



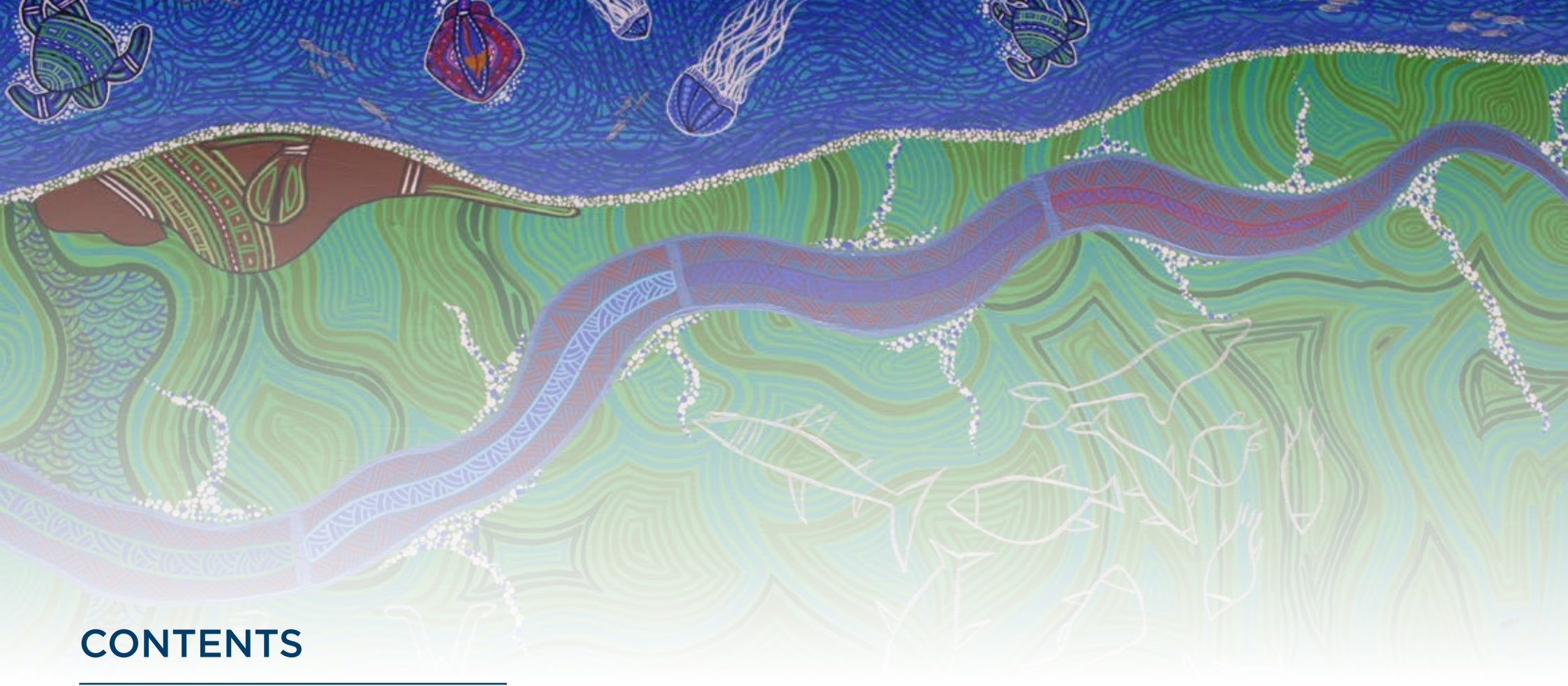
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HUNTER NEW ENGLAND
AND CENTRAL COAST

An Australian Government Initiative

CORE NEEDS ASSESSMENT AND ACTION SUMMARY

2019-21





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Hunter New England and Central Coast (HNECC) PHN acknowledges the traditional custodians of the land we walk upon today, and respect their continuing culture and the contribution they make to the life of this vast region. Aboriginal Nations within our region include: Anaiwan and Nganyaywana; Awabakal; Biripi; Darkinjung; Dunghutti; Geawegal; Kamilaroi; Kuring-gai; Ngarabal; Wonnaru; Worimi.

Please note: Aboriginal and Torres Strait Islander people should be aware that this document may contain images of deceased persons in photographs.



BACKGROUND

Hunter New England and Central Coast Primary Health Network (HNECC PHN) delivers innovative, locally relevant solutions that measurably improve the health outcomes of our communities, working towards our vision of “Healthy People and Healthy Communities”.

What is this Needs Assessment Summary Booklet?

This booklet is a summary of the 2019-2021 Core Needs Assessment completed in November 2018 which is available on our website www.hneccphn.com.au

Within this booklet we have presented the health needs and service gaps for our region. These are grouped under seven overarching themes:

- Health behaviours & chronic disease
- Alcohol & Other drug use
- Vulnerable, marginalised & hard-to-reach groups
- Health & wellbeing of Aboriginal and Torres Strait Islander people
- Mental illness, intentional self-harm & suicide
- Mental health workforce & service capacity
- Health workforce & service capacity

We have included short descriptions of our current and planned activities in response to these health needs and service gaps to improve the health of our communities. Due to the nature of primary care many activities address needs across multiple themes. In this summary however, only activities with a direct relationship to the needs have been listed under each theme.

What is a Needs Assessment?

A Needs Assessment is a process used to identify unmet health and healthcare needs of a population, and present options for work that can be done to address these needs and improve the health of the population.



Why is a Needs Assessment important?

We use Needs Assessments to:

- Gain a better understanding of the health needs and service gaps across our region, including any differences experienced by population groups such as Aboriginal and Torres Strait Islander people and people living in rural areas;
- Identify opportunities and options for action that we can take to address the identified needs and service gaps to improve the health needs of our region;
- Inform the development of our Annual Plan, and decisions about health service planning and delivery; and
- Engage with our partner organisations to ensure corresponding effort and investment to improve the health of our communities.

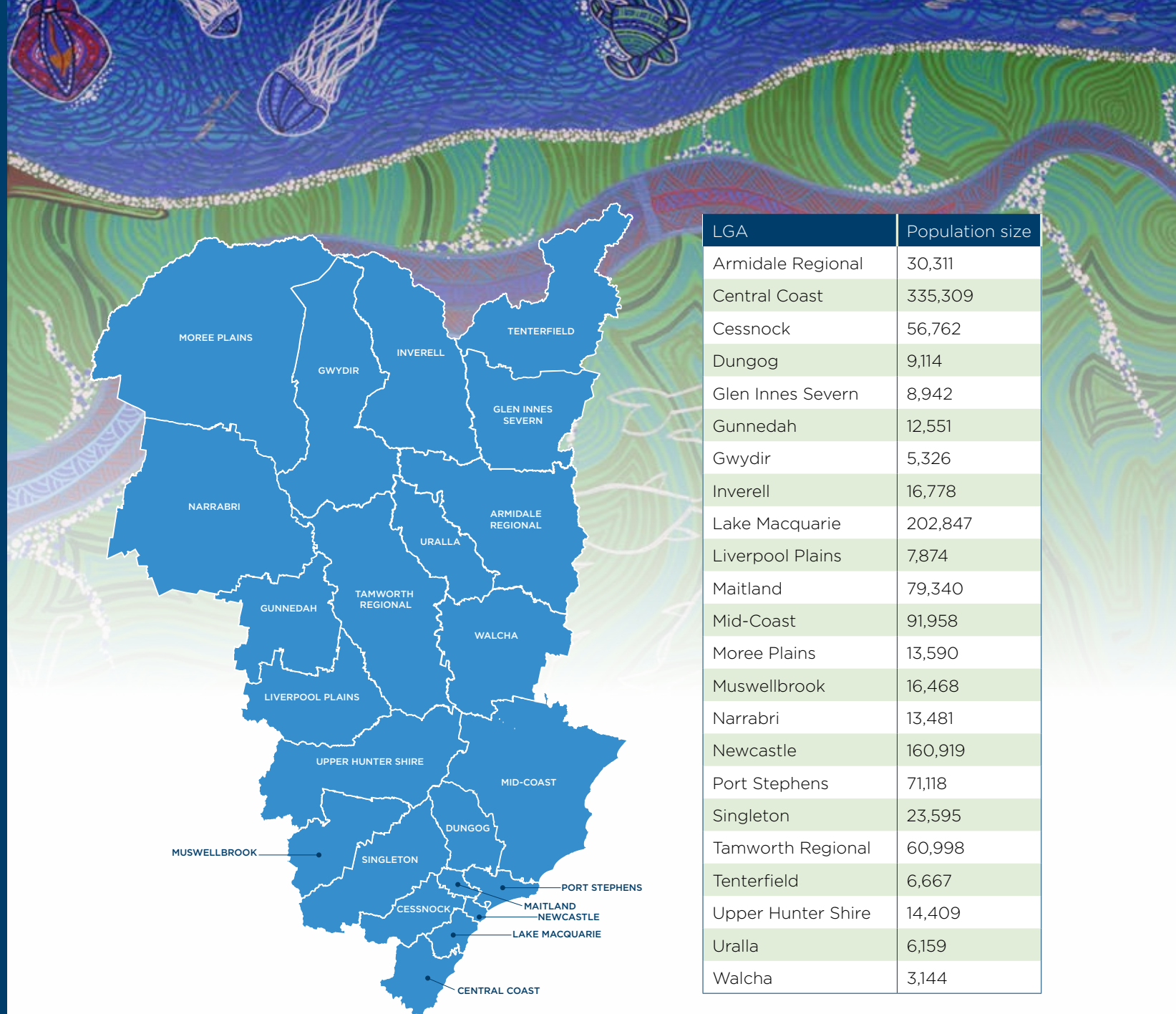
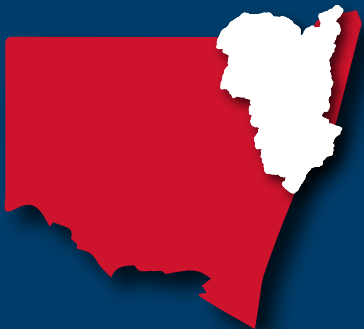
How do we prepare a Needs Assessment?

- We analyse relevant local and national health data such as, data from General Practices in our region, hospital statistics, and other data provided by state and federal government organisations;
- We talk to community members, patients, family and carers, medical and health professionals, and other service providers from across our region to gather information about health needs and gaps in services at a local level;
- We compare the data with the information provided by people from our region and develop a list of health and healthcare needs, including variations by community or population group, such as for people living in rural areas or Aboriginal and Torres Strait Islander people;
- We review the available evidence to identify options for addressing the unmet needs, balancing clinical, ethical, and economic considerations i.e. what should be done, what can be done, and what is affordable;
- And finally, we use this information and share it with others to improve health services in our region.



HUNTER NEW ENGLAND AND CENTRAL COAST PHN DEMOGRAPHICS

The HNECC PHN is the second largest PHN in NSW, covering an area of 133 812km². Our region spans across 23 Local Government Areas and has a mix of metropolitan, regional and rural areas. It reaches from just north of Sydney, across the north west of NSW to the QLD border.





LIFE EXPECTANCY

IN OUR REGION

78.9 YEARS MALES
83.5 YEARS FEMALES

IN AUSTRALIA

80.4 YEARS MALES
84.5 YEARS FEMALES



There are over **1.2 million** people that **live in our region**

Our population is predicted to increase by **19.5%** by **2031**, to well over **1.4 million people**

There are
2 Local Health Districts, **31** Public Hospitals and **303** Pharmacies within our region

19.1% of our population is **aged 65 years and over**

5.4% (65,183) of people in our region **identify as Aboriginal and Torres Strait Islander**

12.4% of the population of our region are **aged 15-24 years**



There are **9 Aboriginal Medical Services** in our region



There are **410 General Practices** in our region with **1,250 General Practitioners**

IDENTIFIED PRIORITY AREA

HEALTH BEHAVIOURS & CHRONIC DISEASE


NEEDS IN OUR REGION

- Poor self-assessed health status
- Lower than average life expectancy
- High rates of chronic disease
- High rates of chronic disease hospitalisations
- High cancer incidence and mortality
- Barriers to cancer screening in Primary Care
- High rates of smoking
- High rates of smoking during pregnancy
- High rates of overweight and obesity
- High rates of physical inactivity and poor nutrition

OUR CURRENT & PLANNED ACTIVITIES

- Commission a range of Allied Health services across the New England North West and rural Hunter regions
- Implement a Healthy Weight Initiative
- Support smoking cessation programs, including promoting referral to the NSW Quitline
- Implement a Community Cancer Screening Participation Strategy
- Support a bulk-billing cervical and breast cancer screening clinic in Wyong
- Participate in the roll-out of the Health Care Homes Initiative across the region
- Build community capacity for participation in health promotion, wellness and lifestyle activities
- Commission Primary Health Care Nursing Clinics and Community Participation programs throughout the New England North West
- Co-commission a new COPD model of care which places pulmonary rehabilitation and specialist appointments in primary care
- Co-commission a Diabetes model of care through the Hunter New England Integrated Care Alliance
- Research Potentially Preventable Hospitalisations in the region and develop recommendations as to how these can be addressed
- Develop scholarships to support the professional development of Practice Nurses
- Design and deliver a Central Coast diabetes case conferencing model in general practice





Within our region 58.0% of adults have a chronic health condition, much higher than the national average of 49.9%

IDENTIFIED PRIORITY AREA


ALCOHOL & OTHER DRUG USE

NEEDS IN OUR REGION

- High rates of alcohol misuse
- Concerning levels of illicit drug use
- Reduced access to drug and alcohol treatment services for:
 - The general population;
 - Aboriginal and Torres Strait Islander people;
 - Pregnant women and/or those with young children;
 - Youth;
 - People exiting the criminal justice system;
 - People with co-occurring substance misuse and mental illness

OUR CURRENT & PLANNED ACTIVITIES

- Support a GP and Practice Nurse Clinical Mentoring Program delivered by drug and alcohol experts
- Support region-specific, cross-sectoral and integrated approaches to drug and alcohol treatment services, based on the needs of clients locally, and focused on improving care coordination at the local level
- Support Regional Drug and Alcohol forums targeting general practice, community pharmacy and psychologists, the administration of addiction medicines and S8 prescription monitoring
- Develop a training package to support GPs in the treatment of chronic pain using psychotherapy and self-management rather than opioid substitution
- Support the workforce by promoting joined-up assessment processes and referral pathways and support continuous quality improvement, evidence-based treatment and service integration /coordination
- Support drug and alcohol treatment partnership networks
- Utilise partnerships and sector engagement opportunities to identify emerging workforce capacity and development needs
- Commission drug and alcohol treatment services including those specific to Aboriginal and Torres Strait Islander people and targeted at:
 - pregnant women and/or those with young children;
 - youth;
 - people exiting the criminal justice system; and
 - people with co-occurring substance misuse and mental illness
- Facilitate and support evidence-based treatment for clients using a range of substances, including flexible and stepped care models tailored to individual need
- Promote quality improvement approaches and support health professionals in identifying and responding to harmful substance use through education and training
- Understand the needs of the community by analysing data; and engaging and consulting with consumers, clinicians, family and carers, providers, peak bodies, community organisations and funders



In 2018, 37.2% of people aged 16 years+ consumed alcohol at levels posing a long-term risk to health (NSW 31.5%); whilst 32.7% consumed alcohol at levels posing an immediate risk to health (NSW 25.8%)

In 2015-16, the rate of alcohol attributed deaths was higher in our region at 22.1 per 100,000 people than the NSW average of 19.1 and was higher amongst males (27.9; NSW 24.2) than females (16.2; NSW 14.0)

IDENTIFIED PRIORITY AREA

VULNERABLE, MARGINALISED & HARD-TO-REACH GROUPS

NEEDS IN OUR REGION

- Low levels of health literacy
- Widespread socioeconomic disadvantage
- Health needs of an ageing population
- Poorer health outcomes for CALD populations
- Areas for improvement in childhood immunisation rates
- Poor health and developmental outcomes for infants and young children
- Youth health needs
- Rural health disparities
- High proportions of people with severe disability and carers
- Increasing prevalence of dementia
- Poorer health outcomes for people experiencing homelessness
- Limited capacity of services to address dementia
- Barriers to accessing disability services
- Transport limitations
- Reduced access to services for:
 - children and youth;
 - older people;
 - rural and remote areas;
 - people experiencing homelessness

OUR CURRENT & PLANNED ACTIVITIES

- Commission Primary Health Care Nursing Clinics and Community Participation programs throughout the New England North West
- Implement a digital health and information sharing strategy, facilitating the use of: shared health summaries, National Health Service Directory, and eReferral systems
- Commission a Mobile X-Ray Service to provide non-urgent, on-site radiography to aged care facility residents on the Central Coast
- Implement a Community Cancer Screening Participation Strategy
- Form health sector partnerships with other primary care agencies i.e. GP Collaboration Unit, service delivery reform partnerships, Central Coast Aged Care Task Force, Hunter Dementia Alliance, Central Coast Dementia Alliance and New England Dementia Partnership
- Collaborate in the delivery of the Aged Care Emergency program, providing support to residential aged care facility staff to address the non-life-threatening acute care needs of residents in the Hunter and New England areas
- Investigate the needs of people:
 - from culturally and linguistically diverse backgrounds;
 - experiencing homelessness;
 - with a disability with a view to commissioning solutions or working in partnership to improve health outcomes
- Investigate activities to improve health outcomes for infants and young children with a view to commissioning solutions or working with key partners
- Develop and implement a GP led integrated Telehealth model of care for the provision of care services in residential aged care facilities in the New England North West region

- Commission:
 - youth complex mental health services in areas of identified need;
 - low intensity youth services;
 - primary mental health services targeted at older people residing in aged care facilities and for underserved and hard-to-reach groups
- Commission existing and advocate for new headspace centres, outreach and satellite services across the region
- Develop early intervention services targeted at youth at risk of, or experiencing mental illness
- Commission a range of Allied Health Services across the New England North West and rural Hunter regions
- Develop a rural communities strategy in partnership with HNELHD and Rural Doctors Network
- Partner in the NHMRC NSW Centre for Innovation in Regional Health supporting scholarship and research activities in primary care
- Develop scholarships to support the professional development of Practice Nurses
- Co-commission scholarships and education programs to assist in retention of primary care practitioners
- Research Potentially Preventable Hospitalisations in the region and develop recommendations as to how these can be addressed
- Commission a rural resilience program in response to the drought
- Deliver the Early Health Literacy Project with partners to address early language and literacy developmental vulnerability in Tamworth Regional Council communities
- Partner on Foetal Alcohol Spectrum Disorder (FASD) to improve health outcomes for infants and young children with a view to commissioning solutions
- Develop, provision and implement the Perinatal Project to support perinatal, maternal and child health in the Tamworth LGA using a shared care model with local GPs
- Early start grants to support early intervention for children, young people and families in areas of high alcohol consumption, focusing on maternal health, school readiness and resilience



IDENTIFIED PRIORITY AREA

HEALTH & WELLBEING OF ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

NEEDS IN OUR REGION

- Poorer health outcomes for Aboriginal and Torres Strait Islander people
- Higher rates of chronic disease amongst Aboriginal and Torres Strait Islander people
- Reduced access to health services for Aboriginal and Torres Strait Islander people
- Lack of integration, flexibility and cultural appropriateness of mental health and drug and alcohol services
- A low proportion of Aboriginal and Torres Strait Islander people having a 715 Health Assessment
- Lack of culturally safe workplaces for the Aboriginal and Torres Strait Islander workforce

OUR CURRENT & PLANNED ACTIVITIES

- Commission the Integrated Team Care activity to facilitate access to clinical support and chronic disease management for Aboriginal and Torres Strait Islander people
- Partner in key Aboriginal Health Partnerships, including: The Hunter Aboriginal Health and Wellbeing Alliance; and the Central Coast Aboriginal Partnership Agreement
- Commission primary mental health services targeted at Aboriginal and Torres Strait Islander people
- Investigate culturally appropriate low intensity social and emotional health and suicide prevention initiatives with the view to commissioning services in areas of need
- Build the capacity of primary care to deliver culturally safe mental health and suicide prevention programs
- Implement a Community Cancer Screening Participation Strategy
- Provide peer support, professional guidance and mentoring to the Aboriginal workforce delivering the Integrated Team Care activity
- Continue to establish processes to capture, collate and report PROMs & PREMs within HNECC programs and services in line with the 2018 HNECC Health and Wellbeing Outcomes Framework
- Commission services with the Healing Foundation community consultation as well as activity plan strategies to assist HNECC to successfully identify the healing needs and aspirations of Aboriginal and Torres Strait Islander individuals, families and communities across the region
- Provide Aboriginal Medical Service grants leading to improved access to GPs, capacity building and service enhancement
- Support Ungooroo Breast Screen Project in Muswellbrook and Singleton communities with the aim of increasing community awareness and knowledge around breast screening and prevention in local Aboriginal communities
- Provide elders grants to assist Elders Groups to attend the Elders Olympics
- Deliver 715 GP and Community Education sessions to Aboriginal and Torres Strait Islander communities in the region
- Develop scholarships to increase the number of identified Aboriginal health workers/practitioners trained/employed with mainstream general practices and Aboriginal Medical Services
- Connect communities to coordinated care and enhance importance of Aboriginal Elders and pilot 'On Country Care'

- Contribute to Closing The Gap in life expectancy between Aboriginal and Torres Strait Islander people through a Healthy Lifestyle Program pilot
- Commission an external forum coordinator and facilitator to work with the AHA Team to develop and deliver a series of Close the Gap Forums

Life expectancy for the Aboriginal population (73.7 years for females and 69.1 years for males) is around 10 years less than the non-Aboriginal population (83.2 years for females and 79.7 years for males)

Socioeconomic disadvantage, including homelessness and insecure housing, health risk factors and chronic disease are contributing to poor health outcomes for Aboriginal and Torres Strait Islander people across our region

MENTAL ILLNESS, INTENTIONAL SELF-HARM & SUICIDE

NEEDS IN OUR REGION

- High rates of mental illness, intentional self-harm and suicide
- Mental health and suicide prevention needs of:
 - youth;
 - males aged 25-65 years;
 - males aged over 80 years;
 - Aboriginal and Torres Strait Islander people;
 - older people residing in aged care facilities;
 - LGBTIQ community members;
 - people experiencing moderate to severe mental illness
- Stigma associated with mental illness including help seeking
- Limited support for families and carers of people living with mental illness

OUR CURRENT & PLANNED ACTIVITIES

- Commission primary mental health services targeted at:
 - underserved and hard-to-reach groups, including rural and remote communities;
 - males aged 25-65 years;
 - Aboriginal and Torres Strait Islander people;
 - older people residing in aged care facilities; and
 - people with severe and complex mental illness
- Commission:
 - suicide prevention services;
 - youth complex mental health services;
 - low intensity youth services
- Commission existing and advocate for new headspace centres, outreach and satellite services across the region
- Develop early intervention services targeted at youth at risk of, or experiencing mental illness
- Investigate culturally appropriate, low intensity social and emotional health and suicide prevention initiatives with the view to commissioning services in areas of need
- Commission psychosocial support services for people with severe mental illness who are ineligible for NDIS support
- Manage the Transitional Care Package Program for patients who need additional support after discharge from inpatient Mental Health services
- Develop a suicide prevention strategy to address stigma encountered to help seeking by medical professionals
- Commission and manage low intensity mental health services
- Develop a Regional Mental Health and Suicide Prevention Plan in collaboration with LHDs and other key stakeholders
- Support the provision of specialised mental health and counselling services to people affected by the Willamtown PFAS exposure
- Commission a rural resilience program in response to the drought
- Commission locally relevant psychosocial services to meet the needs of people with severe and complex mental illness
- Support the establishment and integration of local suicide post-vention groups
- Commission evidence-based aftercare services for those who have attempted suicide or are in a suicidal crisis
- Collaborate with existing providers, LHDs, consumers, community members, headspace National Office, Beyond Blue, Orygen and young people, to design new outreach/satellite services and identify new services that enhance the stepped model of care

In 2016-17, the rate of hospitalisations for intentional self-harm was much higher for people aged 15-24 years (395.9 per 100,000 people) than for all ages (180.0) within our region and was also higher than the NSW average (363.6)



IDENTIFIED PRIORITY AREA

MENTAL HEALTH WORKFORCE & SERVICE CAPACITY

NEEDS IN OUR REGION

- Lack of integration and collaboration between mental health services
- Cost barriers to mental health and suicide prevention services
- Transport barriers to mental health services
- Limited services for people experiencing moderate to severe mental illness
- Support for GPs to play a central role in mental health care
- Reduced access to psychiatrists
- Reduced capacity of services to recruit and retain allied health staff
- Limited availability of early intervention services
- Lack of cross-sectoral mental health promotion and prevention, and suicide prevention strategies
- Limited capacity of services to develop and implement an approach to quality
- Lack of a systematic evidence-based post-vention strategy across communities
- Barriers for Mental Health Nurses to gain credentials to work in general practice

OUR CURRENT & PLANNED ACTIVITIES

- Commission a mental health and psychosocial access, triage and referral service
- Co-commission a GP psychiatry consultation service
- Commission existing Partners In Recovery (PIR) service providers to deliver psychosocial services that meet the needs of the specified cohort population
- Commission new mental health clinical (allied health/ psychology) services
- Commission new Clinical Care Coordination services
- Commission non-clinical psychosocial services
- Build the capacity of primary care to upskill the Aboriginal and non-Aboriginal health workforce on intergenerational trauma and cultural healing, identifying Traditional Healers in the process to build sustainability for ongoing support
- Develop scholarships to support Aboriginal and Non-Aboriginal Health workers delivering services to Aboriginal communities
- Build the capacity of primary care to deliver culturally safe mental health and suicide prevention programs
- Build the capacity of primary care to respond effectively and in an ongoing way to suicide
- Dynamic Simulation Modeling for Suicide Prevention facilitated by the Sax Institute will provide a plan for suicide prevention services post LifeSpan trials
- Promote existing low intensity services and gateways, including the Mental Health Digital Gateway
- Build the capacity of the low intensity mental health workforce
- Develop the capacity of primary care to operate within a patient centred stepped care model

- Work with key stakeholders to develop recommendations for addressing the needs of families and carers of people living with mental illness
- Facilitate integration and standardisation of governance, clinical information management, performance reporting and consumer/staff feedback processes within primary mental health care services

According to stakeholders, there is a lack of access to psychiatrists across the region especially in rural areas, due to a workforce shortage and the cost of private appointments



HEALTH WORKFORCE & SERVICE CAPACITY

NEEDS IN OUR REGION

- A lack of health service integration, coordination and information sharing
- Areas of primary care workforce vulnerability
- Locally relevant professional development and education for primary care clinicians
- Targeted support for general practice
- Limited access to dental services
- Lack of prevention and early intervention services
- Limited access to after-hours GPs
- High proportions of semi-urgent and non-urgent emergency department presentations
- Cost barriers to healthcare

OUR CURRENT & PLANNED ACTIVITIES

- Partner in the NHMRC NSW Centre for Innovation in Regional Health supporting scholarship and research activities in primary care
- Further develop HealthPathways throughout the region, including associate PatientInfo website
- Implement a digital health and information sharing strategy, facilitating the use of: shared health summaries, National Health Service Directory, and eReferral systems
- Participate in the stage 1 roll-out of the Health Care Homes initiative across the region
- Form health sector partnerships with other primary care agencies i.e. GP Collaboration Unit, service delivery reform partnerships, Central Coast Aged Care Task Force, Hunter Dementia Alliance, Central Coast Dementia Alliance and New England Dementia Partnership
- Commission the extraction and collection of aggregated data from general practices to facilitate benchmarking and identification of continuous quality improvement activities
- Provide support and development opportunities to general practices
- Collaborate with NSW Ambulance on an Ambulance Alternative Pathways project
- Develop scholarships to support the professional development of Practice Nurses
- Co-commission scholarships and education programs to assist in retention of primary care practitioners
- Support General Practice quality improvement activities
- Support the administration of a bulk-billing cervical and breast cancer screening clinic in Wyong
- Commission a Mobile X-Ray service to provide non-urgent, on-site radiography to resident aged care facility residents on the Central Coast
- Commission Primary Health Care Nursing Clinics and Community Participation programs throughout the New England North West
- Commission a range of Allied Health Services across the New England North West and rural Hunter regions
- Develop and implement a GP led integrated Telehealth model of care for the provision of care services in residential aged care facilities in the New England North West region
- Develop scholarships to support Aboriginal Health Workers and Non-Aboriginal Health Workers delivering services to Aboriginal communities

- Develop and implement the HNECC PHN Matrix database which captures and links key elements guiding the work of the PHN
- Develop a Care Navigation Training Package
- Improve utilisation of Practice Nurses particularly in areas of workforce shortage
- Build the capability of HNECC PHN, our system partners and service providers to enhance the current level of commissioning moving toward internationally recognised commissioning excellence
- Care Navigation development of health literacy to empower and enable individuals to engage decisions in their healthcare and improve self-management
- Develop unsolicited/start up grants
- 'Empower our communities' grants/initiatives to promote wellness and resilience





SOURCES

- Percentage of adults who reported having a long-term health condition, 2016-17 (Australian Institute of Health and Welfare, 2018).
- Alcohol attributable deaths by PHN, NSW, 2015-16; Alcohol consumption at levels posing long-term risk to health, persons aged 16 years and over, HNECC PHN, NSW 2002-2018 (Centre for Epidemiology and Evidence, HealthStats NSW, NSW Ministry of Health, 2018).
- Socio-Economic Index for Areas (Australian Bureau of Statistics, 2017).
- Hospitalisations for all causes by Aboriginality, Hunter New England and Central Coast PHN, NSW 2006-07 to 2016-17 (Centre for Epidemiology and Evidence, HealthStats NSW, NSW Ministry of Health, 2018).
- Intentional self-harm hospitalisations by Primary Health Network, persons of all ages and 15-24 years, NSW 2016-17; HealthStats (Centre for Epidemiology and Evidence, 2018).
- Consultation with general practices and other key stakeholder groups, including HNECC PHN Clinical Councils and Community Advisory Committees.

