phn
CENTRAL AND
EASTERN SYDNEY

An Australian Government Initiative

Executive summary

2022-2024 Needs Assessment

2023 Annual Review

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

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Abbreviations

ABS	Australian Bureau of Statistics
AHP	Allied Health Professional
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
ANSC	Antenatal Shared Care program
AOD	Alcohol and Other Drugs
ASGS	Australian Statistical Geography Standard
ASR	Age Standardised Rate
CALD	Culturally and Linguistically Diverse
CESPHN	Central and Eastern Sydney Primary Health Network
CPD	Continuing Professional Development
CTG	Closing the Gap
FACS	Family and Community Services
GP	General Practitioner
IARE	Indigenous Area Region
LGA	Local Government Area
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex
LHD	Local Health District
NDIS	National Disability Insurance Scheme
NGOs	Non-Governmental Organisations
NSW	New South Wales
MBS	Medicare Benefits Schedule
MDS	Minimum Data Set
MH	Mental Health
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
PIP	Practice Incentive Program
QI	Quality Improvement
RACF	Residential Aged Care Facility
SA3	Statistical Area Level 3

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SA2	Statistical Area Level 2
SESLHD	South Eastern Sydney Local Health District
SLHD	Sydney Local Health District
SCHN	Sydney Children's Hospitals Network
SVHN	St Vincent's Health Network

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Methods

This is the seventh update to the Central and Eastern Sydney Primary Health Network (CESPHN) Needs Assessment. The 2022-2024 Needs Assessment includes:

- An overview of the region, its geographical and demographic characteristics
- Assessment of health and service needs covering:
    - Population health
    - Aboriginal and Torres Strait Islander peoples (herein referred to as Aboriginal peoples)
    - Older Australians
    - Regional priority populations
    - Mental health and suicide prevention
    - Alcohol and other drugs
    - Access, coordination, and integration of care (including after hours and digital health)
    - Primary care workforce
    - Pandemic and disaster response.

CESPHN's 2022-2024 Needs Assessment builds on previous needs assessments by using recently released data, input from ongoing stakeholder consultation, and learnings from the monitoring and evaluation of our commissioned services.

We have considered the health and service needs across the lifespan and for population groups who have poorer health outcomes relative to the general population. We have also considered areas within the CESPHN region with higher needs, unique challenges or emerging concerns, and the functioning of the primary care system in terms of accessibility, coordination, integration, and workforce.

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

CESPHN developed a stakeholder engagement plan to ensure broad and strategic consultation occurred. Qualitative data were analysed from a range of purposeful and incidental engagement activities that included workshops, group meetings, videoconferences, one-on-one meetings, interviews, online surveys and emails providing opportunity for stakeholder input and feedback. Stakeholders included our Board, Clinical and Community Councils, Clinical Leaders Network, Advisory Committees, Member Networks, commissioned service providers, community and participants of our annual strategic planning day. It is recognised that this sample reflects stakeholders who may be more interested in the role of CESPHN, than the general population.

Our community stakeholder survey was conducted between 2–29 August 2021. We used online platforms to promote the survey to local community members and service providers. There were 203 responses, of which 185 unique responses were analysed. This included 121 community members and 64 service providers. Further to this, our annual stakeholder engagement survey was conducted in October 2022, with 152 respondents. Fifty-two percent (52%) of respondents identified key health needs and service gaps around:

- Affordable access to various mental health services including pre-natal, community-based interventions and tailored services for our priority population groups,
- Supporting older people through a healthy ageing lens, and
- Managing primary healthcare workforce issues (e.g., there are less practices that offer bulk billing, provide more practice support).

Other priorities mentioned by respondents included domestic violence, disability, and alcohol and other drugs support.

To develop a list of priorities, we systematically worked through all the identified needs, as well as the key issues and themes identified through the triangulation process. The priorities of the previous year's needs assessment were reconsidered and retained as relevant, along with the addition of new priorities based on identified needs. Consultation was undertaken on the priorities internally and with stakeholders at our 2021 Strategy Day, noting that not all priorities would necessarily translate into activities within the Activity Work Plans.

The Board reviewed the updated needs assessment prior to submission to the Department of Health. Following the submission of the 2021 needs assessment, we undertook an evaluation of the process to inform an improved process for the 2023 deliverable. Key points for improvement identified for future needs assessment updates included:

- Ongoing updates to data points as released throughout the year,
- Semi-frequent review of internal documents, minutes, evaluations to ensure inclusion of current and accurate qualitative data, and
- Consolidation of data points for clarity and consistency.

Additional data needs and gaps

The amount of data available to PHNs has increased significantly. For the first time we have been able to report on disability and Aboriginal health at the local level. We also have new data on the new Quality Improvement Practice Incentive Program (PIP QI) and the Health Demand and Supply Utilisation Patterns Planning (Heads UPP) Tool. Lumos data will be used in the future when our linked data measures 95% representativeness, as per Lumos recommendations.

There are still data limitations in the areas of:

- MBS data including:
  - bulk billing rates at small geographical areas (2016-17 latest data)
  - telehealth MBS items (2018-19 latest data)
  - MBS items for addiction medicine specialist care at the PHN/ SA3 level
  - MBS items for disability
- Practice Incentive Payment data (May 2018 latest data)
- PBS data by PHN and SA3 (only available for Mental health related prescriptions)
- Local level data for Aboriginal peoples including:
  - lifestyle risk factors
  - Infant and child mortality
  - cancer screening participation

- mental health and suicide prevention
- Updated transition care data in the aged care setting for 2022
- Local level data on multicultural communities
- Information on languages spoken by health professionals
- Local level data on dementia and palliative care
- Recent patient experience data at SA3 level to see if there are differences in barriers to access such as cost
- National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection at the PHN/ SA3 level
- Mental health planning tool (limited access and cannot publish findings)
- Same day admitted mental health-related separations are not available at the PHN/ SA3 level
- Absence of data indicators for trans and gender diverse people is a concern. The ABS has released their new Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020 which we hope will be used in future research and service data collection to better understand the service needs, access and gaps for this population group.

Findings

Regional context

CESPHN is the third largest of the 31 PHNs across Australia by population, with an estimated resident population of 1.56 million in 2022 This includes 16,225 Aboriginal people. We also have a large non-resident population with over 0.4 million additional people entering the region daily for work and many more to visit or study.

Most areas have urban densities above 4,000 persons/km^2. Conversely our region also includes the remote communities on Lord Howe Island (453 people). Our population is projected to increase by 13.4% (to 1,866,105) between 2021 and 2041, with the biggest growth expected in the 85 years and over age group (120.4% increase).

Our population is characterised by:

- Cultural diversity: 40.7% of the community were born outside Australia, 46.8% speak a language other than English at home and 6.3% do not speak English well or at all
- A high concentration of same sex couples: around 14.5% of all those living in Australia
- High numbers of people experiencing homelessness or at risk of homelessness:
  - 35% of the NSW homeless population
  - 66.2% of NSW boarding house residents
  - 20.8% of NSW social housing residential dwellings and long waitlists for general applicants.

The overall level of advantage in the CESPHN region is above that of the Australian average, however there are pockets of disadvantage in the SA3 of Botany, Canterbury, Eastern Suburbs-South, Hurstville, Kogarah-Rockdale, Strathfield-Burwood-Ashfield and Sydney Inner City.

Health services and workforce in our region include:

- 578 general practices including one Aboriginal Medical Service
  - 31.7% of practices have 1 GP, 35.8% have 2-5 GPs, 19.4% have 6 to 10 GPs, and 13.1% have more than 10 GPs

    - 68.1% of practices are accredited or registered for accreditation; 84.6% of GPs in the CESPHN region have an accredited/registered for accreditation practice as their primary organisation.
    - 92.5% of practices are computerised, of which:
        - 90.1% were registered to access the My Health Record (MyHR) system, 98.5% were registered with at least one secure messaging solution, and 89.5% were configured to send eReferrals.
- 2,133 GPs and 440 primary care nurses
- 448 pharmacies and 1,776 pharmacists
- 1,789 allied health organisations and:
    - 2,660 psychologists
    - 2,240 physiotherapists
    - 1,776 pharmacists
    - 1,659 dentists
    - 1,116 occupational therapists
    - 788 social workers
    - 722 exercise physiologists
    - 705 speech pathologists
    - 452 dietitians
    - 24 orthotic prosthetists
- 154 residential aged care facilities with 13,086 places
- 129 services providing home care packages (11,748 people at 30 June 2022)
- 2 local health districts and 2 speciality health networks
- 18 public hospitals
- 5 headspace sites.

Summary of the health needs analysis

The overall health status of CESPHN residents is higher than the national average – life expectancy is higher, there are fewer potentially avoidable deaths and deaths among infants and young children, and lower rates of premature mortality, potentially preventable hospitalisations, chronic diseases, fair or poor self-reported health and psychological distress.

However, there are considerable disparities in health status in certain locations – particularly areas with lower socioeconomic status – and among certain populations including:

- Aboriginal peoples
- Multicultural communities
- people living with a disability
- people who identify as lesbian, gay, bisexual, transgender, queer and/or intersex (LGBTQI)
- people experiencing homelessness or at risk of homelessness
- people in contact with the criminal justice system
- the remote communities on Lord Howe Island.

Risk factors and preventive health measures (such as immunisation coverage and screening) are areas where improvement is required across the CESPHN region as rates are often less than national comparisons. Sexual

health continues to be another area of need given the CESPHN region has the highest rates of sexually transmissible infections in the state.

Rates of gestational diabetes have increased substantially over the last ten years. Other measures of child and maternal health (such as low birth weight, childhood development and antenatal care) point to greater need for support of Aboriginal women and women born overseas in non-English speaking countries.

Aboriginal people have lower life expectancy and higher rates of perinatal, infant and child mortality compared to the non-Aboriginal population. Over four in five Aboriginal people have long-term health conditions and our region has the highest rate of Aboriginal people with one or more selected chronic conditions. There are high rates of psychological distress and mental health-related emergency department presentations for Aboriginal people.

The number of people aged 65 years and over is expected to increase by 56% between 2021 and 2041. Falls, dementia, and social isolation are all prevalent conditions among older people.

Prevalence of psychological distress remains high in the CESPHN region, particularly in vulnerable populations. The COVID-19 pandemic has contributed to high rates of psychological distress, increased social isolation, and increased demand and wait times for mental health services. Almost half (47.6%) of respondents to our stakeholder survey identified mental health and wellbeing as a priority issue for the CESPHN region. Social isolation and family and domestic violence were identified as the second and third most important priority areas for the CESPHN region.

Illicit drug use has declined in recent years, as has the proportion of the population drinking alcohol at a risky level at least monthly. However, there is a high prevalence of estimated alcohol use disorders in the community (122,896 people), one in four people aged 14 years and over drink at a risky level on a single occasion at least monthly, and alcohol related hospitalisations are increasing and are higher than the state average.

The COVID-19 pandemic has highlighted health issues and needs in our region, such as particular challenges for our most vulnerable populations in accessing information and vaccinations. In many ways, the pandemic has rewritten the agenda for primary health care, presenting the sector with both challenges and opportunities.

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Health needs analysis

Identified Need	Key Issue	Description of Evidence
Health status	• Kogarah- Rockdale and Sutherland-Menai-Heathcote have the highest infant and young child mortality rates in the region: higher than the national rate. • Botany has the second highest rates of potentially avoidable deaths and highest rates of premature mortality in the region, higher than national rates. • Canterbury is the only area where the potentially avoidable death rate is increasing – all other areas are seeing a downward trend. • The three highest causes of premature mortality are cancer, circulatory system diseases and external causes. Canterbury has higher premature mortality rates for circulatory disease, ischaemic heart disease and cerebrovascular disease than state and national rates. • Canterbury has the highest rate of poor/fair self-reported health status in the region: higher than state and national rates. • There were 8,161 new cases of cancer in 2020. Prostate cancer is the most common type of cancer, lung cancer contributes to the highest proportion of deaths, and liver cancer is the fastest growing type of cancer. • Rates of chronic disease are lower than state and national rates, except for osteoporosis. • Sutherland-Menai-Heathcote had the highest rates of overweight and obesity among adults in the region. The overweight rate was higher than the state and national rates.	• Quantitative sources include AIHW, PHIDU, NSW Cancer Institute.

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Preventive health measures	• Canterbury had the highest rate of current smokers and rate of adults with low to no exercise in the past week: higher than state and national rates. • Fully immunised rates for 5-year-olds are below state and national rates. • Vaccine preventable PPH rates are higher in the region than national rates, with other vaccine preventable conditions accounting for the majority of the PPHs in 2020-21. • Bowel, breast and cervical cancer screening rates are lower than state and national rates. • Breast cancer screening rates were lower in CALD and Aboriginal women.	• Quantitative sources include DoH statistics, HealthStats NSW, AIHW, PHIDU, Cancer Institute NSW.
Maternal and child health	• Lower rate of mothers with antenatal visits at 14-weeks' gestation compared to the state rate. • Increased prevalence of gestational diabetes. Canterbury and St George Hospital have both reported high rates of gestational diabetes and late presentation of pregnant women to health professionals. • Rate of women fully breastfeeding at discharge is lower in SLHD compared to the state rate. • Canterbury-Bankstown, Bayside and Georges River LGAs have the highest rates of vulnerable children. • Canterbury, Strathfield – Burwood – Ashfield and Eastern Suburbs - South SA3s had developmental vulnerability in one or more domains higher than the state rate. • Language vulnerability has increased in Canterbury, Kogarah – Rockdale and Strathfield – Burwood – Ashfield and Hurstville SA3s.	• Quantitative sources include AIHW, HealthStats NSW, TFM.
Sexual health	• Highest rates of chlamydia, gonorrhoea and infectious syphilis notifications in NSW – 36.2%, 49.6% and 49.4% of all state notifications, respectively.	• Quantitative sources include NSW Health statistics and the National Viral Hepatitis Mapping Project.

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	• Rates for newly diagnosed HIV notification in the region remained the highest in NSW (40.8% of all state notifications). • Prevalence of hepatitis B virus is the fourth highest in Australia. • Prevalence of chronic hepatitis C is above the national average.	
Aboriginal health	• Lower life expectancy and higher rates of perinatal, infant and child mortality compared to the non-Aboriginal population. • Low rates of adequate daily fruit and vegetable intake (5.5% 2–17-year-olds and 2.9% 18+ years). • Low rates of meeting physical activity guidelines (12.5% 15+ years). • High rates of overweight/obesity (42.1% 2-17 years and 76.4% 18+ years). • High rates of imprisonment among adults and young people and children on care and protection orders and in out-of-home care. • High rates of long-term health conditions (81%) • High rates of chronic diseases (51% with at least one chronic condition) – highest among all PHNs with one or more selected chronic conditions. • External causes contributed to the highest proportion of premature and potentially avoidable deaths. • High rates of disability and low NDIS participation. • High rates of PPHs in Sydney-City IARE, higher than state and national rates. • Low immunisation rates for 1- and 2-year-olds (below 95% target). • Low cancer screening participation. • High rates of hearing impairment. • Low rate of antenatal visits (14-weeks). • High rate of low-birth-weight babies - double the proportion born to non-Aboriginal mothers.	• Quantitative sources include 2019 NATSIHS, HealthStats NSW and PHIDU.

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	• High rates of psychological distress (highest in the state), self-harm and suicides. • Sydney-City IARE had the highest rate of lower urgency ED presentations for mental and behavioural disorders in the region higher than the national rate. • High rates of short-term alcohol consumption (highest among all PHNs) and substance use (highest in NSW).	
Older Australians	• 23.3% of older people live alone. • Fall related hospitalisation rate is higher than the state rate. • 2 in 5 people aged 65 years and over in the region have some level of disability. • Higher use of health care services for those living with dementia, especially those living in the community. • Influenza immunisation rate slightly lower than or on par with NSW PHN rates over the past five years, and a decline in influenza and pneumonia hospitalisations over the past three years of data available.	• Quantitative sources include NSW HealthStats, AIHW, ABS.
Mental health and suicide prevention	• Canterbury had the highest rate of high/ very high psychological distress (14.3 per 100 people): higher than state and national rates. • Marrickville-Sydenham-Petersham (21.9 per 100 people) and Leichhardt (21.5 per 100 people) had the highest rates of mental health and behavioural problems in adults: higher than state and national rates. • Leichhardt had the highest synthetic prevalence estimates of mental health illness in children aged 4-11 years (19.6%) and Cronulla-Miranda-Caringbah had the highest synthetic prevalence estimates of mental health illness in young people 12-17 years old (14.8%). • Sydney Inner City had the highest rate of suicide (13.9 per 100,000 population): higher than state and national rates.	• Quantitative sources include AIHW, PHIDU, Young Minds Matter. • Qualitative sources stakeholder consultations.

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	• Higher rates of mental ill health and risk factors among vulnerable population groups in our region: ▪ Children and young people ▪ Refugees settling ▪ Parents experiencing perinatal mental health issues ▪ Older people including residents of aged care facilities ▪ Aboriginal peoples ▪ People from multicultural backgrounds, including newly arrived in the region ▪ People who are homeless or at risk of homelessness ▪ Lesbian, gay, bisexual, trans, queer and intersex (LGBTQI) people ▪ People with an intellectual disability ▪ People living with complex mental health and co-existing complex physical health needs ▪ People living in regions that are highly disadvantaged ▪ People with co-existing alcohol or other drug issues ▪ Family and carers of people experiencing mental ill health ▪ Neurologically diverse people ▪ Veterans.	
Alcohol and other drugs	• High alcohol use disorders, risky alcohol consumption and alcohol related hospitalisations. • Alcohol, amphetamine, cannabis and heroin are the most common principal drugs of concern for which clients seek treatment for. • The number of closed treatment episodes with alcohol as the principal drug of concern decreased overall by 4.14% (from 2,707.1 to 2,595.1) between 2017-18 and 2021-22	• Quantitative sources include AIHW NDSHS, national DASP model, NSW Health Stats. • Qualitative sources include stakeholder consultations.

	• More than 1 in 3 with a substance use disorder have at least one mental health condition. • An estimated 55.1% of the Aboriginal population in the CESPHN region exceeded the NHMRC guidelines for single occasion risk (short term alcohol consumption), ranking CESPHN highest amongst all PHNs. • In comparison to heterosexual people, gay, lesbian or bisexual people were more likely to smoke, exceed the lifetime risk guideline for alcohol, and more likely to have used in inhalants, meth/amphetamines and ecstasy in the past 12-months. • High rates of substance use and mental health issues among people experiencing homelessness.	
Pandemic and disaster response	• Increased anxiety, stress and isolation, drug and alcohol consumption, and domestic and family violence often prompted by loss of employment, restrictions on recreation and social connection.. • Reduced access to care and increased isolation for people with disability and older people. • Increased implications of chronic diseases as a result of people not being able to access preventative treatments during the pandemic. • Increased emphasis on the need to provide care for the most vulnerable who are at particular risk of pandemics.	• Qualitative sources include consultations with stakeholders.

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Summary of the service needs analysis

There were 11 million GP attendances (687.6 services per 100 people), which is slightly lower than the national average (691.4 services per 100 people). Specialist attendances are higher in our region (121.2 per 100 people) compared to the national average (90.8 per 100 people), reflecting the large number of specialists located in the region. Allied health attendances (94.9 per 100 people) were slightly higher than the national average (92.6 per 100 people).

Almost one in five (18.6%) felt they waited longer than acceptable to get an appointment with a GP. Higher proportion of people in the CESPHN region who reported having to wait longer than acceptable to see a medical specialist (71.2% compared to 68.6%).

The bulk billing rate was slightly lower in the CESPHN region (75.5%) compared to the national average (76.6%). Out of pocket costs were on average $4.24 per GP attendance, with a range from $0.72 per GP attendance in Canterbury SA3 to $12.95 per GP attendance in Eastern Suburbs-North SA3. Patients experienced high out-of-pocket costs and long wait times for dentistry and psychiatry.

The CESPHN region have higher rates of GPs (number and FTE) compared to the state and national averages. However, we have an ageing GP workforce, with 50% aged 55 years and older which is higher than state and national averages and almost half of GPs (46.8%) intend to only work up to another 10 years. Furthermore, we have a much lower rate of practice nurses (number and FTE) compared to the state and national averages.

Like previous needs assessments, lower urgency presentations to the emergency department (ED) are decreasing and it is the youngest population group (0-14 years) that are most commonly presenting to the ED. The national helplines are also most often used for young patients (0-4 years) during the after-hours period.

One third of Aboriginal people reported not accessing a service because it was not culturally appropriate. Recruitment, training and support of Aboriginal staff has been identified as the main health service challenge for primary care organisations. The main reported service gaps for Aboriginal people are mental health, youth services, alcohol and other drugs, and prevention/early detection of chronic disease.

Our older population continues to grow, increasing demand for services and access to preventative care and early intervention. There is a desire of older people to remain in their homes and communities for as long as possible and a need for better communication, coordination and integration of services within the health system and at the interface of the health and aged care systems.

Mental health and suicide prevention services have noticed an increase in demand, wait times and duration of interventions required. There is a need for low or no cost psychology and psychiatry services, culturally appropriate services, and better integration between services in our region.

Alcohol is the most common main drug of concern for clients accessing treatment services in the CESPHN region, followed by amphetamines. Very few GPs in the region are active accredited Opioid

Treatment Program (OTP) prescribers and there is low participation of community pharmacies in the program.

The COVID-19 pandemic accelerated the rollout of technologies (e.g., telehealth, electronic prescribing) that streamline the flow of relevant patient information between service providers. However, ensuring the consistent and meaningful use of these tools is a continuing challenge for the region.

Key issues impacting the ability to navigate and coordinate health services in the CESPHN region include service coverage, low patient health literacy, issues with identifying and navigating available and appropriate services, and the inability to reliably communicate patient information between health care providers, such as inconsistencies in the availability of electronic referral processes or variable provision of discharge summaries from hospitals.

The introduction of the new Quality Improvement Practice Incentive Program (PIP QI) in 2019 has significantly increased the total number of practices that submit data to CESPHN. CESPHN was ranked slightly below the national average for the 10 Quality Improvement Measures (QIMS) and 24.2% of patient records did not have Aboriginal status recorded.

The COVID-19 pandemic has created a significant disruption to health services and changed demand in the primary health care sector. Providers have had to adapt quickly and adopt new technology to enable remote working and consultations. Many providers had to reduce the delivery of services due to physical distancing requirements and may now be experiencing reduced revenue, a reduced workforce and limited capacity.

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Service needs analysis

Identified Need	Key Issue	Description of Evidence
Population health	• The average proportion of people living with chronic hepatitis B receiving recommended monitoring and care is lower than other Sydney metro PHNs. • More than half of outpatient cancer clinic patients surveyed did not have a current or ongoing cancer management plan. • The prevalence of diabetes is 9.1% but only 4% of the population are registered for NDSS and 0.2% received an annual diabetes cycle of care.	• Quantitative sources include AIHW, NDSS • Qualitative sources include stakeholder consultation and surveys on cancer management
Aboriginal peoples	• Low uptake of IHI PIP among general practices (127 practices in 2018). • Low uptake of MBS 715 health checks (12.9% of the Aboriginal population) and follow ups (33.3%). • One third of Aboriginal people did not access a service because it was not culturally appropriate. • Aboriginal patients left hospital against medical advice/discharged at own risk at a rate 3.6 times that of non-Aboriginal patients. • Service gaps have been identified in mental health, youth services, AOD and prevention/early detection of chronic disease. • Recruitment, training and support of Aboriginal staff has been identified as the main health service challenge in primary care organisations. • 253 AHPRA registered health professionals who identified as Aboriginal (15.2 per 100,000 population) – lower than state and national rates (29.0 and 25.1 respectively).	• Quantitative sources include AIHW, ED data, HD Australia, MBS data, PHIDU, HWA.
Aged care	• Our older population continues to grow in number and as an increasing proportion of our total population, increasing demand for services and access to preventative care and early intervention.	• Quantitative sources include AIHW and GEN.

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	• Desire of older people to remain in their homes and communities for as long as possible. • 1,764 people are waiting for home care packages. • Over 30% of all residential places (37.5%) and 58.9% of home care places were filled by people born in non-English speaking countries. • Need for services that are culturally safe for Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, refugees, and LGBTQI communities. • People need support to access information and navigate the aged and health care systems. • Support for information sharing to facilitate clinical handover between aged care and health care providers.	

Mental health and suicide prevention services	• In 2020-21 there was a 30.6% increase in the number of Medicare-subsidised services across all mental health providers.
	• Since the COVID-19 pandemic, we have noticed an increase in wait times for people accessing mental health care, a 12% increase in referrals for psychological therapies, an increase in demand for headspace centre services, and an increase in frequency and duration of interventions required.
	• Anticipate a surge in demand for face-to-face services now lockdowns have ceased.
	• Recruitment issues due to:
	  ○ current workforce shortages in the mental health sector,
	  ○ changes to MBS Better Access sessions in 2020,
	  ○ NDIS Billing,
	  ○ Increase in need and program funding, and
	  ○ People leaving the profession following covid.
	• Limited/no low-cost access to LGBTQI inclusive services.
	• Workforce shortage across the mental health sector.
		• Quantitative sources include AIHW, MH MDS.
		• Qualitative sources include stakeholder consultations.

	• Poorer access to services in the Canterbury LGA, particularly services for young people.	
Alcohol and other drug treatment	• Increased need for screening in primary care and brief intervention for alcohol use, amphetamines and cannabis. • Increased access to treatment for people seeking to address their alcohol use given the large number of people requiring treatment as estimated by the DASP model. • The need for increased access to services to meet the needs of priority populations such as multicultural communities and LGBTQI communities. • The dearth of available services for those recently released from custodial settings and the impact of this on relapse. • Very few GPs are active accredited OTP prescribers and there is low participation of community pharmacies in the program. This would address current overwhelming demand on public health OTP clinics. • There is a gap in therapeutic groups for DBT skills development augmenting AOD treatment and short-term relapse prevention groups online and in-person. • There is a need for services to provide holistic support to meet the multitude needs associated with AOD use including wraparound service provision for employment and education needs, along with day to day living support. • There is a general lack of availability of residential rehabilitation beds across the region, along with poor service continuity with withdrawal services. • Poorer access to services in the Sutherland Shire. • Limited culturally appropriate services for Aboriginal peoples, particularly in La Perouse, Mascot and Botany.	• Quantitative sources include Health Stats NSW, AIHW, NSW Ministry of Health, CESPHN survey. • Qualitative sources include consultations with stakeholders.
General practice	• High number of solo practices in the region (31.7%) – these practices are often not computerised, accredited nor have a practice nurse. • While there is a higher rate of GPs (number and FTE) compared to state and national averages, we are seeing a decrease in numbers in certain areas – Marrickville-Sydenham-Petersham, Botany and Cronulla-Miranda-Caringbah. Our community has	• Quantitative sources include HWA, CESPHN's CRM. • Qualitative source includes CESPHN's stakeholder survey.

	expressed a need for a local GP in Kurnell as access to GPs in Cronulla is limited due to transport issues, waitlists or closed books. • We have an ageing GP workforce – 49.8% are aged 55 years and older which is higher than state and national averages and almost half of GPs (46.8%) intend to only work up to another 10 years. • We have a much lower rate of primary care nurses (number and FTE) compared to state and national averages. While a young workforce (48.2% aged 20-34 years), half (50.0%) of primary care nurses intend to only work up to another 10 years.	
Access to primary care	• The main barriers to accessing health services, as identified in our stakeholder survey, were: ▪ Impacts of COVID-19 (68.4%) ▪ Finding the right service (57.9%) ▪ Feeling comfortable/safe to access services (56.6%) ▪ Having time to attend the service (55.2%) ▪ Waiting times (53.9%) ▪ Specific services not available (52.6%) • Survey respondents highlighted the need for: ▪ Better cross-service communication and collaboration to improve patient care ▪ Increased use of telehealth and online platforms for both clinical care and wellbeing checks ▪ Access to education and preventive health services for low-income earners ▪ Evidence based programs and policies including trauma informed care ▪ Improved service for mental health and AOD clients with complex care needs, including transportation options for access to care ▪ Appropriately trained workforce both clinically and culturally appropriate, including peer workers.	• Quantitative sources include ABS, NDIS. • Qualitative sources include stakeholder consultations, CESPHN's stakeholder survey.

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	• For multicultural communities, there is a need to:
	  ▪ build health literacy among consumers and their carers so they can be actively involved in decisions about their health
	  ▪ ensure translation and interpreting services are available
	  ▪ provide cultural competency training for service providers and ensure culturally appropriate services.
	• 180,000 people live with a disability in our region but only 17,265 are NDIS participants. NDIS participation is increasing and is highest among the 7-14-year age group.
	• For the homeless population, disease prevention, assertive outreach and workforce development are the areas of need.
	• Lack of access to LGBTQI inclusive GPs or no pre-existing relationships with a GP is a critical gap in people accessing health services and support.
	• A vast number of prisoners are released into society without identification or Medicare cards, and with little support or planning, especially those who are released without parole. Vulnerable groups include older people, people with cognitive impairment, people who have a mental illness, Aboriginal people, and women with dependent children.	

Access to dental care and medical specialists	• 13.2% of the population delayed or did not access dental care because of cost. • Over 9,803 children and adults are on public dental waiting lists. • There was a higher proportion of people in the region who reported having to wait longer than acceptable to see a medical specialist (71.2% compared to 68.6%). • Cost is often a barrier to accessing medical specialists, particularly psychiatry and dermatology. • There is also a need for improved information on outpatient clinics via HealthPathways and/ or hospital websites.	• Quantitative sources include ABS, NSW Health stats. • Qualitative sources include stakeholder consultations and CESPHN survey of clinicians on outpatient clinic experience.
After Hours	• 58% of general practices in the CESPHN area were receiving a Practice Incentive Payment (PIP) for After Hours services.	• Quantitative sources include DoH statistics, MBS data and

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	• After-hours MBS services are most used by people aged 80+ and 14 years and younger. • Nurse triaged helpline and after-hours GP helpline patients largely aged 0-4 years. • 148,826 lower urgency ED presentations – 47% in the after-hours period.	Healthdirect Australia HealthMap.
Joint planning and collaborative commissioning	• More joint planning and collaborative commissioning to reduce service gaps and duplication and improve care coordination. • LHD/LHNs are developing virtual care models that need to consider coordination and integration with primary care.	• Qualitative sources include stakeholder consultations.
Digital health	• Meaningful use My Health Record (MyHR): ▪ Regular uploads are low in general practice. ▪ Low registration among allied health professionals. ▪ Need more timely discharge summaries and uploading of discharge summaries on MyHR. • Smart forms and eReferrals: ▪ 468 general practices were configured to send Smart Forms and eReferrals. ▪ Need greater consistency in outpatient referral processes and more usage of e-referrals. • Electronic prescribing: ▪ Almost all (96.1%) pharmacies and more than 4 out of 5 (86.8%) of computerised general practices in the CESPHN region are capable of processing electronic prescriptions. • Telehealth: ▪ Uptake of telehealth increased significantly since 2020 as a result of the introduction of temporary MBS telehealth items and the roll out the Healthdirect Video Call (VCC) service.	• Quantitative sources include ADHA Collaborate data, CESPHN's CRM, Healthdirect Video Call. •
Data for quality improvement	• 24.2% of patient records do not have Aboriginal status recorded. • We were below the national average for most of the 10 chronic disease management quality improvement measures.	• Quantitative source includes AIHW.

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Workforce education and training	• Workforce development initiatives are needed in the areas of: • Cancer management – GPs often lack confidence in cancer management due to access barriers to specialist communication. • DFV – 58% feel confident to appropriately respond and provide support and >40% do not know of local support service available. • Gender affirming healthcare – clients of ACON continue to report misgendering and lack of basic awareness in primary care services around gender affirming care. • Sexual health management and treatment – only 4% of surveyed GPs had completed S100 HIV prescriber training. • Increasing capacity to address the complexity of substance use, including screening for blood borne viruses, dealing with issues associated with post-prison release, identifying and responding to co-occurring mental health issues, and the ability to meet cultural and other specific needs.	• Quantitative sources include UNSW Research. • Qualitative sources include stakeholder consultation.
Pandemic and disaster response	• Service disruptions: ▪ Low numbers of community and allied health providers using telehealth. ▪ Barriers to telehealth – difficulties in accessing technology for older people, homeless population, and people from multicultural backgrounds, taxing and labor-intensive for clinicians, difficulties in diagnosing patients, and increased administrative demand for referrals to pathology, radiology, and other services. • Provider viability: ▪ 56% of survey respondents reported that they had experienced a decline or significant decline in income due to COVID-19. ▪ Those surveyed who reported a significant decline reported that this had resulted in their practice or service operating at a financial loss. ▪ 50% of GPs surveyed reported a decline in income, and 22% a significant decline in income.	• Quantitative sources include CESPHN provider survey and UTS Research.

	▪ 18% of community organisations surveyed reported a decline in income, and 27% reported a significant decline in income. ▪ 50% of allied health providers surveyed reported a decline in income, and 33% a significant decline. ▪ Increased costs of personal protective equipment, intensive cleaning, technology investments and additional time off for staff unable to attend work due to illness or following COVID-19 testing. • Provider wellbeing: ▪ Higher levels of anxiety and burnout among healthcare workers. ▪ Heightened risk of exposure and infection to COVID-19. ▪ Increased workloads reported for pharmacists (75%), healthcare managers (75%) and nurses (45%). ▪ Decreased workloads for surgeons (91%) and allied health providers (72%).	

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Priorities

This section summarises the priorities arising from the needs assessment, their coding, and the opportunities for how they will be addressed.

We based our prioritisation on the following criteria: scale and impact of the issue, benchmarking against national/state data and other similar regions, degree of health inequities, alignment with national and state priorities and targets, unmet need and feasibility.

We also considered a people, places and system approach:

- People – priority populations in our region including Aboriginal peoples, older people, socio-economic disadvantaged populations, multicultural communities, people living with a disability, experiencing homelessness or in contact with the criminal justice system, LGBTQI communities and our remote residents on Lord Howe Island.
- Places – the locations that are known to have poorer health status such as Canterbury.
- System – the coordination and integration of services that are accessible with adequate staff resourcing to ensure the patient receives the right care at the right place and at the right time.

We have identified nine priority areas for action:

- Population health
- Aboriginal peoples
- Older Australians
- Regional priority populations
- Mental health and suicide prevention
- Alcohol and other drugs
- Access, coordination and integration of care (including after hours and digital health)
- Primary care workforce
- Pandemic and disaster response.

The expected outcomes listed below are areas where the region needs to improve and largely align with national PHN performance framework indicators established by the Department of Health.

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Population health

Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Chronic diseases and associated risk factors	*Population Health*	*Chronic conditions*	• Increase cancer screening rates • Reduce prevalence of risk factors • Increase number of patients with chronic diseases managed under GP Management Plan and/or Team Care Arrangements • Reduce potentially preventable hospitalisations for chronic conditions	• CESPHN to work with general practice and allied health to ensure appropriate screening and management of patients with chronic diseases and associated risk factors • CESPHN to work with LHD/LHNs, local government and schools to implement health promotion activities that increase population awareness on healthy behaviours, screening programs and health literacy • CESPHN to work in partnership with LHD/LHNs to commission specific services that seek to reduce risk factors among priority populations and encourage self-management of chronic conditions
Immunisation	*Population Health*	*Immunisation*	• Increase immunisation rates • Reduce vaccine potentially preventable hospitalisations	• CESPHN to work with LHD Public Health Units to develop strategies to increase immunisation coverage rates across the region with a focus on priority populations and populations with low coverage rates

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Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Maternal and child health	*Population Health*	*Early intervention and prevention*	• Reduce percentage of children with childhood developmental delays • Increase percentage of women attending antenatal visits	• CESPHN to improve collaborations, pathways and partnerships with child and family health services • CESPHN with work with LHD/ LHNs to maintain access to maternal primary care services, including the GP antenatal shared care program • CESPHN to commission activities to address developmental delay, particularly for multicultural communities • CESPHN to work with LHD/LHNs, Department of Communities and Justice, Department of Education, local government and community providers on implementation of First 2000 days framework
Sexual health and viral hepatitis	*Population Health*	*Early intervention and prevention*	• Increase number of GP prescribers for HVB, HIV S100 medications, HCV and PrEP S85 medications	• CESPHN to support primary care providers to address STIs and other blood borne (HIV and Viral Hepatitis) conditions

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Aboriginal and Torres Strait Islander health

Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Access to culturally appropriate care	*Aboriginal and Torres Strait Islander Health*	*Access*	• Increase general practice IHI PIP uptake • Increase rate of patient records with Aboriginal status recorded • Increase rate of Aboriginal population receiving health assessments and follow-ups • Increase rates of service use for: maternal and child services, chronic disease, mental health and AOD services	• CESPHN to support general practice to enrol in the IHI PIP, identify Aboriginal patients and provide health checks • CESPHN to work with the Aboriginal community and LHD/LHNs to address access issues to culturally appropriate maternal and child health, chronic disease, mental health and AOD services
Culturally appropriate workforce for Aboriginal and/or Torres Strait Islander health	*Aboriginal and Torres Strait Islander Health*	*Workforce*	• Increase proportion of PHN-commissioned services delivered to the regional Aboriginal population that are culturally appropriate • Increase cultural awareness training participation rates among the primary care workforce • Increase support for the Aboriginal workforce	• CESPHN to work with commissioned providers to ensure its workforce is culturally competent and continues to upskill in this area • CESPHN to deliver/ commission training to develop a culturally appropriate workforce for Aboriginal health and wellbeing • CESPHN to support the Aboriginal workforce through the Aboriginal workers circle and training opportunities

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Older Australians

Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Health of older people	*Aged Care*	*Chronic conditions*	• Increase MBS services provided by primary care providers in residential aged care facilities • Increase rate of people aged 75 and over with a GP health assessment	• CESPHN to commission community-based options for palliative care and to support healthy ageing, social connection and people living at home for longer • CESPHN to work with social interaction models of service • CESPHN to support GPs to complete MBS health checks and medication reviews in the community and in aged care
Coordination and integration of primary health care, acute and aged care services.	*Aged Care*	*Care coordination*	• Improve communication, coordination and integration of services within the health system and at the interface of the health and aged care systems • More informed consumers and carers	• CESPHN to work with GPs to develop local dementia care and frailty pathways • CESPHN to commission community care finders to assist older Australians accessing and navigating the aged care system. • CESPHN to work with the Department of Health and LHD/ LHNs to identify gaps in system accessibility and opportunities for improved coordination, integration and reform across the aged care and health systems

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Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
				• CESPHN to support GPs and RACF staff with digital technologies including telehealth care for aged care residents, MyHR adoption, and sharing Advance Care Directives and care plans for transitions between health and aged care systems • CESPHN to support Geriatric Flying Squads to enable deteriorating older people to stay at home and out of hospital
Education, training and workforce development	*Aged Care*	*Workforce*	• Build primary health care workforce capacity and capability to address the health needs of older people	• CESPHN to provide/ commission training for general practice, allied health and RACF staff on local clinical and service pathways, dementia care, palliative care, mental health, and medication and wound management

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Regional priority populations

Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Socio-economically disadvantaged populations	*Population Health*	*Vulnerable population (Non-First Nations specific)*	• Improve health outcomes and access to health care for socio-economically disadvantaged populations	• CESPHN to work with community organisations to build health literacy among consumers and their carers so they can be actively involved in decisions about their health • CESPHN to commission prevention and health promotion programs and services that remove financial and other access barriers • CESPHN to work with the Sydney and South Eastern Sydney Human Services Groups on the social determinants of health
Multicultural communities	*Population Health*	*Vulnerable population (Non-First Nations specific)*	• Culturally appropriate commissioned services • Increase access to services among multicultural communities	• CESPHN to work with community organisations to build health literacy among consumers and their carers so they can be actively involved in decisions about their health • CESPHN to ensure translation and interpreting services are available to allied health professionals and promote TIS National interpreting services to medical practitioners and pharmacies

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Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
				• CESPHN to work with its commissioned service providers to co-design culturally appropriate services, employment of staff from multicultural backgrounds and providing cultural competency training for service providers
People living with a disability	*Population Health*	*Vulnerable population (Non-First Nations specific)*	• Primary care providers are better able to provide best practice care for people with a disability • People with an intellectual disability receive appropriate specialist services	• CESPHN to work with key leaders from across the sector to support the NDIS through the Disability Network • CESPHN to provide training to primary care providers on best practice care for people with a disability, including annual Medicare assessments and access to NDIS care plan • CESPHN to link primary care providers with the most appropriate specialist services for their patients with intellectual disability
People experiencing domestic family violence	*Population Health*	*Vulnerable population (Non-First Nations specific)*	• Primary care providers are better able to identify and respond to DFV presentations • DFV victims receive appropriate services	• CESPHN to provide training to primary care providers to identify and appropriately respond to DFV presentations from patients or colleagues • CESPHN to link primary care providers with appropriate DFV services and

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Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
				secondary consultations to assist health professionals to support their patients
People experiencing homelessness or at risk of homelessness	*Population Health*	*Vulnerable population (Non-First Nations specific)*	• Improve health outcomes and access to health care among people experiencing homelessness or at risk of homelessness	• CESPHN to work with partners to implement the Intersectoral Homelessness Health Strategy 2020-2025 • CESPHN to support general practices and allied health professionals working with people experiencing homelessness • CESPHN to work with registered training organisations to enable and support GP registrars to work in homelessness health clinics during their training • CESPHN to provide training to general practices and allied health professionals on the skills and knowledge required to engage and care for people at risk of, or experiencing, homelessness • CESPHN to explore with the primary care sector the feasibility of new models of primary care in key locations to improve service navigation
Lesbian, Gay, Bisexual, Transgender, Queer and Intersex communities	*Population Health*	*Vulnerable population (Non-First Nations specific)*	• Increase access to LGBTQI inclusive primary care	• CESPHN to provide inclusive practice training to general practices

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Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
People in contact with the criminal justice system	*Population Health*	*Vulnerable population (Non-First Nations specific)*	• Increase post-release transitional services	• CESPHN to work with the health and human services sectors to address the gap in post-release transitional services that provide a through-care outreach model of long-term, wrap-around support
Remote populations	*Population Health*	*Vulnerable population (Non-First Nations specific)*	• Increase participation in PIPs and MBS health checks • Increase uploads on MyHR and uptake of digital technologies • Increase access to chronic disease and mental health services	• CESPHN to work with the local primary care workforce on practice accreditation, access to MBS incentives, using MBS items for the management of vulnerable groups and the uptake of digital technologies • CESPHN to commission services that support the health and wellbeing of the community

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Mental health and suicide prevention

Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Stepped care	*Mental Health*	*Access*	• Consumers have streamlined access to the most appropriate services to support individuals at the stage they are at	• CESPHN to work with partners of the Mental Health and Suicide Prevention Regional Plan to ensure clear and accessible pathways to care at all levels of intensity/acuity, in which consumers, referrers and service providers understand how to navigate, refer to and provide services using a stepped care approach
Low intensity mental health services	*Mental Health*	*Access*	• Increase proportion of population receiving PHN-commissioned low intensity services and have improved clinical outcomes	• CESPHN to work with referrers and community members to promote access to low intensity mental health services, including online services, and resources • CESPHN to commission low intensity services
Child and youth mental health services	*Mental Health*	*Access*	• Increase proportion of population receiving PHN-commissioned youth specific services	• CESPHN to commission headspace centres to provide youth mental health services in line with the headspace model integrity framework (hMIF) and within a stepped care approach • CESPHN to commission early intervention services for young people with or at risk of severe mental illness

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Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
				(e.g., psychosis, major depression, severe anxiety, eating disorders and personality disorders) in the primary care setting • CESPHN to support commissioned providers to use telehealth and other technologies to facilitate access to services
Psychological therapies for priority populations	*Mental Health*	*Access*	• Increase proportion of population receiving PHN-commissioned psychological therapies and have clinical outcomes	• CESPHN to commission services to ensure access to a range of evidence based psychological therapies for priority groups in the CEPSHN region
Severe and complex mental illness	*Mental Health*	*Access*	• Increase proportion of population receiving PHN-commissioned care coordination services and have clinical outcomes	• CESPHN to facilitate access for GPs to the psychiatry support line • CESPHN to work with LHDs on Shared Care arrangements between LHDs and GPs to improve physical health outcomes of mental health consumers • CESPHN to build the peer workforce to provide services • CESPHN to commission care coordination services
Suicide prevention	*Mental Health*	*Access*	• Increase number of people who are followed up by PHN-	• CESPHN to co-commission services that provide support after a suicide attempt or crisis

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Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
			commissioned services following a recent suicide attempt	

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Alcohol and other drugs

Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Access to alcohol and other drug treatment services	*Alcohol and Other Drugs*	*Access*	• Increase access to treatment services	• CESPHN to commission drug and alcohol treatment services that address gaps, are evidence based and accessible to our priority populations • CESPHN to work with service providers to ensure services are accessible and meet the needs of priority populations
Access to alcohol and other drug treatment in the primary care setting	*Alcohol and Other Drugs*	*Care coordination*	• Increase engagement of GPs in responding to AOD problems and shared care arrangements between specialist AOD services and GPs • Increase numbers of GPs prescribing and pharmacy engagement in OTP	• CESPHN to provide support, resources and education to GPs • CESPHN to work with LHD/LHNs to implement the GLAD shared care project with GPs across the region • CESPHN to partner with PHNs to co-fund Primary Care Telehealth Alcohol Withdrawal and Recovery Service Proof of Concept
Capacity to address high need populations and clinical complexity	*Alcohol and Other Drugs*	*Vulnerable population (Non-First Nations specific)*	• Services meet the needs of priority populations and address co-occurring mental health in the context of AOD use	• CESPHN to work with peak bodies and champions to develop effective service models to meet the needs of multicultural communities, gender and sexuality diverse communities, individuals recently released from prison and co-occurring mental health

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Access, integration and coordination

Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
After hours	*Population Health*	*After hours*	• Increase number of general practices receiving the after hours PIP • Reduce low urgency care emergency department presentations	• CESPHN to support general practice to participate in the after hours PIP • CESPHN to commission services to ensure an appropriate use, mix and distribution of after hours services for the population, including enhanced out of hours support for residential aged care • CESPHN to implement health promotion strategies to improve awareness of after hours services (including HealthDirect helplines), appropriate use of emergency departments and options for after hours services particularly frequent users such as people aged 65 years and over, families with young children and priority populations such as people experiencing homelessness
Service navigation and coordination	*Population Health*	*System integration*	• Increase number of HealthPathways developed, sessions of use, unique page views, different users	• CESPHN to provide service navigation support • CESPHN to commission integration projects

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Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
			• Increase number co-designed and co-commissioned services	• CESPHN to work with LHD/LHNs to develop and promote the use of HealthPathways that aim to assist healthcare providers to navigate local services • CESPHN to undertake joint planning and collaborative commissioning with LHD/ LHNs, including sharing insights on supply and demand issues • CESPHN to co-design services and programs with consumers and peer workers • CESPHN to advocate for health system improvements based on feedback from stakeholders (general practice, allied health and community) • CESPHN to work with community organisations to build health literacy among consumers and their carers so they can be actively involved in decisions about their health
Digital health and data	*Digital Health*	*System integration*	• Increase rate of regular uploads to My health Record	• CESPHN to support service providers including general practice, allied health, pharmacies and RACFs to upload relevant patient data to the My Health

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Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
			• Increase rate of discharge summaries uploaded to My Health Record • Increase rate of health care providers using specific digital health systems (smart forms, e-referrals, telehealth)	Record and use specific digital health systems (smart forms, e-referrals, e-prescribing, telehealth) • CESPHN to work with LHD/LHNs and medical specialists to improve the integration of care through the meaningful use of MyHR (e.g., electronic discharge summaries and e-referrals) in the hospital sector • CESPHN to work with LHD/LHNs and general practice on virtual care models and management of patients following discharge to prevent readmissions • CESPHN to work with general practice to implement clinical auditing activities to enhance the integrity of patient data • CESPHN to work with other PHNs to develop efficient methods for collating and analysing data to monitor and evaluate our programs, commissioned services and stakeholder engagement • CESPHN to work with research organisations and primary care providers to conduct, commission and

Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
				support research that builds the evidence base

Primary care workforce

Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Workforce development	*Health Workforce*	*Other*	• Increase the number of unique health professionals accessing professional development opportunities	• CESPHN to work with key experts to identify and implement relevant professional development opportunities for GPs, practice nurses, practice staff, mental health and AOD workforce and allied health professionals • CESPHN to commission, deliver and promote training and education to the primary care workforce specific to our priority areas and priority populations • CESPHN to collaborate with universities to train our public health workforce
Practice support	*Health Workforce*	*Other*	• Increase in number of accredited general practices • Increase the number of practices sharing data for quality improvement	• CESPHN to support general practices with accreditation and continuous quality improvement activities (e.g., PIP QI, Person Centred Medical Neighbourhood, Lumos)

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Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
			• Increase the number of practices participating in quality improvement activities	

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Pandemic and disaster response

Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
Communicate key messages to the community and support at risk populations	*Population Health*	*Emergency response*	• Reduce barriers to accessing care • High community vaccination rates particularly among priority populations	• CESPHN to keep the community up to date with locally relevant information concerning pandemics and natural disasters • CESPHN to work with community stakeholders including commissioned providers to identify at-risk populations, and ensure the more vulnerable groups in our region are supported
Support primary care providers during pandemics and natural disasters (e.g. communications, PPE distribution, testing and vaccination support and coordination)	*Population Health*	*Emergency response*	• A primary care workforce that is informed and prepared for pandemics and natural disasters	• CESPHN to keep primary health care providers up to date with locally relevant information concerning pandemics and natural disasters • CESPHN to support primary care providers with infection control advice and digital technologies • CESPHN to coordinate with the Department of Health on PPE distribution, testing and vaccination support
Regional planning for pandemics and natural disasters	*Population Health*	*Emergency response*	• More coordinated and effective health care responses to pandemics and natural disasters	• CESPHN to work with LHD/LHNs, RACFs and human services on regional

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Opportunities and priorities				
Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
				planning for pandemics and natural disasters

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Checklist

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