitalisations for several conditions which are above the NSW rate, namely bronchiectasis, nutritional deficiencies, perforated/bleeding ulcers and vaccine preventable pneumonia and influenza. We have pockets within our catchment with hospitalisation rates significantly higher than the NSW rate for specific cardiovascular conditions.	*PHN website, Emergency Department data. Triage distribution by hospital (accessed 13 Nov 2016).* *Australian Government Department of Human Services: Medicare Local Statistics Reports. Available at:* http://medicarestatistics.humanservices.gov.au/statistics/med_locals.jsp *NDSS Diabetes Map - Diabetes Australia, accessed 02/09/16 (http://www.diabetesmap.com.au/#/)* Centre for Epidemiology and Evidence. Health Statistics New South Wales. Sydney: NSW Ministry of Health. Available at: www.healthstats.nsw.gov.au Accessed (21 September 2016).
Disability	NDIS is scheduled to rollout throughout the CESPHN region on 1 July 2017. Due to the changing nature of the sector, service provision and providers, a comprehensive analysis of providers delivering disability services is currently not reportable.	*Innovat8 project scoping document 2016*

Outcomes of the service needs analysis		
	CESPHN has contracted Innov8 consultancy group to undertake a NDIS Impact Needs & Planning Project which will provide a clear role for CESPHN in the rollout phase. The consultation phase will involve interviews with 17 key stakeholders and 5 workshops are planned for November/December with a final report due Jan 2017. Some preliminary analysis of the current system reveals: o The specific needs of people with different types of disability are not well understood within the primary health system, leading to a range of significant and diverse issues (including basic lack of access, lack of understanding of the "whole of life" challenges of different disability types, lack of resources to respond to specific disability needs, and others); o the need for a significant shift towards early intervention was a common theme across all disability areas, but was raised particularly in the intellectual and psychiatric disability areas and in indigenous communities; o mental health issues are a critical challenge across the disability sector, not just for people whose primary disability is identified as mental illness – the impact on mental health of living with any type of disability was raised by each of the disability groups interviewed; o an issue identified related to pathways for people with all types of disability after discharge from hospital, with disability advocates citing many examples of GPs and other allied health professionals having little understanding of the specific post-discharge needs of people with disability; o the lack of a robust database of disability and primary health care services, populations of people with disability, including needs assessment and assessments of the level of knowledge across sectors of disability issues, was raised as a key issue; o evidence from NDIS Trial Sites has indicated that many people with disability want to understand the effect of health/ill-health on their capacity to manage their disabilities, but that there is a lack of clarity about where that education should come from	

Outcomes of the service needs analysis		
Emerging Health Needs	Homelessness: A holistic approach is required in the provision of services for people experiencing homelessness with consideration given to their health status, income and interaction with the justice system and the level of intervention required. Majority of homeless people require short term support with housing they can afford (51%) and some (35%) require housing with intensive support, in some cases for the duration of their lives. Most homeless people receive some type of government financial assistance as their primary source of income. They are identified as having multiple interactions with the NSW Health system including utilisation of ambulance, hospitalisation and visits to accident and emergency department. They experience ongoing mental health and substance abuse issues. Refer to mental health for more information on youth mental health Domestic violence: A range of services are available for people experiencing, having experienced domestic violence. Awareness and accessibility of these services are lacking as 39% of women and 70% of men who have experienced domestic violence have never sought advice or support.	Homelessness NSW. Inner City Sydney Registry Week 2015 Report. February 2016. Family and domestic violence (August 2016) Department of Human Service. https://www.humanservices.gov.au/customer/subjects/family-and-domestic-violence9 assessed 27 Sep 2016
Immunisation	Two Public Health Units in the CESPHN region, work collaboratively with the PHN in identifying areas of low immunisation coverage. PHN and PHU staff work with primary care to improve data quality for reporting purposes Approximately 48% of general practices across the CESPHN region were visited in 2015/16 regarding support for immunisation within the practice Approximately 42% of practices were supported in 2015/16 regarding cold chain management; we have seen a reduction in vaccine wastage from human error, however power outages across the region have had a large impact on vaccine wastage	*CESPHN Twelve month report 2015-16*

Outcomes of the service needs analysis		
	Introduction of the "No Jab No Pay" policy regarding child immunisation and family tax benefits has shown a small increase in coverage, however the full effects of this policy is expected in the coming months which could increase demand on services in the region.	
Mental Health	We've seen an increasing rate of mental health treatment plan (MHTP) claims by GPs with mental health skills training, mental health plan reviews and GP mental health consultations across the region. There is also local anecdotal evidence of inappropriate use of GPMP and/or TCAs for people with mental health conditions or concerns. Highlighting the need for further education and support for primary care clinicians regarding MBS claims There has been an increase in the number of psychiatrists including a person other than the patient during initial diagnosis of a patient and continuing management of a patient within our region, however uptake is still low. There is also low uptake of home visits by psychiatrists and low availability of psychiatrists willing to bulk bill patients. Low uptake of use of psychiatrists to conduct an assessment and management plan and/or review on behalf of GPs. There are few out of consult room visits conducted by Allied Mental Health Professionals across the region which can impact on service accessibility for some client groups. There is higher than National and metropolitan PHN rates of hospitalisation and bed days for all mental health disorders (combined) in the CESPHN region There is a range of low intensity services across the CESPHN region, however further mapping of services including waitlists, availability and inclusion criteria will need to be explored to gain a clear picture of services and navigation options across the area. Self-referral rate into headspace sites across our region are high compared to the National self-referral rates, and high uptake of ATAPS services within headspace compared to uptake across all headspace sites nationally.	Health Workforce Australia data, available at: http://data.hwa.gov.au/webapi/jsf/login.xhtml MBS Statistics by Medicare Local Reports (http://medicarestatistics.humanservices.gov.au/statistics/med_locals.jsp) accessed 15 September 2016 Service capacity Source: Salvador-Carulla. L., Maas. C., Fernandez. A., Prigent A, Gandré C., Xu T, Alvarez-Galvez J. & SalinasPerez J. (2016). The Integrated Mental Health Atlas of the Central and Eastern Sydney PHN. Mental Health Policy Unit. Brain and Mind Centre. Faculty of Health Sciences. University of Sydney e-mental health in practice (eMHprac), available at: http://www.emhprac.org.au/services/ Eating Disorder: Community Data and Primary Health Care Needs Assessment joint report from SLHD and SESLHD Consultation with LHDs CESPHN ATAPS Twelve month report 2015-16 Headspace centres: Central and Eastern Sydney PHN Financial Year 2016/17 report

Outcomes of the service needs analysis		
	The former ATAPS program is currently undergoing a redesign process to have resources better placed to meet community needs, particularly for hard to reach populations. This includes a change in how clinicians are contracted and where services will be placed to improve access. Data suggests we have higher than National and metropolitan PHN rates of specialised care hospitalisations, meaning patients are treated in specialised wards instead of general wards. Some areas within the CESPHN region have higher than National/metropolitan PHN rates of overnight hospitalisation and/or bed days for one or more severe mental illnesses There is limited data available at the local level regarding suicide and intentional self harm rates, however our region has a higher proportion of specialised care compared to non-specialised care for intentional self harm. Research regarding service utilisation by those who have suicided, shows that 45% of people had accessed healthcare support in the 6 months prior to their suicide. 31% of people who have suicided had accessed a GP or Psychiatrist and 19% had accessed a Psychologist or Counsellor; highlighting the need to support our primary care professionals in identifying these at-risk individuals. We have limited Aboriginal specific mental health service options across the region and limited access to local level Aboriginal data regarding mental health	National Health Performance Authority analysis of the National Hospital Morbidity Database 2013–14, data supplied March 2015 and Australian Bureau of Statistics Estimated Resident Population 30 June 2013. Accessed 22 September 2016 <u>Limitations:</u> Initial mapping activities through Mental Health Atlas did not include private hospitals – CESPHN will look at exploring this further Eating Disorders data is difficult to capture at a local level Aboriginal specific data is difficult to capture at local level MBS utilization – not available by age groupings or SA3 level (based on MBS stats by Medicare Local reports) *MBS data provided by former Medicare Local (ML) region, therefore same psychiatrist could work across ML catchments
Rural (Lord Howe and Norfolk Islands)	Lord Howe Island is staffed by one general practitioner and two registered nurses. The GP provides 24/7 service provision to LHI residents and tourists, with after hours services in greater demand through the high tourist season (Oct-March). The practice is not accredited and as such does not access any service or practice incentive payments. There are some specialist and allied health services available on LHI, however these are provided from service providers flying in from the mainland on an ad hoc basis and at the expense of the provider. Dentistry is the only publicly funded visitation; all other specialties must fund their own travel expenses. LHI residents are able to access financial support for specialty services through the Isolated Patient's Travel Assistance Scheme (IPTAS) to visit specialists on the mainland.	Eastern Sydney Medicare Local, Lord Howe Island Project Plan, Version 3, 2013. Consultation with LHI GP and nurse, October 2016

Outcomes of the service needs analysis		
	Recent consultations identified the need for a regular specialist and allied health visiting program, particularly for podiatry, dentistry, psychiatry and cardiology. The GP and community nurse identified a lack of diabetes educator and dietician services available to residents. General practice identified the need for better access to professional development opportunities and training on digital health technologies. A lack of home support or palliative services has been identified. Perceived needs for the community include education on topics such as drugs and alcohol, diabetes, mental health and women's health. SESLHD leases the consulting room to the GP, provides some IT infrastructure and equipment, therefore any service related improvements need to be undertaken in consultation with the SESLHD. *Norfolk Island* Refer to BNA for Norfolk Island submitted 30/10/2016	
Sexual Health	Given the high rates of sexually transmissible diseases across the region, particularly in the Sydney and Marrickville LGAs, targeted health promotion to community, including young people and education to primary health care professionals around these issues is a priority. Particular effort needs to be placed in improving chlamydia screening in general practice for young people. The rate of blood borne viruses across the region, is an identified local priority with very high rates of hepatitis B and HIV and increasing rates of hepatitis C. Whilst there are 116 GP prescribers for S100 medications for these diseases, there is a need to increase the number of GP prescribers, ensuring they are in areas of high prevalence but also available across the region, to ensure easy access. Currently most prescribers (approximately 62%) are located within the Sydney LGA, highlighting the low availability of s100 prescribers in remaining LGAs across our catchment. Of equal importance is the recent availability of Hepatitis C treatments, prompting the need for education and training to primary health care professionals to increase uptake of these treatments. Consistently high utilisation of Chronic Hepatitis C and Chronic Hepatitis B health pathways for the Sydney LHD region reinforces the	Consultation with LHDs South Eastern Sydney Local Health District "The right services to the right people in the right locations: A coordinated response to Hepatitis C across the South Eastern Sydney Local Health District" Australasian Society for HIV Medicine (ASHM) NSW s100 Hepatitis B Community Prescribers listing available at: http://www.ashm.org.au/HBV/hbv-prescriber-lists ASHM HCV s100 trained Community Medical Practitioners listing available at: http://www.ashm.org.au/HCV/hcv-prescriber-list

Outcomes of the service needs analysis		
	need for continued information on management and referral pathways among primary health care professionals. Consultations with SLHD identified a burden of liver disease in the community with concerns raised in regard to the capacity of the Liver Clinic at Canterbury Hospital. This is partially being addressed across the two districts, where planning is currently underway for GP clinical placements in Liver Clinics, in addition to MoH funded hepatitis nurse positions working in primary care settings. Consultations with SESLHD identified the following areas of need in Hepatitis C, including: improving access for Aboriginal people, improving access for clients in contact with AOD treatment programs and clinical information systems not supporting an integrated care approach.	ASHM trained HIV s100 Prescribers listing available at: http://www.ashm.org.au/hiv/prescriber-lists
Veterans	The transition of care of defence workers from the Australian Defence Force to the Department of Veteran Affairs have been identified as a barrier to service access and delivery. Several Veterans experience problems accessing a regular GP due to regular relocation and deployment. A best practice service model of addressing service needs is the partnership between Concord Hospital and the Solider On organisation, which applies a case management approach to care coordination, addressing health, housing, employment and social needs Several non DVA funded organisations operating in the PHN region are providing health and support services to Veterans in particular Solider On, RSL Life Care & Homes for Heroes, Veterans off the streets, V360 and Bravery Trust. There are variances in health service utilisation across the Veteran population. A follow up study of Gulf War Veterans found that this group utilised more DVA health services compared to similar military groups, which could indicate higher health needs.	Diverse werks, One on One Consultations – Solider On, Summary Report, March 2016. Australian Gulf War Veterans' FollowUp Health Study: Technical report, 2015, Monash University. Available at: http://www.dva.gov.au/sites/default/files/files/consultation%20and%20grants/healthstudies/ (accessed 19 Sept 206)

Outcomes of the service needs analysis		
Youth	Youth experiencing homelessness is an area for targeting with the majority of homeless people being young people under 35 years of age. The average period of homelessness for young people under 25 years of age is 2.1 years and 60% of homeless youth require short term support with housing that they can afford. Headspace: There are five Headspace sites in CESPHN region with Camperdown site being the busiest centre. Mental health is the nature of services provided to the young people during their first appointments along with other services including engaged and assessment, alcohol and/or drug specific intervention, physical or sexual health, family based intervention and vocational. From 1 July to 30 September 2016, a total of 1,454 young people visited Headspace Centres for services and the average visit frequency was 2.8 occasions. Headspace centres in the CESPHN region are reportedly seeing more young people from CALD background reflecting the demographics of the region and those who identify themselves as lesbian, gay, trans, intersex and questioning. The main reason young people visited Headspace was for problems with how they feel followed by problems with school/work, problems with relationships and that they were made to come. 43.5% of young people who visited headspace in the CESPHN region were formally referred and the majority of referrals were from primary health care GP's (76%). 37.2% of young people were subsequently referred to community based mental health services after visiting headspace in CESPHN region, 25.6% to specialist health care and 18.6% to community based allied health professional.	Homelessness NSW. Inner City Sydney Registry Week 2015 Report. February 2016. Headspace. Headspace Centers Central and Eastern Sydney PHN financial year 2016/17.
Service navigation and pathways	**Health Pathways Sydney** 460 completed Pathways on the website From June – Sept 2016: • number of unique page views ranged from 9404 – 11074 • number of sessions of use ranged from 2690-3099 • number of different users ranged from 692-817	Health Pathways Sydney, data analytics report (Sept 2016) Community and health provider Consultations (Feb 2016)

Outcomes of the service needs analysis		
	Top 5 pathways used (March 2014-Sept 2016) are: • antenatal -first consult • chronic hepatitis B • chronic hepatitis C • emergency department requests • non-urgent antenatal care assessment **South Eastern Sydney Health Pathways** There is currently no HealthPathways product in operation however, work is progressing on a development of an MoU between SCHN, CHN, PHN and SESLHD), due to be signed by Nov 2016. Planned live date is April 2017 **Community consultations identified:** Service users and health professionals want to know what's available and where to access services. Expressed need for service specific portals Service provider boundaries can be unclear, particularly in LGAs serviced by more than one health district for e.g. Riverwood Better transition care and services for specific population groups such as in child and youth (turning 16 years, pertinent for both Aboriginal and non-Aboriginal youth), young adults to adult services, prisoners on release, people with a disability moving into 65+ cohort and those that are 65 + developing a disability.	

Section 4 – Opportunities, priorities and options

This section summarises the priorities arising from the Needs Assessment and options for how they will be addressed. This could include options and priorities that:

- *may be considered in the development of the Activity Work Plan, and supported by PHN flexible funding;*
- *may be undertaken using programme-specific funding; and*
- *may be led or undertaken by another agency.*

Additional rows may be added as required.

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
Aboriginal and Torres Strait Islander Health	▪ Improve and expand on outreach services in Aboriginal community based and controlled organisations with a view to work in partnership with community organisations. ▪ Support health literacy focused programs such as the Schools Aboriginal Health Program ▪ Linking community (including children and youth) with a range of health focused programs and/or services such as smoking cessation, drug and alcohol and mental health ▪ Provide educational opportunities to health providers around cultural awareness and competency and maintain a database of	Better treatment and management of chronic conditions for Aboriginal and Torres Strait Islander people, through better access to the required services and better care coordination and provision of supplementary services. Collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sectors is strengthened Improved capacity of mainstream primary care services to deliver culturally appropriate services to	Number and type of: ▪ education events offered, including cultural competency ▪ community events attended ▪ health promotion programs provided ▪ research programs participating in ▪ collaborative programs expanded or developed ▪ workforce development initiatives	PHN, LHDs, ACCHO

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	culturally appropriate primary health services for distribution. ▪ Work with health providers to improve Aboriginal identification processes. ▪ Advocate for targeted chronic disease management programs, particularly for Diabetes such as LMPs ▪ Support GPs GP registrars in promoting the Indigenous PIP, Indigenous Health Check and follow up allied health services. ▪ Promote the CTG script to pharmacies ▪ Investigate ways to better support Aboriginal people on release from the justice health systems ▪ Support community driven programs and health promotion events through provision of health information, including for children and young people. ▪ Promote accessible and affordable local transport services to organisations working with community ▪ Continue programs in partnership with Academia, such as nurse training mentoring program and Ways of Thinking, Ways of Doing.	Aboriginal and Torres Strait Islander people Increased uptake of Aboriginal and Torres Strait Islander specific Medicare Benefits Schedule (MBS) items, including Health Assessments for Aboriginal and Torres Strait Islander people and follow up items; Mainstream primary care services encourage Aboriginal and Torres Strait Islander people to self-identify; Increased awareness and understanding of measures relevant to mainstream primary care.	▪ strategies developed to improve Aboriginal self-identification Utilisation rates of: ▪ Indigenous Health Initiative PIP ▪ MBS 715 ▪ Follow up Allied Health Services for Aboriginal and Torres Strait Islanders (MBS 81310 -60) ▪ Follow up by a practice nurse or Aboriginal health practitioner (MBS 10987) Strategies developed to strengthen links with Justice Health Number of care co-ordination and supplementary services provided.	

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	▪ Promote employment of Aboriginal staff and support workforce development ▪ Develop a nurse training mentoring program in conjunction with USYD for support and mentoring by CESPHN care coordinators to improve their cultural competency and awareness of measures for Aboriginal and Torres Strait Islander people Note: ITC will be commissioned in the areas of Aboriginal care co-ordination (CCSS) and Aboriginal outreach. Outcomes from this commissioned activity will be reviewed and fed back into the next commissioning cycle.			
Ageing	▪ Support after hours services to RACFs to reduce preventable hospitalisations by RACF residents ▪ Provide referral pathways and up to date care service navigation information to GPs and AHPs ▪ Work in partnership with LHDs and other organisations to ensure continuity of care across the health sectors. **Falls Prevention** ▪ Targeted falls prevention programs **Education**	Reduced unplanned hospitalisations in the after hours period and for falls and falls related injuries. Improved continuity of care for the ageing population across the health sectors. Improved education and awareness of aged related issues among health providers	Models of care developed for after hours service delivery Models of care developed for continuity of care. Number and type of: ▪ Falls prevention programs provided ▪ Education and professional development opportunities provided	PHN, LHD, RACFs

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	▪ Provide education to health care professionals, RACF staff and community including retirement villages on topics such as advance care planning, my aged care, dementia. **Dementia** ▪ Partner with Dementia focused organisations to facilitate access to primary health care. ▪ Investigate dementia friendly strategies for primary health providers, RACF and RV **Staying Well at Home (Innovation proposal)** ▪ Work with general practices in the Canterbury and Sutherland LGAs to systematically identify patients aged 75 years and over with CCF, COPD and/or frailty and link into a chronic disease management program, utilising private health insurance programs, community based programs and hospital based programs. With the aim to reduce unplanned hospital presentations, particularly in the winter period. **Medication Management** • Continue to work with UNSW and academic research and other providers in addressing medication management	Number of dementia strategies and partnerships developed Populations with COPD, CCF and frailty can better manage their health. Number of medication related strategies to improve medication management.	▪ Dementia strategies in place ▪ Medication management strategies in place Monitor hospital presentations for falls and fall related injuries. *Refer to submitted Innovation proposal for measures.*	

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
Alcohol and Other Drugs	• Improve regional care coordination through collaboration with LHDs, SHNs and NGOs • Develop a more comprehensive understanding of the services available in our region through systematic mapping with key stakeholders including LHDs, SHNs, NGOs, pharmacies and general practice • Improve access to and/support through AOD rehabilitation services • Improve referral pathways including for withdrawal, aftercare and community care services • Explore population health interventions e.g. reduce rates of risky alcohol consumption **High needs populations:** • Explore access issues for families with AOD issues • CALD community focussed services/programs • LGBTIQ population • Services for young people with identified AOD issues • Aboriginal/Torres Strait Islander population **Clinical Complexity and clinical pathways:**	Established a region wide AOD consultation and governance structure Improved service capacity across the PHN region Improved access to services across the PHN region for high needs populations Reduction in inappropriate misuse of pharmaceuticals Increased proportion of the GP population involved in treatment and management of AOD problems of their patients Reduced rates of alcohol consumption at risky levels	Membership of region wide structure Proportion of population receiving rehabilitation, withdrawal and/or aftercare services Proportion of clients from identified high needs populations Rates of prescribing Number or proportion of GPs involved in AOD management Proportion of the population drinking at risky levels	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	• Programs/services to address high rates of pharmaceutical drug misuse • Support primary care clinicians re: AOD treatment and management			
Child Health Maternal Health	▪ Continue supporting Antenatal Shared Care (ANSC) program with a targeted focus on vulnerable populations and linking to parent support programs ▪ Support placed based initiatives that target priority populations, such as Healthy Homes and Neighbourhoods and Can Get Health ▪ Implement strategies to support GPs and work with LHD, community health and specialists in identifying, managing and appropriately referring children who do not meet developmental milestones such as a 3-year-old health check. ▪ Work with practices to expand the role of practice nurses in early childhood interventions. ▪ Support the implementation of the Inner West Sydney Child Health and Wellbeing Plan ▪ Work with Sydney Children's hospital to explore activities in relation to identified needs such as care co-ordination, potentially preventable hospitalisations and working	GP uptake and utilisation of ANSC is maintained and improved Improved links between ANSC and parental support programs Improved access to prevention and assessment programs aimed at identifying developmental problems in children Supporting healthy children, families and their communities in collaboration with other agencies. Reduction in potentially preventable admissions among children. Improved shared care planning processes in primary care.	ANSC participation rates (GPs and patients) Parental support programs identified and utilised. Number of families supported by placed based initiatives Number and type of child health specific pathways developed Number of GPs/PNs undertaking early childhood screening Monitor potentially preventable admissions among children Number and type of shared care planning tools utilised by primary care.	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	with primary care such as the Sydney Kids GPS project ▪ Explore the role of shared care planning tools in asthma management in partnership with LHDs, NGOs and other specialist services for primary health care. ▪ Review evaluation outcomes of the paediatric speech pathology service commissioned in 2016-17 for future recommendations.	Increased access to paediatric speech pathology services.	Evaluation outcomes and recommendations from commissioned speech pathology services	
Chronic Disease prevention and management	**Healthy Lifestyle** ▪ Support the establishment of no/low cost Lifestyle Modification Programs in areas of highest need (including for Aboriginal populations) ▪ Raise awareness of the Get Healthy Coaching Services. **Workforce Development** ▪ To support the foundation of the HCH model approach, activities include: o Data driven quality improvement through digital health technologies and data cleansing and management.	Improved access to health promoting programs and services in areas of highest need. Improved primary health care capability and quality improvement processes in managing and appropriately referring patients with chronic disease. Reduced unplanned hospital admissions and length of stay in patients with chronic diseases	Number and type of LMPs developed. Monitor utilisation of Get Healthy Coaching Service Utilisation rates of: ▪ Asthma PIP ▪ Diabetes PIP and SIP ▪ Cervical screening MBS items 2501-2507 ▪ Referrals to AHPs to group diabetes education MBS 81100-81125 ▪ CDM items MBS 721, 723, 732, 10997	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	○ Supporting a team based care approach for multidisciplinary care through improved linkages with other health providers. ○ Supporting practices to facilitate a patient-team partnership through education opportunities to general practices to better support patients with chronic disease management. ○ Comprehensive care planning through the provision of tailored support to practices in promoting and systematically utilising MBS items and PIPs related to chronic disease management and health assessments. ▪ Implement recommendations from the evidence based shared care planning tools scoping exercise. **Diabetes** ▪ Engage primary care in continuous QI projects such as Putting Data into Practice ▪ Explore options around better use of MBS items regarding chronic disease management.	Improved access to participation in cancer screening programs for identified populations. A flexible and tailored model of care proven to work in general practice that contributes to the foundation of health care homes and is based on practice capacity and need *(Innovation proposal)* Improved uptake of chronic disease management items for general practice	▪ Referrals to AHPs for CDM (MBS items 10950 – 10970 Uptake of shared care planning tools Number of practices undertaking QI Monitoring of QI clinical indicators Monitor cancer screening rates Utilisation rates of the Rockdale women's health clinic Potentially avoidable hospitalisations *Refer to Innovation proposal for outcome measures.*	

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	▪ Support LHDs in the delivery and improvement of community based diabetes education. ▪ Promote use of NDSS for patients diagnosed with diabetes **Cardiovascular Disease** ▪ Engage primary care in continuous quality improvement programs such as Q pulse **Respiratory (Asthma and COPD)** ▪ Support GPs to better manage respiratory illness through evidence based interventions in partnership with research institutions and other providers (explore commissioning) ▪ Improve GP management of Asthma in children to reduce avoidable hospital presentations (explore commissioning). ▪ Explore options around better use of MBS items regarding chronic disease management. **Cancer** • Work with GPs in identified areas of low participation to improve participation rates in cancer screening programs through the Cancer Institute Grant, Quality Systems and			

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	Local Leaders – improving primary care systems and knowledge across the three screening programs ▪ Improve access to cervical screening services for identified areas of need, such as the Rockdale Women's Health Service (commissioned service). ▪ Build primary care capacity to improve uptake of cancer screening programs. ▪ Work with peak cancer organisations to improve data sharing ▪ Scope evidence based intervention addressing identification and management of prostate cancer ▪ Maintain partnerships with Cancer Institute to ensure there is a primary healthcare focus.			
Disability	▪ Consider the outcomes and recommendations from the NDIS Impact Needs and Planning Project. The outcomes will work towards address the following: o resolve the currently unresolved questions and issues around the connection between the primary	GPs and AHPs have adequate information in supporting their patients transition to NDIS	Evidence of information and strategies on NDIS to primary health care providers.	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	health system and the disability support system needs; ○ each of the stakeholders, particularly the disability groups and the NDIA, recognise that there are potentially significant opportunities for the primary health system and the disability support system to work together to provide more effective and integrated support for people with disability; ○ the potential benefits of the Health Care Homes initiative to improve support particularly for people with intellectual disability was highlighted as a key opportunity for people with intellectual disability; ▪ Provide information to GPs and AHPs on NDIS to ensure optimal regional transition to NDIS in July 2017 ▪ Continue to work with LHDs, FACS, Speciality Health Networks, and NGO disability providers on NDIS readiness			
Emerging needs	**CALD and refugees**	**CALD and refugees** Increased utilisation of TIS by AHPs	**CALD and refugees** Utilisation rates of TIS	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	▪ Continue to work with SLHD in developing the District's multicultural health plan ▪ Work with SESLHD to address the needs identified in the needs and assets assessment. ▪ Increase the uptake of TIS to AHPs ▪ Provide access to cultural awareness training to health professionals ▪ Continue mapping bilingual GPs and AHPs within the region and provide information to LHDs, community groups and other key agencies. ▪ Work with organisations involved in local urban planning to proactively source specific bilingual health professionals to accommodate the needs of their new residents ▪ Promotion of CALD friendly and appropriate resources on health service navigation ▪ Provide resources to health professionals (health pathways, education, etc.) on emerging CALD and newly arrived refugee groups **Veterans**	Improved awareness around availability and access to bilingual health professionals Culturally appropriate resources developed Improved access to cultural awareness training to health professionals **Veterans**	Bilingual health professionals mapped and information provided Number of culturally appropriate resources developed and accepted by the CALD community. Number of cultural awareness training opportunities. **Veterans**	

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	▪ Provide health professionals working with Veterans a comprehensive directory/resource of services, in particular, mental health and housing services ▪ Promote PSS to GPs treating Veterans and their families **Homelessness** ▪ refer to mental health ▪ Support existing programs and link with Primary Health Care **Domestic Violence** Work with organisations to raise awareness of domestic violence and routes to accessing available services **Boarding house tenants** ▪ Work with key organisations to identify and address the health needs of boarding house tenants in the inner west Sydney region	Improved knowledge of services available to Veterans among health professionals **Domestic violence** Improved knowledge of domestic violence services available to community and health professionals **Boarding house tenants** Key health needs of boarding house residents identified.	Number and type of promotional material provided to health professionals on Veteran health **Domestic violence** Number and type of promotional materials provided to community and health professionals on Domestic Violence **Boarding house tenants** Needs assessment report with recommendations for action.	
Immunisation	▪ Provide immunisation support programs with a focus on vulnerable populations and populations with low childhood immunisation coverage rates	Maintain and increase immunisation coverage rates, particularly in vulnerable populations and	Immunisation rates by age, suburb and cultural background, including Indigenous	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	▪ Cold chain management support in general practice ▪ Work with the PHU to communicate timely information to General Practices	populations with low childhood immunisation coverage rates General Practices are supported in cold chain management and receive timely information from the PHU	Number of: ▪ practices support in cold chain management ▪ Cold chain breaches Incidence of communicable disease across the region	
Mental Health	▪ Explore development and implementation of a stepped care approach to mental health across the region **Low Intensity:** • Promote e-mental health resources • Access to low intensity digital mental health services • Coaching services (non-digital low intensity mental health services) • QI project re: stepped care integration into General Practice (Lead Site Activity) • Mindfulness in CALD communities (Lead Site Activity) • Coaching services in Aboriginal and Torres Strait Islander communities (Lead Site Activity)	Clear and accessible pathways to care for mental health concerns at all levels of intensity/acuity **Low intensity:** Increased awareness and uptake of low intensity services across the region **Children and Youth:** Increase in awareness of youth mental health programs, services and providers	**Low Intensity:** Proportion of regional population receiving PHN-commissioned mental health low intensity services Average cost per PHN commissioned mental health low intensity service Clinical outcomes for people receiving PHN-commissioned low intensity mental health services **Children and Youth:** Proportion of regional youth population receiving youth-specific	CESPHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	• Mental Health First Aid for underserviced groups (Lead Site Activity) • Map Low Intensity Mental Health Services in the region (Lead Site Activity) **Children and Youth:** • Youth mental health awareness activity • Commission headspace centres to provide youth mental health services • Promote and facilitate family support services • Early intervention activities for severe mental illness • Regional plan to include children and youth • Commission pathways for assessment and treatment of children and young people within a stepped care model **Psychological therapies for underserviced and/or hard to reach groups:** • Provide access to a range of applied psychological therapies for people from under-serviced and/or hard to reach populations	Increased utilisation of child and youth mental health programs, services and providers **Psychological therapies for underserviced and/or hard to reach groups:** Mental health needs of hard to reach groups addressed through better targeting of services and introduction of stepped care models **Severe and Complex Mental Illness:** Appropriate services available to address the health needs of individuals with severe and complex mental illness Improved care coordination for individuals with severe and complex mental illness **Community based suicide prevention activities:** Improved access to suicide prevention support through primary health care	PHN commissioned mental health services **Psychological therapies for underserviced and/or hard to reach groups:** Proportion of regional population receiving PHN commissioned mental health services – Psychological therapies delivered by mental health professionals Average cost per PHN commissioned mental health service – Psychological therapies delivered by mental health professionals Clinical outcomes for people receiving PHN commissioned Psychological therapies delivered by mental health professionals. **Severe and complex mental illness:** Proportion of regional population receiving PHN-commissioned mental health services – Clinical care	

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	• Expand the number and type of referrers across the region to ensure inclusion of hard to reach and underserviced groups **Severe and Complex Mental Illness**: • Transition the MHNIP • Multidisciplinary teams to provide co-ordinated care across the PHN region • Support GP assistance program to better manage severe and complex mental illness in primary care setting • Explore delivery of group therapy **Community based suicide prevention activities:** • GP education to increase proportion of GPs with MHST • Deliver psychological therapies targeting suicide prevention • Explore commissioning options for community based suicide prevention • Improve care coordination approach via locally developed protocols **Aboriginal and Torres Strait Islander mental health** • Target services to needs of Aboriginal youth	Services delivered to meet needs of the population **Aboriginal and Torres Strait Islander mental illness:** Services address specific needs of Aboriginal community	coordination for people with severe and complex mental illness (including clinical care coordination by mental health nurses). Average cost per PHN-commissioned mental health service – Clinical care coordination for people with severe and complex mental illness. **Community based suicide prevention:** Number of people who are followed up by PHN-commissioned services following a recent suicide attempt. **Aboriginal and Torres Strait Islander mental health services:** Proportion of Indigenous population receiving PHN-commissioned mental health services where the services were culturally appropriate. **Stepped care:** Proportion of PHN flexible mental health funding allocated to low	

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	• Provide culturally appropriate mental health services for Indigenous community		intensity services, psychological therapies and for clinical care coordination for those with severe and complex mental illness	
Rural health (LHI and NI)	▪ **Norfolk Island** Refer to submitted Needs assessment and Activity Work Plan (to be submitted 30/11/16) ▪ **Lord Howe Island** ▪ Joint plan with SESLHD regarding: ○ increasing AHP and specialist provision on LHI ○ Support GP and nurses to provide community education ○ Practice support: provide support to GP Practice to obtain accreditation ○ Promotion of My Health Record to residents and staff ○ Investigate the coordination of referrals of patients transferred to the mainland ○ CPD – increase education opportunities for GP and nurses on LHI	▪ **Norfolk Island** Refer to submitted Needs assessment and Activity Work Plan (to be submitted 30/11/16) **Lord Howe Island** ▪ Primary health care is supported through telehealth, digital health, professional development opportunities and practice support services. ▪ Clear referral pathways from general practice to health services and providers ▪ Reduced gaps in workforce availability and improved sustainability of local services ▪ Dedicated funding from the Department to address health and service needs	**Lord Howe Island** ▪ A consistent program of practice support is planned and implemented ▪ Types of referral pathways developed ▪ Workforce plan developed with SESLHD.	CESPHN SESLHD

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	○ examine contingency and succession planning for GP, AHP and speciality services ○ Investigate solutions to enable telehealth services to be utilised ▪ Consult with the Department of Health on seeking funding for a Lord Howe Island schedule (similiar to the Norfolk Island schedule).			
Sexual Health	**Workforce development**: ▪ increase role of practice nurses around STI testing and need for early treatment, management and follow up. ▪ Improve GP capability for opportunistic testing for STIs in priority populations ▪ Increase number of GP prescribers for HVB, HVC, HIV S100 medications ▪ Review outcomes of the I-Chat Initiative (Hepatitis Nurses working with primary care across the region) for future applications ▪ Explore increasing role of primary care in offering HCV management and follow up among people from priority populations. **Education** ▪ Education for health professionals including for new treatments.	Improved uptake of STI testing across general practice Increased awareness and uptake around new and existing treatments among health professionals New models of care implemented Better service integration among primary health and hospital and community based services Increased focus on priority population groups	Number of programs aimed to build capacity of general practice to address prevention and management of sexual health issues Number of new models of care implemented Number and type of programs focusing on improving service integration Number and type of programs focusing on priority population groups.	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	Integration ▪ Trialling a shared care model for HIV with Albion Centre and general practice ▪ Focused work with LGBTIQ CALD and Aboriginal populations			
Youth Health	▪ Support the development and implementation of the SLHD youth health plan ▪ Refer to youth mental health in mental health plan	SLHD Youth Health Plan developed Scoping paper and implementation plan developed	Number of PHN strategies outlined in joint youth plan	PHN
Priority populations	▪ Explore use of bilingual community educators (BCE) in partnership with LHDs ▪ Continue support for delivery and evaluation of placed based initiatives such as Can Get Health ▪ Working with organisations who target needs of priority communities such as Redlink and Healthy Homes and Neighbourhoods. ▪ *Refer to emerging needs - CALD for additional options*	BCE model agreed and developed Supporting healthy children, families and their communities in collaboration with other agencies.	BCE model in place Number of families supported by placed based initiatives Community needs identified through placed based initiatives.	PHN
Digital Health	▪ Support general practices, pharmacies, allied health professionals, specialists and residential aged care facilities to implement digital health technologies, such as secure messaging.	Improved uptake of digital health technologies among health professionals and consumers	Monitor: ▪ My Health record registrations and utilisation ▪ Utilisation of secure messaging	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	▪ Support practices to take up e-referrals ▪ Continue to work with both SLHD and SESLHD to improve the communications using Health e-Net ▪ Community education around MyHealth Record ▪ Support and promote the use of the digital health PIP among practices ▪ ▪ Support practices who participate in QI programs using the Pen Clinical Audit Tool (PenCAT) including support around training, data extraction and troubleshooting. ▪ Continue to work with Strata Health to support the test of change using the PRISM program, an electronic referral system ▪ Implement recommendations from the evidence based shared care planning tools scoping exercise. ▪ Work with the Digital Health Agency in the following areas: o Secure messaging o Shared care planning tools o Telehealth o myHealth Record	Increase awareness of digital health technologies among health professionals and consumers as well as increased electronic communications between health care providers – such as secure messaging, accessing My Health Record Increase use of technologies to support digital health initiatives including use of PRISM, PenCAT Improved sharing of patient health information across health care providers	Number of educational sessions and resources provided to health professionals and community groups. Number of practices submitting data to CESPHN via PenCAT Number of practices participating in a CESPHN QI project – e.g. Q Pulse, putting data into practice. Number of practices participating in Strata Health PRISM test of change project Uptake of share care planning tools Number of practices participating in ePIP	

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	▪ Explore digital health needs of Lord Howe Island and Norfolk Island ▪ Ongoing support to other CESPHN program areas to embed digital health across all program areas			
Workforce	▪ Support practices around the upcoming changes to the PIP redesign (the redesign of the PIP will introduce a new Quality Improvement Incentive which will give general practices increased flexibility to improve their detection and management of a range of chronic conditions, and to focus on issues specific to their practice population). ▪ Work with training providers to support GP registrars ▪ Employ business modelling for the promotion of practice nurses in practices. ▪ Support GPs in succession planning ▪ Support newly opened practices – including both general practices and allied health practices ▪ Undertake a regional Strategic workforce plan to determine the state of primary care in the region.	Support practices in navigating around the new PIP changes and in QI activities Sustainable and highly skilled primary health care workforce Development of resources to support succession planning Work with organisations involved in local urban planning to ensure better planning for primary health care services Primary health care professionals have access to a number of education opportunities Practices are health care home ready	Number and type of: ▪ CPD events held and attendances ▪ Practice support activities undertaken ▪ GP registrars supported ▪ Practice nurses supported ▪ Allied Health Professionals and/or practices supported ▪ New practices in the CESPHN area and support provided ▪ Number of primary health professionals undertaking cultural awareness training Uptake rates of PIP in general practice	PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
	▪ Provide opportunities for professional development to GPs, practice nurses, practice staff and allied health professionals. ▪ Provide opportunities for cultural awareness training ▪ Continue to lay the foundations of the health care home model by: o Supporting practices through targeted quality improvement initiatives and practice support visiting program (accreditation, practice management and workforce support) o Promoting the model of team based care in practices o Building capacity of staff to systematically manage and refer patients with chronic disease ▪ QI activities, Q pulse and new digital PIP incentives ▪ Continue to work with organisations involved in local urban planning to ensure the equitable and appropriate supply of primary health care providers in areas of new developments		Refer to innovation proposal for measurements relating to health care homes.	

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
Service navigation	▪ Promotion and/or development of service navigation tools in partnership with LHDs and Specialty Health Networks, including: o Health Pathways Sydney o South East Sydney Health Pathways ▪ Promotion of National Health Services Directory ▪ Strata Health e-referrals resource matching ▪ Work with stakeholders to assess the delivery at key transition points, and aim to improve these. ▪ Riverwood boundary issues	Improved knowledge of services available across the region and how to access them	Number of pathways developed Number of pathways reviewed Number of sessions of use Number of unique page views Number of different users Number of practice visits Number and type of promotional materials developed and distributed	PHN SESLHD SLHD

Section 5 - Checklist

This checklist confirms that the key elements of the needs assessment process have been undertaken. PHNs must be prepared, if required by the Department, to provide further details regarding any of the requirements listed below.

Requirement	✓
Governance structures have been put in place to oversee and lead the needs assessment process.	✓
Opportunities for collaboration and partnership in the development of the needs assessment have been identified.	✓
The availability of key information has been verified.	✓
Stakeholders have been defined and identified (including other PHNs, service providers and stakeholders that may fall outside the PHN region); Community Advisory Committees and Clinical Councils have been involved; and Consultation processes are effective.	✓
The PHN has the human and physical resources and skills required to undertake the needs assessment. Where there are deficits, steps have been taken to address these.	✓
Formal processes and timeframes (such as a Project Plan) are in place for undertaking the needs assessment.	✓
All parties are clear about the purpose of the needs assessment, its use in informing the development of the PHN Annual Plan and for the department to use for programme planning and policy development.	✓
The PHN is able to provide further evidence to the department if requested to demonstrate how it has addressed each of the steps in the needs assessment.	✓
Geographical regions within the PHN used in the needs assessment are clearly defined and consistent with established and commonly accepted boundaries.	✓
Quality assurance of data to be used and statistical methods has been undertaken.	✓
Identification of service types is consistent with broader use – for example, definition of allied health professions.	✓
Techniques for service mapping, triangulation and prioritisation are fit for purpose.	✓
The results of the needs assessment have been communicated to participants and key stakeholders throughout the process, and there is a process for seeking confirmation or registering and acknowledging dissenting views.	✓
There are mechanisms for evaluation (for example, methodology, governance, replicability, experience of participants, and approach to prioritisation).	✓