PRIMARY HEALTH NETWORK

Core Needs Assessment

2022-2025

phn
HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

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EXECUTIVE SUMMARY

The Core Needs Assessment 2022-2025 has built upon the 2019-2022 CNA utilising a convergent parallel design approach to undertaking the health and service needs analysis. 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.

The following activities in order were undertaken to complete the needs assessment:

1. Review and rationalisation of health and service needs identified in the 2020 CNA
2. Update and review quantitative data trends associated with current needs, including scoping for additional data sources
3. Consultation across the PHN region, inclusive of external stakeholders to understand perception, context and viewpoints of current, new and emerging need
4. Qualitative coding and theming of consultation notes, survey responses, PHN reports, evaluations and other sources of grey literature
5. Confirmation of needs via data triangulation inclusive of the results generated from a comprehensive needs prioritisation strategy
6. Opportunities and mapping of needs to activity
7. Review and approvals of needs assessment
8. Submission to DoH by 16th December 2021

Key pieces of work analysed and incorporated into the 2022-25 CNA include:

- Have Your Say Stakeholder and Community Surveys
- Mental Health and Suicide Prevention Regional Plan 2020-2025
- Market Mapping: Human Services
- Alcohol and other Drug Evaluation Findings
- Psychosocial Supports Evaluation
- Healing Forum Reports: Inverell, Cessnock, Taree

We will know our communities, including vulnerable groups, and use information provided by them to inform our programs.

New identified needs resulted from the CNA 2022-2025 process, including:

- Emerging needs which are those that come into view from evolving environmental factors and have various impacts upon individuals and their community's health, including drought, COVID-19 Pandemic, Bushfires, floods, and industries such as agricultural, coal, cotton and other chemicals.
- Mental Health Comorbidities
- Alcohol Other Drugs and Comorbidities
- Closing The Gap for First Nations People
- First Nations Child, Maternal and Family Health
- Reduced Access to Services for Culturally and Linguistically Diverse Populations
- Lack of Drug and Alcohol Rehabilitation Services
- Access to and Utilisation of Digital Health and Telehealth in Service Delivery
- A Greater role for Pharmacy in Delivering Primary Health Care
- Lack of Men's Health Services and Program for First Nation's Men

THIS ACADEMIC REPORT IS THE FULL VERSION OF THE 2022-2025 CORE NEEDS ASSESSMENT COMPLETED IN DECEMBER 2021. WITHIN THIS REPORT WE HAVE PRESENTED ALL IDENTIFIED HEALTH NEEDS AND SERVICE GAPS FOR THE HNECC PHN REGION.

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NEEDS ASSESSMENT PROCESS

The Core Needs Assessment (CNA) is the first stage in the broader PHN commissioning framework and provides the basis for planning and commissioning of services. The CNA identifies the health and service needs of the HNECC PHN population and inform the PHN's understanding of our region.

The CNA involved the following:

- Population health planning and an analysis of the health needs of the HNECC PHN region
- Reviewing and identifying market factors and drivers of health services in the PHN region
- Analysing and interpreting relevant local, state and national data
- Identifying service gaps or market failures
- Stakeholder, clinician and community consultation
- Determining priorities for the PHN to address through commissioning, innovation/ integration activities and projects

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HAVE YOUR SAY STAKEHOLDER AND COMMUNITY SURVEYS

MENTAL HEALTH AND SUICIDE PREVENTION REGIONAL PLAN 2020-2025

MARKET MAPPING: HUMAN SERVICES

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PSYCHOSOCIAL SUPPORTS EVALUATION

HEALING FORUM REPORTS: INVERELL, CESSNOCK, TAREE

Have Your Say Stakeholder and Community Surveys

Stakeholder and community consultation was an important process for the needs assessment. Two surveys were developed to capture the perceptions and viewpoints of the community and of stakeholders who work within the primary care sector or are partners of the PHN.

The Have Your Say Stakeholder survey was distributed to the PHN's networks of commissioned service providers, Aboriginal Medical Services, allied health networks and via the PHN General Practice newsletter. There were 108 responses to the stakeholder survey with 43% of respondents indicating they had read the previous core needs assessment update, 47% had not, and 9% were unsure.

Stakeholder Survey Results:

The most important health service areas needing improvement in descending order, according to stakeholders:

1. Allied health services
2. After hours health services
3. Moderate to severe mental health services and General Practitioner Services tied for third place

The largest overall health concern facing the community in descending order, according to stakeholders:

1. Mental health and suicide prevention
2. Alcohol and drug use
3. Unhealthy lifestyles

Community Survey Results:

The most important health service area needing improvement in descending order, according to community members:

1. Mental health services including psychiatrists, psychologists and counsellors
2. General Practitioner Services
3. After hours health services

The largest overall health concern facing the community in descending order, according to community members:

1. Mental health and suicide prevention
2. Alcohol and drug use
3. Rural health

THE HAVE YOUR SAY COMMUNITY SURVEY WAS DISTRIBUTED VIA PEOPLEBANK, THE PHN SOCIAL MEDIA CHANNELS AND THROUGH THE NETWORKS OF THE COMMUNITY ADVISORY COMMITTEES. THERE WERE 236 RESPONSES TO THE COMMUNITY SURVEY WITH 26% INDICATING THEY HAD READ THE PREVIOUS CORE NEEDS ASSESSMENT, 67% HAD NOT AND 6% WERE UNSURE.

Mental Health Regional Plan 2020-2025:
A Partnership approach to Regional Mental Health and Suicide Prevention

The Mental Health and Suicide Prevention Regional Plan 2020-2025, has been developed in partnership with:

Hunter New England and Central Coast Primary Health Network	**Central Coast Local Health District**	**Hunter New England Local Health District**

The plan outlines a vision for a more robust, integrated mental health system focusing on seven priorities to improve mental health and wellbeing and reduce suicides across the Hunter, New England and Central Coast regions. Seven priorities were identified in the plan with clients, carers, families and communities at the centre of the plan.

The seven priorities are:

1. Improved integration
2. Aboriginal mental health and wellbeing
3. Access to care
4. Importance of general practice
5. Strengthening suicide prevention
6. Building workforce capacity
7. Planning, innovation and evaluation

In development of the plan, key stakeholders participated in priority setting workshops and asked to rank their perceptions of mental health needs and mental health target groups. These health areas and target groups were identified from the literature, burden of illness data and the 2017 Mental Health Needs Assessment.

The following mental health needs and target groups are ranked in descending order:

Needs:

1. Moderate to severe mental illness
2. People impacted by trauma
3. People at risk of mental illness
4. People with chronic disease
5. People with eating disorders

Target Groups:

1. Children and young people
2. Aboriginal people
3. People in rural and remote areas
4. Vulnerable population groups
5. Males 25-65 years
6. Older people 80+

The following suicide prevention target groups and challenges were identified in priority setting workshops and are ranked in descending order:

Groups:

1. Young people
2. Aboriginal people
3. Males 25-65 years
4. People from vulnerable population groups
5. People from rural and remote areas
6. Older males 80+ years

Suicide Prevention Challenges:

1. Follow-up support for those with suicidal ideation
2. Follow up support after presentation for suicide attempt
3. Evidence based approaches to suicide prevention
4. Intersectoral commitment to suicide prevention
5. Community capacity to address suicide
6. Evidence based approaches to postvention

The following mental health service gaps and challenges were identified in priority setting workshops and are ranked in descending order:

Gaps:

1. Services for moderate to severe mental illness
2. Services for children and young people
3. Early intervention services
4. Rehabilitation services
5. Culturally safe mental health services
6. Services for people experiencing eating disorders

Challenges:

1. Integration across service system
2. Navigating the mental health system
3. Capacity of GPs to address mental health problems
4. Workforce challenges especially in rural areas
5. Service responsiveness
6. Evidence based mental health promotion and prevention strategies
7. Monitoring and assessing quality outcomes
8. Person and carer centred care

HNECC PHN Market Mapping Insight: Human Services

Insight Consulting Australia conducted a market mapping exercise* of the Hunter New England and Central Coast regions. The assessment of the regional service provider market will help to inform future commissioning and market stewardship activities of the HNECC PHN.

The assessment scope included organisations delivering seven types of human services: allied health, social services, disability, non-residential aged care, mental health, housing, and disaster recovery.

*Note that this market mapping exercise only includes the charitable providers that are registered with the Australian Charities and Not-for-Profits Commission (ACNC) and does not include private providers.

The analysis found that within the HNECCPHN region there are many local charitable providers who earned less than $1m in 2018. These organisations represent 78% of the total number of locally based charities, which exceeds the national average of 64%. This may indicate greater fragmentation of the provider market compared to other regions and may be reflective of the large proportion of the region which is rural and remote.

The market mapping exercise identified areas of concern regarding provider supply or capability which was raised as a concern in interviews conducted with commissioned services and further supported in the results of a subsequent data analysis:

13 LGAs within the HNECC PHN region with low population (less than 20, 000 people, excepting Singleton) and less than 30 ACNC registered charitable providers delivering any of the seven service types, and which are underserved for each service type include:

- Liverpool Plains
- Walcha
- Dungog
- Uralla
- Gwydir
- Tenterfield*
- Glen Innes Severn
- Moree Plains
- Narrabri
- Gunnedah*
- Upper Hunter
- Muswellbrook*
- Singleton

The service provider markets in 11 of these LGAs include providers with an annual income of more than $1m, indicating there should be capacity to build and further develop services in those areas. While LGAs with an asterisk* have low numbers of providers, they have a high number of staff employed by local charities in comparison to their population, indicating that while the provider supply and choice may be low, the relative supply of services ought not to be.

The number of mental health and disaster recovery providers across the whole region is low in comparison to other service types, and especially thin in low population LGAs.

There is a very thin supply of several professions, including psychologists across multiple LGAs, potentially indicating issues arising from workforce supply/distribution and pricing.

Opportunities are available to the PHN and other commissioners to:

- Establish a network of commissioners for communication and shared strategic objectives
- Build a market of rural/remote specialists, including using long-term panels, founded on the existing community engagement and presence of small and large providers in rural/ remote areas
- Build on the strengths of existing Aboriginal organisations for sustainability and capability
- Engaging providers to co-design commissioning and capacity-building strategies

Evaluation of commissioned Alcohol and other Drug Services

Grosvenor recently completed an evaluation of commissioned Alcohol and other Drug services within the HNECC PHN region.

Key findings include:

- **Significant unmet demand** for Alcohol and Other Drug (AoD) Services throughout New South Wales (NSW). The Hunter New England and Central Coast region's unmet demand is highlighted in the needs assessment and evidenced further through extensive waitlists and wait times described by providers.
- Providers have indicated further **gaps in services for residential rehabilitation** for women and children and youth as well as outreach services in regional and rural communities. They have provided further comment on the prevailing impacts of the COVID-19 Pandemic and potential for further increased demand for AoD treatments in the immediate future.
- **Lack of detox facilities** for young people was highlighted as a barrier to accessing AoD services. Providers are supported by multiple funding bodies and PHN funding is typically one input of many, into the overall delivery of a provider's AoD services. Contribution to achievement of service outputs and outcomes should be viewed in this context.

Specificity in how the PHN can utilise funding may be inhibiting opportunities to deliver holistic commissioning solutions to address a continuum of care across mental health and AoD comorbidities. One to three-year funding cycles may be a barrier to commissioning of innovative and alternative approaches to service delivery because they do not support sufficient timeframes required for recruitment, raising awareness, service development / evolution and building of relationships.

Most referrals to AoD Services appear to be self-referral, family and community driven or sourced from outside the health or AoD service system. If targeted awareness raising was undertaken, it should focus on maintaining positive levels of awareness and engagement with these community groups and seek to develop greater awareness and support referral processes within the system by targeting GPs/ medical practitioners and in the hospital setting.

Providers interviewed indicated support and treatments were contributing to positive client outcomes.

The NADAbase dataset, while limited, indicates positive outcomes are being achieved for clients within these services and provides a baseline for supporting the PHN and its commissioned providers to track trends and improvements in patient outcomes.

Providers, Local Health Districts (LHDs) and PHN have all acknowledged the difficulty in finding and retaining staff to support AoD service delivery.

All consulted stakeholders emphasised having the right staff to deliver AoD services is critical to successful delivery of client outcomes. They also identified finding, and retaining quality staff as a major, ongoing challenge, experienced further in acute services and rural and remote regions.

Psychosocial Support Program - Evaluation Report and Findings

The Health Intelligence and Performance (HIP) Team recently completed an in-house evaluation of the Psychosocial Support program, in collaboration with the Psychosocial commissioning coordinator. A process and outcome evaluation were undertaken to assess and understand how well the program had been implemented, identified areas for program improvement and to assess the overall performance of the program against its objectives.

Key findings of the evaluation include:

- Clients accessing the program are likely to have very high levels of psychological distress and/or have a severe mental disorder. The evaluation indicates with some confidence that the target cohort is being identified, the need for the program exists and clients are accessing the program.
- Initial results indicate the PSS Program is effective in increasing client awareness, confidence, and capacity, to access community-based services to address their health and wellbeing needs and goals. This only applied to those who had achieved their key activity goal and had 'other' recorded as the reason for exit and cannot be generalised to all participants, particularly those who disengaged from the program. Two thirds of client key activity goals focussed around 'Building broader life skills', 'managing daily living needs' and 'social skills and friendships', indicating that these areas are the most pressing for the client cohort.
- In more rural and remote regions travel requirements for clients and workers was identified by PSS providers as problematic, while in other regions small town social issues were tricky to navigate to get clients involved in the program. The COVID-19 pandemic presents multiple challenges for service providers in the delivery of the PSS program. Service providers were, however, still able to successfully deliver the program to the target cohort during and preceding COVID-19 restrictions, through innovations in program service delivery.
- Providers noted the difficulties in promoting the service due to COVID-19. The local nature of the program means cooperation between local service providers, for referral into the program and to help achieve clients' goals, is critical in the delivery of the service.

Healing Forum Reports

Three healing forums have been delivered across the PHN footprint including Inverell, Cessnock and Taree, through a partnership between HNECC PHN and The Healing Foundation. The aim of the healing forums is to increase access to Aboriginal and Torres Strait Islander community-identified approaches to improving the healing and wellbeing needs of the HNECC Aboriginal and Torres Strait Islander communities.

The forums aim to:

- Empower Aboriginal and Torres Strait Islander communities to identify and design local, culturally relevant approaches to meeting the healing and wellbeing needs of their community.
- Resource localised approaches to healing that are driven at a local level and led by Aboriginal and Torres Strait Islander communities addressing mental, physical, emotional and spiritual needs, and connection to culture, family and land.
- Integrate community healing programs with existing Aboriginal and Torres Strait Islander mental clinical services – including both Aboriginal and Torres Strait Islander Community Controlled and mainstream services – to ensure services holistically meet the clinical and cultural healing needs
- Promote community development and meaningful partnerships to strengthen the sustainability, community governance and service delivery of community healing programs.

The Inverell and surrounding communities healing forum prioritised three key themes, including:

1. Healing for our young people
2. Healing from grief and loss
3. Building a trauma aware, healing informed health support network.

Other key issues discussed in the healing forum yarning circles included grief and loss, trauma, cultural disconnection, social media and a lack of access to resources. Healing solutions identified included:

- Build a proactive, flexible and trauma aware, healing informed service sector
- Filling the gap in service provision for children and young people
- Service coordination and accountability
- Support for collective community healing
- Provision of access to resources

The Cessnock, Kurri Kurri and surrounding communities healing forum identified several key themes:

1. Social and emotional wellbeing for children and young people
2. Safe families
3. Supporting healing for children and families

Other key issues discussed in the healing forum yarning circles included cultural disconnection, family breakdown and isolation, trauma and mental health issues, alcohol and other drugs, incarceration, barriers to information and from services and bullying and lateral violence. Healing solutions identified included:

- Co-design of person-centred, culturally safe services and information sharing
- A focus on accessible health promotion
- Support from health services for holistic healing
- Health promotion and cultural healing in schools
- Kinship restoration – a whole of family support focus
- Police and community partnerships
- Through care and reintegration support
- Evidence based practice

The Taree and surrounding communities identified several key themes, including:

1. Families
2. Children and young people
3. Gaps in local health service provision

Other key issues discussed in the healing forum yarning circles included culture and country, racism, trauma, grief and loss, mental health, suicide, out of home care and child protection, family and lateral violence, education, housing and homelessness, detention and incarceration, alcohol and other drug misuse and family and community resilience. Healing solutions identified included:

- A community healing space
- Community governance
- Opportunities to connect with culture and country
- Support for children and families
- A focus on cultural safety in services
- Enhancement to the health service sector
- Improved health service accountability
- Improved youth service and support
- Improved access to safe housing
- Recovery and reintegration

Additional Data Needs and Gaps

Additional data required

Generally, for all data sets, information at discrete geography levels, including SA2, SA3 and LGA (as per the revised boundaries) will allow better data analysis at a local community level. In addition, it is imperative the data available to inform our needs assessment processes are current and so require regular updating.

Further, it is important to have data available on vulnerable populations, such as First Nations, Culturally and Linguistically Diverse (CALD) and LGBTQIA+ populations.

Additional data that would enhance the needs assessment processes includes:

- Current prevalence rates of chronic disease at a PHN and local level, with Indigenous rates included.
- Regular release of suicide data from the NCIS.
- Dementia prevalence data by PHN and either SA3 or LGA levels.
- Psychosocial disability data by PHN and either SA3 or LGA levels.
- Specific data on youth mental health at SA3 or LGA levels.
- Broaden the PHNs ability to utilise HeadsUPP workforce and other DoH published data for PHN regional profiles, funding submissions and research collaborations.
- Data to build an accurate picture of need relating to Drug and Alcohol use across the HNECC PHN region is inadequate, with specific requirements including:
    - Data at the PHN level as a minimum and preferably at LGA and SA3 levels.
    - Access to up-to-date data is crucial to the success of this activity, particularly given the anecdotal reports of the increasing misuse of drugs, especially in rural areas, it is challenging to accurately gauge the scale and impact of this issue without the solid evidence base of current data.
    - Due to the tendency for clients to access a service outside of their local community, any treatment data made available would be enhanced through the provision of residential postcodes or SA3's, this would provide valuable information regarding client flows

Data from stakeholders in a qualitative format was challenging to obtain at times as a result of the impacts of the COVID-19 Pandemic. A stakeholder engagement and communications plan were developed, however challenges in engagement occurred in completing surveys or responding to information requests due to the impact of the vaccination roll out, survey fatigue, and saturation of the primary care sector from engagement associated with the pandemic and pandemic response.

TO ENSURE THE NEEDS ASSESSMENT IS IMPLEMENTED THROUGHOUT THE ORGANISATION, A USER-FRIENDLY VERSION WILL BE DEVELOPED TO ASSIST PHN STAFF TO INTERPRET, CONSIDER AND IMPLEMENT RESPONSES TO NEED INTO THEIR ACTIVITY PLANNING. EDUCATION SESSIONS WILL BE OFFERED TO STAFF TO EXPLAIN THE NEEDS ASSESSMENT PROCESS AND TO DISCUSS THE KEY FINDINGS.

Health Needs

GENERAL POPULATION HEALTH NEEDS

- Low levels of health literacy
- Poor self-assessed health status
- Lower than average life expectancy
- Socioeconomic disadvantage
- Health needs of an ageing population
- Poorer health outcomes for culturally and linguistically diverse populations
- Areas for improvement in childhood immunisation rates
- High rates of smoking during pregnancy
- Poor health and developmental outcomes for infants and young children
- Youth health needs
- Rural health Inequalities
- High proportions of people with severe disability and carers
- Increasing prevalence of dementia
- High rates of overweight and obesity
- High rates of physical inactivity and poor nutrition
- High rates of smoking
- High rates of chronic disease
- High cancer incidence and mortality
- Poorer health outcomes for people experiencing homelessness
- Emerging needs

FIRST NATIONS HEALTH NEEDS

- Poorer health outcomes for First Nations people
- Higher rates of chronic disease amongst First Nations people
- Closing The Gap for First Nations people
- First Nations Child, Maternal and Family Health

MENTAL HEALTH AND SUICIDE PREVENTION HEALTH NEEDS

- High rates of mental illness, intentional self-harm and suicide
- Mental health and suicide prevention needs of youth
- Mental health and suicide prevention needs of males aged 25-65 years
- Mental health and suicide prevention needs of males aged over 80 years
- Mental health, suicide prevention and trauma informed needs of First Nations people
- Mental health and suicide prevention needs of older people residing in aged care facilities
- Mental health and suicide prevention needs of LGBTIQA+ community members
- People experiencing moderate to severe mental illness including psychosocial support needs
- Stigma associated with mental illness including help seeking
- Mental Health Comorbidities

ALCOHOL AND OTHER DRUGS HEALTH NEEDS

- Higher rates of alcohol misuse
- High levels of Illicit drug use
- Alcohol, Other Drugs and Comorbidities

Low levels of health literacy

Health literacy is associated with how people use, access, and understand health and healthcare information in ways that benefit their health. People with low levels of health literacy are at higher risk of worse health outcomes and poorer health behaviours, these include lower engagement with health services, higher hospital re-admission rates, lower ability to self-manage and poorer understanding of medication instructions/management.

In 2018, in Australia the ABS Health Literacy Survey reported:

- 4.2% of people aged 18 years and over 'strongly disagreed/disagreed' to feeling understood and supported by health care providers
- 2.8% of people aged 18 years and over 'strongly disagreed/disagreed' to having sufficient information to manage their health
- 11.5% of people aged 18 years and over found it 'difficult' to actively engage with healthcare providers
- 14.3% of people aged 18 years and over found it 'difficult' in navigating the healthcare system
- 12.4% of people aged 18 years and over found it 'difficult' in their ability to find good health information
- 7.8% of people aged 18 years and over found it 'difficult' in understanding health information well enough to know what to do

Low levels of health literacy are a barrier to improved health outcomes for people throughout the HNECC PHN region, particularly vulnerable populations, including people aged over 65 years, Aboriginal and Torres strait Islander people, LGBTQI+ community members, culturally and linguistically diverse (CALD) populations, socioeconomically disadvantaged communities, rural residents and youth (particularly those transitioning to adult services).

Further findings from the 2018 ABS Health Literacy Survey demonstrated such variations across vulnerable population groups:

- 19% (almost 1 in 5) of people aged between 18–24 years found navigating the health care system difficult
- 7.9% for people aged 65 years and over, found navigating the health care system difficult
- There was a higher proportion of people who spoke English in the home who strongly agree they felt understood and supported by health care providers (33%) than those who did not speak English in the home (20%).
- There was a higher proportion of people who spoke English at home who found it easy to actively engage with health care providers (34%) than those who spoke a language other than English at home (26%).

Stakeholder and community consultation identified there was a need for increased health literacy campaigns within the HNECC PHN region covering a variety of areas including:

- Pharmacy and medication management
- Tailored health literacy for CALD populations
- Tailored culturally safe health literacy for First Nations peoples
- Preventative health literacy for youth and children focusing on diet and exercise
- Navigating the health system for youth
- Women's health including menopause health literacy
- Available services within the community

Poor self-assessed health status

Self-rated health also known as self-assessed health or self-perceived health refers to a single-item health measure in which individuals rate the status of their own health on a four- or five-point scale being from 'excellent' to 'poor'. It is a subjective assessment to measure health status.

In 2017-18, 15.1 in every 100 adults in the HNECC PHN region rated their health as 'fair' or 'poor' (Australia 14.7). Within the HNECC PHN region the rate of self-assessed health status has decreased since 2014-15, with more people reporting an improvement in self-rated health (15.5 per 100 population). LGAs within the HNECC PHN region with the poorest self-assessed health status included: Lake Macquarie (13.5), Walcha (14.0), Central Coast (14.2), Newcastle (14.2), and Singleton (14.2).

Whilst PHN level data isn't available, in 2018-19, self-assessed health status for Indigenous Australians aged 15 years and over, found 9.1% of those living in NSW reported 'poor' health, with a further 14.3% reporting 'fair' health.

People with disability rate their health poorly compared to people without a disability. Nationally, in 2017-18, 41.2% of people with a disability aged 15 years and overrated their health as "Fair/Poor" compared to only 6.7% of people without a disability aged 15 years and over. In HNECC PHN, 6.6% of the population or 1,150,365 people have a severe or profound disability.

Self-assessed health status declined with severity of disability with 59.9% of people with severe or profound disability aged 15 years and over rating their health as "Fair/poor".

Older people with a disability rated their health lower than younger people with a disability. 44.3% of people with a disability aged 65 years and overrated their health as "Fair/Poor" compared to 39.3% of people with a disability aged 15-64 years of age.

Self-assessed health status was lowest for people with head injury, stroke or brain damage and psychological disability. 68.7% of people with head injury, stroke or brain damage aged 15 years and over and 58.5% of people with psychological disability aged 15 years and overrated their health as "Fair/poor".

Lower than average life expectancy

In 2018, life expectancy at birth in the HNECC PHN region was 81.5yr (females 83.8; males 79.3), lower than the NSW average 83.6yr. A similar trend observed in 2016 when compared to the state average (HNECC PHN 81.9; and NSW 83.2) and 2017 (HNECC PHN 81.1; and NSW 83.0). Cessnock LGA (81.0) was the only LGA with a lower average life expectancy than the HNECC PHN region average.

It is estimated that the life expectancy gap for homeless people in Australia is more than 30 years.

Socioeconomic disadvantage

Socioeconomic disadvantage is correlated with poor health, higher incidence of risky health behaviours and reduced access to health services. In 2016, all LGAs including the HNECC PHN region (976) are socioeconomically disadvantaged relative to Australia (1000) and NSW (1002). This ranges from Tenterfield (910), the most relative disadvantaged, to Lake Macquarie (995) and Newcastle (995), equally the least relative disadvantaged.

Some sub-population groups experience greater socioeconomic disadvantage than the general population. Aboriginal and Torres Strait Islander people consistently experience greater socioeconomic disadvantage relative to the SEIFA score for the area in which they reside, the Indigenous Relative Socioeconomic Outcomes index is the preferred method of examining socioeconomic disadvantage amongst this population. Indigenous Areas with the most relative disadvantage on this index in the region, and more disadvantaged than the NSW average (36), are Moree Plains (81), Tenterfield-Jubullum Village (77), Moree (76), Guyra-Tingha (75), Inverell-Gwydir (70), Taree (69), Armidale (66), Narrabri (61), Great Lakes (59), Glen Innes (58), Muswellbrook (55), Liverpool Plains (48), Uralla-Walcha (47), Gunnedah (43), Tamworth (43), Gloucester-Dungog (42) and Cessnock (39). A similar trend was observed in 2011, with all Indigenous areas within the HNECC PHN region are more disadvantaged than the NSW average apart from Muswellbrook.

The situation and needs of older culturally and linguistically diverse (CALD) Australians vary greatly. However, in general, older people from CALD backgrounds have poorer socioeconomic status, compared with the older Anglo-Australian population.

The PHNs Mental Health & Suicide Prevention Regional Partnership Plan indicated that unemployment benefits within the PHN region were higher compared to National levels. During March 2019, the unemployment rate across the PHN was 5.5% compared to NSW (4.5%) and National (5.2%). The LGAs with the highest rates of unemployment were Glenn Innes Severn (9.6%), Tenterfield (8.7%) and Moree (8.1%).

Health needs of an ageing population

An ageing population is challenging the health system, with many health conditions increasing in prevalence with age, and older people being high health service users. In 2020, there was a higher proportion of people aged 65 years and over in the HNECC PHN region (20.3%) than NSW (16.7%) and Australia (16.3%). The proportion of people aged 65 years and over is projected to increase to 22.0% in 2025 and 23.5% in 2030 within the HNECC PHN region.

The top 5 LGAs with the highest proportion of older residents aged 65 years and over include: Tenterfield (32.0%), Mid-Coast (31.6%), Walcha (29.3%), Gwydir (26.0%), and Glen Innes Severn (26.0%).

In 2015-16, people aged 65 years and over in the HNECC PHN region were hospitalised for influenza and pneumonia at a rate (1,364.5 per 100,000) that was almost 4 times the average for all ages (349.8). A similar trend was observed in the following years with over 4 times the average than for all ages in 2016-17 (1450.3; and 341.6); 2017-18 (1699.1; and 405.7, respectively) and 2018-19 (1405.8; and 369.2, respectively). In 2016-17, people aged 65 years and over in the HNECC PHN region were hospitalised as a result of falls at almost 4 times the rate of all ages (2656.5; and 678.0 per 100,000). A similar trend was observed within 2017-18 (2716.0; and 677.5 per 100,000); and 2018-19 (2729.4; and 691.4 per 100,000).

In 2018-19, people aged 75 years and over in the HNECC PHN region were hospitalised due to stroke at 10 times the rate of those aged 0-74 years (1157.6 and 112.1 per 100,000 respectively). Furthermore, in 2018-19 people aged 75 years and over in the HNECC PHN region were hospitalised due to coronary heart disease at a rate more than five times the rate for persons aged 25-74 years (3190.0 and 589.1 per 100,000 population respectively). Trends over time analysis highlights a similar trend was observed in the previous three consecutive years.

In 2017-18, the rate of COPD hospitalisations for people aged 65 years and over in the HNECC PHN region was 15 times greater than the rate for those under 65 years (1,757 and 116 per 100,000 population respectively)

In 2020, there were 65.1 residential care places per 1,000 people aged 70 years+ in the HNECC PHN region (NSW 65.7) (Australia 65.6). The availability of residential care varied throughout the HNECC PHN region as follows (by aged care planning region), Central Coast (70.3), New England (62.7), Mid-North Coast (70.3) and Hunter (81.0).

Poorer health outcomes for culturally and linguistically diverse populations

The health of culturally and linguistically diverse consumers can be affected by poor access to health services and a lack of appropriate information to make informed decisions. Factors that can affect access to appropriate healthcare services include: English language proficiency and access to professional interpreters; lack of knowledge of the healthcare system, particularly primary health care; isolation and absence of social and family support networks; cultural stigma and shame around health issues including disability, sexually transmitted diseases (such as HIV), tuberculosis, mental illness, alcohol and other drug use; previous unfavourable or negative experiences with a health system, overseas or after migration to Australia; and past and ongoing experience of psychological trauma.

People from culturally and linguistically diverse backgrounds, particularly those from non-English speaking backgrounds, are less likely to access health services due to difficulty understanding and accessing mainstream systems of care and a lack of culturally safe services. The majority of the HNECC PHN population was born in Australia (82.3%), well above the NSW average (65.5%). In 2016, there were 63, 184 people born in non-English speaking countries within the HNECC PHN region (5.2%), this is a much smaller proportion of the population from non-English speaking backgrounds in comparison to NSW (21.0%). The highest proportions of people from non-English speaking backgrounds in the HNECC PHN region included: 14,322 people in Newcastle (9.2%), 2,287 people in Armidale Regional (7.8%) and 20, 292 in the Central Coast (6.2%) LGAs. Only 0.5% of HNECC PHN residents born overseas report poor proficiency in English, with Armidale Regional LGA reporting a higher level at 0.8% (NSW 3.8%).

People residing in the HNECC PHN who were born in the top ten non-English speaking countries were from the following countries, in order of population size:

Philippines (0.5% of the HNECC PHN population)

- China (0.4%)
- India (0.4%)
- Germany (0.4%)
- Italy (0.2%)
- Malaysia (0.1%)
- Korea, Republic of (South) (0.1%)
- Vietnam (0.1%)
- Greece (0.1%).
- Sri Lanka (0.1%)

A NSW Population Health Survey for 2014-2017 indicated that when compared to all NSW residents, people born in some overseas countries have higher rates of:

- Daily or occasional smoking (NSW 15%, Iraq 27%, Lebanon 25%)
- Overweight or obesity (NSW 53%, Lebanon 75%, Italy 72%, Iraq 66%)
- Inadequate physical activity (NSW 42%, Lebanon 60%, Italy 58%, Vietnam 55%, Iraq 55%)
- Diabetes or high blood glucose (NSW 9%, Italy 23%, Lebanon 17%, Vietnam 14%, United Kingdom 12%)

In 2017, Armidale LGA was chosen as a regional humanitarian resettlement location. Resettlement commenced in 2018, and currently (2021) there are more than 650 Ezidi humanitarian arrivals settled in Armidale, with an estimated 300 more expected to arrive. These refugees have primarily arrived from Iraq, Syria and Turkey and the majority are Kurmanji speaking.

Stakeholder consultation identified that an expected increase in refugee numbers may be seen in the New England region. Migration and settlement can adversely affect the physical and/or mental health of both individuals and communities. Factors that may affect physical and/or mental health include, stress associated with practical aspects of migration and settlement in a new country such as learning a new language and culture, finding accommodation, gaining recognition of qualifications, and finding suitable employment. Other factors include whether migration was voluntary or involuntary, absence of supportive family, community and social networks, racism and discrimination, health literacy, including cultural perspectives on illness, attitudes to preventive health care and navigating the health care system.

Stakeholders also report that social and cultural isolation is being experienced by CALD students at boarding schools or university in Armidale. Additionally, community stakeholders report domestic violence issues with CALD populations with many not seeking medical attention.

Areas for improvement in childhood immunisation rates

In June 2021, the proportion of fully immunised 1-year old in the HNECC PHN region was 95.90% (NSW 94.79%) for 2-year-old it was 94.46% (NSW 92.52%) and for 5-year-old it was 96.75% (NSW 95.00%). Whilst rates for all age groups are above the state average, with a national aspirational target of 95% there are still areas within the PHN region that require further attention and improvement. This includes 1 year old in Upper Hunter (94.81%), Great Lakes (94.24%), Taree-Gloucester (94.33%), Armidale (93.40%), Inverell-Tenterfield (94.66%) and Lake Macquarie-West (94.49%) SA3s. Along with 2 years old in SA3s Gosford (93.96%), Wyong (94.24%), Lower Hunter (94.33%), Port Stephens (93.71%), Upper Hunter (94.55%), Great Lakes (90.17%), Taree-Gloucester (92.17%), Armidale (94.85%), Inverell-Tenterfield (92.86%), and Newcastle (94.95%)

In June 2021, among Aboriginal and Torres Strait Islander children the average rates of immunisation for 1-year old (fully immunised) in the HNECC PHN region were above the state rate (95.04%; and 94.39%, respectively). Among 2-year-olds (fully immunised) were slightly above the state rate (93.37%; and 93.01%, respectively). And for 5-year-olds (fully immunised) in the HNECC PHN region were above the state rate (98.34%; and 97.65%, respectively).
SEE ALSO *'First Nations Child, Maternal and Family Health'*

By mid-2017, in the HNECC PHN region HPV coverage for females aged 15 years was 85.5% and for males was 81.6%, both higher in comparison to the state rate (NSW 83.0%; and 78.2%, respectively).

High rates of smoking during pregnancy

Smoking during pregnancy is associated with greater risk of maternal and infant complications. In 2019, 14.7% of women in the HNECC PHN smoked during pregnancy this was higher than the NSW average at 8.8%. Between 2016-18 there was an observed increase in the proportion of women who smoked during pregnancy in the HNECC PHN region from 13.8% (2016); 14.3% (2017) to 15.4% (2018). This rate decreased slightly in 2019 to 14.7%. Between 2017-19, 22 out of the 23 LGAs within the HNECC PHN region had rates of maternal smoking in pregnancy higher than the state average (NSW 8.9%). Tenterfield LGA had the highest proportion of maternal smoking in pregnancy within the HNECC PHN region at 52.5%, which was more than five times the state rate.

SEE ALSO *'First Nations Child, Maternal and Family Health'*

Poor health and developmental outcomes for infants and young children

In 2014-16 within the HNECC PHN region the infant and young child (less than 5 years) mortality rate was 5.0 deaths per 1,000 live births, substantially higher than the Australian average (3.9). 13 out of 15 SA3's recorded higher rates than the national averages, including: Taree-Gloucester (8.8); Great Lakes (7.0); Inverell-Tenterfield (6.6); Newcastle (6.4); Tamworth-Gunnedah (5.7); Upper Hunter (5.6); Lower Hunter (5.4); Maitland (5.4); Armidale (5.0); Port Stephens (4.9); Wyong (4.8); Lake Macquarie- West (4.3); and Moree-Narrabri (4.0).

In 2017-18, the rate of perinatal deaths was 10.7 per 1,000 births in the HNECC PHN region, this being higher than the national average (Australia 9.5 per 1,000). Within the same year, the rate of stillbirths within the HNECC PHN region was 7.7 per 1,000 births, once again higher than the national average (Australia 7.0). In 2017-18, the rate of neonatal deaths 3.1 per 1,000 births in the HNECC PHN region (Australia 2.5).

This was also highlighted in stakeholder consultation which identified the HNELHD Peel sector and New England region experiencing higher than average perinatal mortality rates.

The Australian Early Development Census collects data on children in their first year of school focusing on: language and cognitive skills; communication skills and general knowledge; emotional maturity; physical health and wellbeing; and social competence.

Results of this instrument predict health and wellbeing later in life. In 2018, in the HNECC PHN region one in five (20.8%) children in their first year of school were considered developmentally vulnerable this being higher than the state rate but lower than the national rate (NSW 19.9%; Australia 21.7%). This is an increase across the region since 2015 (19.7%) (NSW 20.2%: Aust 22.0%). In 2018, LGAs with higher than the Australian average included: Armidale regional (24.9%); Cessnock (23.4%); Glen Innes Severn (30.9%); Gwydir (24.2%); Inverell (22.2%); Liverpool Plains (22.1%); Mid-Coast (23.7%); Moree Plains (36.5%); Tamworth Regional (23.5%); Tenterfield (37.5%); Uralla (21.9%); and Walcha (30.6%).

The PHNs Mental Health and Suicide Prevention Regional Plan identified that within the PHN region 9.6% of children are developmentally vulnerable on two or more domains, a rate the same as NSW. There are 3 LGAs within the PHN region that have close to or more than double the proportion of children who are developmentally vulnerable on two or more domains Gwydir (17.6%), Moree Plains (18.8%) and Walcha (18.2%).

In 2018, the rate per 1000 population of children and young people in statuary out of home care for Central Coast (14.1) and Hunter New England (13.8) were third and fourth highest of all NSW districts, with First Nations children relatively more likely to experience out of home care.

Youth health needs

In 2019, 12.1% of the population of the HNECC PHN region were aged 15-24 years (NSW 12.8%) with 82.3% of earning or learning (NSW 85.0%). In 2020, there was a high proportion of HNECC PHN population aged 16-21 receiving an unemployment benefit (13.0%) compared to the state rate (NSW 8.1%).

Suicide and risky drug and alcohol use amongst youth are a concern for communities across the HNECC PHN region. Feedback from stakeholders in Moree, Narrabri and Inverell and surrounding communities indicate that youth health is being impacted by child sexual assault; child protection issues; online bullying; homelessness; domestic violence; drug and alcohol use; and truancy. In 2018-19, in the HNECC PHN region the rates of intentional self-harm hospitalisations for young people aged 15-24 years (males, 214.6 per 100,000 population; females 471.9) were higher than the NSW averages (males 130.6; females, 326.0) and the averages for all ages in the region (males, 98.2; females, 179.8).

The rate of intentional self-harm hospitalisations is also much higher amongst Aboriginal and/or Torres Strait Islander people. In 2019-20, across Australia, the highest rate of hospitalised intentional self-harm for Indigenous Australians was those aged 15-19 years old (772 hospitalisation per 100,000 population). The highest rate for non-Indigenous Australians was also recorded in the 15-19 age group, however, was less than half that of Indigenous Australians (337 per 100,000 population).

In 2000-2013 in HNECC PHN, there were 78 intentional self-harm fatalities amongst people aged 24 years and younger.

Rural health Inequalities

On average, people living in rural and remote locations experience poorer health outcomes and shorter life expectancy than those living in metropolitan areas. People in regional and remote areas are more likely to: smoke daily; be overweight or obese; be insufficiently active; drink alcohol at harmful levels; and have high blood cholesterol. Socioeconomic disadvantage is often higher within these areas, reduced access to fresh food, levels of health literacy lower and often limited opportunities for education, training and work for young people. The environment impacts industry, livelihood and mental health. This is often seen in times of drought and economic instability. Rates of injury and accidents are higher due to types of industry (farming) and risky social behaviours. Travelling long distances, often in poor road conditions can lead to higher rates of accidents.

In 2019, in the HNECC PHN region, there was a slightly higher proportion of people living in inner regional areas and a slightly lower proportion of people living in major cities compared to 2016. In 2019, 64.7% (65.4% in 2016)

of the HNECC region lived in major cities, 26.2% (25.0%) lived in inner regional areas, 9.0% (9.4%) lived in outer regional areas and 0.2% (0.2%) lived in remote areas.

Of the eight LGAs in the HNECC region with 100% of the population living in outer regional or remote areas, all but one rated higher than the HNECC average for self-assessed fair or poor health, all but two had a rate of diabetes mellitis higher than the HNECC average, and all but one had a rate of low birthweight babies higher than the HNECC average.

The Rural Communities Project delivered in Glenn Innes Severn and Tenterfield LGAs identified through the project evaluation that both LGAs experienced:

- High levels of socioeconomic disadvantage
- An aging population
- A higher proportion of people with disabilities and care and chronic disease in comparison to NSW average
- Lack of engagement with preventative health measures such as breast and bowel cancer screening
- High rates of health risk factors such as obesity and alcohol misuse and low levels of health literacy
- Very high rates of moderate to severe mental illness
- Higher than average rates of Indigenous disadvantage

In the recent "Have Your Say Community Survey, 2021" community members ranked rural health issues as the **third highest health concern** for the community.

High proportions of people with severe disability and carers

In 2016, 6.6% of the population had a severe or profound disability (NSW 5.6%). 16 of the 23 LGAs within the HNECC PHN region reported a higher proportion of people with a severe or profound disability than the state average. 12.6% of people aged 15 years and over provided unpaid assistance to persons with a disability (NSW 11.6%). LGAs with above average proportions of unpaid carers than the PHN region included Dungog (13.5%), Glen Innes Severn (12.7%), Inverell (13.0%), Lake Macquarie (13.6%), Maitland (12.9%), Mid-Coast (13.8%), Port Stephens (12.8%), Tenterfield (12.8%) and Uralla (13.9%). In the Armidale, Glen Innes and Tenterfield communities there is reportedly a lack of support for young carers of family members experiencing mental illness. Further to this the Gloucester Local Community Plan reported that 6.4% of their LGA reported needing help in their day to day lives due to a disability.

Stakeholder consultation also noted that there was severe shortage of carers within the Gunnedah region.

The PHNs Mental Health & Suicide Prevention Plan identified that adults with a disability experience higher rates of psychological distress than people without a disability. Nationally, in 2017-18, 32% of adults with a disability were likely to experience a high or very high level of distress compared to only 8% of people without a disability.

Stakeholders report concerns about the lack of availability of training for people who work with people with a disability in early detection of health problems. Upskilling is needed for a range of personnel who deliver in-home services and basic preventative screening in areas of early identification, particularly in skin and foot problems, medication management and food safety.

Stakeholder concerns also include negative experiences with the NDIS, with more severely disabled clients struggling with the paperwork required for NDIS applications. Other concerns include problems navigating the NDIS and ACAT process requiring social workers to help navigate the system (however, social workers are unable to bill via Medicare). Further NDIS funding issues were raised for travel under the NDIS creating disadvantage for clients in rural and remote areas.

Increasing prevalence of dementia

An ageing population presents increased health needs particularly related to dementia, with the rates of dementia predicted to rise. Primary health care plays a key role in early detection and diagnosis of dementia, and in the management, support and referral for people with dementia and their families.

In 2019, dementia, including Alzheimer's disease, overtook lung cancer as the second leading cause of death for men and remained the leading cause for women nationally. The rate of hospitalisations per 100,000 for dementia as a principal diagnosis or as a comorbidity for people aged 65 years and over in HNECC PHN region was 1,351.2, which was lower than the NSW rate of 1,611.0. The HNECC rate for both females and males and the rate for all HNECC LGAs was below the state rate. However, while the state rate of hospitalisations for both males and females decreased between 2017-18 and 2018-19, the HNECC rate for both males and females increased over the same period. In 2021, the Federal Electorate of Lyne estimated 4,981 people with dementia, this being the second highest dementia prevalence estimate per commonwealth electoral division in NSW.

Dementia has a deep impact on Aboriginal and Torres Strait Islander people and communities. From receiving a diagnosis, to accessing health and aged care services, Indigenous Australians often face additional challenges. There are also gaps in our understanding of dementia in Indigenous Australians, including lack of national Indigenous representation in key data, and limited data on Indigenous-specific services. Whilst PHN level data is not available, in 2018 dementia prevalence was estimated to be 2–5 times higher among Aboriginal and Torres Strait Islander people than among non-Indigenous people. Furthermore, Indigenous Australians experience many risk factors for dementia (such as heart disease, diabetes, and tobacco use) at higher rates than non-Indigenous people. During 2017-19, 314 Indigenous Australians died due to dementia (196 women and 118 men), with dementia reported as the fifth leading cause of death among Indigenous Australians aged 65 and over.

In June 2020, 52.3% of people using permanent residential care in Hunter New England and Central Coast PHN had a diagnosis of dementia, which is slightly more than the rate reported in 2019 (49.9%).

Community consultation identified that Dementia was a concern for an ageing population in Tamworth.

High rates of overweight and obesity

Being overweight or obese is a risk factor for many health conditions, including chronic disease, and associated preventable hospitalisation. Rates of overweight and obesity are concerningly high in the HNECC PHN region.

In 2019, in the HNECC PHN region, 29.7% of adults were overweight (NSW 32.8%) and 29.2% of adults were obese (NSW 22.4%). Within the HNECC PHN region rates of overweight adults have decreased over time (2017, 34.3%; 2018, 35.6%) whereas obesity rates in adults have increased over time (2017, 24.4%; 2018, 27.0%). A similar trend has been observed at a state level for obese adults (2017, 21.0; 2018, 21.4) but there has been little change at a state level in the rate of overweight adults.

In 2017-18, in the HNECC PHN region, 17.1% of children aged 2-17 years were overweight (NSW 17.0%) and 9.2% were obese (NSW 7.4%). Within the HNECC PHN region rates of both overweight and obesity have increased over time for children aged 2-17 years in comparison to 2014-15 rates (overweight 15.7%; and obese 8.0%). A similar trend has been observed at a state level for overweight children aged 2-17 years but there has been little change at a state level in the rate of obesity in children. LGAs with higher than NSW average rates of overweight children include Narrabri (20.6); Moree Plains (20.0); Gunnedah (18.0); Liverpool Plains (18.0); Tamworth Regional (18.0); Central Coast (17.7); Walcha (17.5) and Upper Hunter Shire (17.2). All LGAs in the HNECC PHN region reported higher rates of childhood obesity than the NSW average (7.4).

Without further action, Australia faces a future of more weight related chronic diseases, and early death, greater vulnerability to infectious disease, and huge costs to health care, economic development, and community wellbeing. The COVID-19 pandemic has revealed that people with obesity or chronic diseases get sicker and are more likely to die from infectious diseases.

Living with overweight or obesity can have major impacts on a person's life. It can affect a person's health and wellbeing, including their mental health, and their social and economic opportunities. Obesity is a major cause of preventable chronic diseases, including heart disease, type 2 diabetes and some forms of cancer.

Stakeholder consultation identified the following areas of Obesity as a concern:

- Overweight and obese youth aged between 16-25 years within the PHN region
- Unhealthy lifestyles as a contributing factor to obesity within the PHN region for both children and adults
- Obesity and overweight as an issue for men and contributing to heart disease
- Obesity and overweight contributing to an increase in many health issues within the community
- Obesity as an issue for the Tamworth region with lifestyle issues as a contributing factor according to community perception

People with disability are more likely to be overweight or obese than people without disability. Nationally, in 2017-18, 71.6% of people aged 2 years and over were overweight or obese compared to 54.8% of people without disability. People aged 65 years and over with a disability were more likely to be overweight or obese than people aged less than 65 years with a disability (72.7%; and 52.7%, respectively). Adult males with a disability are more likely to be overweight or obese than females with a disability (80.2%; and 71.4%, respectively). In HNECC PHN, 6.6% of the population have a severe or profound disability.

According to stakeholders in the recent "Have Your Say Stakeholder Survey, 2021" unhealthy lifestyles were ranked as the **third highest health concern** for the communities that stakeholders operate in.

High rates of physical inactivity and poor nutrition

High rates of physical inactivity and poor nutrition in the HNECC PHN region, are contributing to high rates in chronic disease, potentially preventable hospitalisations and premature mortality. In 2019 in the HNECC PHN region only 38.1% of people aged 16 years and over consumed the recommended daily consumption of fruit and 7.6% consumed the recommended daily consumption of vegetables (NSW 40.6% and 6.3% respectively). Rates of adequate fruit and vegetable consumption has decreased since 2017 in our region, where recommended intake was 44.8% for fruit and 9.3% for vegetables in people aged 16 and over. A similar trend is observed in recommended daily fruit consumption at a state level since 2017 (NSW 46.4%).

In 2019, in the HNECC PHN region 39.9% of people were insufficiently physically active (NSW 38.5%). The rate of people insufficiently physically active has improved over time in our region. In 2017, 46.3% of people aged 16 years and over were insufficiently physically active. A similar trend is observed at a state level (NSW 41.6% in 2017).

Identified barriers to a healthy lifestyle in the HNECC PHN region include cost of healthy food; easy access to fast foods; fast food advertisement; limited healthy takeaway options; awareness of where to shop; cooking knowledge; limited areas designated for exercise; knowledge of gyms; feeling unsafe exercising; and hours of work. Poor nutrition, and physical inactivity have been identified by stakeholders as contributing to the poorer health status of the Aboriginal and Torres Strait Islander population in the HNECC PHN region.

Stakeholder perception indicated that food and nutrition play a vital role in majority of health concerns throughout the PHN region, and that physical inactivity is intertwined with poor mental health, increased co-morbidity development, and reduced life expectancy, all of which are a burden on the health system. Further to this, community consultation noted a need for safe walking tracks, local parks, curb and guttering on all streets to lead towards a healthier and more physically active community.

In 2017-18, nationally 71.7% of people aged 18 and over with a disability living in households and 82.7% of people with a severe or profound disability did not meet recommended levels of physical activity, compared to 49.5% of people without a disability. In HNECC PHN, 6.6% of the population or 1,150,365 people have a severe or profound disability.

Females aged 18 and over with a disability were less likely to meet recommended levels of physical activity compared to males (25.3%; and 32.1%, respectively).

Older people aged 65 and over were less likely to meet recommended levels of physical activity compared to younger people aged 15 to 64 (17.2%; and 35.3%, respectively). Disability groups most likely not to meet recommended levels of physical activity were among adults with head injury, stroke or brain damage (17.4 % compared to 71.7% across all disability groups).

Nationally, in 2017-18 people aged 18 to 64 with a disability are less likely than people aged 65 and over to meet recommended guidelines for fruit consumption (44.3%; and 59.4%, respectively). Females are more likely to meet the recommended guidelines for fruit consumption compared to males (55.1%; and 43.9%, respectively). The least likely disability group to meet the recommended guidelines for fruit consumption is intellectual disability (42.5%) followed by psychological disability (44.2%) when compared to other disability groups.

High rates of smoking

There are high rates of smoking in the HNECC PHN region, contributing to chronic diseases such as COPD and cancer, and associated potentially preventable hospitalisations and premature mortality. The World Health Organisation highlights tobacco use as the single greatest avoidable risk factor for cancer mortality worldwide and kills more than 8 million people each year, from cancer and other diseases. In 2019, 17.9% of adults in the HNECC PHN region were current smokers (NSW 15.5%). Rates of smoking in adults have increased since 2017 (15.2%); 2018 (15.0%). At the NSW level, rates of smoking increase with remoteness and socioeconomic disadvantage. Further in 2018-19 in NSW, Aboriginal and Torres Strait Islander people are more than twice as likely to smoke than non-Aboriginal people (26.4% and 10.1%, respectively). This is identified as contributing to the poorer health status of Aboriginal and Torres Strait Islander population in the HNECC PHN region. People experiencing mental illness are also twice as likely to smoke as those without, and despite a similar readiness to quit are less likely to have access to smoking cessation resources or treatment.

Higher smoking rates were recorded in people with a disability compared to people without. Within Australia in 2017-18, 18.7% of people aged 18 years and over living with a disability were a current daily smoker when compared to 12.2% of people without a disability. Males aged 18 and over living with a disability were more likely to be a current smoker compared to females (22.8%; and 15.4%, respectively). Similarly, in people aged 18 to 64 with a disability were more likely to be a current daily smoker compared to people without (25.3%; and 8.2%, respectively).

High rates of chronic disease

Chronic diseases are conditions with long lasting and persistent effects. There are 10 major chronic condition groups reported these include: Arthritis, Asthma, Back pain, Cancer, Cardiovascular disease, Chronic obstructive pulmonary disease, Diabetes, Chronic kidney disease, Mental and behavioural conditions, and Osteoporosis. In 2017-18, 1 in 2 Australians (47%) had 1 or more of these 10 conditions. Chronic diseases are leading to increased premature mortality and hospitalisations in the HNECC PHN region. In 2019-20, 57.9% of adults reported having a long-term health condition in the HNECC PHN region, higher than the national average (51.6%).

Diabetes. In 2018-19, there were 905 new cases of Type I diabetes diagnosed in the HNECC PHN region at a rate of 76.5 per 100,000 (NSW 49.7) and 1,972 new cases of Insulin treated Type II diabetes at a rate of 111.7 per 100,000 (NSW 100.5). Since 2017-18 within the HNECC PHN region, the rate for both Type I and Type II diabetes has increased (76.0; 105.4, respectively). A similar trend has been observed at a state level for both Type I and Type II diabetes in 2017-18 (NSW 48.8; 89.6, respectively).

In 2019, 13.2% of adult males and 11.5% of adult females reported diabetes or high blood glucose within the HNECC PHN region, slightly higher than the state averages (NSW males 12.3%, females 10.3%). There were 678 diabetes-related deaths in the HNECC PHN region in 2018 at a rate of 33.6 per 100,000 (NSW 27.6). In 2017-18, all LGAs in the HNECC PHN region except for the Central Coast LGA recorded rates of diabetes-related deaths higher than the NSW average (28.6). The highest rates were in Cessnock (46.2); Maitland (41.5); Mid-Coast (38.7); Singleton (37.2); Newcastle (36.5); Dungog (36.0); Gunnedah (36.0); and Glen Innes Severn (35.9).

The rate of hospitalisations for diabetes in the HNECC PHN region was 199.5 per 100,000 in 2018-19, which was higher than the NSW average (162.5). In 2018-19, the hospitalisation rate for Type I diabetes in the HNECC PHN region (76.5 per 100,000) was higher than the NSW average (49.7). In 2018-19, all 23 LGAs within the HNECC PHN region recorded higher rates of Type I diabetes hospitalisation than the NSW average and all LGAs except for Port Stephens; Lake Macquarie and Singleton reported higher rates of Type II diabetes hospitalisations. Inverell LGA (215.5 per 100,000) recorded more than double the rate of the total NSW average (100.5).

There is increasing concern that rural areas have a lower proportion of services to address and treat Diabetes compared to the major and inner regional areas of the HNECC PHN region. Stakeholder consultation highlighted that Diabetes is a concern for the community, particularly in the Moree Plains region. Further to this, the following was noted as concerns for Diabetes according to stakeholders:

- Alcohol consumption is a growing concern in the rural and remote areas leading to weight grain and Diabetes
- More funding is needed for school and education programs on Diabetes
- A low ratio of Diabetes specialists in the rural and remote areas
- Food security stress is a major barrier to rural and remote areas which poses challenges towards making healthy lifestyle changes to reduce complications from Type 2 Diabetes

People born in some non-English speaking countries are more likely to have diabetes or high glucose compared to all NSW residents. 0.2% of the HNECC PHN population were born in Italy. The prevalence of diabetes or high glucose in this population group is 23% compared 9% for all NSW residents. People born in Italy have some of the highest rates of episodes of admitted patient care per 1,000 persons for diabetes.

Respiratory Disease. Rates of childhood asthma in the HNECC PHN region in 2018-19 were higher than the NSW average, with 20.9% of children having ever had asthma (NSW 20.6%) and 14.6% with current asthma (NSW 12.9%).

In 2018-19, within the HNECC PHN region the rate of COPD was 236.1 per 100,000 population, higher than the NSW average (201.6). The COPD related hospitalisation rate per 100,000 population for the HNECC PHN region remains higher than the NSW average in 2018-19 (257.0 compared with 224.8). The HNECC PHN COPD related hospitalisation rate per 100,000 population decreased from 275.7 in 2017-18 to 257.0 in 2018-19, which also occurred at the NSW level (NSW 235.3 to 224.8, respectively).

Between 2017-19, the top five highest rates of COPD related hospitalisations per 100,000 population for LGAs across the HNECC PHN region include: Moree Plains (700.8), Inverell (474.3), Gunnedah (424.9), Gwydir (408.5), and Liverpool Plains (393.8).

The rate of deaths from COPD in 2017-18 in the HNECC PHN region was 31.2 per 100,000, which is higher than the NSW average (22.7). Data from general practices across the HNECC PHN region collected through the PATCAT tool indicates that as of

September 2020, 4.0% of non-Indigenous and 4.1% of Aboriginal and/or Torres Strait Islander patients aged 16 years+ have COPD (diagnosed or indicated) *.

Circulatory Disease. The rate of deaths from circulatory disease in 2017-18 in the HNECC PHN region (154.5 per 100,000), was also higher than the NSW average (130.7). The rate of deaths from circulatory disease within the HNECC PHN has decreased since 2016-17 (158.9 per 100,000), with a similar trend observed in NSW (141.6). Stakeholders in the New England region have expressed concern about the higher-than-average circulatory disease mortality rates in the Tamworth Regional LGA. Data from general practices across the HNECC PHN region collected through the PATCAT tool indicates that as of September 2021, 8.9% of non-Indigenous and 6.2% of Aboriginal and/or Torres Strait Islander patients aged 16 years+ have a recorded diagnosis of cardiovascular disease*.

Other.

PATCAT data also indicates that 9.6% of non-Indigenous and 7.1% of Aboriginal and/or Torres Strait Islander patients aged 16 years+ in the HNECC PHN region have a diagnosis of chronic kidney disease (diagnosed and indicated) on record*.

*HNECC PATCAT data does not provide a complete picture of disease in the PHN region but includes characteristics or a profile of patients who attend General Practices in the HNECC PHN region. HNECC PATCAT data is drawn from around 70% of General Practices in the region, representing over 1.2 million 'active' patients (who have visited their General Practice 3 or more times in the past 2 years). Consequently, HNECC PATCAT data does not represent the prevalence or incidence of a disease in the region but is a good indication of the burden of disease experienced in General Practices.

High cancer incidence and mortality

In 2017, in the HNECC PHN region, the incidence rate for all cancers for males was 601.2 per 100,000 population (NSW 549.7) and for females was 444.3 per 100,000 population (NSW 424.0). The most common cancer types (proportion of cases) between 2013-17 included: prostate (14.7%), Melanoma of skin (12.2%), Breast (11.7%), Lung (9.1%), and Colon (8.4%).

In 2017, in the HNECC PHN region, the mortality rate for all cancers for males was 208.3 per 100,000 population and for females was 132.8 per 100,000 population (NSW 182.5, and 118.1, respectively). In 2013-17, compared to the NSW average, the HNECC PHN region experienced significantly higher incidence of the following cancers: respiratory; bowel; prostate; head and neck; skin; Lymphohematopoietic; Leukaemia; and cancer unknown primary. Significantly higher morality was reported for the following cancers: respiratory; Upper gastrointestinal; bowel; prostate; head and neck; skin; skin non-melanoma; and cancer unknown primary. As many as one third of cancers are attributable to modifiable behaviour, such as smoking, overweight or obesity, unhealthy diet, physical inactivity and risky alcohol consumption. There is an identified need for prevention in the community and the facilitation of early screening and detection within primary health care.

In 2015-16, the HNECC PHN cervical screening participation rate was 57.6%, with eight LGAs reporting participation rates below the NSW average (55.3%): Cessnock (50.7%), Dungog (55.2%), Liverpool Plains (49.6%), Mid-Coast (54.2%), Moree Plains (51.2%), Muswellbrook (50.7%), Narrabri (46.3%), and Tenterfield (43.3%). Reliable data on participation in cervical screening by Aboriginal and Torres Strait Islander women is unavailable, however available evidence suggests that Aboriginal women are under-screened, with estimates of screening rates as much as 18% below the average for that particular region.

In 2019-20, breast screening participation rate was 55.1% for target age group 50-74 years in the HNECC PHN region (NSW 49.4%). Within the HNECC PHN region two LGA recorded participation rates below the NSW average, these include the Central Coast (46.4%) and Moree Plains (47.0%). Breast screening amongst CALD women in the HNECC PHN region is lower (42.6%) than the general population, but higher than the state average for CALD women (NSW 39.3%). Screening amongst Aboriginal and Torres Strait Islander women in the HNECC region is also lower than the general population at 50.4%, but higher than NSW average for Aboriginal and Torres Strait Islander women (NSW 44.0%). Low breast screening rates within Aboriginal and Torres Strait Islander communities has been attributed to low levels of health literacy and cultural barriers.

In 2016-17, the National Bowel Cancer Screening Program (NBCSP) participation rate for the HNECC PHN region was 40.9%, with screening rates below the NSW average (38.3%) recorded in: Cessnock (37.9%), Gunnedah (36.9%), Moree Plains (30.3%), Muswellbrook (36.0%), Narrabri (33.1%), Singleton (37.1%), and Tenterfield (36.3%) LGAs. The NSW Bowel Cancer Screening Program aims to increase participation to 60% by 2025. There are multiple avenues for participation in bowel cancer screening, including through GPs, NBCSP, pharmacies and NGOs. These do not all provide participation details to the national register, and it is therefore impossible to determine the true screening participation rate.

Data from General Practices in the HNECC PHN region in September 2021 indicate that the most common cancer diagnosis for patients attending those practices is Melanoma (1180 patients per 100,000), Breast Cancer (1057), Prostate cancer (969), and bowel cancer (712). Cancer was diagnosed at significantly lower rates in Aboriginal and/or Torres Strait Islander patients

compared to non-indigenous patients. The most common cancer diagnoses for Aboriginal and/or Torres Strait Islander patients were breast cancer (457 patients per 100,000), bowel cancer (302) and Melanoma (293). Melanoma was diagnosed at a significantly higher rate in non-indigenous patients at 1294 patients per 100,000 (4.4 times higher), as was breast cancer (1140 patients per 100,000, or 2.5 times higher).

In 2017 the HNECC PHN region was identified as having only 16% of patients who were diagnosed with lung cancer being diagnosed at an early stage. This region was the worst performing when compared to the remainder of NSW. Early diagnosis and provision of appropriate, evidence-based treatment are critical to improving outcomes for people with lung cancer.

Poorer health outcomes for people experiencing homelessness

People experiencing homelessness are among Australia's most socially and economically disadvantaged. Homelessness can result from many factors, such as whether a person is working, experience of family and domestic violence, ill health (including mental health) and disability, trauma, and substance misuse. Ill-health can contribute to homelessness; however, homelessness also causes illness and can exacerbate pre-existing conditions. Homeless people are at increased risk of chronic and infectious diseases, with reduced access to primary care. As reported by the ABS 2016 Census, more than 116,000 people were estimated to be homeless in Australia in 2016, 58% were males, 21% were aged 25-34 and 20% identified as Aboriginal and Torres Strait Islander Australians.

There were an estimated 3,751 homeless people in the HNECC PHN in 2016, which represents an increase of 18.10% since 2011. This is higher than the national increase since 2011 (13.70%) but lower than the NSW increase (37.30%). The homelessness rate per 10,000 of the population for the HNECC PHN in 2016 was 30.10, compared to the NSW rate of 48.72 and the national rate of 49.80.

LGAs with the highest number of homeless people included Central Coast LGA (1,031), Newcastle LGA (797), Lake Macquarie LGA (403), Armidale Regional LGA (259) and Mid-Coast (210). While PHN level data was unavailable, data on homeless people in NSW in 2016 indicates:

- 58.2% were born in a country outside Australia
- 5.0% had a need for assistance with core activities (16% "Not stated")
- 6.0% identified as Aboriginal and/or Torres Strait Islander (11.0% "Not stated")
- 60.0% identified as Male; 40.0% identified as Female
- 11.0% were under the age of 12 and 7.0% were 65 years and over

On a local level, as of early October 2021, the Hunter New England Local Health District were assisting 147 clients in temporary accommodation. Of these approximately:

- 120 were located in the Newcastle LGA
- 26 were classified as Rough Sleepers
- 60% were male and 40% female
- 15% were between 18-24 years old
- 30% were between 25-34 years old
- 35% were between 35-44 years old
- 20% were between 45-54 years old
- Less than 2% were aged 55+ years

Being homeless puts an individual at increased risk of many health problems including psychiatric illness, substance use, chronic disease, musculoskeletal disorders, skin and foot problems, poor oral health, and infectious diseases such as tuberculosis, hepatitis C and HIV infection. Overcrowded living environments have been found to lead to negative health outcomes, such as chronic ear infections, eye infections, skin conditions, gastroenteritis, respiratory infections, and exacerbation of family violence and mental health issues.

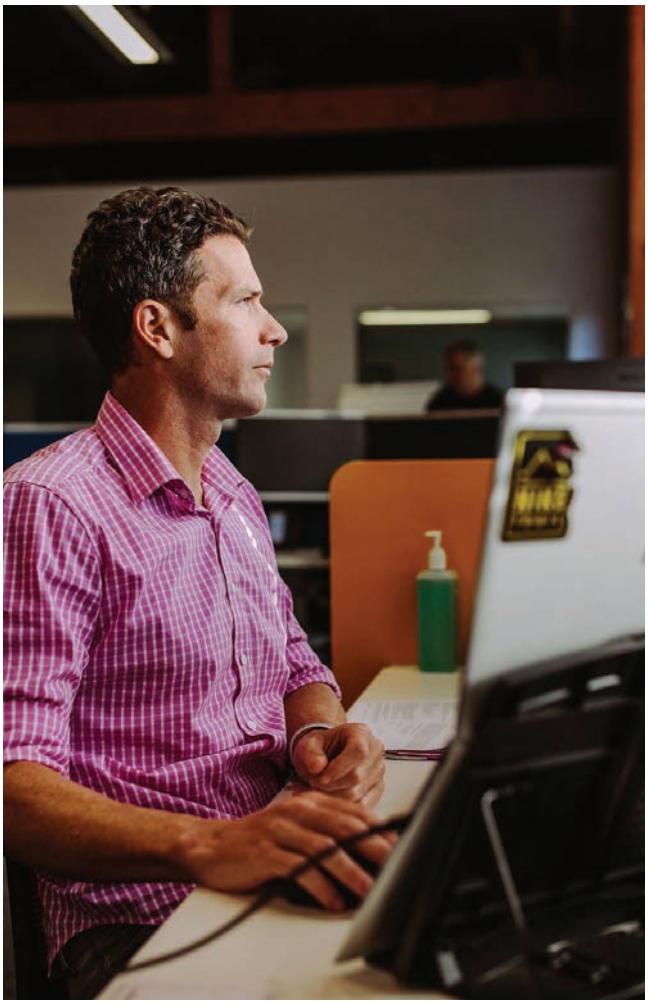
According to local Newcastle stakeholder organisations, people who experience homelessness have health needs in mental health support, bulk billing GP services, disability supports and other supports to maintain tenancies along with daily activities. Further to this, within Newcastle LGA, of identified people experiencing homelessness, 82% indicated mental health issues, 70% of people experiencing homelessness are males, and families were also identified as experiencing homelessness within Newcastle LGA. There were 16% of people who identified as First Nations experiencing homelessness. 73% of people experiencing homelessness within Newcastle LGA, identified their main source of income as Unemployment Benefit or Disability Support. Other forms of income include Age Pension, parenting Payment, Family Tax Benefit as well as employment or cash jobs.

Mental health is a high need for people experiencing homelessness. According to stakeholders in the recent Have Your Say Stakeholder Survey, 2021, those who are

homeless and have severe mental illness have difficulty in accessing services. This is often due to transience and moving from one providers service boundary to the next in order to find somewhere to stay for the night. Further to this, stakeholders identified that people experiencing homelessness have significant difficulties with maintaining regular medication, and often are discharged from a hospital setting with advice to follow up with GP, however people experiencing homelessness often do not have a GP.

Community consultation identified homelessness as an area of concern within the Hunter Manning areas including Gloucester, Stroud, Kramback and Maitland due to people being priced out of rental housing.

Trans and gender diverse people reported higher rates of ever experiencing homelessness than cisgender people in the recent Private Lives 3 survey, Australia's largest national survey of the health and wellbeing of lesbian, gay, bisexual, transgender, intersex and queer people to date. The survey indicated that 34.3% of trans men, 33.8% of non-binary, 31.9% of trans women, 19.8% pf cisgender women and 16.8% of cis gender men reported ever experiencing homelessness.



EMERGING NEEDS

Emerging needs are those that come into view from evolving environmental factors and have various impact upon individuals and their community's health, including drought, COVID-19 Pandemic, Bushfires, floods, and industries such as agricultural, coal, cotton and other chemicals.

COVID-19 Pandemic

The COVID-19 pandemic has had both direct and indirect health effects within Australia, including numbers of cases and deaths, burden of disease, impacts on other diseases such as mental health, and changes in health behaviours. There has also been a range of impacts upon health services, with how the health system operates and its utilisation and on the social determinants of health. There were 85,392 deaths that occurred over a seven-month period between January and July 2021 across Australia. By October 2021, there were 65,876 confirmed cases of COVID-19 and 439 deaths in NSW. Population groups reported as being more affected than others in terms of numbers of cases and deaths included: people living in residential aged care facilities, health care workers, and people living in the lowest socioeconomic areas.

The indirect health effects of COVID-19 included adverse impacts on the mental health of young people with increasing level of psychological distress. Health behaviours were reported as both improving and worsening, with similar proportion of people increasing as had decreased exercise and other physical activity, and an increase in alcohol consumption compared with before COVID-19 restrictions.

With the significant events and economic impacts of Covid-19 on Australian jobs, industry and the economy. It was reported between February-November 2020, job losses in 64,000 retail and hospitality managers, 64,000 hospitality workers, and 43,000 sports and personal service workers. In June 2021, 8.2% of people aged between 22-64 years were receiving JobSeeker payment within the HNECC PHN region, this being higher than both the state (NSW 6.3%) and national averages (Australia 6.9%).

As of November 2021, 94.3% of people aged 16 years and over have received the first dose of

the Covid-19 vaccination in NSW, with 91.4% fully vaccinated. The NSW Covid-19 Vaccination rate for people aged 12-15 years having received their first dose was 80.7% with 74.2% fully vaccinated.

Community and stakeholder consultation identified the following needs and concerns regarding COVID-19:

- Concerns of COVID-19 emerging in isolated communities
- Inability to obtain preferred vaccine and insufficient supplies of preferred vaccine
- Concerns of immediate need for testing
- Concerns of not being able to visit family in hospitals during restrictions
- COVID-19 has increased the gap in accessing services for those who are already vulnerable including those with severe mental illness, people experiencing homelessness and people who are using drugs and alcohol

Drought

Australia is drought-prone, and many areas have a dry climate. Extensive periods of below average rainfall adversely affect the natural environment, having resulting effect on human health of these communities. It is reported mental health effects of people living in drought-affected areas of rural Australia had higher levels of distress than people living in urban areas, with increased risk of suicide particular reported among males living in rural areas.

Bush fires

The Black Summer Bushfires of 2019-20, were recorded as the worst bushfire season to the state of NSW, impacting 17 of the 23 LGAs within the HNECC PHN region. LGAs with the largest proportion of land burnt included 46% of Singleton LGA (2,260 sq km), 41% of Walcha LGA (2, 582 sq km) and 34% of Tenterfield LGA (2,469 sq km).

There was a variation in the estimated cost of damage to the local economies across all affected LGAs, from $163.3 million on the Central Coast equating to 1.2% of the total local economy, Mid-Coast LGA $99.2 million (3.2% of the total local economy) to Walcha LGA estimated $10 million in damage equating to 7.2% of the total local economy, and Tenterfield LGA estimated $9.7 million equating to 5.5% of the total local economy. These events result in devastating loss of life and property, as well as the destruction of environments and native wildlife across Australia.

The health impacts across NSW during the 2019-20 bushfire season highlight a clear increase in hospital emergency department presentations for respiratory problems compared to the previous year. Further data from pharmacies highlight large increase in inhalers for shortness of breath corresponding with the spread of bushfires throughout the bushfire season when compared with the same weeks in the previous year. Reports estimated following the 2019-20 bushfires more than half of Australian adults had feelings of anxiety and worry, with bushfire-related calls to Lifeline crisis support hotline increasing. Further the use of mental health related services increased in some areas associated with fire activity during the 2109-2020 Australian bushfires. During April – June 2020, there were approximately 500-600 mental health services utilised per week and 200-300 mental health services utilised per week during February 2021.

NSW Storms and Floods

In March 2021, less than 18 months after Australia was impacted by bushfire crisis, many of the same towns were affected with NSW flooding and declared disasters zones. Within the HNECC PHN region the highest total area impacted by the floods was Maitland LGA with 12% (47 sq km) of the total area flooded, followed by Newcastle LGA at 7% (12 sq km) and Port Stephens LGA at 6% (51sq km) of the total area flooded.

It is reported, health effects from storms and floods may be short-term such as physical trauma, medium term including the spread of vector-borne diseases or long-term including post-traumatic stress and depression. Further storm and flood damage to a community can restrict food available and increase food prices.

Of note, the recent HNECC PHN Market Mapping Exercise identified that there are low provider numbers across the region for disaster recovery and were service types of concern for commissioners.

Poorer health outcomes for First Nations people

More Aboriginal people live in NSW than in any other Australian state or territory. In 2016, the Aboriginal and Torres Strait Islander ERP for the HNECC PHN region was 79, 405 or 6.4%, compared to 3.3% nationally. Within the HNECC PHN region, the LGAs with the highest proportion of Aboriginal and Torres Strait Islander peoples include Moree Plains, Gunnedah, Liverpool Plains, Narrabri and Tamworth Regional.

First Nations concepts of holistic self and wellbeing are founded on the national culturally appropriate framework of social and emotional wellbeing, which recognises the influence of social, historical, and cultural determinants.

In 2015–2017, life expectancy at birth for Indigenous Australians was estimated to be 71.6 years for males and 75.6 years for females. In comparison, over the same period life expectancy at birth for non-Indigenous Australians was 80.2 years for males and 83.4 years for females. In 2015–2017, life expectancy at birth among Indigenous Australians decreased with increased remoteness, among both males and females.

In 2016-17 the hospitalisation rate for Aboriginal and Torres Strait Islander people (50,423.2 per 100,000) in the HNECC PHN region was higher compared to non-Indigenous people (34,545.2). Whilst the number of 715 health assessments being claimed is increasing across the region over time, the usage rate in 2015-16 was 25.5%, similar to the NSW average of 24.7%. In 2016, the Indigenous relative socioeconomic outcomes index for HNECC PHN was 37, this was lower than the national rate (43) but higher than the state rate (36). Indigenous areas with lower than the state rate include Gosford (15); Lake Macquarie (22); Maitland (26); Newcastle (16); Port Stephens (29); Singleton (26); Upper Hunter (16); and Wyong (23).

The spread of disadvantage suggests the need for careful health service planning in these areas, particularly taking account of issues related to accessibility, transport, awareness and affordability of primary health care services, specialist and allied health services. The poor health outcomes of the most disadvantaged members of our communities consistently emerge as a theme, and the need for action on the social determinants of health is evident.

Local stakeholders noted that social isolation, family and domestic violence, mental health and depression are issues that are facing First Nations health and wellbeing within the community. It was further noted that reducing isolation and reconnecting community members to the community and promoting social cohesion is key to wellness and participation in education and employment.

Higher rates of chronic disease amongst First Nations people

Chronic conditions are long-term health conditions that contribute to premature mortality and morbidity. People diagnosed with one or more chronic conditions often have complex health needs, poorer quality of life and die prematurely. In 2018-19, almost half (46%) of Aboriginal and Torres Strait Islander people had at least one chronic condition that posed a significant health problem in Australia. 44% of Aboriginal and Torres Strait Islander males and 47% of Aboriginal and Torres Strait Islander females were reported with one or more selected chronic condition and was higher for people living in non-remote areas (48%) than in remote (33%).

Whilst PHN level data isn't available on a state level, in 2018-19 chronic obstructive pulmonary disease (COPD) hospitalisations for Aboriginal people for all ages was 1,187.8 per 100,000 population, this was more than five times the rate than for non-Aboriginal people (203.5). COPD hospitalisations for Aboriginal people aged 65+ years, was 6109.6 per 100,000 population, this was more than four times the rate for non-Indigenous people (1258.6). In 2016-17, the rate of hospitalisations for dialysis among Aboriginal and Torres Strait Islander people in the HNECC PHN region was over four times that of non-Indigenous people (14,513.5 per 100,000 compared to 3,357.1) these rates and the substantial disparity have remained steady over time. The rate of hospitalisations for endocrine diseases amongst Aboriginal and Torres Strait Islander people in the HNECC PHN region is nearly twice that of non-Indigenous people (923.7 per 100,000 compared to 544.4). A similar trend can be observed for circulatory disease hospitalisations and for hospitalisations due to respiratory diseases where the gap between the two populations continues to widen. In accordance with this data, previously stakeholders have particularly highlighted diabetes, cancer and kidney disease as health needs for local Aboriginal communities and have called for better care coordination and improved follow up care for Aboriginal and Torres Strait Islander people with chronic disease.

Results from a HNECC PHN survey of Aboriginal health needs in 2019 found that 45% of respondents had a health condition or illness that limited their daily activity.

While not directly comparable, this result is similar to the prevalence of long-term health conditions in Aboriginal and Torres Strait Islander people reported by the ABS National Aboriginal and Torres Strait Islander Health Survey 2018-19 at a proportion of 46%. The top three health conditions/illness which limited daily activity identified by respondents to the HNECC PHN survey included diabetes (20%), hypertension (20%) and mental illness (9%).

Closing The Gap for First Nations people

Close the Gap' is a social justice campaign launched in 2007, created as a response to the Social Just Report 2005. Closing the Gap began in response to a call for governments to commit to achieving equality for Aboriginal and Torres Strait Islander people in health and life expectancy within a generation. The 'Gap' refers to the difference (gap) in health and socioeconomic outcomes between indigenous and non-Indigenous Australians.

There are many lasting impacts on First Nations health these include: distrust towards non-Indigenous people and services; experiencing judgment or racism; identity issues as Aboriginal and/or Torres Strait Islander people are not willing or afraid to identify; high rates of depression, anxiety, PTSD, suicide, chronic conditions; low health literacy; fear or shame talking about health to non-Indigenous people. These impacts can lead to non-attendance, non-health compliance and disengagement.

Multiple interrelated factors contribute to the poorer health status of Aboriginal people. There is a clear relationship between socio-economic inequalities and the health gap. An appreciation of the social determinants of Aboriginal health, including the contributions of historical factors, education, employment, housing, environmental factors, social and cultural capital and racism, is critically important to closing the gap between Aboriginal and non-Aboriginal people. Common behavioural risk factors, such as smoking, high body mass and alcohol misuse are best understood and addressed in their social context.

In April 2021 the NSW Coalition of Aboriginal Peak Organisations (CAPO) met with Aboriginal people in community engagement across nine locations across NSW to discuss the development of an NSW specific implementation plan to close the gap. Community engagement across NSW identified that to achieve real progress in Closing the Gap:

- Government had to publicly commit to a strategy to address and eliminate racism from its departments and systems
- We need to take stock of what partnerships exist with Aboriginal people, where the gaps are, and whether existing processes are working; simplify bureaucracy
- Aboriginal community-controlled sector needs simpler, more flexible and culturally appropriate contracting and processes, in addition to increased capacity
- Governments cultural competency needs to continue to expand, including Aboriginal people being well represented across all levels of government
- Self-determination needs data sovereignty and governance for Aboriginal people to own their future
- Economic independence is fundamental in changing the future of Aboriginal people

Further to this, the community engagement highlighted that the voices of Aboriginal people need to be heard; that their culture and heritage must be acknowledged, respected and protected; and that Aboriginal people are the best people to make decisions about Aboriginal people.

First Nations Child, Maternal and Family Health

Yarning circles were conducted in the Taree and surrounding communities Healing Forum and identified the following themes in relation to child and family health:

- Taree and surrounds generally have families that take pride in culture, however some participants noted that some families within the region may be culturally disconnected and don't know their story.
- It was suggested that some children within the Juvenile Justice system do not show respect for Elders, and that Elders have a key role to play in connecting children and young people with culture.
- Young people identified that they continue to face system racism in schools, from peers and some teachers, in stores, on transport and when seeking employment
- Institutional racism was cited as a factor in child removal and poor school engagement with concerns that some institutions are too quick to blame an Aboriginal or Torres Strait Islander parent rather than the system.
- Lack of cultural safety for children in care and child protection and the need for genuine trauma aware and healing informed care for children

Yarning circles from Cessnock, Kurri Kurri and surrounding communities healing forum identified a number of needs relating to children, young people and families including:

- Disconnection from culture and country and the impact this has on identity and wellbeing for children and young people
- Racism makes it difficult for children to identify and connect to culture
- High levels of child removals from local families causing children to be removed from kinship structures
- Families that are living off country are living in isolation with housing policies exacerbating family isolation

Connection to family and kin is acknowledged to underpin social and emotional wellbeing across the lifespan and across generations. First Nations people are burdened by trauma from colonisation and the ongoing transmission of trauma across generations as result of the forced removal of children from their families and communities, which contribute to poor health outcomes for First Nations people.

Healthy connections to family and kin are enabled by processes that empower cultural continuity and community control. Pathways to strengthening connection to family and kin interrupt the transmission of historical trauma, decrease stress, strengthen identity, and increase resilience. These pathways include:

- Secure and safe housing
- Healing centres
- Employment
- Cultural healing spaces for women and men
- Caring for and connecting with Country
- Cultural practices
- Intergenerational knowledge exchange
- Language use
- Connecting with skin groups
- Engagement in cultural values

In 2019, 11.8% of non-Indigenous mothers and 42.5% of Aboriginal and/or Torres Strait Islander mothers in the HNECC PHN region smoked during pregnancy (NSW 6.3% and 43.6%). In comparison to the state rate the proportion of smoking in pregnancy in the HNECC PHN region was higher for non-indigenous mothers but lower for Aboriginal and/or Torres Strait Islander mothers. A similar trend was observed in previous years.

In 2019, 10.3% of babies born to Aboriginal mothers were of low birth weight within the HNECC PHN region, compared to 6.1% of those born to non-Indigenous mothers (NSW 10.3% and 6.1%). A similar trend was observed in previous years with higher rates of low-birth-weight babies born to Aboriginal mothers compared to non-Indigenous mothers.

In 2017-18, the rate of perinatal deaths was 16.4 per 1,000 births for Indigenous women within Australia, this being nearly double that of non-Indigenous women (9.2). Within the same year, the rate of stillbirths for Indigenous women in Australia was 11.1 per 1,000 births, once again higher than non-Indigenous women (6.8). In 2017-18, the rate of neonatal deaths for Indigenous women in Australia was 5.3 per 1,000 births, higher than the rate for non-Indigenous women (2.4).

High rates of mental illness, intentional self-harm and suicide

People experience psychological distress and chronic mental illness at higher-than-average rates across the HNECC PHN region, with the most common conditions being depression, anxiety and drug and alcohol misuse. In 2017-18, in the HNECC PHN region, the rate at which adults experienced high or very high psychological distress was higher at 13.5 per 100 population than the NSW (12.4) and Australian (12.9) averages.

Since 2014-15, the rate at which adults experienced high or very high psychological distress has increased at the HNECC PHN (12.2), state (NSW 11.0) and national level (11.7). LGAs with rates of high or very high psychological stress above the HNECC PHN rate were greatest in Cessnock (16.0), Glen Innes Severn (14.8), Central Coast (13.7), Muswellbrook (14.4), Mid-Coast (14.0), Tenterfield (14.0) and Maitland (13.8).

Feedback from stakeholders regarding mental health included the importance of lifestyle factors and their impact on mental health. The Central Coast Clinical Council discussed that diet has now been officially recognised as a modifiable risk factor and treatment target for mental illness according to the 2020 Australian Productivity Commission Mental Health Report and the new Australian and New Zealand College of Psychiatrists' Clinical Practice Guidelines for mood disorders. Addressing lifestyle factors including a healthy diet is a foundational step in treatments for mood disorders.

Priority setting workshops with key stakeholders regarding mental health needs, were conducted to help inform the Mental Health and Suicide Prevention Regional Plan. The rank order from highest priority in descending order, for mental health areas and target groups across the region are as follows:

Mental Health area

1. Moderate-severe mental illness
2. People impacted by trauma
3. People at risk of mental illness
4. People with chronic disease
5. People with eating disorders

Mental Health Target Groups:

1. Children and young people
2. Aboriginal people
3. People in rural and remote areas
4. Vulnerable population groups males aged 25-65 years
5. People aged 80 years and older

Other mental health needs identified through the mental health needs assessment and discussions at priority setting workshops include:

- Mental health needs for children under the age of 12 years, as separate from those of "youth" or young people between 12 and 25 years of age.
- Excessive use of screen time and the mental and physical health impacts for the younger population
- Those who are isolated and experiencing relationship breakdowns
- People impacted by drought, fires, and COVID-19
- The impact of drug and alcohol use on mental health of individuals and communities
- Stigma associated with mental illness and preventing access to care
- Stoicism, especially in rural communities reducing help-seeking
- The impact of unemployment on mental health
- Lack of community connectedness

The premature mortality rate from suicide and self-inflicted injuries in the HNECC PHN region is higher than the NSW rate. In 2018, there were 178 suicides recorded in the HNECC PHN region, a rate of 14.5 per 100,000 population, which is higher than the rate for NSW (10.5 per 100,000). Since 2017, this rate has decreased within the HNECC PHN region (16.8) with a similar trend observed at a state level (NSW 10.7). Between 2017-18, the Central Coast LHD recorded 50 suicides at a rate of 14.8 per 100,000 and Hunter New England LHD recorded 147 suicides (16.0 per 100,000). People living in regional and remote areas and Aboriginal people have higher rates of suicide. While PHN-level data are not available, 2018 suicide rates are higher in outer regional and remote areas of NSW (16.7 per 100,000) than inner regional areas (14.4 per 100,000) and major cities (9.9 per 100,000). The greatest number of suicides in the HNECC PHN occur between the ages of 25 and 55 years, with males accounting for most deaths.

In 2018-19, the rate of hospitalisation due to intentional self-harm is consistently higher for the HNECC PHN region than NSW, with higher rates among females, and 15–24-

year age group. In 2017-19, the rates of hospitalisations due to intentional self-harm in 19 of our LGAs were significantly higher than the state (NSW 93.0), with Armidale regional LGA being more than double the state rate (196.4)

Priority setting workshops with key stakeholders for suicide prevention needs, were conducted to help inform the Mental Health and Suicide Prevention Regional Plan. The rank order from highest priority in descending order, for suicide prevention needs and target groups across the region are as follows:

Suicide Prevention Challenges:

1. Follow-up support for those with suicidal ideation
2. Follow up support after presentation for suicide attempt
3. Evidence based approaches to suicide prevention
4. Intersectoral commitment to suicide prevention
5. Community capacity to address suicide
6. Evidence based approaches to postvention

Suicide Prevention Target Groups:

1. Young People
2. Aboriginal People
3. Males 25-65 years
4. People from vulnerable population groups
5. People from rural and remote areas
6. Older males 80 years and over

All workshops identified young people as the highest priority for suicide prevention target groups. Other suicide prevention needs identified through the needs assessment and discussions at priority setting workshops include:

- People living in regional and remote areas experience higher rates of suicide and higher risk factors
- People who are isolated and experiencing relationship breakdowns
- People impacted by disasters including drought, fires, flood and the pandemic
- People affected by drug and alcohol abuse
- Lack of evidence-based suicide prevention strategies
- Lack of a systematic evidence-based postvention strategy across the region, including lack of services or awareness of available services for families, carers, friends and colleagues of people who have attempted suicide or died by suicide

People with disability experience higher rates of psychological distress than people without disability. Nationally, in 2017-18 12.7% of people with a disability aged 18 years and over were likely to experience a very high level of distress as measured by the Kessler Psychological Distress Scale (K10) compared to only 1.6% of people without disability. Psychological distress increased with severity of disability and age. 18.6% of people with severe or profound disability reported very high levels of distress. People aged 18 to 64 years with a disability were more likely to experience a very high level of distress (17.2%) when compared to people aged 65 years and over (5.4%). There are differences in the extent to which disability groups are likely to experience a very high level of distress. People with a psychological disability aged 18 years and over were the most likely disability group to experience a very high level of psychological distress, (43.6%) compared to people without (1.6%). Other disability groups which experienced very high levels of psychological distress were people aged 18 years and over with intellectual disability (30.2%) and head injury, stroke or brain damage (29.1%).

Older culturally and linguistically diverse consumers are at higher risk of mental health issues than their Australian-born peers. They are less likely to use mental health services and are more likely to present at a later stage of their mental illness. Stigma attached to having a mental health problem can lead to delays in diagnosis and treatment. Consistent with studies from other countries, Australian studies have shown that immigrant suicide rates tend to reflect the rates of their country of birth, an association that is particularly evident in males. In general, suicide rates are higher among immigrants born in countries that have higher suicide rates such as Western, Northern, and Eastern European countries, while rates are lower in immigrant groups from countries with lower suicide rates including those in Southern Europe, the Middle East, and South-East Asia.

Further to this stakeholder consultation identified that mental health had become a major concern for stakeholders over the last 10 years, across the age spectrum and that mental health is a multidimensional issue.

It was also identified that mental health and suicide are rampant within the community and that there is stigma surrounding mental health within the community.

According to stakeholders in the recent "Have Your Say Stakeholder Survey, 2021" and community members in the recent "Have Your Say Community Survey,

2021" mental health and suicide prevention was the largest overall health concern facing the community for both community members and stakeholders who worked in the community. Stakeholders also noted the Central Coast was an area of concern for suicide, and for drug dependence and domestic violence.

Mental health and suicide with drug and alcohol issues was identified as a primary concern for stakeholders engaged with the Rural Communities Project.

Mental health and suicide prevention needs of youth

Young people aged 12-25 years are a priority cohort for mental health and for suicide prevention in the HNECC PHN region. The estimated prevalence of mental illness amongst populations aged 12-25 years with moderate to severe mental illness in 2018 was 10% in the Central Coast, 9.3% in Newcastle, 9.4% in the Hunter, and 9.3% in the New England. In 2018-19, the rate of hospitalisations due to intentional self-harm in the HNECC PHN region was substantially higher for people aged 15-24 years (339.8 per 100,000) than for all ages (138.5) and was higher than the NSW average (225.9). Rates were much higher for young females (471.9) than males (214.6) within the HNECC PHN region, whilst a similar trend was observed at an NSW level, rates for young males in the HNECC PHN region were well above the state average (NSW females 326.0 and males 130.6). The high suicide related needs of youth in the region were associated with social and geographic isolation, relationship breakdown and bullying at school and through social media.

Factors such as family functioning, exposure to trauma and violence, and parental mental illness are associated with the mental health and wellbeing of children, and on their developmental outcomes. Children who are exposed to trauma and abuse in childhood are also more likely to experience mental illness as adults. Further, children who experience out-of-home care, and who are considered at risk of harm, are more likely to experience adverse mental health and developmental outcomes. In 2018, the rate per 1,000 population of children and young people in statutory out-of-home care for Central Coast (14.1) and Hunter New England (13.8) were third and fourth highest of all NSW districts, with Aboriginal children relatively more likely to experience out-of-home care.

Factors identified by stakeholders as being associated with mental illness in young people included: family dysfunction; lack of hope for future employment; lower high school retention rates; bullying at home, in schools, in sporting teams and cultural groups, particularly through social media; and social isolation

Services for people up to 18 years of age was a gap identified throughout the region, with access to child and adolescent mental health services limited to those with severe mental illness. Inpatient services for children are only available in Newcastle area, and there is a general lack of accredited psychologists available to work with children across the region. Barriers identified as impeding access to mental health care for young people included: a lack of follow-up care after a suicide attempt; stigma associated with mental illness; poor mental health literacy; long waiting lists; expensive treatment; reluctance to engage in treatment; parental stress; lack of mental health professionals to treat children; the shift to prescribing medication to address children's needs rather than considering non-pharmacologic approaches; parents / caregivers distrust of mental health providers; caregiver fear; transport issues; embarrassment; confidentiality concerns; and mistrust.

Stakeholder consultation identified that excessive 'screen time use' and social media has mental health impacts on younger generations. It was further identified in stakeholder consultation that there are increasing mental health needs for children under the age of 12. It was noted that there are severe mental health issues for youth in the Westlakes and Toronto region, with children as young as 6 and 7 needing mental health support within schools, particularly for First Nations children. Concerningly, community consultation identified that youth attempt suicide as early as 10 years old with "Pact to Suicide" an issue in the region. Suicide ideation and depression are very high within the youth community, with some stakeholders noting that the Port Stephens area has some of the highest rates of mental health issues for young people within the State.

Stakeholder consultation identified a noticeable increase in adolescent mental health and unhealthy lifestyle health related issues

Mental health and suicide prevention needs of males aged 25-65 years

Stakeholders across the HNECC PHN region consistently identified males aged 25 - 65 years as being at-risk for experiencing mental illness and as a priority population group for suicide prevention. For this cohort, stigma in accessing services and reluctance to discuss mental illness were perceived as contributing to reduced service access. Across all communities, stakeholders reported that this cohort was most likely to experience suicidal

ideation or complete suicide. The highest numbers of suicides in the HNECC PHN region were amongst people aged between 25 and 55 years, with males accounting for four in five deaths. The suicide related needs of males aged 25-45 years were identified as particularly high and were associated with social and geographic isolation, and relationship breakdown. It was identified that young men are less likely to seek help than women, potentially due to stigma and shame around help-seeking. In 2019, in Australia an average of 6.9 men died by suicide each day. Three times as many men in comparison to women took their lives in 2019.

There were 2,502 suicide deaths among males (at a rate of 19.8 deaths per 100,000 population) compared to 816 female deaths (6.3 deaths per 100,000).

Mental health and suicide prevention needs of males aged over 80 years

Males aged over 80 years were identified as a priority population group for mental health and suicide prevention in the HNECC PHN region, as this cohort reportedly commonly experience suicidal ideation or complete suicide. Contributing factors include grief and loss; adjustment to life in aged care facilities; geographic isolation; and social isolation, particularly following the death of a partner. While PHN level data is not available, in 2020 the suicide death rate for males within Australia was highest among 85+ years at 36.2 per 100,000 population (Females 6.2). Further for males aged 80-84 years the suicide death rate was 21.7 per 100,000 population.

Significant service gaps were recognised as this cohort cannot seek support through the NDIS due to the 65-year upper age limit and need to seek services through My Aged Care. Access to allied health services is available through a GP chronic care plan but is limited to five services per year, and it was perceived that older patients prioritised services such as podiatry and physiotherapy over mental health services. Residents of aged care facilities are also ineligible for services under the Better Access mental health program. Further to this, older people are less likely to seek help for mental illness due to perceived stigma, self-reliance, poor mental health literacy, lack of available transport, service gaps and a lack of professional specialisation in mental health later in life.

Mental health, suicide prevention and trauma informed needs of First Nations people

In 2016, the Aboriginal and Torres Strait Islander ERP for the HNECC PHN region was 79, 405 or 6.4%, compared to 3.3% nationally. There is limited data about First Nations suicide-related behaviour (self-harming and suicidal ideation). Most of the evidence for suicide and suicide-related behaviour in the community (suicidal attempts, suicidal ideation and self-harm) is not reported or monitored, so the national and international evidence base for suicide prevention programs and suicide prevention policy is underdeveloped.

Whilst PHN level data is unavailable, in 2018-19, 24.2% of Indigenous Australians living in Australia reported mental and behavioural conditions. In 2019, 23.7% of Aboriginal people (aged 16 years and over) in NSW experienced psychological distress (non-Indigenous 17.4%). Further in 2018-19, the rate of hospitalisations for intentional self-harm for Aboriginal people all ages were 264.6 per 100,000, substantially higher than the rate for non-Indigenous people (85.6). The rate for Aboriginal youth (aged 15-24 years) was particularly high (411.0), compared to non-Indigenous (222.8) with the rate for young females (499.5) higher than males (311.9). In 2018-19, there were 4,975 admissions for mental health related conditions in Aboriginal persons at a rate of 2,092.9 per 100,000 population (NSW 2,414.4).

Aboriginal people have higher rates of suicide. Between 2014-18, suicide rates for Aboriginal people (all ages) living in NSW are 17.7 per 100,000 (non-Indigenous 10.5), with males having higher rates of suicide than females (29.5; and 7.0, respectively) and higher rates than non-Indigenous people (males 16.3; females 5.0). Suicide rates for Aboriginal people where higher among 15-24 years old at a rate of 21.0 per 100,000, in comparison to all ages, alongside higher than the non-Indigenous 15-24 years rate (9.9).

A recent report conducted by the Australian Institute of Health and Welfare describing the connection between family, kinship and social and emotional wellbeing stated that there is a gap in research relating to the relationship between intergenerational poverty, intergenerational trauma, the disruption of healthy connections to family and suicide and suicide related behaviour. Further to this, cultural continuity or community control is recognised across the literature as central to First Nations suicide prevention and an important protective factor. Self-determination is the governing systemic principle, theory and mechanism that delivers best-practice First Nations suicide prevention programs and policy. Empowering cultural attachment, cultural connection and cultural continuity are similar forms of resilience building mechanisms that protect against suicide and suicide related behaviour.

Existing trauma and intergenerational trauma are compounded by family violence and substance

misuse as well as stress caused by personal, cultural and institutional racism, which have been linked to biological markers of stress. Further to this, the extent of family violence and the impact of family violence on women and child victims is unknown because there are many barriers to reporting family violence.

Stakeholders consider the mental health needs of Aboriginal people to be a priority across the region. The impact of inter-generational trauma on Aboriginal communities and the associated impact on mental health was perceived to contribute to a range of other associated health and social problems including drug and alcohol use, family dysfunction and domestic violence. It was perceived that there was a need for more than 12 sessions maximum available under different allied health access programs for clients who had experienced trauma and abuse, particularly Aboriginal and Torres Strait Islander clients.

Aboriginal males are less likely than females to seek help from mental health services and are more likely to contact services when they are acutely unwell. Although Aboriginal people access mental health services at a higher rate than the non-Indigenous population, there is likely to be many Aboriginal people who need services but do not access them, with underutilisation attributed to cultural inappropriateness of services.

Stakeholder consultation identified mental health concerns for First Nations people to incorporate the whole person, to consider generational trauma and that a First Nations led mental health and healing program is required within the community. It was identified in yarning circles held within Taree and surrounds that there is crossover in trauma and mental health with an increased need for young men needing extra support within this space.

Yarning circles held within the Taree and surrounds Healing Forum, identified the impacts of trauma, grief and loss on families, with concerns raised about the wellbeing of community members dealing with repeated loss. Forum participants raised concerns about the lack of service support for people dealing with grief, loss and trauma. A key gap was identified in support for mothers whose babies pass away, with them being placed in a general ward at the hospital. It was suggested that healing from trauma was necessary to reduce the misuse of alcohol and other drugs, and that drug and alcohol workers need to understand how substance misuse manifests from trauma. The yarning circles held in Taree and surrounds, as well as Cessnock, Kurri Kurri and surrounds discussed mental health and noted that there is crossover in discussion about trauma and mental health. Young people themselves identified the need for improved mental health support and advised that they need adults to check in on them daily ('We want you to walk with us'). Older participants at the forum also suggested the need for everyone to check in on each other and to see that kids and families are okay. Discussion suggested that there is a lack of awareness of trauma in the community, that many people live with undiagnosed trauma and that trauma is often misdiagnosed as depression or other mental health conditions. People identified how trauma impacts people in different ways, undermining social, emotional and mental health, with suggestions that trauma is what causes some people to live in isolation from the community. Concern was voiced about waiting lists to access mental health services.

Mental health and suicide prevention needs of older people residing in aged care facilities

The mental health needs of older people in the HNECC PHN region, and particularly older males, were frequently mentioned by stakeholders as increasing with the ageing population. The mental health needs of older people in aged care facilities were identified as significant, due to a higher risk of completed suicide than any other group worldwide. National data indicates rates of depression among people living in residential care are much higher at around 30 per cent for older adults. Factors associated with these needs included: grief and loss after the death of partner; adjustment to life in aged care facilities; loss of local community connection when the facility was located distantly to their previous home; and social and sometimes geographic isolation from family.

Stakeholder consultation identified that there was a need for low intensity mental health support for people residing in aged care facilities and that this extended to wellbeing, prevention, and early mental health intervention for older people.

Mental health and suicide prevention needs of LGBTIQA+ community members

A higher proportion of members of the LGBTIQ community meet criteria for experiencing a major depressive disorder and report high or very high levels of psychological distress, suicidal ideation and suicide attempts compared to heterosexual people, these are magnified in young people. LGBTIQ+ Health Australia, reported in a 2021 snapshot of mental health and suicide prevention statistics:

- Compared to the general population, LGBTIQA+ young people aged 16-17 years old

were almost three times more likely to have attempted suicide in the past 12 months

- 25.6% of LGBTQA+ young people aged 16-17 years had attempted suicide in their lifetime.
- LGBTIQ people are two and a half times more likely to have been diagnosed or treated for a mental health condition in the past 12 months
- LGBTI people are nearly six times more likely to experience and be diagnosed with depression
- Transgender and gender diverse people aged 14-25 years old are over seven times more likely to experience and be diagnosed with depression
- 40.5% of LGBTQA+ young people aged 14-21 years reported being diagnosed with generalised anxiety disorder
- LGBTQA+ young people aged 16-17 years old were over three times more likely (83.3%) to report high or very high levels of psychological distress compared to the general population.

According to local stakeholders, LGBTQIA+ communities have experienced increased rates of mental health due to COVID-19 and exacerbations of social isolation and feeling of uncertainties for these communities. Many people in the LGBTQIA+ community have lost jobs and needed to move, resulting in considerable loss of community support and connection. Further community consultation identified that older people within the LGBTQIA+ community living with HIV who reside in their own homes or in residential aged care facilities, are at greater risk of adverse health outcomes due to COVID-19 and are therefore harder hit by lockdowns, with social visiting schemes and home-visiting practical support services being limited or halted. LGBTQIA+ people with pre-existing mental health issues experience a lack of access or uncertainty around accessing services such as day programs, has resulted in an increase in suicidality and hospitalisation. Moreover, trans and gender diverse people experiencing a lack of community connection and social engagements are affecting community mental health, especially among trans and gender diverse people, or people of all sexualities and genders who are having to stay at home with a family that don't affirm them.

The Private Lives 3 survey, Australia's largest national survey of the health and wellbeing of lesbian, gay, bisexual, transgender, intersex and queer people, identified that more than half of participants reported high or very high levels of psychological distress during the past four weeks.

Three fifths reported having ever been diagnosed with depression and almost half with generalised anxiety disorder. Over two fifths of participants reported that they had considered attempting suicide in the previous 12 months and almost three quarters had considered attempting suicide at some point during their lives.

One in 20 reported having attempted suicide in the past 12 months and almost one third reported having attempted suicide at some point during their lives. These rates are higher than those observed within studies of the general population.

One seventh of trans men, 10.9% of trans women, 6.8% of non-binary participants, 4.2% of cisgender women and 3.3% of cisgender men reported having attempted suicide in the past 12 months. In total, 7.8% of pansexual, 6.0% of bisexual, 5.1% of queer, 4.2% of asexual, 4.1% of lesbian and 3.3% of gay identifying participants reported having attempted suicide in the past 12 months

The needs of the LGBTIQ community were identified as significant by stakeholders across the HNECC PHN region. Factors including stigma, discrimination, community and service awareness and respect were associated with higher levels of mental ill-health for this community. For people who are transgender and intersex, discrimination and stigma by service providers were identified as significant factors affecting their mental health. The mental health and suicide need of younger LGBTIQ people were also highlighted by stakeholders with factors such as difficulties in coming out, stigma, discrimination, acceptance and isolation, contributing to mental ill-health and suicide. Stakeholders reported that some services refused access or refused to acknowledge transgender people by offering gender appropriate services based on sexual and gender diversity.

People experiencing moderate to severe mental illness including psychosocial support needs

The needs of people experiencing moderate to severe mental illness included those people experiencing other complex health and social problems such as physical illness, drug and alcohol misuse, access to sustained housing, unemployment and difficulties in daily living. Providers, consumers and carers indicate that social connectedness is one of the greatest areas of need for people who are ineligible for NDIS assistance yet are experiencing severe mental illness with reduced psychosocial functional capacity.

In 2017-18, the rate at which people experienced chronic mental and behavioural disorders within the HNECC

PHN region was 22.7 per 100 population, higher than the national (20.1) and state rates (18.8) and was higher for females (24.6) than males (20.9). 20 out of 23 LGAs within the HNECC PHN region had higher rates of people experiencing mental and behavioural problems than the Australian average, these include: Armidale Regional (20.5); Central Coast (22.5); Cessnock (25.2); Dungog (21.6); Glen Innes Severn (21.6); Gunnedah (20.7); Gwydir (20.6); Inverell (25.2); Lake Macquarie (22.8); Liverpool Plains (21.4); Maitland (23.5); Mid-Coast (23.5); Moree Plains (25.2); Muswellbrook (27.6); Newcastle (23.1): Port Stephens (21.5); Tamworth Regional (21.6); Tenterfield (20.8); Upper Hunter Shire (20.5); and Uralla (21.3).

Factors contributing to the unmet needs of this priority group include access, waiting times and cost barriers for psychiatrists across communities; patient and service provider experience of the mental health line; reduced access to experienced psychologists across communities; gaps in case management and follow-up; and a lack of focus across all services on prevention and early intervention to reduce the need for more intensive services.

A recent evaluation was conducted of the Psychosocial Support Programs throughout the PHN region and indicated that clients accessing the program are likely to have very high levels of psychological distress and have a severe mental disorder. The evaluation concluded with some confidence that the target cohort is being identified, the need for the program exists and clients are accessing the program. Further to this, based on the Personal Wellbeing Index entry scores for clients accessing the program it was identified that the cohort accessing the program had subjective wellbeing scores which places them in the bottom 16% of the nation.

Further to this, a recent Market Mapping exercise for the HNECC PHN region identified that greater coordination across services and providers is needed, particularly in mental health where commissioners noted that the biggest issue in the system is the lack of coordination with people with significant mental health needs are falling through the cracks between the NDIS and psychosocial services.

Stigma associated with mental illness including help seeking

Stigma related to mental illness was identified by stakeholders across the HNECC PHN region as impacting on help seeking and engagement with services, including stigma in the general community and on behalf of service providers. SANE Australia 'A life without stigma' Survey reported almost three-quarters of respondents living with a mental illness (74%) had experienced stigma regarding their mental health. Males, particularly in rural areas, were reluctant to seek care due to the stigma associated with needing help. Stigma was also reported to be a barrier to treatment for adolescents and young people, members of the LGBTIQ community and older people. Stigma has been identified as a barrier in implementing school-based interventions and to help-seeking due to fear of being shamed or socially excluded.

Previously, stakeholders identified a need to address stigma in asking for help and concern around mandatory reporting, which are substantial barriers to help seeking for medical professionals experiencing mental illness.

Mental Health Comorbidities

Comorbidity is the presence of two or more physical or mental disorders (or diseases) in one person at the same time. Almost all people (94.1%) with a mental and behavioural condition report another co-existing long term health condition.

There is a significant gap in life expectancy between people with a mental illness and the general population, with 80% of this gap attributable to chronic diseases, many of which are preventable. Those with a severe mental illness die 10-15 years earlier.

- People with mental illness are more likely also to have a range of chronic health problems and associated risk factors compared to those without a mental illness
- While there have been improvements in morbidity and mortality indicators for chronic disease in the general population over the last few decades, this trend is not observed in people with a mental illness
- There is evidence that people with chronic diseases and mental illness have worse health outcomes, poorer quality of life and incur higher costs associated with treatment
- Stigma also impacts on access to care for chronic conditions for those with mental illness
- Substance abuse problems and mental illness account for 12% of the total burden of disease and is the leading cause of non-fatal burden
- Data from general practices across our region indicated that patients with a record of a mental health diagnosis were: 2.5 times more likely to have an asthma diagnosis; 3.3 times more likely to have a COPD diagnosis; and 2.4 times more likely to have a diabetes diagnosis
- It is estimated that 24.4% of GP patients in our region with a mental health diagnosis recorded also at least one other mental health diagnosis

Higher rates of alcohol misuse

Alcohol misuse is a concern across the HNECC PHN region and has been flagged by stakeholders as contributing to mental illness and suicide. Between 2017-18, 19.4% of persons aged 18 years and over in the HNECC PHN region consumed alcohol at levels posing lifetime risk. In 2019, 31.1% consumed alcohol at levels posing an immediate risk to health (NSW 26.7%). Compared to NSW, the HNECC PHN region has slightly higher proportions of adults drinking daily (males 12.7%, females 6.9%; NSW males 10.1%, females 4.8%), and weekly (males 44.5%, females 37.0%; NSW males 43.9%, females 34.2%). Alcohol consumption has been identified as contributing to the poorer health status of the Aboriginal and Torres Strait Islander population in the HNECC PHN region.

The proportion of the population who consumed alcohol at more than two drinks per day is higher for HNECC PHN (19.5%) compared to the State (15.5%) and national (16.15%). Five LGAs have more than 25% of their populations drinking alcohol at more than two drinks per day (Gunnedah, Inverell, Liverpool Plains, Moree Plains and Walcha). The Central Coast LHD (38.6%) and Hunter New England (36.7%) LHDs ranked second and third of all LHDs (31.5%) in NSW in the proportion of the population that drink alcohol at levels posing long-term risk to health.

In 2017-18, the rate of alcohol attributed deaths was higher in the HNECC PHN region (24.3 per 100,000) than the NSW average (20.0) and was higher amongst males (33.6; NSW 27.1) than females (15.7; NSW 13.4). Trends over time analysis highlights a consistent increase in the rate of alcohol attributed deaths for adults over three consecutive years within the HNECC PHN region (2015-16; 23.8 per 100,000; 2016-17; 24.0 per 100,000; 2017-18; 24.3 per 100,000). In 2018-19, the rate of alcohol attributable hospitalisations was lower in the HNECC PHN region (482.1 per 100,000) compared to the NSW average (523.6). A similar trend was observed in previous years with the state average consistently higher than the HNECC PHN region for over three consecutive years.

People from CALD backgrounds are less likely to misuse alcohol compared with people from English speaking backgrounds. People from CALD backgrounds (49%) are more likely to be 'abstainers/ex-drinkers' compared with primary English speakers (18.9%). While there has been significant reduction Australia-wide in the proportion of people exceeding lifetime risk guidelines between 2013 and 2016, a much greater proportion of primary English speakers (18.6%) reported exceeding the National Health and Medical Research Council (NHMRC) guidelines for lifetime risk by consuming on average more than two standards drinks per day, compared with people from CALD backgrounds (5.4%). In 2016, 10.3% of people from CALD backgrounds compared with 28% of primary English speakers reported exceeding the NHMRC guidelines for single occasion risk by consuming on average more than 4 standards drink on one occasion and doing so, at least monthly. Further, between 2013 and 2016 there was a significant reduction in people from CALD backgrounds exceeding single occasions guidelines, while the proportion for English speaking backgrounds remained stable

Factors contributing to drug and alcohol misuse in communities across the HNECC PHN region flagged by service providers include family breakdown; poor understanding of mental illness; poor understanding of drug and alcohol issues; reduced access to services; and distance to services.

According to stakeholders and community members in the recent "Have Your Say Stakeholder Survey, 2021" and "Have Your Say Community Survey, 2021" Alcohol and Drug use were the second largest health concern facing the community. This is further supported in the Rural Communities Project which highlighted that drug and alcohol use is a health concern within the Glen Innes and Tenterfield regions. Community Advisory Committee consultation also noted drug and alcohol misuse was a concern for the Mid Coast and Maitland regions. The HNECC PHN AoD Evaluation also highlighted that AoD stakeholders have identified significant AoD demand growing across all service areas.

High levels of Illicit drug use

Illicit drug use is an increasing concern for stakeholders across the HNECC PHN region and has been flagged by stakeholders as contributing to mental illness and suicide. Stakeholders have particularly identified substance misuse as an issue for the Central Coast, including increasing methamphetamine use and associated issues, and the impact of drug use on mental health and domestic violence. Drug misuse has been identified by stakeholders as a key contributing factor to the poorer health status of the Aboriginal and Torres Strait Islander population in the HNECC PHN region. In 2018-19, there were 1,555 methamphetamine-related hospitalisations in the HNECC PHN region, at a rate of 184.0 per 100,000 population, higher than the NSW average (142.7). There is an increasing trend in methamphetamine-related hospitalisations in the HNECC PHN region over time (2015-16; 152.9; 2016-17; 172.9; 2017-18; 175.9).

In 2018-19, the rate of heroin-related, emergency department presentations for persons aged 16 years and over in NSW was 1.12 per 1,000 unplanned presentations, trends over time analysis highlight an increase from the previous year (2017-18; 0.95 per 1,000). Heroin-related emergency department presentations were the highest opioid-related emergency department presentation for persons aged 16 years and over in NSW in 2018-19 (Oxycodone-related: 0.61 per 1,000; codeine-related: 0.36 per 1,000; and Fentanyl-related: 0.09 per 1,000).

Data from general practices across the HNECC PHN region indicated that 439 per 100,000 patients had a record of drug misuse. This rate was much higher for people with a record of a mental health diagnosis (1584 per 100,000) who were 3.6 times as likely to have a record of drug misuse as those without. The likelihood of comorbid mental illness and drug misuse varied by diagnosis. A record of drug misuse was 14 times as likely with a schizophrenia diagnosis recorded; 11 times as likely amongst patients with a bipolar disorder recorded; 4 times as likely amongst patients with a depression diagnosis recorded; 3.6 times as likely amongst patients with an anxiety disorder recorded; and twice as likely amongst patients with a postnatal depression diagnosis recorded.

Factors contributing to drug and alcohol misuse in communities across the HNECC PHN region flagged by service providers include family breakdown; poor understanding of mental illness; poor understanding of drug and alcohol issues; reduced access to services; and distance to services.

People from CALD backgrounds are less likely to use illicit drugs than people from English speaking backgrounds. In 2016, 16.4% of people aged 14 years and over from English speaking backgrounds were a recent user of an illicit drug, compared to 7.6% of people aged 14 years and over from CALD backgrounds. Further, in 2016, a much smaller proportion of people from CALD backgrounds reported that they had ever used an illicit drug compared with those from English speaking backgrounds (17.7% compared with 46.0%).

According to stakeholders and community members in the recent "Have Your Say Stakeholder Survey, 2021" and "Have Your Say Community Survey, 2021" Alcohol and Drug use were the second largest health concern facing the community. This is further supported in the Rural Communities Project which highlighted that drug and alcohol use is a health concern within the Glen Innes and Tenterfield regions. Community Advisory Committee consultation also noted drug and alcohol misuse was a concern for the Mid Coast and Maitland regions. The recent Have Your Say Stakeholder Survey, also noted that the Central Coast was an area with high drug dependence.

Alcohol, Other Drugs and Comorbidities

People who drink alcohol at risky levels are more likely to have high levels of psychological distress and have a mental illness. Alcohol can negatively affect thoughts, feeling and actions, and contribute to the development of, or worsen, existing mental health issues over time. Research has found that those who reported self-medicating their mood by drinking alcohol have a greater likelihood of developing alcohol dependence. Alcohol use can play a role in the development and progression of mental health conditions. Whilst PHN level data is unavailable, across Australia it is estimated at least 30-50% of people with an alcohol and/or other drug issue also have a mental health condition. Furthermore, even when consumed at low levels (one or two drinks a day) alcohol can negatively interact with the most common medications commonly prescribed for mental health conditions.

Findings from the recent HNECC PHN AoD Evaluation suggested that there is a need for continuum of care across mental health and AoD comorbidities. Mental health and AoD comorbidities were also raised as a health need from stakeholder consultation.

Service Needs

GENERAL POPULATION SERVICE NEEDS

- Limited access to dental services
- Limited capacity of services to address dementia
- Lack of prevention and early intervention services
- High rates of chronic disease hospitalisations
- Barriers to cancer screening in primary care
- Barriers to accessing disability services
- Reduced access to services for children and youth
- Limited access to after-hours GPs
- High proportions of semi-urgent and non-urgent emergency department presentations
- Reduced access to services for older people
- Reduced access to services in rural and remote areas
- Transport limitations
- Cost barriers to healthcare
- Reduced access to services for people experiencing homelessness
- Reduced access to services for culturally and linguistically diverse populations
- Access to and utilisation of Digital Health and Telehealth in Service Delivery
- A greater role for Pharmacy in delivering primary health care

FIRST NATIONS SERVICE NEEDS

- Reduced access to health services for First Nations people
- Lack of integration, flexibility and cultural appropriateness of mental health and drug and alcohol services
- A low proportion of First Nations people having a 715-health assessment
- Lack of culturally safe workplaces for First Nations workforce
- Lack of men's health services and programs for First Nations Men

MENTAL HEALTH AND SUICIDE PREVENTION SERVICE NEEDS

- Lack of integration and collaboration between mental health and other services
- Cost barriers to accessing 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 and psychologists
- 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
- Limited support for families and carers of people living with mental illness
- Lack of a systematic evidence-based postvention strategy across communities
- Barriers for mental health nurses to gain credentials to work in general practice

ALCOHOL AND OTHER DRUGS SERVICE NEEDS

- Reduced access to drug and alcohol treatment services
- Reduced access to drug and alcohol treatment services for First Nations people
- Reduced access to drug and alcohol treatment services for pregnant women and/or those with young children
- Reduced access to drug and alcohol treatment services for youth
- Reduced access to drug and alcohol treatment services for people exiting the criminal justice system
- Reduced access to drug and alcohol treatment services for people with co-occurring substance misuse and mental illness
- Lack of drug and alcohol rehabilitation services

A lack of health service integration, coordination and information sharing

Patients, health professionals and other stakeholders indicate that a lack of integration and coordination of services, including hospitals, primary care services, older person's health services in the community and in RACFs, and mental health services, and limited exchange of information across the health system is a barrier to health service access, making the system difficult for patients to navigate and affecting continuity of care. Vulnerable groups more likely to experience inequities in service provision due to lake of integration and coordination include: people experiencing mental illness; people with low health literacy; older people; Aboriginal and Torres Strait Islander people; CALD populations; youth transitioning to adult services; palliative and end of life care patients and their families and people living in regional and rural areas, where the ability to share information is hampered by poor infrastructure, including slow internet speeds or no internet at all.

General practice stakeholders have highlighted a need for support with the uptake of MyHealth Record and Secure Messaging. There is a need to reduce the fragmented nature of care for Aboriginal and Torres Strait Islander people, with specific needs including improved prenatal service coordination. enhanced care coordination and improved follow-up care, particularly for people with complex health care needs; and provision of holistic care taking into consideration mental health, physical health, disability, and social issues.

HNECC PHN conducted a survey in 2020 for Allied Health professionals to gauge usage and uptake of electronic health information and clinical systems. Clinical systems encompass platforms used to store health information, as well as electronic technologies such as telehealth (telephone and videoconferencing), secure messaging, and My Health Record. Survey results revealed 75% of respondents used an electronic clinical system to store information. However, the type of system used varied widely. This differs to general practice where a few key clinical systems are used, which enable data extraction technologies for monitoring and quality improvement. Allied Health clinical systems do not currently have a data extraction tool that enable data collection and analysis. 54% of respondents reported they were not using secure messaging systems. The main barriers to use were a lack of perceived benefits, no impetus to change current practice and a lack of compatibility with current clinical systems.

Results also highlighted challenges in ensuring safe and secure methods of telehealth videoconferencing platforms. 98% of respondents reported they were not using My Health Record.

Good patient experiences are an important component of quality health care, along with clinical effectiveness and patient safety. In 2019-20 in the HNECC PHN region, 30.7% of adults reported they could not access their preferred GP in the preceding 12 months (Australia 28.0%), 23.9% of adults felt they waited longer than acceptable to get an appointment with a GP (Australia 18.6%), and 23.8% of adults referred to a medical specialist waited longer than they felt acceptable to get an appointment in the preceding 12 months (Australia 23.3%).

Discussions at Clinical Councils and Community Advisory Committees noted a variety of issues regarding lack of health service integration, coordination and information sharing. This included:

- Lack of service integration and coordination between GPs and allied health professionals
- Further collaboration and partnering with different sectors is required and to expand beyond the LHD partnership. Aboriginal Medical Centres also need to be consulted with regarding culturally appropriate services.
- Further collaboration is required between services already available and operating within the community.
- An increase in care navigators and coordination in practices
- Services available but are not linked up and supported
- Integrated services between GPs, allied health, NGOs and the LHDs, need to be able to be accessed by a variety of people
- Agile in how care can be delivered in an integrated way that is non-siloed

Community consultation identified the need for greater communication, coordination and collaboration between the hospitals and the local community. Further to this, a recent Market Mapping exercise for the PHN region identified through interviews with commissioners that there are relatively high levels of demand for services within the PHN region, and that a lack of coordination and integration of services was a key concern. The Market Mapping exercise also indicated that the HNECC PHN region has a higher number of locally based charities/

human services providers compared to the national average, potentially indicating greater fragmentation of the provider market than other regions and may also be reflective of the large proportion of rural and remote areas within the HNECC PHN region. The Market Mapping exercise indicated that the HNECC PHN region may well be over-served by very small organisations and experience greater fragmentation of service delivery.

Greater coordination in the region is needed where government silos and poor planning have led to gaps and duplication, services with competing objectives and stewards losing sight of the users' overall wellbeing. Better planning and coordination are needed within and across governments. Greater efforts, for example, are needed to coordinate services for people with multiple and complex needs. Smoother transitions are also required. Policy reform in human services is a complex task and transitioning between providers can also be disruptive as users find new providers and build a relationship of trust with them. Governments should plan and prepare for change to preserve continuity of outcomes and minimise any negative effects on users from the transition. Information and clarity about changes in advance can help.

Further to this, the Rural Communities Project Evaluation recommended that a strengthening of community engagement was needed. It was identified that communication of health services to the community was a barrier in accessing local health services. The recommendation highlighted that building on the strength of the current community engagement approach, it is recommended formalising mechanisms for ongoing community input, feedback and continuous improvement. This should include targeted strategies to encourage and support harder to reach people and groups to engage in service planning and design.

Areas of primary care workforce vulnerability

The primary care workforce is inequitably distributed across the HNECC PHN region, with some areas (generally rural) having lower rates of health professionals than others, and when compared to the rest of NSW. Workforce shortage and geographical distribution are key determinants of access to health care for the community. Primary care workforce issues also impact small rural hospitals serviced by GPs.

The HNECC PHN region is serviced by 387 General Practices and 17 Aboriginal Medical Service sites (9 Aboriginal Medical Centres with additional outreach locations). The average GP FTE / 100,000 population rate for the region is 109.9 (1 FTE = 37.5hr/wk.). This suggests a region well serviced, however there is maldistribution, with the least serviced LGAs being: Gunnedah (57.5/100,000 population); Liverpool Plains (79.0); Cessnock (79.7); Maitland (83.6); Dungog (92.1) and Muswellbrook (96.6).

There is an identified need to minimise workforce vulnerability in communities across the HNECC PHN region. Key contributors include:

- An ageing GP workforce leading to workforce shortages across the region, highlighting the need for succession planning to ensure continuity of care.
- Younger GPs (with a higher proportion of female GPs) preferring reduced hours of work to sustain a work/life balance; thus, causing a flow-on effect of requiring more than one GP to replace an older retiring GP, or consequently accepting a reduced service.
- Difficulties attracting GPs to rural areas leads to a reliance on international medical graduates (IMGs) in areas of shortage. IMGs require additional support, such as mentoring, placing an additional load on GPs within these regions.
- An expansion of corporate general practices often requiring additional support for non-vocationally recognised doctors.
- A lack of reliable, regular locum support.
- Challenges in relation to after hours and on-call hospital rostering.
- Reduced networking opportunities in rural areas.
- Changes to Distribution Priority Areas (DPAs) affect the capacity to employ overseas trained doctors; and
- Lack of suitable mentoring programs for GPs and nurses in rural areas.

A measure of workforce vulnerability is the proportion (%) of GPs aged 65 years and over, given these GPs will not work for much longer due to retirement. In 2020, 13.9% of GPs within the HNECC PHN region were aged 65 years and over (NSW 17.5%). Glen Innes Severn LGA had the highest rate of GPs aged 65 years and over at 40.3% highlighting a higher rate of vulnerability. The proportion (%) of GPs who worked 50+ hours / week is an additional measure of workforce vulnerability as consistently higher working hours may lead to GP burnout. In 2020, 16.1% of GPs within the HNECC PHN region worked 50+ hours a week (NSW 15.6%). Moree Plains LGA had the highest rate of GPs who worked 50+ hours/week at 53.3%. A further

measure of workforce vulnerability is the proportion (%) of GPs who, for one reason or another, are intending to cease working as GPs soon. In 2020, 40.4% of GPs within the HNECC PHN region intended to remain in the GP workforce for less than 10 years (NSW 40.8%). Inverell LGA had the highest proportion of GPs who intended to work less than 10 years at 61.1%. In 2020, the proportion (%) of GPs who gained qualifications outside of Australia and New Zealand was 44.4% within the HNECC PHN region (NSW 42.9%). Cessnock LGA had the highest rate of GPs who gained qualifications outside of Australia and New Zealand (69.0%) followed closely by Muswellbrook (68.4%).

Due to the application of data suppression to GP data for the local government areas of Gwydir, Liverpool Plains, Uralla, and Walcha it is not possible to identify workforce vulnerability issues for these LGAs individually. However, as a combined area, it is clear these 4 LGAs have workforce vulnerability issues, such that their combined rate of GP FTE / 100,000 population is 76.1, the combined proportion of their GP FTE workforce aged 65 years and over is 37%, the combined proportion of GPs who worked greater than 50 hours a week was 40% and the combined proportion of GPs who intend to work for no more than 10 years is 53%.

A high proportion of trainee GPs implies workforce vulnerability, due to the support required to train and mentor these health professionals, as well as their high turnover rate. In 2020 HNECC had 8.1% of GP FTE Trainees (NSW 6.6%), with Liverpool Plains (45.7%) and Narrabri (36.9%) particularly vulnerable.

A final measure of workforce vulnerability is the proportion of GPs who are not vocationally registered (VR), that is, those who have not completed a recognised training program in General Practice. In 2020, the ratio of VR to Non-VR GPs was 6.9 GP FTE across the HNECC region (NSW 10.2). Local Government Areas within the region with low ratios include Tenterfield (0.8); Liverpool Plains (1.7) and Dungog (1.7).

Stakeholder feedback and community consultation regarding after-hours care has highlighted the burden of excessive after-hours on call arrangements in some parts of our region. Younger clinicians who are prepared to move to regional areas were seen as having expectations of a work-life balance that does not extend to providing after-hours services or being regularly on-call. Similarly, GP representatives from the New England region indicated that after-hours work in their community is exhausting and exacts a considerable personal toll. A number of GPs stated that the shortage of GPs was compounded by a lack of access to allied health services and support services, including pharmacy, imaging and pathology. That is, even if patients were able to access after-hours GP care, they may not be able to obtain medications or diagnostic services without visiting an emergency department or waiting until the next day.

Stakeholder consultation identified that rural workforce is a major concern and issue for the HNECC PHN region, with a need to increase the number of General Practitioners, particularly GP Registrar numbers and allied health professionals within the rural and remote areas of the PHN. GP supply and geographic distribution of GPs is noted as a problem. Further stakeholder survey consultation identified that rural and remote vulnerabilities in workforce include vulnerabilities in healthcare professional outreach services, primary care nurses with appropriate training and support, social workers, occupational therapists and physiotherapists and further allied health and disability workforce are hard to attract to rural settings, and there is a need for more rural emergency doctors.

Other areas of primary care workforce vulnerability include workforce challenges in the mental health sector. Findings indicate:

- 16 out of 23 HNECC PHN LGAs with no psychiatry presence
- Access to psychiatrists is a significant challenge on the Central Coast, with approximately 6 psychiatrists per 100, 000 population with the Central Coast region having a population of approximately 340, 000 people
- Several LGAs within the HNECC PHN region had no clinical psychology presence including Gwydir, Moree Plains, Tenterfield, Uralla and Walcha
- LGAs with low rates of FTE psychology per 100, 000 population included Cessnock (25.3), Gunnedah (25.5), Upper Hunter Shire (25.9) and Port Stephens (28.6)
- During 2017, there were 88.7FTE mental health nurses per 100, 000 population in the HNECC PHN region, with 13 out of 23 LGAs having no mental health nurses including Cessnock and Singleton with populations of 57, 607 and 23, 550 respectively.

Further workforce vulnerabilities for the mental health sector within the HNECC PHN region include; reduced capacity of services, particularly in rural areas to recruit and retain specialised mental health staff such as psychiatrists and psychologists, significant turn over in mental health clinical and support staff, overreliance on provisional psychologists, especially in rural areas impacting on retention and lack of focus in

undergraduate nursing programs on providing care for people with a mental illness. This is further supported by the Market Mapping exercise conducted within the PHN region which identified that mental health services have low provider numbers across the region and were service types of concern to commissioners.

Allied Health workforce vulnerabilities include retention challenges for allied health professionals working in rural areas to include financial barriers, limited access to sufficient supervisions and support as significant factors that drive allied health professionals in their early careers to seek early opportunities to return to the cities. Recent community and stakeholder surveys further noted that there are limited allied health workforce in the community often resulting in long wait times. None to limited physiotherapists in some local hospitals is increasing the need for private physio and exercise professionals to help with rehabilitation of injuries and chronic diseases.

Primary care workforce vulnerabilities in General Practice are also a key concern for stakeholders within the HNECC PHN region. Stakeholder and community surveys indicated that there is a severe shortage of GPs within the rural and remote regions of the PHN region. Further to this, stakeholder consultation identified a need to increase and upskill the primary care nurse workforce who play an integral role within general practice and that GP wellbeing and succession planning is needed, particularly on the Central Coast.

A continuing issue for stakeholders is the excessive wait times to see a GP, which may reflect primary care workforce vulnerability. Stakeholders noted an increase in GPs closing their books, and waiting lists getting longer, and fewer GPs bulk billing. Further to this, General Practitioner Services were rated as the third most important health service area needing improvement according to stakeholders in the recent "Have Your Say Stakeholder Survey, 2021", and was considered the second most important health service area needing improvement according to community members.

Locally relevant professional development and education for primary care clinicians

Stakeholders have identified a need for professional development and education opportunities for primary care clinicians that are locally relevant and targeted to address the changing needs of the sector. Specific needs that have been identified in the HNECC PHN region include:

- Ongoing Regional Continuing Professional Development advisory groups.
- Greater education for GPs, Practice Managers and Nurses, and administrative staff.
- Education relative to the changing needs of General Practice for example, changes in models of care, changes to Practice Incentive Payments, quality improvement and accreditation, and Digital Health; and
- Investigation into alternative methods of education via webinars, live streaming, focused groups and small group learning
- GP education of the recognition of people experiencing homelessness and their needs (e.g., mental health, drug and alcohol, diabetes).

HNECC PHN's Allied Health – Health Information and Clinical Systems survey (2020) highlighted the need for support and education of allied health professionals in relation to their use of telehealth platforms, including security and privacy compliance. During the COVID-19 pandemic, the use of videoconferencing platforms to deliver key services represents a fundamental component of how services are currently being delivered in this sector. Current usage reflects variable understanding of these requirements and may place some providers at risk of compliance breeches. The vast number of clinical systems used amongst allied health professionals presents some challenges in providing widespread education and professional development.

Recent stakeholder consultation in 2021 identified the need for allied health providers to be included in further CPD opportunities provided by the PHN as an opportunity to network and engage with other providers. It was also noted that grant writing workshops would be beneficial for local health service providers who require additional support.

Targeted support for general practice

General practice stakeholders have identified a need for support to maximise their practice viability and sustainability, and to provide high quality, evidence-informed patient care. Areas that have been identified for support include:

- Continuing Quality Improvement
- Practice data extraction and analysis
- Practice management
- Practice Nurse optimisation
- Education and professional development
- Digital Health

- Accreditation
- Chronic disease management
- Preventative health and models of care
- Workforce capacity and capability
- Immunisation
- Pathways
- General Practice Quality Planning
- MBS item number and Practice Incentive Payment changes awareness
- Model of care development and support
- Workforce planning

The HNECC PHN's COVID-19 Impact survey (2020) revealed staff emotional wellbeing, caseloads, financial viability and a reduction in staff levels have had the biggest impact primary Care. These needs were identified as crucial areas of support required in the recovery of the COVID-19. Results revealed 42% of staff in the Hunter, 43% of staff in the New England, and 22% of staff in the Central Coast regions experienced a serious or severe impact on staff wellbeing, with 60% of the respondents overall concerned for the future emotional wellbeing of staff. 59% of Hunter general practices, 72% of New England general practices, and 70% of Central Coast general practices are concerned about their future financial viability due to COVID-19. 42% of Hunter general practices, 53% of New England general practices, and 50% of Central Coast general practices have experienced a serious to severe impact on caseloads. A reduction in staff levels during the pandemic has also affected general practices with 32% of Hunter general practices, 48% of New England general practices, and 43% of Central Coast general practices having reported changes to their workforce. Clinician wellbeing also comes up as a major priority of the clinical councils, with more support requested from the PHN.

Ongoing support for telehealth usage was seen a major priority moving into the COVID-19 recovery phase, with 97% of respondents wanting the PHN to advocate for ongoing Medicare rebate eligibility for telehealth consultations. The survey revealed a rapid uptake in telehealth usage with 48% of providers reported they were using telehealth for 50-100% of appointments, 22% of providers reported using it for 25-50% of appointments, 23% of providers reported using it for up to 25% of appointments, and only 6% reported not using telehealth for appointments. Telehealth use was particularly high amongst Aboriginal Medical Services, with 100% using telehealth and 78% using telehealth for more than 50% of consultations.

Limited access to dental services

Dental conditions are one of the leading causes of potentially preventable hospitalisation in our region. In 2018-19 there were 3,544 hospitalisations in the HNECC PHN region for acute dental conditions at a rate of 269.7 per 100,000 (NSW 241.5). Dental conditions affect Aboriginal people disproportionally compared to non-Aboriginal people. While data at a PHN level are not available, across NSW, the rate per 100,000 people of dental condition for Aboriginal people is 342, 50% higher than the rate for all people living in NSW. National data show that rates of PPH for dental conditions are highest for young children, with the main cause of admission being tooth decay.

In 2019-20, 43.9% of adults saw a dentist / hygienist / dental specialist in the previous 12 months within the HNECC PHN region (Australia 48.9%), whilst 21.9% of adults did not see, or delayed seeing, a dentist / hygienist / dental specialist due to cost over this time (Australia 19.1%).

Reduced access to affordable dental services is consistently identified by stakeholders across the HNECC PHN region as a considerable area of need, particularly in rural areas. Access to private dental services is cost-prohibitive for many members of the HNECC PHN community, public dental services are available to people with a Health Care Card, however there is a 3 – 6 month waiting list for non-emergency appointments. Whilst most Aboriginal Medical Services provide dental care, this is restricted to clients of the service who have engaged in a 715-health assessment and there are also lengthy waiting lists.

A variety of stakeholder consultation noted a need and concerns for dental access and services including:

- Concern regarding lack of dental/ mouth care in Aged Care facilities
- Lack of publicly funded dental care

Dental issues in adults are a significant cost to the health care system and there are limited primary health services funded in dental care or preventative dental care

Limited capacity of services to address dementia

Throughout the HNECC PHN region people are presenting to hospital in the advanced stages of dementia, due to under-diagnosis and misdiagnosis, leading to poorer outcomes for people living with dementia and their careers, increased avoidable hospitalisations and premature admission to aged care facilities. Identified service needs include improved awareness and understanding of dementia; increased understanding of

the importance of timely diagnosis and early intervention; improved knowledge of dementia assessment and management; increased understanding of and access to dementia services; improved flexibility of MBS item numbers to support complex dementia assessment and carer support by GPs; and improved understanding of My Aged Care. The number of deaths attributed to dementia has risen by 68% in the past decade, yet health services remain ill-equipped to address the increasing prevalence and provide timely access to care, including access to dementia assessment services, geriatricians and psycho-geriatricians.

In 2019, 49.9% of people using permanent residential aged care facilities in the HNECC PHN region had a diagnosis of dementia (Australia 53.0%). Breakdown by sub-region included 46.2% of people using residential aged care with a diagnosis of dementia were in the New England region, 49.5% in the Hunter and 50.9% in the Central Coast.

Stakeholder consultation identified concerns regarding dementia services capacity including a need for inpatient beds for people living with Dementia and who experience responsive behaviours. Further to this stakeholder feedback identified a need to expand current dementia services across the region and to enhance current services with a multidisciplinary team in the effort to provide a more complete service with improved quality of service delivery.

Lack of prevention and early intervention services

Ongoing, targeted health promotion and prevention is required to maintain and improve health outcomes. The availability and awareness of services that prevent illness and chronic disease or assist in the early detection of ill-health within the HNECC PHN region are limited for some population groups.

Community consultation identified several needs relating to early intervention services (for children) including:

- Excessively long wait lists for early childhood developmental assessment and treatment, with children starting school before any help has been accessed
- Lack of early intervention and preventative services for the 0-12 age group
- Difficulties in accessing paediatricians and allied health services for early childhood interventions services within the rural and remote region of the PHN

Clinical Council and Community Advisory Committee feedback noted the need for the PHN to develop and align work with the National Preventative Health Strategy. Other recommendations for increasing prevention services included:

- Advocate for an updated national nutritional policy
- Further education for clinician education in constructive conversations for overweight patients
- Innovative approaches to overweight and obesity programs including local cooking classes with a focus on budget friendly healthy meals and cooking skills for low socioeconomic groups
- Increased health and food literacy programs for youth
- Increase in preventative health programs for the aged care sector
- An increased need for dietitians and exercise physiologists
- Increase in physical activity health promotion programs
- Further considerations into upskilling primary care clinicians in basic preventative screening as an important preventative measure for the elderly and disabled who are still living independently within the community.
- Consideration into early intervention for alcohol misuse and domestic violence were also raised by council members, particularly because of COVID-19 lockdown measures.

Preventative services identified as a need by community consultation included:

- Further funding needed for community health and wellness programs
- More training for health care staff on preventative measures for chronic disease
- An increased need for further preventative and health promotion activities within the region

High rates of chronic disease hospitalisations

The Australian health system is experiencing an increased demand on services due to an ageing population and a shifting burden of disease from acute to chronic and complex conditions. High rates of chronic diseases place a significant burden on the health of our community and on the health system, including through chronic Potentially Preventable Hospitalisations (PPH). A PPH is an admission to hospital for a condition whereby the hospitalisation could potentially have been prevented through primary care and community-based care settings.

In 2018-19, chronic PPH conditions were the leading PPH category in the HNECC PHN region at an age-standardised rate of 1,350.3 per 100,000, which was above both the state and national rate (1,213.6; and 1,328.0, respectively). In 2018-19, within the HNECC PHN region the top five highest chronic PPH conditions were COPD at a rate of 340.2 per 100,000 population followed by congestive cardiac failure (254.9), diabetes complications (220.5), iron deficiency anaemia (217.0) and asthma (113.3). Trends over time analysis shows the average rate for total chronic conditions has increased over time.

A person's likelihood of having a potentially preventable hospitalisation varies by where they live and their individual circumstances. Analysis was conducted on PPH rates for the following vulnerable population subgroups within the HNECC PHN region, these included for: Aboriginal and/or Torres Strait Islander people, people from a low socioeconomic background, people living in rural and remote areas and people aged 65 years and over.

Indigenous status

Aboriginal Australians tend to be more likely than non-Indigenous Australians to have the conditions for which hospitalisations are regarded as potentially preventable and to live in remote areas where non-hospital health services are more limited. While PHN level data are not available, NSW level data provides an indication of the top PPH conditions for Aboriginal people within the HNECC PHN. In 2018-19, the top chronic PPH conditions in NSW for Aboriginal and/or Torres Strait Islander people were COPD at a rate of 1224.3 per 100,000 population followed by diabetes complications (497.8), congestive cardiac failure (383.4), iron deficiency anaemia (369.0), and asthma (212.8). In 2016-17, the rate of chronic PPH conditions was more than double for Aboriginal and/or Torres Strait Islander people compared to non-indigenous Australians within the HNECC PHN region (2,364.5; and 959.1, respectively).

Socioeconomic status

For nearly all health measures, people from lower socioeconomic groups in Australia have an inferior quality of health. This is reflected in PPH rates, where PPH rates decreased with increasing levels of socioeconomic advantage. In 2018-19, NSW data shows that the rate of chronic PPH per 100,000 population for people in the 1st or most advantaged quintile was 626.5 compared with 1,179.3 for people in the least advantaged or 5th quintile. While PHN level data are not available, NSW level data provides an indication of the top PPH conditions for people with low socioeconomic status within the HNECC PHN. In 2018-19, the top chronic PPH conditions in NSW for people in the 5th or most disadvantaged quintile were COPD at a rate of 302.0 per 100,000 population followed by diabetes complications (197.8), congestive cardiac failure (195.0), iron deficiency anaemia (193.6) and asthma (138.7).

Remoteness area

While PHN level data are not available, NSW 2018-19 data shows that the rate of chronic PPH conditions per 100,000 population for people living in major cities in NSW was 856.2 compared to 1539.1 for people living in remote areas and 1766.1 for people living in very remote areas. In 2018-19, the top PPH conditions in NSW for people living in remote and very remote areas were by remoteness area were COPD at a rate of 537.9 followed by diabetes complications (424.5), congestive cardiac failure (180.7), iron deficiency anaemia (119.8) and angina (98.2).

People aged 65 years and older

In 2017-18 people aged 65 and over in HNECC PHN had a rate of total chronic PPH conditions at 5,421 per 100,000 population (crude) in comparison to under 65 years (657). Chronic PPHs are the highest priority category of PPHs for older people in the region. The rate of chronic PPH conditions for people aged 65 and over is eight times the rate of chronic PPH conditions for people aged under 65. The top eight PPH conditions which are experienced at a much higher rate for people aged 65 and over are ranked in descending order these include: COPD (1757), congestive cardiac failure (1480), iron deficiency anaemia (758), diabetes complications (556), angina (448), hypertension (151), bronchiectasis (113) and asthma (102).

Barriers to cancer screening in primary care

Cancer screening participation rates for the HNECCPHN region are low within some communities and priority population groups. Primary healthcare can have a significant impact on improving screening rates. In the General Practice setting, there are varying levels of connection and sense of responsibility towards the national cancer screening programs. Clinicians report reduced confidence in explaining the recent cervical screening clinical guideline changes, and indicate a disconnection with, and low sense of responsibility for, the national breast and bowel screening programs. Clinician engagement with each screening program is reflected in their use of practice systems, with 82% actively reminding patients to attend for cervical screening but only 26% sending reminders for breast screening and 18% for bowel screening. There is a high use of private radiology providers for breast

screening, particularly in the Central Coast region (which could link to low participation rates reported by the National Program), and private pathology or commercial FOBT test kits for bowel screening. These results are currently not communicated to the national screening programs or included in national screening datasets.

Within the HNECC PHN region only 32% of people diagnosed with colorectal cancer are diagnosed when cancer is in localised phase. The National Screening Register for bowel screening was activated in December 2020. Of the 5.7 million people invited between January 2018- December 2019, 43.5% participated in the program. The national participation rate being similar to that for the previous 2-year period (2017-18; 42.4%). Therefore, General Practice is key in identifying screening participation, as not all patients are utilising the National Screening Program and access screening kits from a variety of sources. General Practice data from across the HNECC PHN region indicates that 45.7% of eligible patients have bowel cancer screening (FOBT) on record. This indicates that 54.3% patients attending General Practice in the HNECCPHN region have no bowel screening status recorded, with some Practices identified as much higher. There is a need for data and system improvement to improve recording, with potential opportunities to then increase bowel screening participation.

Stakeholder feedback noted that cancer screening in rural and remote areas is difficult to access and that many people cannot access accommodation and transport to be able to receive these services within the Newcastle area.

Barriers to accessing disability services

The disability sector is challenged by a lack of carer recognition, limited residential facilities, a lack of respite services, an ageing workforce (including carers) and declining volunteer numbers. Concerns about service accessibility with the NDIS implementation include need that is currently not visible; lack of capacity and skilled workforce in the NGO sector; change of business practices for service providers; and loss of skilled workforce during the transition. Stakeholders have identified a need for greater support for clinicians in navigating the NDIS. There is a need for programs for active individuals with mild cognitive impairment.

The NSW Government has been progressively phasing out Large Residential Centres, with the Hunter sites being some of the last to close. Many former residents have limited social and family networks and require significant personal care and social support. This cohort often require a combination of disability and health services, and some have challenging behaviours necessitating specialised support and housing. The challenges this presents to the health community and the limited capacity, particularly of general practitioners, to address this demand is a concern for stakeholder groups.

Stakeholder consultation conducted for the After-Hours Primary Care Needs Assessment also identified the need for improved access to after-hours primary care for people with disabilities, including those living in group homes. It was reported that many people living in group homes do not have a regular GP and therefore are transferred to EDs for lower urgency care. These transfers could be better managed within a primary care setting and are disruptive to the individual's care routine. This issue is not limited to the after-hours period and there is scope for improved access and inclusivity of people with a disability in future urgent care initiatives. Key stakeholders identified models of care that could support people with a disability, such as phone-based clinical support to staff in participating services.

The recent HNECC PHN Market Mapping exercise indicated that the disability provider market within the HNECC PHN region is demonstrating a high level of volatility with many providers exiting the market since it commenced or becoming inactive, reflective of the very diverse nature of providers. Many charitable providers of disability services are uncertain as to the long-term viability of those markets for themselves. Despite the volatility of the market, there is a large supply of disability services within the region, with national NDIS market analysis indicating that the Central Coast and Hunter New England regions as two of the larger and better performing markets. Even though this may be the case, commissioners have still highlighted specific gaps in disability services including an undersupply of NDIS services for adolescents, particularly in relation to alternative therapies and reported continuing difficulties people face accessing the right supports in a timely way.

Reduced access to services for children and youth

There is a significant gap in the region for affordable and timely mental health services for children and youth. Service gaps include general mental health; mental health in-patient services psychology; psychiatry; dental; eating disorders; mental health promotion and prevention; drop-in centres suicide prevention; services for children/youth experiencing behavioural issues and

autism; and family-based therapies. Barriers to accessing mental health services include: cost; limited awareness of services; a lack of locally based services; low confidence and mistrust of services; service suitability; affordability of internet access/technology; lack of service integration and coordination; lack of support during the transition from adolescent to adult support services; safety concerns for young people in mental health in-patient settings with adults; lack of nursing education in youth mental health and early psychosis. More specifically, there is a need for specific mental health, health promotion and education activities, including leadership and mentoring, for Aboriginal and Torres Strait Islander youth throughout the region and cross-border issues for the Boggabilla/ Toomelah community are complicating service provision.

Community and Clinical consultations have highlighted significant areas of unmet need and service gaps for youth mental health within the Mid-Coast region, which comprises Greater Taree, Forster, Gloucester Local Government Areas (LGAs). The Mid-Coast as a rural and regional area is impacted by high demand and in particular access barriers for mental health services, distance to services, difficulties getting an appointment, reduced availability of public transport (or cost of private travel), and limited availability of services and health workforce in rural, isolated and small communities.

Community consultation identified several needs relating to early intervention services for children and youth including:

- Excessively long wait lists for early childhood developmental assessment and treatment, with children starting school before any help has been accessed
- Lack of early intervention and preventative services for the 0-12 age group
- Difficulties in accessing paediatricians and allied health services for early childhood intervention services within the rural and remote region of the PHN

Limited access to after-hours GPs

Limited access to a GP outside standard operating hours is a barrier to health service access across the HNECC PHN region, particularly in rural areas where a lack of workforce coordination and collaboration in sharing after hours availability compounds the issue. Only 40% of respondents to the 2019 HNECC Urgent and After-Hours Care Survey found it easy to determine what health services are available and just 31% of respondents found it always or usually easy to access the health provider they needed to see. Respondents relayed significant difficulty accessing GPs for urgent care during business hours due to long waiting lists (particularly in the New England and Mid Coast). Respondents frequently expressed that there were limited, or no after-hours GP services available, particularly in the New England and Mid Coast regions. Many commented that their only option for after-hours health care was the Emergency Department. However, they also noted this was not their preferred option. Other barriers to accessing after-hours GP services included limited services offering bulk billing, travel time and limited ancillary services such as pharmacy and imaging.

In locations with after-hours services there is a lack of service awareness, with residents continuing to present to emergency departments for non-emergency treatment. In 2018-19 there were 92.3 after hours lower urgency ED presentations in the HNECC PHN region per 1,000 population, this was higher than the national average (55.8) and state average (74.4). In 2018-19 in the HNECC PHN region, the age categories 0-14 years and 15-24 years had the highest number of lower urgency after-hours ED presentations per 1,000, at 137.5 and 139.4, respectively. Lower urgency after-hours ED presentations per 1,000 decreases with age, with the 80+ years age category having the lowest overall number of presentations per 1,000 population (46.3).

After hours GP support to Residential Aged Care Facilities (RACFs) is of variable quality across the region. Without reliable and effective support RACF residents are at a disadvantage and often rely on presentation to ED rather than care in place. During the after-hours period, residents of Aged Care Facilities are reliant on access to primary care via home visits or on call (phone based) support. During the HNECC PHN led After-hour Needs Assessment focus groups and interviews, several GPs reported that most of the demand for after-hours on-call services through their practice came from Residential Aged Care Facilities.

A Composite Index Score for each LGA in the HNECC PHN region was used to understand and quantify the relative need for and access to after-hours primary care across the HNECC PHN region. The Composite Index Score was based on three sub-indices including the After-hours Health Need Index, After-hours Service Availability Index and the Unmet AH Demand Index. The approach allows LGAs to be ranked in order from most to least need, with a high score indicating high need combined with high unmet demand and low service availability. Regional clusters (regional groupings of LGAs) were prioritised based on the Composite Index

Score, stakeholder and community consultation and survey results. Clusters (with the Composite Index Score included with each LGA) in order of need were:

- Priority 1 – Peel: comprising the LGAs of Gunnedah (3.32), Liverpool Plains (2.33), Tamworth Regional (3.03) and Walcha (12.17)
- Priority 2 – Mehi: comprising the LGAs of Gwydir (10.98), Moree Plains (4.79), and Narrabri (2.69)
- Priority 3 - Mid Coast: comprising the LGA of Mid Coast (4.44)
- Priority 4 – The Tablelands: comprising the LGAs of Armidale Regional (3.89), Glenn Innes Severn (5.42), Inverell (5.28), Tenterfield (2.19) and Uralla (4.86)
- Priority 5 - Lower Hunter Valley: comprising the LGAs of Cessnock (3.68), Dungog (3.64) and Maitland (3.51)
- Priority 6 - Upper Hunter Valley: comprising the LGAs of Muswellbrook (3.67), Singleton (3.19) and Upper Hunter Shire (3.99)
- Priority 7 - Central Coast: comprising the LGA of Central Coast (3.05)
- Priority 8 - Greater Newcastle: comprising the LGAs of Newcastle (1.37), Port Stephens (4.17) and Lake Macquarie (2.42)

Recent stakeholder consultation identified a concern for after-hours services within the region. It was highlighted that after hours services by GPs for small and rural communities are considered very important to these residents.

Where there may not be a GP or a GP can't provide 24 hours on-call because they are the only GP in town or don't have visiting rights at a health service, then access to an after-hours service can at least reduce the impact on the community who need after hour medical care. Clinical Council and Community Advisory Committees noted that after hours services within the region require novel models of care and that the rural and remote regions require greater and more equitable access to after-hours services within the region.

According to stakeholders in the recent "Have Your Say Stakeholder Survey, 2021" and community members in the recent "Have Your Say Community Survey, 2021" after hours health services was the second most important health service area needing improvement for stakeholders, and third most important for community members.

High proportions of semi-urgent and non-urgent emergency department presentations

Emergency departments (EDs) can be a preferred option for care for some people if a timely GP appointment is unavailable; in the after-hours period; and for those community members who are financially disadvantaged, as medications and diagnostic services are provided at no cost in a single visit. A heavy reliance on EDs can indicate a lack of accessible health services in the community and leads to higher health care costs. Semi-Urgent and Non-Urgent ED attendances are often considered best managed in general practice.

Over the whole HNECC region, which covers two Local Hospital Networks, 59% of emergency presentations in 2019-20 were either semi-urgent or non-urgent, compared with 47% across Australia. Large hospitals in the HNECC PHN region with high proportions of semi-urgent and non-urgent presentations in 2019-20, were Glen Innes Hospital (79%), Manilla Hospital (77%), Scone Hospital (76%), Tenterfield Hospital (74%), Kurri Kurri Hospital (73%), Wee Waa Hospital (73%) and Armidale Hospital (72%).

Reduced access to services for older people

Older people experience difficulties accessing health and community care services, with barriers including cost, transport, appointment waiting times, and lack of knowledge and understanding of the aged care system, including navigating My Aged Care. There is a need for improved care planning and management of older people within the community and in residential aged care facilities, especially those with complex and deteriorating conditions, and those at the end of their life. Greater support and education is required for consumers, carers and families in navigating the system and negotiating with providers in the consumer directed care model.

People aged 65 years and over represent 20.3% of the total HNECC PHN population (NSW 16.7%). In 2020, there were 75.7 residential care places per 1,000 people aged 70 years+ in NSW. The availability of residential care varied throughout the HNECC PHN region as follows (by aged care planning region), Central Coast (70.3), New England (62.7), Mid-North Coast (70.3) and Hunter (81.0). Workforce capacity and the ability to attract and retain skilled and suitably qualified staff in aged care (due to wages, ageing workforce, and lack of understanding or expertise in the existing workforce) are challenges in achieving better outcomes in aged care.

RACF residents have reduced access to GP services, allied health, dental and mental health services, leading to poorer health outcomes and avoidable ED presentations. Needs specific to HNECC PHN RACFs include:

- Greater capability to manage unexpected deterioration, end of life care, deprescribing, and behavioural and psychological symptoms.
- Increased number of regular GPs available to provide services to Aged Care facilities, both within and after-hours.
- Improved access to GPs and allied health professionals through funded telehealth consultations; and
- A review into RACF clinical information storage systems.

HNECC PHN commissioned Aged Care Emergency Service (ACE) provides phone based clinical support to staff in RACFs to manage residents' acute non-life-threatening conditions within the nursing home, or when hospital transfer is required support high quality handovers to be provided. RACFs that do not have access to the ACE program rely on GP arrangements, which can often result in challenges and hospital transfers when their usual GP is not available. In the after-hours focus groups, representatives from Aged Care Facilities on the Central Coast reported significant difficulty at times accessing GP services for simple reasons such as phone orders for medications.

Stakeholder consultation identified several needs related to services for older people.

- A need for a PHN and LHD partnership prioritising aged care and ageing population as a dedicated workstream
- Strategies for mental health support for RACF residents
- Workforce issues within aged care need to be highly prioritised, including GP shortages in visiting RACFs and that RNs and Nurse Practitioners can play a role in supporting aged care.
- A need for novel models of care for older people including telehealth and assistant therapy models
- A need for staff skills to be increased within RACFs to manage behaviourally challenging residents

According to the Gloucester Local Community Plan, affordable aged care facilities are a priority for the Gloucester region. Further engagement with community and stakeholders also noted several needs for older persons in accessing services:

- Access to low intensity mental health services
- Access to wellbeing, prevention, and early mental health intervention
- Increased collaboration between primary health care sector and the LHD Multi-Purpose Services to improve healthcare for older people within the rural and remote communities

Reduced access to services in rural and remote areas

In 2019, 64.7% of the HNECC region lived in major cities, 26.2% lived in inner regional areas, 9.0% lived in outer regional areas and 0.2% lived in remote areas. Eight LGAs in the HNECC region have 100% of the population living in outer regional or remote areas. On average, people living in rural and remote communities experience poorer health outcomes, have reduced access to health services and report higher rates of some diseases, this is enhanced for people who are disadvantaged or vulnerable. Barriers to accessing care include: the upfront cost of accessing primary care, with few providers bulk billing; distance to services; difficulties getting an appointment; limited public transport options and increased cost of private travel; issues recruiting and retaining the health workforce; educed availability of health services; fewer health professionals per capita; and lack of anonymity in small communities. Additional specific needs identified in rural areas include the need for:

- enhanced outreach capability, workforce capacity and access to medical specialists for Aboriginal Medical Services.
- greater access to Allied Health Services, particularly dentists, physiotherapy, podiatry, psychology, child mental health clinicians, exercise physiology, endocrinology, psychiatry, urology, gerontology, speech pathology, radiology, audiology, and drug and alcohol support services.
- increased availability of bulk-billing imaging services (particularly in Inverell where there are high rates of high-risk pregnancies).
- greater access to specialist services, particularly Ear, Nose and Throat specialists; and
- increased after hours services.

With the influx of Yazidis refugee families, access to healthcare in the Armidale LGA remains a significant concern reported by stakeholders. While Armidale was identified as having the infrastructure and capacity

to meet the medical needs of refugees, the additional refugees the town has accepted above the original forecast numbers has created capacity concerns for GP's. General Practice is already stretched meeting the needs of the existing community and there is potential that additional incoming patients will pose further demands on access to medical services. Armidale LGA, unlike other resettlement areas, does not have a GP run Refugee Clinics within the Hospital. The Hospital Refugee Clinic is run by Registered Nurses, meaning refugees experiencing serious/urgent health matters find it increasingly difficult to obtain correct care immediately.

In addition, existing restrictions with access to specialist care in Armidale LGA, and regional areas in general, often see patients required to travel large distances to access the care required, either to Tamworth or Newcastle. While this is not a specific issue to just refugees and migrants themselves, it certainly creates greater challenges for this patient cohort stakeholders report. The communication challenges for refugees and some migrant groups can make travelling these distances extremely difficult, expensive or prohibitive all together. Stakeholders also report there is urgent need to access allied health service providers, particularly social workers and physiotherapists. Provisions for these services are minimal and difficult to access for refugee groups. This creates slower progression towards health and social wellbeing goals, placing this already vulnerable group at further risk.

Analysis of after-hours primary care service supply conducted for the After-Hours Primary Care Needs Assessment found that the LGAs with low levels of after-hours service supply were based in rural and remote parts of the HNECC PHN region. Many respondents to an after-hours community survey conducted by HNECC PHN, particularly those from the Mid-Coast and New England reported waiting times of several weeks to see the local GP during business hours. They expressed that often their only option was to attend the ED, though this was not their preferred option. In the after-hours focus groups and interviews, GPs indicated that many practices, especially those in regional and rural areas, did not provide after-hours care or, where they did, it was often practice-based and only available for patients of that practice. The factors driving the low uptake of after-hours service delivery included:

- the physical inability of small or single doctor practices to provide after-hours care
- the lack of demand in smaller, less populous areas
- the associated lack of financial incentive in the face of insufficient demand
- the personal toll on doctors being on call on top of their busy practice workload during standard hours
- safety concerns in staffing practices late at night, especially for female doctors and patients
- the high cost of locums for rural locations if practices did wish to employ someone to provide after-hours care.

A recent Market Mapping Exercise within the PHN region noted areas of concern in terms of provider supply or capability, arising from interviews with commissioners and quantitative data. There are 13 LGAs within the PHN region with low population (less than 20, 000 people – except Singleton) and less than 30 ACNC registered charitable providers delivering any of the seven service types (Allied health, social services, disability, aged care non-residential, mental health, housing, disaster recovery) and which are under-serviced for each service type include:

- Liverpool Plains
- Walcha
- Dungog
- Uralla
- Gwydir
- Tenterfield*
- Glen Innes Severn
- Moree Plains
- Narrabri
- Gunnedah*
- Upper Hunter
- Muswellbrook*
- Singleton

The Market Mapping exercise highlighted the strategic importance of LGAs with stronger market capacity which are adjacent to the LGAs of higher risk: Inverell, Armidale, Tamworth, Cessnock and Mid-Coast. Some providers in these LGAs may be experienced partners or provide a useful foundation for building capacity and capability in more remote areas. Further to this, the LGAs with an asterisk * have low numbers of providers but have a high number of staff employed by local charities in comparison to their population – more than 1000 FTE per 100 000 of population, potentially

indicating that while the provider supply may be low, the relative supply of services ought not to be.

Further to this the 13 LGAs with low populations and low provider numbers indicated that the pricing and/or resourcing levels applied are not sufficient to meet their costs of delivery, which could be due to the complex needs of a client group, the very few people who need a service in a location or the remoteness of a location and the travel and/or workforce costs involved.

NDIS analysis indicated that despite the HNECC PHN region being well serviced compared to other regions, access issues are still experienced in remote areas, correlating to the 13 LGAs of concern.

The many smaller providers in the rural and remote regions of the PHN, do provide benefits in terms of community engagement that enable them to be 'first to know' agencies. Localised delivery was identified as especially critical to the delivery of disaster recovery and psychosocial supports.

Clinical Councils, Community Advisory Committees, community and service provider stakeholders highlighted several issues regarding rural and remote access to services including:

- A lack of transport and accessibility in rural areas has an impact on vulnerable individuals within communities
- Geographic distribution of GPs is an issue for the rural and remote communities
- Quality of medical care was flagged as lacking compared to medical care within the cities
- Access to majority of health services is limited within the Glen Innes region with high wait lists and books closed to new patients
- Limited physiotherapists within rural and remote regions, often resulting in high wait lists
- Severe shortage of doctors and mental health services including suicide prevention services
- Limited after-hours access

A recent evaluation of the Psychosocial Support (PSS) program within the HNECC PHN region identified several issues for the program within the rural and remote regions including:

- Travel requirements for clients and workers was problematic
- Small town social issues were tricky to navigate around to get clients involved in the program
- Recommendations to expand and utilise innovative approaches to service delivery within rural and remote areas including the use of e-mental health solutions, where appropriate, would support continued service provision and connection, benefiting both clients and health professionals
- A mapping exercise could be conducted within the rural and remote regions to determine current community services that exist and address the three top key activity areas for PSS clients.

The recent Rural Communities Project evaluation for the Glen Innes and Tenterfield regions highlighted that the community within these regions perceive access to primary and mental allied health services as limited, and that Glen Innes and Tenterfield are over 90 km away from their nearest major centre with additional services.

Transport limitations

Limited transport is a barrier to accessing health services in our region, particularly for Aboriginal and Torres Strait Islander peoples, for older persons and for those residing in rural areas. In 2014, in the HNECC PHN region, the rate of people who often had difficulty or could not get to places as needed with transport was 4.1 per 100, compared to 4.0 per 100 Australia-wide, and 4.3 per 100 for NSW. LGAs with the highest rate of people encountering transportation barriers were Moree Plains (4.7 per 100), Liverpool Plains (4.5 per 100), Inverell (4.4 per 100), Central Coast (4.3 per 100), Cessnock (4.3 per 100), Gunnedah (4.3 per 100), Newcastle (4.3 per 100), Tamworth Regional (4.3 per 100) and Tenterfield (4.2 per 100).

Stakeholders believe that an area wide review of transport is required, with significant involvement across a broad range of sectors. Specific needs in the HNECC PHN region include:

- the coordination of transport services with timing of medical appointments.
- limited transport services to / from Singleton hospital, including for dialysis patients.
- limited transport services to facilitate access to health and social support services for the community of Tilligerry Peninsula.
- no patient transport from Barraba to Tamworth hospital except NSW Ambulance; and
- limited or no public transport in regional areas.

The 2019, HNECC PHN survey of Aboriginal health needs found that 32% of respondents travelled more than 30

minutes to access the last health service they used.

Transport limitations continues to be an issue for the community and local stakeholders. The recent "Have Your Say Community Survey" and Clinical Council and Community Advisory Committee consultations, highlighted the limited transport options in the community including:

- limited bus services during the weekdays and often none on the weekend
- transport limitations often a major barrier to accessing specialist services
- limited to no public transport options for residents in Gloucester, resulting in the reliance of neighbourhood group transport services
- Referral services are difficult to access for people in rural and remote regions with long distances to travel to access the service

Further to this, the recent Market Mapping exercise conducted for the HNECC PHN noted that in stakeholder interviews, reference was made to faster than planned development of greenfield sites and higher than projected population growth in Maitland, Cessnock and the Central Coast placing considerable strain on limited services and infrastructure. The thin-ness of services combined with limited transport options create significant challenges for the community. Limited transport services throughout the region inhibits access to specialist services. Maitland was a particular location of concern as an area at risk of market failure.

Cost barriers to healthcare

Cost of accessing health care for consumers, particularly for vulnerable groups such as Aboriginal and Torres Strait Islander people, is a major barrier across the HNECC PHN region, particularly in rural areas where bulk billing is anecdotally less common. Cost prohibitive primary care services encourage financially disadvantaged people to attend Emergency Departments where medications and diagnostic services are provided at no cost, in a single visit. There are also variations in the per capita cost of care between comparable services in the HNECC PHN region.

In 2019-20, 4.6% of adults in the HNECC PHN region did not see or delayed seeing a GP due to cost (Australia 3.8%). Within the same year, 6.8% of adults within the HNECC PHN region delayed or avoided filling a prescription due to cost (Australia 6.6%).

Cost was identified during the After-Hours Primary Care Needs Assessment stakeholder consultations as a barrier for accessing after-hours primary care services. Consumer stakeholders commented that out-of-pocket costs are common in after-hours primary care services and there are limited bulk billed services available, which is particularly problematic for financially disadvantaged and vulnerable groups. Community survey respondents from the Central Coast were the most likely to identify cost as a barrier to access. A key driver for private billing in after-hours care is the limited rebates available under the MBS, which GPs indicate is insufficient to cover the rising costs of providing care.

Reduced access to services for people experiencing homelessness

People experiencing homelessness find it difficult to access support services, including mental health services, as services will often not accept, or follow-up on, referrals which do not include a contact address. Crisis accommodation services, refuges and other accommodation services will often not accept people with substance use issues or those experiencing mental illness, with some services asking for a letter from a doctor stating that they do not pose a risk. Mental health needs of people who are homeless are high and the delays in accessing a mental health assessment through the Mental Health Line are particularly counterproductive for this vulnerable cohort. There is a lack of coordination and integration between homelessness services and primary care services, including mental health services.

Support for people who are experiencing homelessness has been identified as an issue within the Newcastle region, consultation with this cohort has identified the following needs: housing; brief support; and ongoing support. People who are homeless, find it difficult to attend appointment-based services, leading to reduced access to primary health care, and increased use of hospital and ambulance services. Improved access to safe, appropriate and non-judgmental primary health care, including in the after-hours period is required.

In 2019-20, 12,582 people were recorded as accessing specialist homelessness services within the HNECC PHN region (NSW 63, 283).

The HNECC PHN's Hunter Manning Community Advisory Committee has identified homelessness as a growing area of concern. This Committee covers the LGAs of Cessnock, Dungog, Lake Macquarie, Maitland, Mid Coast, Muswellbrook, Newcastle, Port Stephens, Singleton and Upper Hunter Shire.

Stakeholder consultation continues to identify barriers in accessing services for people experiencing homelessness. It was highlighted that the Tamworth region is experiencing a less than 1% rental vacancy, currently increasing the risk of homelessness for vulnerable populations. Consultation further identified that there is difficulty in accessing services for those who experience homelessness and have severe mental health illnesses. People experiencing homelessness are often transient meaning they are constantly moving from one provider's service boundaries to the next due to finding somewhere to stay for the night. People experiencing homelessness often have significant difficulties with maintaining regular medication. Other limitations in accessing services include hospital discharges that advise to follow up with GP, however people experiencing homelessness often have no GP, resulting in regular hospital readmissions.

A local service provider within the Newcastle LGA region recently reported on several service needs and gaps for people experiencing homelessness within the Newcastle region including:

- A need for improved sector development and collaboration engaging in Assertive Outreach practice
- Continuity of care from street and shelter to hospital requires an enduring and trusting relationship between the clinician and patient
- There are currently inconsistencies between mental health teams and the Police responses when dealing with vulnerable people experiencing homelessness
- Most health and mental health support is not available as an outreach service, particularly for those who have no residential address
- Improved access to GP services in more informal locations is required to prevent ED presentations and responses

Reduced access to services for culturally and linguistically diverse populations

Stakeholder consultation identified several challenges for CALD populations in being able to access health services including:

- People who speak English as a second language less likely to go to public health services such as Diabetes management education or a dietician
- A lack of cultural awareness of health professionals
- A lack of interpreters used consistently in primary care services
- A lack of translated resources on health topics
- Inadequate support and lack of available time for mainstream primary care services to better support CALD populations
- The challenges in accessing health services for CALD populations has been further highlighted during the COVID-19 pandemic.

Despite the availability and use of translator services there are times when health consumers from CALD populations may wish to access clinicians who speak other languages. There is a lack of a bilingual service directory for health services within the HNECC PHN region. Further to this, there is a need to strengthen relationships and partnerships with CALD community leaders and clinicians within the region as well as engage further with the local health districts multicultural and refugee health service to enable grater integrations with PHN programs and primary care clinicians within the region.

Access to and utilisation of Digital Health and Telehealth in Service Delivery

Telehealth was raised in all forms of consumer engagement with stakeholders noting strong support for the use of telehealth in service delivery. Areas of need identified and of areas of continued support included:

- An underutilisation of telehealth within mental health services and a high need for alternative models of care, with most communities facing issues of access and lack of transport.
- Strong support to keep the MBS telehealth item numbers that were made available temporarily during the COVID-19 pandemic, with stakeholders wishing to continue telehealth options long term
- Strong support for the continuation of telehealth medicine and to provide a community awareness campaign on options available when seeking healthcare including telehealth
- A need to provide continuing education for GPs on communication methods when utilising telehealth
- Workforce and access to health services for the rural and remote regions of the HNECC PHN footprint, and the support for telehealth to bridge these gaps

Whilst PHN level data is unavailable, in Australia between April and June 2021, 18.0% of consultations were delivered by MBS Telehealth. Trends over time analysis highlight the proportion of consultations delivered by MBS Telehealth have decreased since April-June 2020 from 32.1% to 29.8%

in July-September 2020, 23.3% in October- December 2020, and further 19.8% in January-March 2021.

Insights from an ABS Patient Experiences Survey in Australia, 2021 reported:

- 23.6% of people aged 15 years and over reported having a telehealth consultation with a GP in the last 12 months
- Of those who had a telehealth consultation, 83.4% reported they would use telehealth for a consultation again if it was offered
- Those with a long-term health condition (40.1%) were more likely to use telehealth services than those without (16.5%).

Telehealth is also a strong focus for the LGBTQIA+ community. ACON highlighted that telehealth provided vital support for the LGBTQIA+ communities in navigating the impact of COVID-19. The COVID-19 pandemic has seen many LGBTQIA+ people impacted financially, with the need to move into suburban areas away from city centres. This has resulted in less access to LGBTQIA+ affirming health services. Telehealth has enabled this community to continue to access LGBTQIA+ affirming health services. For some community members this has resulted in sustained clinical engagement and enabled members to feel safer and more secure.

Telehealth was also identified as a recommendation in the Psychosocial Support Programs Evaluation findings. It was recommended to expand and further utilise innovative approaches to service delivery using new and emerging technologies or technologies that are becoming more common place (videoconferencing/ Skype/ web-based group activities) in times of environmental challenges (e.g., COVID-19, bushfires, floods) and to address geographical barriers in rural and remote areas. The nature of rural and remote areas means that greater use of e-mental health solutions, where appropriate, would support continued service provision and connection, benefiting both clients and health professionals.

The HNECC PHNs COVID-19 Impact survey (2020) identified that ongoing support for telehealth usage was seen a major priority moving into the COVID-19 recovery phase, with 97% of respondents wanting the PHN to advocate for ongoing Medicare rebate eligibility for telehealth consultations. The survey revealed a rapid uptake in telehealth usage with 48% of providers reported they were using telehealth for 50-100% of appointments, 22% of providers reported using it for 25-50% of appointments, 23% of providers reported using it for up to 25% of appointments, and only 6% reported not using telehealth for appointments. Telehealth use was particularly high amongst Aboriginal Medical Services, with 100% using telehealth and 78% using telehealth for more than 50% of consultations

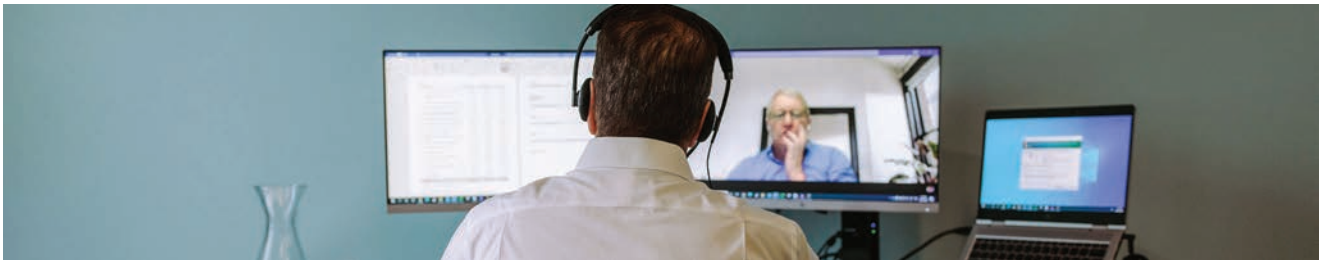
A greater role for Pharmacy in delivering primary health care

The Fourth Australian Atlas of Healthcare Variation highlighted high rates of polypharmacy within NSW. There were approximately 2 400 people dispensed five (5) or more medicines per 100, 000 people aged 75 years and over during 2018-2019, within Maitland, which was listed as the second highest region Nationally.

Stakeholder consultation highlighted several needs relating to Pharmacy including:

- A stronger role for Pharmacy for primary care service delivery reducing the demands on GPs
- Increase in chronic pain medication management reviews
- Increase in medication reviews to reduce the inappropriate use of medication and incorrect interpretation of medication use
- Stronger integration and partnerships between pharmacy and other health services

Further to this, it was highlighted in stakeholder consultation that Pharmacy is a vastly underused service which was evidenced by the large positive impact Pharmacy has had in providing COVID-19 vaccines to the community. Pharmacy can provide cooperative services with other health care professionals, in particular GPs to support continuity of care.



Reduced access to health services for First Nations people

Reduced access to health services is a key contributing factor to the disproportionate burden of disease experienced by Aboriginal and Torres Strait Islander people. Rates of potentially preventable hospitalisations (PPHs) in the HNECC PHN region remain consistently higher for Aboriginal and Torres Strait Islander populations across all categories, including vaccine-preventable conditions; chronic conditions; and acute conditions. This can indicate a lack of appropriate individualised preventive health interventions and early disease management in primary care and community-based care settings.

Aboriginal and Torres Strait Islander people and communities that experience inequities in the social determinants of health not only carry a heavier burden of health problems, but they also often face greater barriers to accessing services that might mitigate these problems.

Barriers to healing and wellbeing should be considered within the social determinants of health and include social, economic, educational, and political marginalisation, lack of secure and adequate housing, especially for women and children, high incarceration rates of children, men, and women, including parents and lack of access to services and support.

Continuing conversations are crucial to ensure Aboriginal and Torres Strait Islander people are at the centre of decision making and that actions to drive progress on Closing the Gap are delivered in partnership with Aboriginal and Torres Strait Islander people. Further to this, engagement with Aboriginal and Torres Strait Islander people and communities, reflected the importance of involving Aboriginal and Torres Strait Islander communities at all stages of the process, including sharing decision making through partnership built on mutual respect and determining shared goals and aspirations. Further to this, stakeholders noted that major health and wellbeing issues that are seen by local First Nations health service providers are cultural safety and security, family violence and suicide.

Other barriers to accessing health care for the Aboriginal and Torres Strait Islander population of the HNECC PHN region, include: the cost of appointments and medications; lack of public and affordable private transport; low health literacy; lack of culturally friendly services; mistrust of mainstream service providers; misunderstandings between clients and health professionals; confidentiality concerns when accessing Aboriginal Medical Services; low motivation, competing work and family commitments; a lack of knowledge of available services; not bringing or having a Medicare card; patient discomfort in waiting rooms and consulting rooms; difficulty contacting transient community members; system complexity, particularly for people with complex needs; a shortage of Aboriginal health staff, especially Aboriginal Outreach Workers, Aboriginal maternal health workers, Aboriginal sexual health workers, Aboriginal Health Workers and Aboriginal Health Practitioners; high rate of 'burn out' and Aboriginal health staff turnover; closed books and long waiting times at Aboriginal Medical Services and general practices in rural areas; limited access to after-hours GP services particularly where upfront fees are required and in rural areas; reduced availability of GPs, specialists and outreach services in rural areas; limited health professional service knowledge.

None of the nine Aboriginal Community Controlled Health Organisations (ACCHOs) in the HNECC PHN region are open during the after-hours period and over two thirds direct patients to their local hospital in the after-hours period. Aboriginal people present at the ED for lower urgency issues at a much higher rate than non-Aboriginal people. Aboriginal and / or Torres Strait Islander people make up 6.4% of the HNECC PHN region. However, 12% of after-hours lower urgency ED presentations in the HNECC PHN region are by people who identify as Aboriginal and / or Torres Strait Islander and in some LGAs this increases up to 48%. Moree Plains LGA has the highest proportion of after-hours lower urgency ED presentations by Aboriginal and / or Torres Strait Islander people (48.1%) followed by Narrabri LGA (28.5%) and Gunnedah LGA (27.5%), whereas the proportion of Aboriginal people living in these LGAs is 26.6%, 15.2% and 15.3%.

Recent stakeholder feedback noted:

- A need for improved access to allied health professions (dietitian, physio, speech, OT, podiatry) to address aboriginal health
- Aboriginal people need to access services within a trusted organisation to feel safe and comfortable
- There is value in having staff members from the local Aboriginal Community to link Aboriginal clients into services to meet their health needs Reducing the need to travel long distances to access services may result in an Aboriginal client being prepared to see a health professional

- Further support is needed for mainstream GPs to provide care to Aboriginal and Torres Strait Islander people
- Cultural healing and leadership training is needed within primary care

Several structural barriers to accessing health services were identified at the Taree and surrounds Healing Form and included:

- Concerns that the Aboriginal Medical Service (AMS) has transitioned from a community to a mainstream service model.
- A lack of transport to access key health services.
- Services limited to daytime, with no crisis support at night.
- Intake processes that are perceived to be 'bound up in red tape'.
- A lack of referrals of Aboriginal and Torres Strait Islander clients to some services, with input suggesting referrals of First Nations peoples to palliative care are significantly below the average for the broader population.
- A perception that there are too many non-Indigenous gatekeepers undermining service delivery to Aboriginal and Torres Strait Islander peoples.
- Staff shortages at the hospital that result in significant delays and cause many people aged 25 and younger to leave without getting medical support.
- Shortage of specialist services, particularly mental health
- Lack of awareness of services and how to access them
- Lack of transport
- Siloed services with lack of communication and information sharing
- More support needed for Elders and affordable respite
- Gaps in education and services for young people in sexual health and sexuality

The Cessnock, Kurri Kurri and surrounding communities healing forum identified several barriers to accessing services and to accessing information regarding services including:

- Historical behaviours of services and the community's own experience, makes it hard to trust service providers
- Fear of removal of children
- Stigma when accessing services
- Lack of co design and lack of consideration of communities needs
- Lack of First Nations people working within the services
- Inadequate communication and information sharing
- Too many "liaison" roles who do not know anyone within the community

The Inverell and surrounding communities healing forum identified several barriers to accessing services including:

- Stigma prevents young people from accessing services
- Lack of awareness from service providers of the prevalence of trauma and complex needs
- Lack of understanding and awareness of community issues among local police and shire councils
- Poor coordination of services
- Lack of support for Elders
- Limited access to local resources such as council halls and other venues to be able to hold community events and services
- Transport and cost barriers

A HNECC PHN survey of Aboriginal health needs in Tuggerah on the Central Coast found that of people who used a health service in the past 12 months, 49% used an Aboriginal Medical Service and 40% used a GP. Respondents who used a hospital, community health service, NDIS service provider or mental health service comprised the remaining 11%. Distance to appropriate health services remains an issue, with 32% of those who reported using a health service in the past 12 months reporting they needed to travel more than 30 minutes to access the health service.

The survey also found that respondents rated the cultural appropriateness and other quality indicators of health services highly. For example, of people who used a health service in the past 12 months:

- 98% felt respected
- 89% felt culturally safe
- 97% felt that the staff listened to them and understood their problem
- 89% felt that staff helped them to understand their health problems, treatment and any medicines needed
- 91% felt that staff helped them or their family/ carer to understand their health problems
- 85% felt that staff involved them in making decisions about health treatment.

Lack of integration, flexibility and cultural appropriateness of mental health and drug and alcohol services

There is a need for greater integration between mental health and drug and alcohol services, for more flexibility in treatment approaches, and for an increased emphasis on culturally appropriate mental health treatment. There is also concern amongst health professionals that the physical health needs of Aboriginal people experiencing mental illness, particularly severe and complex mental illness, are being overlooked.

According to subject matter experts working within Indigenous Mental Health and Alcohol and Other Drugs, there is a greater need to integrate and allow for flexibility in service delivery for indigenous mental health services with alcohol and other drug services, as often one is not without the other.

Community and stakeholder engagement identified the following mental health service needs for First nations people:

- The whole person needs to be considered, including history, support and follow up
- First Nations mental health training for service providers and primary care clinicians is needed
- Increased Aboriginal health workers to accompany First Nations people to mental health appointments
- First Nations led mental health and healing programs and for primary care organisations to increase cultural training to understand the impacts of generational trauma

A recent needs assessment conducted by the network of alcohol and other drug agencies (NADA) noted that members of the network stated that that access to sustainable and increased funding was a priority, including for Aboriginal AoD services.

The HNECC PHN's recent Evaluation Report for the Psychosocial Support Program (PSS), identified that there was a higher proportion of Aboriginal and Torres Strait Islander people accessing the program (13%) compared to those identifying in the total PHN population (5.4%), suggesting an increased need for this service for Aboriginal clients, aligning with higher prevalence of severe mental illness for this group.

A recent AIHW report: *Beyond evidence deficit narratives in Indigenous Suicide Prevention*, identified what does and does not work in programs and interventions with First Nations communities in health and wellbeing, including mental health and suicide prevention. Building blocks for successful programs and interventions include:

- Adequate resourcing and planned and comprehensive interventions
- Community involvement and engagement
- Respect for First Nations languages and cultures
- Commitment to doing projects with, not for, First Nations people
- Development of social capital
- A recognition of underlying social determinants of health and welfare status
- A recognition that issues are often complex and contextual

The following were identified as approaches that do not work:

- One size fit all
- Lack of collaboration and poor access to services
- Interventions without local First Nations community control and culturally appropriate adaptation
- Short-term, one-off funding piecemeal interventions
- Provision of services in isolation and failure to develop First Nations capacity to provide services

Specific criteria for what work in suicide prevention was identified by The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention's framework and are based on evidence of what works in suicide prevention and social and emotional wellbeing programs and services including:

- Assist in First Nations capacity building
- Prioritise First Nations knowledge and experience
- Respect cultural values
- Recognise First Nations rights and self-determination
- Facilitate cultural strengthening
- Facilitate and promote First Nations leadership and governance
- Foster genuine partnerships and community engagement
- Promote healing

At the local level, yarning circles were recently held in Taree and surrounding areas with mental health a key theme emerging from discussions. Some social and emotional wellbeing support programs for young people were identified, including the Feeling Deadly, Not Shame program, Mind Matters, and the Headspace drop-in centre. However, input at the forum suggests there is not adequate mental health support, with concerns raised about the lack of supports for young men. Concerns were also raised about barriers to mental health support for the broader community, with a gap identified since the departure of a local psychiatrist and a perceived lack of specialist services. Concerns about high rates of suicide were also raised in yarning circles, with participants linking suicide with poor mental health. The Manning Suicide Prevention Network was identified as one local initiative established to support suicide prevention, but discussion suggested the need for more strategies to raise awareness and to encourage people in the community to check in on one another, especially young people.

Further to this, the Taree and surround healing forum yarning circles discussed the lack of local support services and programs to address alcohol and other drug misuse in the community. It was noted there is no local detox facility or rehabilitation service, with reports that community members must go as far as Brewarrina to access rehabilitation. Community members conveyed a perception that services lack awareness of intergenerational trauma and the use of alcohol and other drugs as self-medication. It was also suggested there is little by way of drug education in the community, or other services targeting alcohol and other drug misuse.

Whilst PHN level data is not available, in 2018-19, 33.0% of Indigenous patients did not access health services when needed due to service not being culturally appropriate in NSW (Australia 32.0%). Further 67.0% did not access health services when needed due to other reasons (Australia 68.0%).

A low proportion of First Nations people having a 715-health assessment

The annual Indigenous-specific 715 health assessment promotes earlier detection of disease, and diagnosis and treatment of common, treatable conditions. The proportion of HNECC PHN's Aboriginal and Torres Strait Islander population having a 715-health assessment in 2019-20 was 31.1% (NSW 26.9%). 28.8% of Indigenous health checks were delivered Face-to-face (NSW 25.5%) and 2.7% delivered via Telehealth (NSW 1.5%).

Trends over time analysis highlights the proportion of total 715 health checks among Aboriginal and Torres Strait Islander people have increased from 2018-19 (29.0%). Stakeholders have flagged issues with the use of the 715-health assessment, including: numerous instances where non-regular primary health care providers have visited a community, performed health assessments and claimed the payments, but not offered continuity of care; providers not performing all components of the assessment; and difficulties providing continuity of care for transient populations.

Despite this, results from a recent HNECC PHN survey of Aboriginal health needs in Tuggerah on the Central Coast found that 70% of respondents had received a 715 health assessment in the last 12 months, and 16% had received a 715 health assessment in the one to three years prior. Over 85% of respondents who had previously received a 715 health assessment had followed through with the recommendations following the assessment. Only 7% of respondents had never received a 715 health assessment.

Lack of culturally safe workplaces for First Nations workforce

Increasing the Aboriginal workforce in the health system will enhance health service access for Aboriginal and Torres Strait Islander people, however this workforce must be well supported. Members of the Aboriginal workforce working in non-Aboriginal workplaces across the HNECC PHN region consistently report a lack of workplace cultural safety due to ignorance on behalf of non-Aboriginal staff and managers; little awareness of culture and customs; and a limited understanding of the work practices of Aboriginal staff. There are widespread reports of Aboriginal staff experiencing racism, not being listened to, and feeling tokenistic, under-valued and isolated. The Aboriginal workforce has identified a substantial need for improvement in the cultural competence of the non-Indigenous workforce, through for example mandatory cultural awareness or competence training, or compulsory input into an organisational Reconciliation Action Plan.

The NSW Implementation Plan for Closing the Gap 2021 included engagement with Aboriginal and Torres Strait Islander communities, who highlighted the strong support that communities want to see more Aboriginal and Torres Strait Islander people in employment, especially where those jobs are in local communities and contribute to economic development. It was this feedback that informed the decision to include an NSW specific Priority Reform – *Employment, business growth and economic prosperity*.

The NSW Aboriginal Health Plan, 2013-2023 also outlines six strategic directions in improving the health and wellbeing of Aboriginal and Torres Strait Islander people and communities including:

1. Building trust through partnerships
2. Implementing what works and building the evidence
3. Ensuring integrated planning and service delivery
4. Strengthening the Aboriginal workforce
5. Providing culturally safe work environments and health services
6. Strengthening performance monitoring, management and accountability

Lack of men's health services and programs for First Nation's men

Several forum participants in the Taree and surrounds healing forum, identified the absence of specialist services and programs for men. There was an identified need to support men across a range of issues, including social and emotional wellbeing, and substance misuse and behaviour change. Spaces where men can role model for younger men are also needed, with community members suggesting a need to build men's leadership capacity.

There is also a need to support children and young people to understand and talk about emotions, with concerns that young men are 'bottling up trauma', as they think it's not manly to show feelings. Some participants indicated there are many local healing stories, suggesting that healing from trauma can occur through yarning, through learning language, and through culture.

Lack of integration and collaboration between mental health and other services

In 2018-19 the rate of overnight hospitalisations for mental illness in the HNECC PHN region was higher (113.4 per 10,000) than the Australian rate (107.6). 5 out of the 15 SA3s in the HNECC PHN region recorded higher than the Australian average, including Gosford (123.5), Wyong (129.9), Port Stephens (107.9), Moree-Narrabri (113.6) and Newcastle (136.7).

Distribution of primary mental health care service providers, psychiatry services and patient to provider ratios vary across the HNECC PHN region. Access to and retention of psychiatrists and experienced psychologists is the most common mental health workforce need highlighted across all communities, but particularly in rural areas, with significant turnover in mental health staff affecting continuity of care.

Integrated planning is a substantial area of need in this region, with the lack of integration and collaboration between mental health services is making it difficult for people to navigate the fragmented mental health system. Further to this, the effectiveness of primary mental health care is dependent on integration with specialist services.

Stakeholders have identified a need to increase the capacity of community based social support services for people with severe mental health and other complexities. This includes strengthening the approaches to quality and governance across all health and social services; ensuring staff have the knowledge and skills to provide support to people experiencing mental illness and understand their scope of practice; and building clear protocols and pathways within services for escalating those with deteriorating mental illness to clinical care.

Additional priority service needs identified by stakeholders include: mental health training for GPs; greater capacity of general practice to provide multidisciplinary care; services for people experiencing moderate to severe chronic mental illness; early intervention approaches and services, particularly for young people; transport to and from services; evidence-based and systematic approaches to mental health promotion and prevention; and support, recognition and involvement for families and carers of people living with mental illness.

Service needs specific to suicide prevention relate to ensuring people at risk are identified across the service system, with support services accessible as needed. Supporting community and service-based approaches to suicide prevention, including postvention strategies, is a high priority.

During consultations for the After-Hours Primary Care Needs Assessment, several stakeholders, including mental health professionals, noted that people with mental ill-health often need support or care outside of traditional hours. While some of these people may have regular GPs, many practices do not offer after-hours services and LHD community-based mental health crisis services are often stretched or not readily accessible. As a result, it was noted that people with mental health conditions or co-morbidities often present to EDs, a setting that is often busy and frantic, which may be detrimental to the patient's condition.

Stakeholder consultation identified a need to increase the integration of mental health services within the region including the need to widen the scope of commissioning opportunities that allow for service delivery across the continuum of mental health and AoD comorbidities.

The Mental Health and Suicide Prevention Joint Regional Plan highlights that integration of mental health services is a pivotal theme that underpins the 5th National Mental Health and Suicide Prevention Plan and is a number one priority area. Integration of care focuses on the organisation and delivery of health services to provide seamless, coordinated, efficient and effective care that responds to all a person's health needs.

Perspectives of integrated care for mental health differ, but from the system include integration of care:

- between health services, social services and other care providers
- across primary, community, hospital and tertiary mental health care services supported by care pathways and care transitions
- between mental health and general health services
- between health care providers and consumers and other service users to engage and empower people through health education, shared decision-making, supported self-management, and community engagement
- to support both a population-based and person-centred approach to care, to focus on whole of community and individuals needs

Shared care models between primary health services and specialist mental health services, which support integration of care, can lead to improved clinical

outcomes and potentially reduced relapse rates. Effective shared care models can be effective with a commitment to improvement across the system, and clinical models supported by care pathways.

Service challenges relating to integration were identified in stakeholder consultation. There are challenges related to the effective implementation of the stepped care model in communities where the required services and programs at each level across the service system and pathways to support integration across the stages are limited or non-existent.

There are problems with integration of services with concerns including:

- inadequate communication about care for people with a mental illness between specialist mental health and primary care services, and support services
- timeliness and quality of care planning
- lack of attention to mental health needs in the general health system
- lack of adequate measures of integration which reflect the whole of the system

The Mental Health and Suicide Prevention Joint Regional Plan identified several priorities including Priority area 1 – Integration.

Integration of mental health services within the region will ensure:

- Improved consumer and provider experience
- Improved patient outcomes
- Better care planning, coordination and referral practices
- Better physical health of people with a mental illness
- Improved mental health for those with a chronic illness
- Improvements in the quality of care and its reporting across the service system
- A systematic approach to mental health promotion across the service system.

Cost barriers to accessing mental health and suicide prevention services

Consultation across the HNECC PHN region showed that many consumers, clients and carers indicated that cost was a significant barrier to accessing services for mental illness and suicide prevention, with 81% of service providers and 71% of consumers, clients and community members reporting cost as a barrier to accessing services. Many GPs, psychiatrists and private allied health staff charged a gap payment on top of the Medicare rebate with few bulkbillings. The cumulative effect of these costs is considerable especially for those with moderate to severe mental illness, who are reliant on welfare payments as due to work is limited work opportunities because of their illness. Service providers indicated that their decisions about referral were often made on knowledge about service costs rather than on care needs. Consumers also reported making decisions about accessing care based on cost, often waiting until symptoms deteriorated before seeking care, leading to the need for more intensive help through specialist services such as acute wards, at an increased cost to the health system. Additionally, there is a cost disincentive for services to take on patients with complex needs as billing is the same whether the patient requires treatment for less complicated or more complex needs.

The Mental Health and Suicide Prevention Regional Plan highlighted that significant cost barriers continue to be an issue in accessing mental health and suicide prevention services, this includes travel costs to services and was raised as a significant issue by clients and community members during consultation in the development of the plan.

Transport barriers to mental health services

Transport has been identified as a barrier to accessing services for mental illness and suicide prevention throughout the HNECC PHN region, with public transport limited or unavailable in many communities. This is a particular barrier to engagement in mental health services for low-income individuals, adolescents and frail older people, and is not unique to rural parts of the region. Clients are often relying on public transport to access specialist clinical services distant to their home, leading to whole day or overnight stays. Community transport, while available, is often cost prohibitive and consumers reported experiencing stigmatising attitudes when requesting access.

The Mental Health and Suicide Prevention Regional Plan noted that transport continues to be an issue in accessing mental health and suicide prevention services, including limited to no public transport in many communities and the cost of transportation was prohibitive for many clients and community members.

Limited services for people experiencing moderate to severe mental illness

Stakeholders in the HNECC PHN region report service gaps for people experiencing moderate to severe mental illness, both episodic and chronic, including those experiencing other complex health and social problems. As clinical care for people experiencing severe mental illness is unavailable, providing care for this population group is stretching the capacity of primary care, with LHD specialist services only available for acutely unwell people. The gaps in the current system tend to channel people into the acute setting. Stakeholders suggest there is a priority need to strengthen the capacity of services including approaches to quality and governance across services to provide care for this cohort.

The capacity to provide the breadth of services for this cohort is limited, with few services providing seamless access to clinical, therapeutic and support services. Referral between services is described as difficult, with challenges around information sharing, case management and role delineation. The mental health line, the initial point of access for someone experiencing acute mental health symptoms, was criticised due to long delays on the phone and most people eventually being deemed ineligible for state based mental health services. If triaged as eligible upon presentation to an acute facility, clients were often either not admitted or discharged early, including late at night and far from home without transport.

Many community-based service providers indicated they felt ill-equipped to provide the type and intensity of services needed by these consumers. There is a clear need to strengthen quality and governance across these services. Support service staff working with this cohort are often welfare trained without mental health specific expertise and working beyond their level of qualification and scope of practice. There is also a lack of formal mechanisms for escalating clients with deteriorating mental health.

Under the various allied health access programs, clients are eligible for between 6 and 12 sessions per year, which is considered insufficient for this population group and specifically for clients with a history of trauma and abuse including intergenerational trauma.

Due to the introduction of the NDIS, services providing support to people experiencing severe mental illness are in a state of flux as funding and business models are adapted. Those services using an NDIS business model are unable to provide support to non-NDIS participants. Anecdotal reports suggest that NDIS recipients are encouraged to access mainstream services to maximise their funds available to purchase other services, further limiting the availability of services to people with severe mental illness who are ineligible for NDIS assistance. Stakeholders indicate that whilst the type of psychosocial support services required by people who are not eligible for NDIS assistance are similar to those of people who are eligible, services of shorter duration and/or lower intensity are required.

Service providers has also highlighted that due to the considerable documentation and effort required to apply for access to the NDIS, in some instances people who would be eligible for the program are electing not to apply or to reapply if rejected initially.

There is considerable concern amongst stakeholders as to the impact of the changes to funding and programs available to people with severe mental illness, this includes a lack of clarity around how the Continuity of Support arrangements will apply for current participants in Partners in Recovery, Personal Helpers and Mentors service and Day to Day Living, how this will differ from the National Psychosocial Support measure, and how the integration of services within a stepped care framework will be facilitated.

Some vulnerable population groups access HNECC PHN commissioned primary mental health services at a lower or higher rate compared to their population prevalence. 2020-21 data from the Primary Mental Health Care Minimum Data Set (PMHC-MDS) suggests that people from a CALD background in the HNECC PHN access commissioned primary mental health services at a lower rate (1.2%) than their population prevalence (5.2%). Conversely, the same dataset suggests that homeless people in the HNECC PHN access commissioned primary mental health services at a higher rate (3.8%) than their population prevalence (0.3%). However, these data should be used with caution due to the high rate of not stated/unknown/etc. entries in the MDS. (Population prevalence is taken from 2016 Census).

The Mental Health and Suicide Prevention Regional Plan in priority setting workshops with stakeholders, ranked "services for moderate to severe mental illness" as number one in services gaps within the HNECC PHN region.

The recent PSS Evaluation highlighted service challenges for the program including access to services for people with moderate to severe mental illness:

- In more rural and remote regions, travel requirements for clients and workforce was identified by PSS service providers as problematic
- Some regions within the PHN found that small town social issues were difficult to navigate around to get clients involved in the program

Further to this, it was also highlighted that key workforce challenges within the region include the capacity of community based social support services to be able to provide care for people with severe mental illness and other complexities, within their scope of practice. This is further supported with stakeholder consultation that identified there are barriers in accessing the psychosocial supports within the community, and that people with severe mental health illness are falling through the cracks between the NDIS and psychosocial services due to the lack of coordination within the system. There is also difficulty in accessing health services for those who have severe mental illness and who are homeless.

Further to this, moderate to severe mental health services were ranked as third most important health service area needing improvement within the community.

Support for GPs to play a central role in mental health care

Primary mental health care is a necessary part of comprehensive mental health care, provided at a primary (frontline) care level and is an essential part of general primary care. In 2020-21, in the HNECC PHN region, there were 199,089 GP mental health services provided through the MBS to 126,594 patients. At a local level, the rate at which services were delivered ranged from 9,139 per 100,000 in Tamworth-Gunnedah SA3 to 18,413 per 100,000 in Gosford SA3. Lower rates were recorded in Moree-Narrabri (9,249), Inverell-Tenterfield (9,256) and Upper Hunter (9,847) SA3s.

Common across all levels of the service system for mental health care and suicide prevention, is the provision of care by GPs. GPs are often the first point of contact for people experiencing mental illness and potentially play an essential role in the mental and physical health care of patients and in coordination of their care. However, the capacity of GPs to provide mental health care was a concern expressed by many consumers, carers and service providers, partially due to the attitudes of GPs towards mental illness and to those experiencing mental illness. It was perceived that the attitude of the GP determined care, rather than the patient's symptoms or principles of best practice, with GPs often relying on medication for the initial treatment of depression and anxiety and appearing reluctant to prepare a mental health care plan. Clients and carers signified GPs were critical in ensuring a comprehensive and supportive approach to care, however their attitudes could compromise care. Additional capacity challenges for GPs included: time; knowledge; skill; and interest. While it was recognised that GPs play a key role in managing mental ill-health, there is a need for greater involvement in care by other general practice staff such as practice nurses and other allied health providers.

Given the lack of services for people with severe and complex mental illness stakeholders reported a reliance on primary care to service this population group. This was perceived by clients, carers and service providers, including GPs, to be beyond the capacity of primary care particularly for those experiencing escalated symptoms, leading to poorer outcomes. Many GPs focus on physical health viewing the treatment of mental health, particularly severe mental illness, as the role of mental health professionals.

The capacity of GPs to provide care for people with suicidal ideation and attitude towards suicide, were concerning for stakeholders, particularly young people. It was perceived some GPs lacked skills in identifying a patient at risk of suicide including ignoring risk factors or being reluctant to begin a conversation about suicide.

The central role of the GP in the provision of mental health care needs to be a key tenet of service models, however this needs to occur in the context of support and capacity building across the service system. Specific requirements include training GPs in mental health with a focus on skills, knowledge and attitudes towards mental illness across population groups; and improving the capacity of general practice to provide multidisciplinary care.

During consultations for the After-Hours Primary Care Needs Assessment, stakeholders identified the need for improved access to qualified primary mental health care practitioners during the after-hours period. Stakeholders reported this would improve access to care in the community for people experiencing mental ill-health and reduce the need for them to seek care via emergency departments. While many people experiencing mental health issues have regular GPs, many practices don't offer after-hours services and community-based services are not readily available.

Reduced access to psychiatrists and psychologists

In 2020-21, in the HNECC PHN region, a total of 18,831 patients received 62,784 psychiatry services through the MBS. At a local level, the rate at which psychiatry services were delivered ranged from 1,904 per 100,000 in Moree-Narrabri SA3 to 6,724 per 100,000 in Newcastle SA3. Lower rates were also recorded in Tamworth-Gunnedah (3,246), Upper Hunter (3,343), Armidale (3,650), Wyong (3,744) and Port Stephens (3,762) SA3s.

According to stakeholders access to psychiatrists across the HNECC PHN region especially in rural areas was a significant barrier to care, with insufficient numbers to meet needs alongside cost due to a gap payment. The ability of consumers to access psychiatrists in a timely manner was a consistent concern with lengthy waiting lists particularly for those who bulk billed. This was applicable across all ages but especially for children and young people with few child psychiatrists available and these being in Newcastle and only for those with severe mental illness.

Telehealth was thought to enhance access to psychiatry services, particularly in rural areas but was mostly unavailable. There was reliance in many rural communities on fly-in fly-out psychiatrists to provide specialist medical input, with access to care only available when the specialist was in town. Retention of psychiatrists is seen as disruptive to continuity of care.

Stakeholder consultation identified the following issues as reduced access to psychiatrists:

- Large gaps between mental health services, with wait times excessively too long to access a private psychiatrist (or psychologist) and that this places people at risk of deteriorating further and requiring more intensive support
- Rural and remote access to psychiatrists is difficult with long wait times and often no to limited psychiatrists within the rural and remote regions
- Poor access to public psychiatrists for adult care on the Central Coast, with this problem further exacerbated by the distribution of training positions for junior doctors in this area based on allocation from Northern Sydney LHD

Consultation from Clinical Councils noted concerns of capacity of local mental health services to meet community demand during the pandemic, noting that local psychologist wait times have significantly increased or have closed books, disadvantaging new patients requiring services. This was further supported by the Taree and surrounds healing forum which noted that since the local psychiatrist relocated, the only available service costs community members $150 and has a waiting list. Forum participants suggested it is common for community members to wait six to 12 months for an appointment with specialist services, such as psychologists and occupational therapists.

Further consultation identified the following regarding reduced access to psychologists:

- A need to increase utilisation of counsellors as part of the strategy to address lack of available psychologists
- Waiting lists are long for psychologists within the rural and remote regions
- Costs of psychology services are beyond the means for most people that require treatment

No psychologists in some regional towns that accepts mental health care plans, 2.5 hours to nearest psychologist that does take mental health care plans, and a 5-week waiting list.

Reduced capacity of services to recruit and retain allied health staff

There is a need to strengthen the capacity of mental health services to recruit and retain allied health staff, particularly psychiatrists and psychologists and in rural areas. Strategies such as incentives are in place to attract psychiatrists, and other professionals such as teachers and police to rural areas but are not available for psychologists. There is significant turnover in mental health staff, which affects continuity of care, and an overreliance on provisional psychologists impacts retention. Service providers indicated that the challenges faced by provisional psychologists in terms of case complexity, and lack of support, results in many leaving services.

According to stakeholders in the recent "Have Your Say Stakeholder Survey, 2021" allied health services was the most important health service area needing improvement.

Limited availability of early intervention services

A lack of early intervention and prevention approaches and services was identified as a high service need throughout the HNECC PHN region, especially for young people and for people experiencing early psychosis. This includes early intervention to prevent onset or deterioration of mental illness; support recovery; and specifically, for those experiencing first onset of psychosis. Not only are these specific services unavailable, but

there is a need for a significant shift in the delivery of services to ensure early intervention is applied across the service system. There is a need to increase capacity to identify associated factors and intervene before symptoms manifest or conditions deteriorate. A stronger early intervention and prevention focus across all services will help prevent people requiring more intensive services rather than the current system which, due to service gaps, channels people into the acute setting.

Early intervention and prevention services were raised in community and stakeholder consultation, in particular early intervention mental health services for children and youth.

- Lack of preventative and early intervention mental health services for the 0-12 age group was identified as a high need
- Limited services for children and adolescents with behavioural problems, including poor or no access to child adolescent psychiatrists in all communities across the region, and poor access to developmental psychologists for children with mental and behavioural problems
- A need to empower communities and focus on prevention and early intervention in all areas including mental health

Youth mental health services were raised as a need frequently throughout stakeholder consultation including:

- A high need for child and adolescent inpatient mental health services
- Mental health services for youth under the age of 12
- An increased burden on schools to address the issues of mental health as well as alcohol, other drugs, domestic family violence and homelessness
- Access to mental health services for youth for is limited, particularly when there is a need for hospitalisation
- Long waiting lists over 6 or 7 months for youth mental health services
- Lack of integration between organisations and mental health services who deliver or support youth mental health programs

Lack of cross-sectoral mental health promotion and prevention, and suicide prevention strategies

In 2018-19, in the HNECC PHN region the rate of admissions into all hospitals for mental health related conditions was 2,247.4 (age standardised) per 100,000 population, which was higher than the NSW average (2,048.0). An increase in mental health related condition admissions across the PHN region was observed from the previous year (2017-18; 2,206.5 per 100,000), similar to state trends. The premature mortality rate from suicide and self-inflicted injuries in the HNECC PHN region is higher than for NSW. In 2018, there were 178 suicides recorded in the HNECC PHN region, which translates to a rate of 14.5 per 100,000 population, NSW (11.0 per 100,000).

Reduced availability of mental health promotion and prevention services was identified by stakeholders as a key service gap in the HNECC PHN region. There is a need to ensure evidence-based and systematic approaches to mental health promotion and prevention alongside suicide prevention, with an emphasis on strategies which are broader than the current focus on education and training. Initiatives needed for implementation across sectors including youth specific services; education and training; community and sporting groups; workplaces; aged care facilities; and the general health system.

Limited capacity of services to develop and implement an approach to quality

Inconsistencies exist in the approaches to quality and quality improvement across all services throughout the HNECC PHN region. There is a need for frameworks aligned to sound clinical governance approaches across the mental health service system, including support services, and with support for case review and clinical supervision to manage risk.

Stakeholders were particularly concerned about the quality of mental health treatment services provided across the region, including by the Local Health District and in the acute setting. Further concerns related to the lack of experienced clinical staff in some organisations, including a reliance on provisional psychologists. This was suggested as occurring in the absence of supervision by an experienced psychologist and to reduce session costs, whilst jeopardising quality of care.

Few support services had a systematic approach to quality. A quality framework including an approach to manage clinical risk was considered imperative for all services but was not a focus of many services. Mechanisms for escalating clients' needs to more specialist services for example were not available in some services. In addition, there were few examples of services reporting client outcomes, and clinical and client experience, with a reliance on activity reporting.

Limited support for families and carers of people living with mental illness

Support services for families and carers of people living with mental illness was identified by stakeholders as a high need throughout the HNECC PHN region. This includes providing direct support whilst recognising and respecting the key role that families and carers play in supporting and caring for people experiencing mental illness and involving them in decision making. It is accepted that involvement of family and carers in care leads to better outcomes, however carers feel that there is a lack of recognition of their role in care, with their lack of involvement often attributed to confidentiality. Service providers especially those in the LHD mental health services recognise a need to strengthen the involvement of carers in care planning particularly for patients with severe and complex mental illness. The impact on family and carers of someone with severe mental illness is significant. Support and recognition for carers and family members should be a key element of services.

Lack of a systematic evidence-based postvention strategy across communities

Stakeholders identified a lack of services, or lack of awareness of services, for family and friends after a suicide attempt as a need in the HNECC PHN region. The provision of support for families following a suicide attempt or completed suicide was also perceived as a significant system challenge and a barrier to addressing suicide. It was perceived that families were often the best placed to provide support for a loved one following a suicide attempt, however the claimed need for privacy and confidentiality was used as a barrier to family involvement. This was considered a significant barrier to recovery for both the person who had attempted suicide and the family.

The capacity of communities to respond following a suicide was identified as an area of need across the HNECC PHN region. Strategies to support families, friends, and colleagues of people after suicide have been implemented in some communities such as: partnerships with organisations like Lifeline Hunter and United Synergies; suicide prevention networks established without organisational support; and school based postvention strategies supported by headspace. Many communities however do not have such strategies in place.

The results of priority setting workshops determined the rank -order for perceptions of suicide prevention target groups and challenges across the region:

Target Groups:

1. Young people
2. Aboriginal people
3. Males 25-65 years
4. People from vulnerable population groups
5. People from rural and remote areas
6. Older males 80+ years

Suicide Prevention Challenges:

1. Follow up support for those with suicidal ideation
2. Follow up support after presentation for suicide attempt
3. Evidence based approaches to suicide prevention
4. Community capacity to address suicide
5. Evidence based approaches to postvention

Other suicide prevention needs identified in the discussion at priority setting workshops include:

- People living in regional and remote areas experience higher rates of suicide and higher risk factors
- People who are isolated and experiencing relationship breakdowns
- People impacted by disasters including drought, fires, flood and the pandemic
- People affected by drug and alcohol abuse
- Lack of evidence-based prevention strategies
- Lack of systematic evidence based postvention strategy across the region, including a lack of services or awareness of available services for families, carers, friends and colleagues of people who have attempted suicide.

Further to this, stakeholder consultation identified the following needs for suicide prevention and postvention strategies and services for the region:

- Stakeholders noted the difficulties in accessing suicide prevention and other mental health services where referrals are often rejected for reasons including patient too unwell or patient too complex.
- Suicide patients discharged too soon and actively deteriorating young people rejected access to specialist mental health services despite multiple referrals
- Youth suicide an issue in Maitland and surrounding areas

Barriers for mental health nurses to gain credentials to work in general practice

Substantial barriers in gaining the required credentials to provide mental health nursing care in general practice have resulted in few completing required training. Further to this, the pay differential between mental health nurses in general practice and those working in LHD mental health services limits supply. Stakeholders indicate the role of general practice in mental health care needs to be strengthened by supporting multidisciplinary teams located in general practice.

Reduced access to drug and alcohol treatment services

Stakeholder engagement has confirmed that alcohol-related harm and subsequent treatment service provision remains the single largest contributing factor across the AOD sector, however methamphetamine-related presentations continue to increase as reported by HNECC PHN-funded providers. The availability of drug and alcohol residential services across the HNECC PHN region is inadequate, with waiting lists of up to 3 months in some services being reported. There is a particular lack of detoxification and residential treatment services in the Upper Hunter, Singleton, Muswellbrook and Greater Taree and Great Lakes LGAs.

Service providers indicate that people do not understand the signs and symptoms of drug and alcohol misuse and are delaying help-seeking, due in part to stigma. People are also finding it difficult to travel to access the services they require, particularly in rural and remote regions of the HNECC PHN region.

Service providers and other stakeholders indicate that the following factors need to be in place to improve outcomes across the region: increased coordination between services; improved patient access, engagement and sector navigation; improved access to primary mental health care services; more investment in drug and alcohol and mental health promotion and prevention; increased access to early intervention services; improved quality of treatment services in the hospital system; improved follow up of patients after hospital discharge; greater access to community mental health services; improved referral to counselling services; and improved access to residential and aftercare services; greater support for clients during transition between services; improved access to services for vulnerable population groups; greater support for primary care services in identifying and treating substance misuse, particularly General Practice; availability of services in languages other than English; increased availability of services after hours; more holistic treatment; increased access to psychiatrists; support for carers; and improved access to housing, accommodation, employment and skills-based training.

The recent HNECC PHN AoD Evaluation indicated challenges for service providers in delivering services and keeping up with demand including:

- Funding cycles are too short a period to support the establishment of new and alternative approaches and exploring innovative solutions
- Warm referral processes were noted as integral to supporting an individual access an AoD service

Patterns of referrals for Drug and Alcohol treatments indicated the following:

- Overwhelmingly, clients self-refer to drug and alcohol services - particularly evident in home, residential treatment, and non-residential treatment settings. During 2019-2020, there was a significant spike in self-referrals, potentially due to COVID
- Family and friends and community services are key contributors to referrals of clients to a service
- Referrals from correctional services and court diversions are also significant which affirms provider feedback regarding the increased demand from this sector. This is particularly the case for outreach, where correctional facilities provided the highest number of referrals.
- Referral rates from hospitals are regularly low
- Patterns in GP referrals showed an increase from a low rate up until 2020-2021, potentially attributable to COVID, and / or improved use of the HealthPathway platforms, or increased awareness of service availability.

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for non-government alcohol and other drugs services in NSW. As a member driven peak body, NADA's decisions and actions are informed by the experiences, knowledge, and concerns of its membership. A recent needs assessment conducted by NADA found the following needs according to AoD services in NSW:

- Increased and sustainable funding as a top priority for service delivery
- Improved contracts and compliance
- Increased access to service delivery and improved referral pathways
- Continuity of care and collaboration, in particular linkages and access pathways between mental health and AoD comorbidities
- Treatment access and equity including transport needs, barriers such as cost and long waiting lists

- Building service and workforce capacity including support in applying evidence-based practice and undertaking quality improvement initiatives.
- Workforce development opportunities
- Improvements to data systems and data sets

Reduced access to drug and alcohol treatment services for First Nations people

Greater access to drug and alcohol treatment services for Aboriginal and Torres Strait Islander community members throughout the HNECC PHN region has been identified as a need. Specific needs identified by stakeholders in relation to this vulnerable cohort include more culturally appropriate services; greater integration between mental health, and drug and alcohol services; more flexibility in treatment approaches. ongoing support and referral pathways; and targeted support for services to provide treatment for this population group.

Yarning circles conducted in the Cessnock, Kurri Kurri and surrounding communities healing forum identified that Alcohol and Other Drugs was a concern for the community. While considered to be symptomatic of trauma in many instances, alcohol and other drug use was itself identified as a major factor that is harming children and families. Alcohol and drugs were cited as key to the incidence of family violence, incarceration and child neglect and removal, with a participant suggesting 'We need more rehabs and less prisons.' Concerns were raised about the easy access to illicit drugs, with known drug dealers living around housing estates. There was some frustration that drug dealers continued to live in the community despite numerous reports being made. Several participants also voiced frustration at the 'massive' wait lists to access rehabilitation and the lack of services and resources to support people to transition back to community after rehab.

A recent needs assessment conducted by the network of alcohol and other drug agencies (NADA) noted that members of the network stated that that access to sustainable and increased funding was a priority, including for Aboriginal AoD services.

Reduced access to drug and alcohol treatment services for pregnant women and/or those with young children

Pregnant women and women with young children have been identified as a vulnerable population group with reduced access to drug and alcohol services in the HNECC PHN region.

Stakeholders have indicated that there is a need for more services for families, mothers and children, including day programs and peer support groups.

Reduced access to drug and alcohol treatment services for youth

Youth are a vulnerable population group with reduced access to drug and alcohol treatment services in the HNECC PHN region. Service providers indicate that early intervention services are inaccessible for young people, and stakeholders in general have highlighted a need for improved access and more age-appropriate drug and alcohol services for youth, and greater support for families. Due to a lack of youth residential services in the HNECC PHN region, young people are travelling to other PHN regions to engage in treatment.

Several stakeholders raised concerns about the lack of access to drug and alcohol treatment services and mental health services for youth, with a lack of adolescent specific mental health beds and detox units/ programs a growing concern for community members.

Reduced access to drug and alcohol treatment services for people exiting the criminal justice system

Stakeholders have indicated that there is reduced access to drug and alcohol treatment services for people upon exit from the criminal justice system, calling for increased availability of services via probation and parole for court mandated counselling clients and for those who have a requirement of treatment as a component of their parole conditions.

The recent HNECC PHN AoD Evaluation noted that the current support to individuals in correctional facilities is limited and therefore when an individual is released into the community, there is a high risk of recidivism. This is further supported in stakeholder consultation where concerns were raised about the limited support offered to people who are exiting the criminal justice system and that more drug and alcohol services and supports are needed to safely transition into the community.

Reduced access to drug and alcohol treatment services for people with co-occurring substance misuse and mental illness

Reduced access to treatment for people experiencing co-existing substance misuse and mental illness has been consistently flagged as a need by services providers and community members throughout the HNECC PHN region.

Recent feedback from the HNECC PHN AoD Evaluation indicated that several providers and other stakeholders highlighted the specificity of funding allocations for AoD service delivery, correspondingly narrowed the scope of potential commissioning opportunities. For example, service delivery that could support continuum of care across Mental health and AoD comorbidities. This is further supported by stakeholders working within service delivery who have highlighted that there is reduced AoD and mental health comorbidity support for health professionals and that there is a need for clearer referral pathways for mental health and AoD services, and lack of clear information in finding the right service for the right health needs.

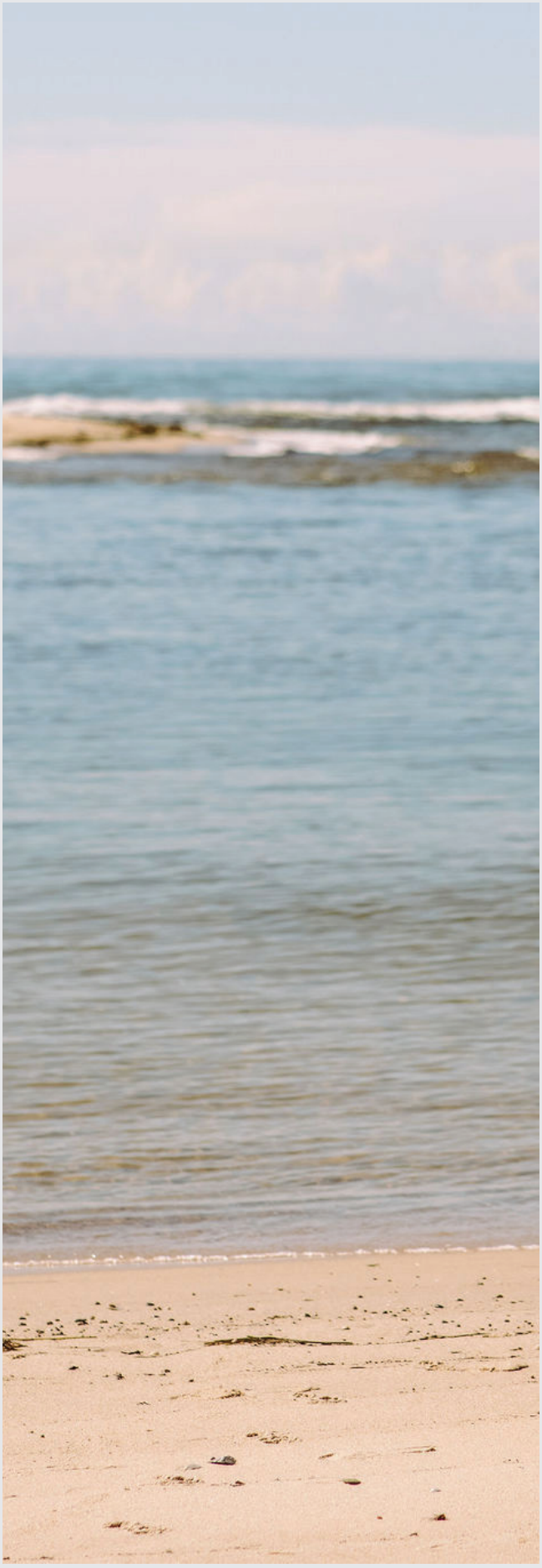
Lack of drug and alcohol rehabilitation services

The recent HNECC PHN AoD Evaluation highlighted consistent messaging from service providers including not being able to keep up with the demand and pressure for residential rehabilitation where services are limited based on physical restrictions such as number of beds. This is reflective of the waiting lists and long wait times for clients to get into services.

Lack of supporting infrastructure for residential rehabilitation services is a concern for service providers within the region, with feedback highlighting that more facilities and more beds are needed to meet the demand. The gap in services was seen to be particularly an issue for women and their children and young people. Provider feedback indicated that 1000 people had applied for rehabilitation services and that service delivery could only provide service for 44 clients. Further to this, NADA estimated that NSW requires an additional 1,700 residential rehabilitation beds to provide adequate care across the state. Currently, there are only approximately 700-800 beds available.

Further feedback identified:

- There is a lack of detoxification beds, especially for the youth population (13–16-year-olds)
- Drug Courts and Magistrates Early Referral into Treatment Program (MERIT) have high expectations of the residential rehabilitation facilities to require individuals to stay in their services
- The support offered to individuals in correctional facilities is limited, and therefore when an individual is released into the community, there is a high risk of recidivism



Opportunities, Priorities and Options

This section summarises the priority needs and possible options / activities to address these.

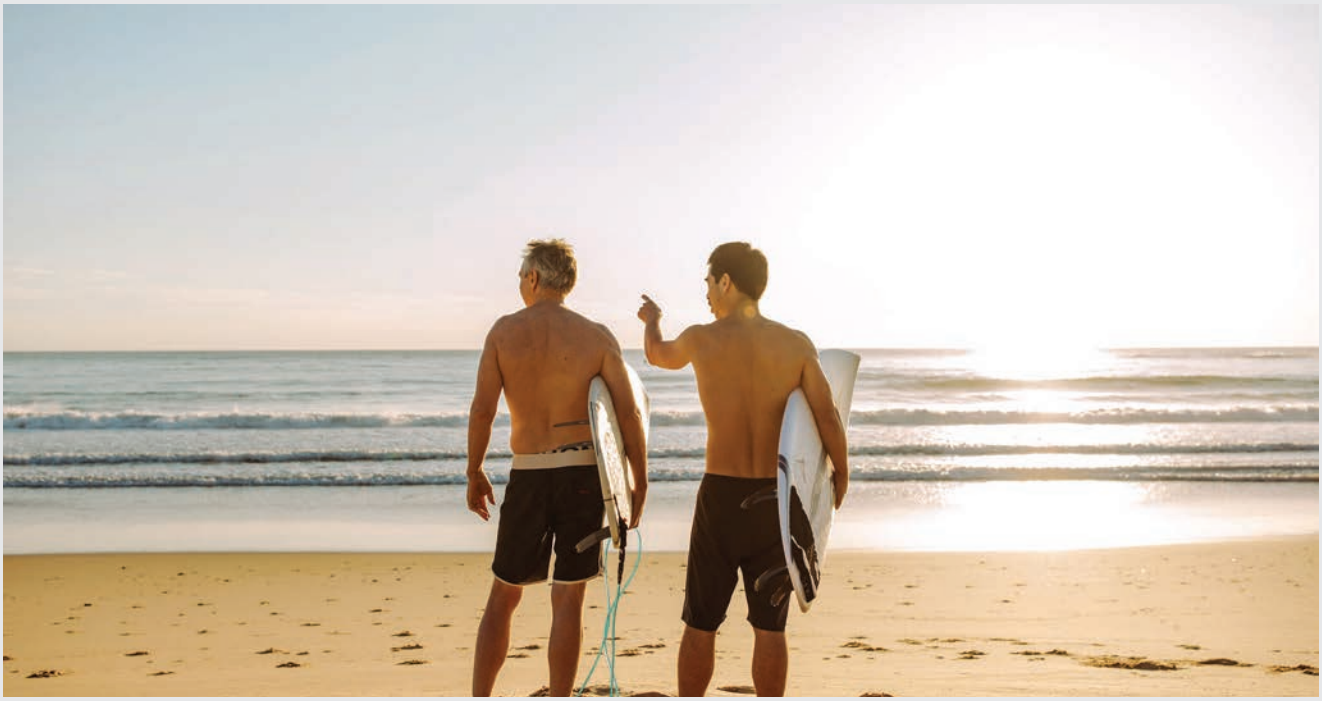
Each need has a unique code which also indicates the focus area*, these are used in the Opportunities and Options tables to highlight the needs addressed by each activity. The number of options against each need are listed in the blue tables.

*PH - General Population Health. MH - Primary Mental Health Care & Suicide Prevention. IH - First Nations Health. AOD - Alcohol and Other Drug Treatment. #opt - Number of options.

General Population Health Priority Needs

GENERAL POPULATION HEALTH PRIORITY NEEDS		
Code	**Need**	**No. of options**
NxPH1	Low levels of health literacy	2
NxPH2	Poor self-assessed health status	4
NxPH3	Lower than average life expectancy	11
NxPH4	Socioeconomic disadvantage	0
NxPH5	Health needs of an ageing population	8
NxPH6	Poorer health outcomes for culturally and linguistically diverse populations	3
NxPH7	Areas for improvement in childhood immunisation rates	1
NxPH8	High rates of smoking during pregnancy	1
NxPH9	Poor health and developmental outcomes for infants and young children	4
NxPH10	Youth health needs	7
NxPH11	Rural health Inequalities	11
NxPH12	High proportions of people with severe disability and carers	1
NxPH13	Increasing prevalence of dementia	2
NxPH14	High rates of overweight and obesity	3
NxPH15	High rates of physical inactivity and poor nutrition	3
NxPH16	High rates of smoking	2
NxPH17	High rates of chronic disease	7
NxPH18	High cancer incidence and mortality	7
NxPH19	Poorer health outcomes for people experiencing homelessness	1
NxPH20	A lack of health service integration, coordination and information sharing	8
NxPH21	Areas of primary care workforce vulnerability	6
NxPH22	Locally relevant professional development and education for primary care clinicians	4
NxPH23	Targeted support for general practice	5
NxPH24	Limited access to dental services	2

GENERAL POPULATION HEALTH PRIORITY NEEDS		
Code	**Need**	**No. of options**
NxPH25	Limited capacity of services to address dementia	4
NxPH26	Lack of prevention and early intervention services	3
NxPH27	High rates of chronic disease hospitalisations	5
NxPH28	Barriers to screening in primary care	5
NxPH29	Barriers to accessing disability services	1
NxPH30	Reduced access to services for children and youth	7
NxPH31	Limited access to after-hours GPs	3
NxPH32	High proportions of semi-urgent and non-urgent emergency department presentations	5
NxPH33	Reduced access to services for older people	7
NxPH34	Reduced access to services in rural and remote areas	10
NxPH35	Transport limitations	4
NxPH36	Cost barriers to healthcare	4
NxPH37	Reduced access to services for people experiencing homelessness	1
NxPH38	Emerging Needs	0
NxPH39	Reduced access to services for culturally and linguistically diverse populations	2
NxPH40	Access to and utilisation of Digital Health and Telehealth in Service Delivery	13
NxPH41	A greater role for Pharmacy in delivering primary health care	4



General Population Health Opportunities and Options

GENERAL POPULATION HEALTH OPPORTUNITIES AND OPTIONS					
Possible Activities	**Expected Outcome**	**Possible Performance Indicators**	**Data Source**	**Potential Lead**	**Need/s**
Commission a Mobile X-Ray Service to provide non-urgent on-site radiography to RACF residents	Reduction in transportation of RACF residents to hospital	*Output indicator* – Number of participants Proportion of RACFs in the area with access to the service *Outcome indicator* – Number of instances where transport to hospital has been avoided	HNECC	HNECC CCLHD	NxPH5 NxPH32 NxPH33 NxPH35
Commission targeted pilot activities for people from culturally and linguistically diverse backgrounds that improve their health outcomes.	Increased understanding of the needs of people from culturally and linguistically diverse backgrounds, improved health outcomes and access to services for this cohort	*Process indicator* – Investigation is completed *Output indicator* - Recommendations / solutions are made Services are commissioned in response to local identified need	HNECC	HNECC HNELHD CCLHD NGOs	NxPH6 NxPH39
Evaluate existing strategies and plans for child and maternal health in collaboration with key stakeholders	Improved child and maternal health outcomes	*Process indicator* – Evaluate existing strategies and plans *Output indicators* – Recommendations/ solutions are made to inform partnerships and planning *Outcome indicators* – To influence planning and where appropriate services are commissioned in response to local identified need	HNECC AIHW NSW HealthStats	HNECC HNELHD CCLHD	NxPH3 NxPH8 NxPH9 NxPH16 NxIH3 NxIH8 NxPH9

GENERAL POPULATION HEALTH OPPORTUNITIES AND OPTIONS

Possible Activities	Expected Outcome	Possible Performance Indicators	Data Source	Potential Lead	Need/s
Commission Primary Health Care Nursing Clinics and Community Participation programs throughout New England North West	Improved health and wellbeing of people living within small rural and remote communities	*Output indicator* – Proportion of the rural population receiving PHN-commissioned primary health care nursing services Proportion of the rural Aboriginal and Torres Strait Islander population receiving PHN-commissioned primary health care nursing services	HNECC	HNECC	NxPH1 NxPH3 NxPH5 NxPH11 NxPH14 NxPH15 NxPH17 NxPH18 NxPH28 NxPH34 NxPH35 NxPH36
Commission a range of Allied Health services across the New England North West and rural Hunter regions in accordance with local need	Improved health and wellbeing of people living in rural areas	*Process indicator* – Services are commissioned in accordance with local need *Output indicator* - Proportion of the rural population receiving PHN-commissioned allied health services *Outcome indicator* – Clinical outcomes for people receiving PHN-commissioned allied health services	HNECC	HNECC	NxPH2 NxPH3 NxPH11 NxPH14 NxPH15 NxPH17 NxPH18 NxPH28 NxPH34 NxPH35 NxPH36 NxPH40 NxPH41
Commission the Ear, Nose and Throat Telehealth project, using technology to increase rural people's access to the John Hunter Hospital ENT Outpatient Service and upskilling rural GPs to manage ENT conditions	Increased access to ENT services for rural and remote children	*Output indicators* – Number of telehealth ENT consultations performed Increase in confidence of GPs in managing ENT conditions *Outcome indicator* – Patient / Carer experience of care	HNECC HNELHD	HNECC	NxPH9 NxPH11 NxPH30 NxPH34 NxPH35 NxPH36 NxPH40

GENERAL POPULATION HEALTH OPPORTUNITIES AND OPTIONS

Possible Activities	Expected Outcome	Possible Performance Indicators	Data Source	Potential Lead	Need/s
Continue to implement with key stakeholders a Rural Communities strategy that identifies local health and service needs and prioritises locally developed solutions.	Increased access to health services and improved outcomes for rural communities	*Process indicators* – Rural communities' strategy is developed Local health and service needs are identified Solutions are developed to address identified needs *Output indicator* - Activities are commissioned to address identified needs	HNECC	HNECC RDN HNELHD	NxPH2 NxPH3 NxPH11 NxPH40 NxPH41
Partner in the NHMRC NSW Centre for Innovation in Regional Health supporting scholarship and research activities in primary care	Increased research capacity in primary care	*Process indicator* – HNECC actively participates in the Centre for Innovation in Regional Health	HNECC	NHMRC	NxPH11 NxPH20 NxPH21 NxPH22
Continue to identify key partners in the disability space to better understand how Primary Care can work to improve health outcomes of this population	Increased understanding of the needs of people with a disability, improved health outcomes and access to services for this cohort	*Process indicator* – Key stakeholders are identified and where possible are included in discussions to inform need *Output indicator* - Recommendations / solutions are made Services are commissioned in response to local identified need *Outcome indicator*- Improved understanding of the needs of this population	HNECC	HNECC HNELHD CCLHD NGOs	NxPH12 NxPH29
Commission a healthy weight initiative, supporting people to engage in healthier behaviours	Reduced waist circumferences, increased productivity and reduced burden of chronic disease and demand on health services	*Outcome indicators* – Average reduction in waist circumference Rates of overweight and obesity Rates of physical inactivity and poor nutrition Rates of chronic disease	HNECC PHIDU PAT CAT	HNECC	NxPH2 NxPH3 NxPH14 NxPH15 NxPH17 NxPH18 NxPH26 NxPH27

GENERAL POPULATION HEALTH OPPORTUNITIES AND OPTIONS

Possible Activities	Expected Outcome	Possible Performance Indicators	Data Source	Potential Lead	Need/s
In partnership with Local Health Districts support smoking cessation programs through HealthPathways	Reduction in rates of smoking	*Output indicator* – Rate of calls to the NSW Quitline *Outcome indicator* – Rates of smoking	Cancer Institute NSW	HNECC	NxPH2 NxPH3 NxPH16 NxPH17 NxPH18
Co-commission a new COPD model of care which places pulmonary rehabilitation and specialist appointments in the primary care setting	Increased proportion of patients who commence and complete Pulmonary Rehabilitation Reduced hospital admissions for patients	*Outcome indicators* – Proportion of patients completing Pulmonary Rehabilitation Rate of hospital admissions for the patients involved	HNELHD	HNE Integrated Care Alliance	NxPH17 NxPH27
Co-commission a Diabetes Model of Care through the Hunter New England Integrated Care Alliance	Enhanced diabetes care in primary care, and reduced demand on tertiary services	*Outcome indicator* – Rate of hospital admissions for diabetes	HNELHD	HNE Integrated Care Alliance	NxPH17 NxPH27
Develop and implement a Community Cancer Screening Participation Strategy under the guidance of key stakeholders and community groups	Increased access to, and participation in, cancer screening programs, with a key focus on vulnerable groups including Aboriginal and Torres Strait Islander people, rural and remote communities and culturally and linguistically diverse populations	*Outcome indicators* – Cervical screening participation rates Breast screening participation rates, all women Breast screening participation rates, CALD women Breast screening participation rates, Aboriginal and Torres Strait Islander women Bowel cancer screening rates	Cancer Institute NSW	HNECC	NxPH2 NxPH3 NxPH5 NxPH6 NxPH11 NxPH18 NxPH26 NxPH28 NxIH1 NxIH2
Support and provide targeted cancer care education opportunities for rural clinicians.	Enhance workforce capacity to undertake cancer screening. Increased access to and participation in cancer screening within targeted populations and/or communities.	*Output indicator* – Number of rural clinicians completing training *Outcome indicators* – Cancer screening participation rates are both maintained and improved	HNECC Cancer Institute NSW	HNECC	NxPH11 NxPH18 NxPH21 NxPH28 NxPH34 NxPH40

GENERAL POPULATION HEALTH OPPORTUNITIES AND OPTIONS

Possible Activities	Expected Outcome	Possible Performance Indicators	Data Source	Potential Lead	Need/s
Commission the administration of a bulk-billing cervical and breast cancer screening clinic in Wyong.	Increased access to screening for socially disadvantaged women, and greater early detection of cancer and other abnormalities	*Outcome indicators* – Cervical screening participation rates Breast screening participation rates, all women Breast screening participation rates, CALD women Breast screening participation rates, Aboriginal and Torres Strait Islander women	Cancer Institute NSW	HNECC CCLHD	NxPH2 NxPH3 NxPH6 NxPH18 NxPH26 NxPH28 NXPH36
Undertake HealthPathways extended reach projects, including supporting the associated PatientInfo website	Improved planning of patient care through primary, community and secondary health care systems. Improved service navigation for patients, families and carers.	*Output indicators* – Number of pathways localised Proportion of pathways with Closing the Gap information Rates of utilisation	HNECC HNELHD CCLHD	HNECC HNELHD CCLHD	NxPH20 NxPH40
Implement a digital health and information sharing strategy, facilitating the use of shared health summaries; National Health Service Directory; Central Coast Home Care Package Provider Portal; and eReferral systems.	Improved uptake of digital health systems and improved efficiency, safety, quality and security of referrals to both public and private healthcare providers	*Process Indicators* – Updates are provided to NHSD NHSD is promoted to stakeholders Contact database of health care providers is maintained *Output indicators* – Utilisation of shared health summaries Number of eReferrals sent and received Utilisation of secure messaging Uptake of MyHealthRecord	HNECC DoH	HNECC HNELHD CCLHD	NxPH1 NxPH20 NxPH23 NxPH40

GENERAL POPULATION HEALTH OPPORTUNITIES AND OPTIONS

Possible Activities	Expected Outcome	Possible Performance Indicators	Data Source	Potential Lead	Need/s
Continue to evolve 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; and Central Coast Dementia Alliance	Improved service integration and coordination, increased access to services and improved health outcomes for the HNECC PHN population	*Process indicators* - Evidence of formalised partnerships with other regional service providers to support integrated regional planning and service delivery HNECC actively participates in all relevant activities associated with each of the partnerships	HNECC HNELHD CCLHD	HNECC HNELHD CCLHD	NxPH5 NxPH11 NxPH13 NxPH20 NxPH25 NxPH32 NxPH33 NxPH34
Identify primary care workforce gaps and facilitate appropriate scholarships and education programs to innovatively attract and retain primary care practitioners to the region.	Increased retention of primary care practitioners in areas of workforce vulnerability	*Outcome indicators* – Numbers of primary care practitioners Change in vulnerability index of areas	HNECC RDN HNELHD	HNECC RDN HNELHD	NxPH11 NxPH21 NxPH22 NxPH23 NxPH24 NxPH34 NxMH16
Work in partnership with General Practice and other primary care providers to implement Quality Improvement activities	Improved efficiency and sustainability of general practices, patients receive high quality, evidence-informed care	*Process indicators* – General Practice stakeholders identify areas of quality improvement where support is required Current workforce data is maintained A system for calculating workforce vulnerability of an areas is developed *Output indicators* – Areas of immediate workforce vulnerability are identified and managed Short and longer-term workforce plans are developed and executed	HNECC	HNECC	NxPH21 NxPH22 NxPH23 NxPH24 NxMH16 NxPH40

GENERAL POPULATION HEALTH OPPORTUNITIES AND OPTIONS

Possible Activities	Expected Outcome	Possible Performance Indicators	Data Source	Potential Lead	Need/s
Commission a third-party provider to extract and collect aggregated data from general practices to facilitate benchmarking and identification of continuous quality improvement activities	Identification of practices that would benefit most from quality improvement activities, and improved quality of primary care	*Process indicator* – Data extraction and aggregation function is commissioned *Output indicator* – Data is used to identify areas for continuous quality improvement	HNECC	HNECC	NxPH20 NxPH23 NxPH40
Areas of immediate workforce vulnerability are identified and managed. Short and longer-term workforce plans are developed and executed	Improved efficiency and sustainability of general practices, patients receive high quality, evidence-informed care	*Output indicator* – Benchmarking of general practices against peers Utilisation of Practice Nurses Number of eReferrals sent and received Utilisation of secure messaging Uptake of MyHealthRecord Utilisation of HealthPathways	HNECC DoH	HNECC	NxPH20 NxPH21 NxPH22 NxPH23 NxPH40
Implement a Preventive Health Strategy that focusses on encouraging, supporting and building community capacity to participate in health promotion, wellness and lifestyle activities.	Improved health outcomes for the population	*Output indicator* – Capacity building activities are undertaken according to locally identified need	HNECC	HNECC	NxPH2 NxPH3 NxPH25 NxPH41
Commission a Memory Assessment Program in the New England region	Improved access to timely comprehensive dementia assessment for people with mild to moderate cognitive impairment.	*Output indicators* – Number of assessments performed *Outcome indicators* – Patient and carer experience of care Provider experience of care	HNECC	HNECC	NxPH5 NxPH13 NxPH25 NxPH33

GENERAL POPULATION HEALTH OPPORTUNITIES AND OPTIONS

Possible Activities	Expected Outcome	Possible Performance Indicators	Data Source	Potential Lead	Need/s
In partnership with key stakeholders develop and implement plans to respond to recommendations made around to potentially preventable hospitalisations.	Recommendations are made with a view towards commissioning services to reduce rates of potentially preventable hospitalisations in the region	*Process indicator* – Research is undertaken *Output indicators* - Recommendations are provided Services are commissioned in response to identified need *Outcome indicator* – Rates of potentially preventable hospitalisations	HNECC AIHW NSW HealthStats	HNECC	NxPH11 NxPH17 NxPH27 NxPH34
Collaborate in the delivery of the Aged Care Emergency program, providing support to RACF staff to address the non-life-threatening acute care needs of residents within the facility	Reduced Emergency Department presentations and improved coordination and experience of hospital care for RACF residents	*Output indicator* – Proportion of RACFs participating Number of telephone consultations provided to RACFs *Outcome indicators* – Patient experience of care Rates of semi-urgent and non-urgent emergency department presentations	HNECC HNELHD NSWA HPC RACFs	HNECC HNELHD NSWA HPC RACFs	NxPH5 NxPH31 NxPH32 NxPH33 NxPH40
Commission a Small-Town After-Hours service in the New England region, providing telephone medical support to local hospitals when the usual GP VMO is absent/unavailable	Improved access to After Hours primary medical care for residents of small towns, and improved retention and job satisfaction of GPs working in small towns	*Output indicator* – Proportion of small communities covered by the program *Outcome indicator* – Experience of GPs involved	HNECC	HNECC	NxPH21 NxPH31 NxPH34 NxPH40

GENERAL POPULATION HEALTH OPPORTUNITIES AND OPTIONS					
Possible Activities	**Expected Outcome**	**Possible Performance Indicators**	**Data Source**	**Potential Lead**	**Need/s**
Commission a GP After Hours service in accordance with local need	Improved access to After Hours primary medical care for residents of the HNECC PHN region	*Output indicators* – Number of patients seen Number of transfers / referrals from local EDs *Outcome indicators* – Number of consultations that resulted in hospital avoidance Number of semi-urgent and non-urgent ED presentations in the after-hours period	HNECC	HNECC	NxPH31 NxPH32

Primary Mental Health Care and Suicide Prevention Priority Needs

PRIMARY MENTAL HEALTH CARE AND SUICIDE PREVENTION PRIORITY NEEDS		
Code	**Need**	**# opt**
NxMH1	High rates of mental illness, intentional self-harm and suicide	30
NxMH2	Mental health and suicide prevention needs of youth	6
NxMH3	Mental health and suicide prevention needs of males aged 25-65 years	1
NxMH4	Mental health and suicide prevention needs of males aged over 80 years	2
NxMH5	Mental health and suicide prevention needs of Aboriginal and Torres Strait Islander people	3
NxMH6	Mental health and suicide prevention needs of older people residing in aged care facilities	1
NxMH7	Mental health and suicide prevention needs of members of LGBTIQ community members	1
NxMH8	Needs of people experiencing moderate to severe mental illness	5
NxMH9	Stigma associated with mental illness including help seeking	1
NxMH10	Lack of integration and collaboration between mental health services	4
NxMH11	Cost barriers to accessing mental health and suicide prevention services	16
NxMH12	Transport barriers to mental health services	16
NxMH13	Limited services for people experiencing moderate to severe mental illness	5
NxMH14	Support for GPs to play a central role in mental health care	1
NxMH15	Reduced access to psychiatrists	1
NxMH16	Reduced capacity of services to recruit and retain allied health staff	2
NxMH17	Limited availability of early intervention services	9
NxMH18	Lack of cross-sectoral mental health promotion and prevention, and suicide prevention strategies	3
NxMH19	Limited capacity of services to develop and implement an approach to quality	1
NxMH20	Limited support for families and carers of people living with mental illness	1
NxMH21	Lack of a systematic evidence-based postvention strategy across communities	1
NxMH22	Barriers for mental health nurses to gain credentials to work in general practice	1
NxMH23	Mental Health Comorbidities	7

Primary Mental Health Care and Suicide Prevention Opportunities and Options

PRIMARY MENTAL HEALTH CARE AND SUICIDE PREVENTION OPPORTUNITIES AND OPTIONS					
Possible Activities	**Expected Outcome**	**Possible Performance Indicators** (*Mandatory Performance Indicator)	**Data Source**	**Potential Lead**	**Need/s**
Commission primary mental health care services for underserviced and hard-to-reach groups, including rural and remote communities	Increased access to primary mental health care services for underserviced groups	Output indicator – Proportion of regional population receiving PHN-commissioned mental health services – Psychological therapies delivered by mental health professionals* Outcome indicator – Clinical outcomes for people receiving PHN-commissioned psychological therapies delivered by mental health professionals*	PMHC-MDS	HNECC	NxMH1 NxMH11 NxMH12 NxPH10 NxPH34
Commission suicide prevention services in areas of identified need	Increased access to services for people at risk of suicide	Output indicator – Number of people who are followed up by PHN-commissioned services following a recent suicide attempt*	PMHC-MDS	HNECC	NxMH1 NxMH11 NxMH12
Support first responder training and suicide-risk screening programs to facilitate early identification and intervention	Increased early identification and intervention for people at risk of suicide	Output indicator – Average increase in confidence of participants in intervening with people at risk	HNECC	HNECC	NxMH1
Collaborate with LifeSpan consortiums to facilitate QPR training and deliver the Black Dog StepCare program through General Practice	Decreased suicide attempts and decreased suicide deaths	Outcome indicators – Rates of suicide Rates of intentional self-harm hospitalisation	NCIS HealthStats NSW	Black Dog	NxMH1

PRIMARY MENTAL HEALTH CARE AND SUICIDE PREVENTION OPPORTUNITIES AND OPTIONS					
Possible Activities	**Expected Outcome**	**Possible Performance Indicators** (*Mandatory Performance Indicator)	**Data Source**	**Potential Lead**	**Need/s**
Commission Headspace centres in Gosford / Lake Haven, Maitland, Newcastle and Tamworth with outreach to Armidale, Moree, Narrabri and Gunnedah	Increased access for youth and their families to help with issues affecting wellbeing.	Output Indicator - Proportion of regional youth population receiving youth-specific PHN-commissioned mental health services*	Headspace MDS PMHC-MDS	HNECC	NxMH1 NxMH2 NxMH11 NxMH12 NxMH17 NxPH10 NxPH30
Commission youth complex services in areas of identified need	Improved outcomes for youth experiencing severe and/or complex mental illness	Output Indicator - Proportion of regional youth population receiving youth-specific PHN-commissioned mental health services*	Headspace MDS PMHC-MDS	HNECC	NxMH1 NxMH2 NxMH11 NxMH12 NxPH10 NxPH30
Commission low intensity youth services (LITe Model) in areas of identified need	Improved outcomes for youth at risk of, or experiencing, mental illness	Output Indicators - Proportion of regional youth population receiving youth-specific PHN-commissioned mental health services* Proportion of regional population receiving PHN-commissioned mental health services – Low intensity services* Outcome Indicator - Clinical outcomes for people receiving PHN-commissioned low intensity mental health services*	Headspace MDS PMHC-MDS	HNECC	NxMH1 NxMH2 NxMH11 NxMH12 NxMH17 NxPH10 NxPH30

PRIMARY MENTAL HEALTH CARE AND SUICIDE PREVENTION OPPORTUNITIES AND OPTIONS					
Possible Activities	**Expected Outcome**	**Possible Performance Indicators** (*Mandatory Performance Indicator)	**Data Source**	**Potential Lead**	**Need/s**
Conduct further investigation into early intervention services targeted at youth at risk of, or experiencing, mental illness with a view to commissioning appropriate services in response to local need	Identification of communities with the greatest unmet need for early intervention services for youth Improved outcomes for youth at risk of, or experiencing, mental illness	Process Indicators – Communities with highest unmet need identified Services commissioned in response to need Output Indicators - Proportion of regional youth population receiving youth-specific PHN-commissioned mental health services* Proportion of regional population receiving PHN-commissioned mental health services – Low intensity services*	HNECC PMHC-MDS	HNECC	NxMH1 NxMH2 NxMH17 NxPH10 NxPH30
Develop the capacity of primary care to provide early intervention and low intensity support to children and youth with, or at risk of developing, mental illness including eating disorders	Improved outcomes for children and youth at risk of, or experiencing, mental illness including eating disorders	Output indicator - Support region-specific, cross sectoral approaches to early intervention for children and young people with, or at risk of mental illness (including those with severe mental illness who are being managed in primary care) and implementation of an equitable and integrated approach to primary mental health services for this population group*	HNECC	HNECC	NxMH1 NxMH2 NxMH17 NxPH10 NxPH30
Commission primary mental health services targeted at males aged 25-65 years	Greater access to services and improved outcomes for males aged 25-65 years	Output indicator – Proportion of this cohort receiving PHN-commissioned mental health services Outcome indicator – Clinical outcomes for this cohort receiving PHN-commissioned mental health services	HNECC PMHC-MDS	HNECC	NxMH1 NxMH3 NxMH11 NxMH12

PRIMARY MENTAL HEALTH CARE AND SUICIDE PREVENTION OPPORTUNITIES AND OPTIONS					
Possible Activities	**Expected Outcome**	**Possible Performance Indicators** (*Mandatory Performance Indicator)	**Data Source**	**Potential Lead**	**Need/s**
Commission primary mental health services targeted at males aged over 80 years	Greater access to services and improved outcomes for males aged over 80 years	Output indicator – Proportion of this cohort receiving PHN-commissioned mental health services Outcome indicator – Clinical outcomes for this cohort receiving PHN-commissioned mental health services	HNECC PMHC-MDS	HNECC	NxMH1 NxMH4 NxMH11 NxMH12 NxPH5 NxPH33
Commission primary mental health services targeted at Aboriginal and Torres Strait Islander people	Greater access to services and improved outcomes for Aboriginal and Torres Strait Islander people	Output indicator - Proportion of Indigenous population receiving PHN-commissioned mental health services where the services were culturally appropriate*	PMHC-MDS	HNECC	NxMH1 NxMH5 NxMH11 NxMH12 NxIH1 NxIH3 NxIH4 NxMH23 NxIH7 NxIH9

PRIMARY MENTAL HEALTH CARE AND SUICIDE PREVENTION OPPORTUNITIES AND OPTIONS					
Possible Activities	**Expected Outcome**	**Possible Performance Indicators** (*Mandatory Performance Indicator)	**Data Source**	**Potential Lead**	**Need/s**
Investigate culturally appropriate low intensity social and emotional health and suicide prevention initiatives with the view to commissioning appropriate services in areas of need	Identification of culturally appropriate low intensity social and emotional health and suicide prevention initiatives Greater access to services and improved outcomes for Aboriginal and Torres Strait Islander people	Process Indicators – Appropriate initiatives are identified Low intensity social and emotional health and suicide prevention services are commissioned Output indicator - Proportion of Indigenous population receiving PHN-commissioned mental health services where the services were culturally appropriate* Proportion of regional population receiving PHN commissioned mental health services – Low intensity interventions Outcome indicator – Clinical outcomes for people receiving PHN-commissioned low intensity mental health interventions	HNECC PMHC-MDS	HNECC	NxMH1 NxMH5 NxIH1 NxIH3 NxIH4 NxPH39 NxIH7 NxIH9
Build the capacity of primary care to deliver culturally safe mental health and suicide prevention programs	Greater access to mental health and suicide prevention services and improved outcomes for Aboriginal and Torres Strait Islander people	Output indicator – Improved cultural safety of services Outcome indicator – Patient experience of care	HNECC	HNECC	NxMH1 NxMH5 NxIH1 NxIH3 NxIH4 NxIH7 NxIH9

PRIMARY MENTAL HEALTH CARE AND SUICIDE PREVENTION OPPORTUNITIES AND OPTIONS					
Possible Activities	**Expected Outcome**	**Possible Performance Indicators** (*Mandatory Performance Indicator)	**Data Source**	**Potential Lead**	**Need/s**
Commission primary mental health services for older people residing in aged care facilities	Greater access to services and improved outcomes for people residing in aged care facilities	Output indicator – Proportion of the regional cohort receiving PHN-commissioned mental health services Outcome indicator – Clinical outcomes for this cohort receiving PHN-commissioned mental health services	HNECC PMHC-MDS	HNECC	NxMH1 NxMH4 NxMH6 NxMH11 NxMH12 NxPH5 NxPH33
Undertake targeted consultation and further investigation to ascertain the mental health and suicide prevention needs of LGBTIQ community members, including the size of the population affected	Increased understanding of the mental health and suicide prevention needs of LGBTIQ community members that can form the basis for commissioning appropriate services	Process indicator – Targeted consultation and further investigation completed Recommendation/s made as to how this need can be addressed	HNECC	HNECC	NxMH1 NxMH7 NxMH23
Commission primary mental health services targeted at people with severe and complex mental illness	Greater access to services and improved outcomes for people with severe and complex mental illness	Output indicator – Proportion of regional population receiving PHN-commissioned mental health services – Clinical care coordination for people with severe and complex mental illness (including clinical care coordination by mental health nurses) *	PMHC-MDS	HNECC	NxMH1 NxMH8 NxMH11 NxMH12 NxMH13 NxMH23

PRIMARY MENTAL HEALTH CARE AND SUICIDE PREVENTION OPPORTUNITIES AND OPTIONS					
Possible Activities	**Expected Outcome**	**Possible Performance Indicators** (*Mandatory Performance Indicator)	**Data Source**	**Potential Lead**	**Need/s**
Commission psychosocial support services as needed for people with severe mental illness who are ineligible for NDIS support	Greater access to psychosocial support services and improved outcomes for people with severe mental illness	Process indicator – Needs assessment completed Services commissioned in accordance with identified need Output indicator - Proportion of the regional cohort receiving PHN-commissioned psychosocial support services Outcome indicator – Psychosocial outcomes for people receiving PHN-commissioned psychosocial support services	HNECC	HNECC	NxMH1 NxMH8 NxMH11 NxMH12 NxMH13 NxMH23
Commission a transitional care package program in areas of identified need	Improved outcomes for people with severe and complex mental illness	Output indicator - Proportion of regional population receiving PHN-commissioned mental health services – Clinical care coordination for people with severe and complex mental illness (including clinical care coordination by mental health nurses) *	PMHC-MDS	HNECC	NxMH1 NxMH8 NxMH11 NxMH12 NxMH13
Co-commission a GP psychiatry consultation service	Increased access to psychiatric advice for GPs, and improved outcomes for people with severe and complex mental illness	Process indicator – GP psychiatry consultation service is available to HNECC PHN GPs GPs report increased access to psychiatry advice	HNECC	NSW PHN Network	NxMH1 NxMH8 NxMH11 NxMH12 NxMH13 NxMH14 NxMH15

PRIMARY MENTAL HEALTH CARE AND SUICIDE PREVENTION OPPORTUNITIES AND OPTIONS					
Possible Activities	**Expected Outcome**	**Possible Performance Indicators** (*Mandatory Performance Indicator)	**Data Source**	**Potential Lead**	**Need/s**
Collaborate with LHDs and the Butterfly Foundation to strengthen the capacity of primary care to deliver early intervention for eating disorders	Improved outcomes for people with eating disorders	Output indicator – Reduction in hospitalisation rates attributed to eating disorders	NSW Ministry of Health	HNECC, LHDs, Butterfly Found'n	NxMH1 NxMH2 NxMH8 NxMH13 NxMH17 NxPH10 NxPH30
Develop a suicide prevention strategy to address stigma encountered by medical professionals regarding help seeking	Increased access to suicide prevention services for medical professionals, reduction in suicide rates of this cohort	Process indicator – A strategy is developed The strategy is implemented and evaluated	HNECC	HNECC	NxMH1 NxMH9
Commission a mental health and psychosocial service access, triage and referral service	Improved access to mental health and psychosocial support services across the region within an integrated stepped care model	Process indicator – An access, triage and referral service model is developed The service is commissioned	HNECC	HNECC	NxMH10 NxMH23
Commission low intensity mental health services	Increased access to low intensity services across the region within an integrated stepped care model	Output indicator - Proportion of regional population receiving PHN-commissioned mental health services – Low intensity services Outcome indicator - Clinical outcomes for people receiving PHN-commissioned low intensity mental health services	PMHC-MDS	HNECC	NxMH1 NxMH11 NxMH12 NxMH17 NxMH18
Promotion of existing low intensity services and gateways, including the mental health digital gateway	Increased access to low intensity services across the region within an integrated stepped care model	Output indicator – non-PHN low intensity services promoted across networks and communication platforms Non-PHN low intensity services built into the stepped care model	HNECC	HNECC	NxMH1 NxMH11 NxMH12 NxMH17 NxMH18

PRIMARY MENTAL HEALTH CARE AND SUICIDE PREVENTION OPPORTUNITIES AND OPTIONS					
Possible Activities	**Expected Outcome**	**Possible Performance Indicators** (*Mandatory Performance Indicator)	**Data Source**	**Potential Lead**	**Need/s**
Build the capacity of the low intensity workforce in accordance with locally identified need	Increased growth and development of the low intensity workforce, including the peer workforce	Process indicator – Low intensity workforce gaps are identified Capacity building activities are undertaken in response to locally identified need/s Capacity building initiatives are evaluated	HNECC	HNECC	NxMH1 NxMH17
Continue to work with key partners to implement the recommendations of the Joint Regional Mental Health Plan. Advocate and where appropriate make representations for additional funding to support delivery against the plan's recommendations.	Improved coordination and integration of services, and improved mental health outcomes and reduced suicide rates for the HNECC PHN population	Process indicator - Evidence of formalised partnerships with other regional service providers to support integrated regional planning and service delivery*	HNECC	HNECC, LHDs	NxMH1 NxMH10 NxMH11 NxMH12 NxMH18 NxMH21 NxMH23
Develop the capacity of primary care to operate within a patient centered stepped care model	Improved integration of services, increased efficiency of services, and improved mental health outcomes for the HNECC PHN population	Process indicators – A stepped care model is developed for the HNECC PHN region Proportion of PHN annual flexible mental health funding allocated to low intensity mental health services, psychological therapies and services for people with severe and complex mental illness	HNECC	HNECC	NxMH1 NxMH10 NxMH17

PRIMARY MENTAL HEALTH CARE AND SUICIDE PREVENTION OPPORTUNITIES AND OPTIONS					
Possible Activities	**Expected Outcome**	**Possible Performance Indicators** (*Mandatory Performance Indicator)	**Data Source**	**Potential Lead**	**Need/s**
Facilitate integration and standardisation of governance, clinical information management, performance reporting and consumer/staff feedback processes within primary mental health care services	Improved quality and governance of services, and greater integration of services	Process indicators – Governance standards are developed for primary mental health services Governance standards are incorporated within HNECC contracts Extent to which governance processes are in place and being managed according to national, state and local standards, including the National Standards for Mental Health Services 2010*	HNECC	HNECC	NxMH1 NxMH10 NxMH19 NxPH40
Work with key stakeholders to develop recommendations for addressing the needs of families and carers of people living with mental illness	Greater support is accessible for families and carers of people living with mental illness	Process indicator – A working group of relevant stakeholders is convened Output indicators – Recommendations for addressing the needs of this cohort are developed Recommendations are acted upon	HNECC	HNECC HNELHD CCLHD NGOs	NxMH20 NxIH8
Co-commission an activity aimed at increasing the number of credentialed mental health nurses working in general practice	Increased numbers of mental health nurses working in general practice	Output indicator – An activity to increase the number of mental health nurses in general practice is co-commissioned Outcome indicator - Number of mental health nurses working in general practice	HNECC	HNECC HNELHD	NxMH1 NxMH8 NxMH13 NxMH14 NxMH22

First Nations Health Priority Needs

FIRST NATIONS HEALTH PRIORITY NEEDS		
Code	Need	# opt
NxIH1	Poorer health outcomes for First Nations people	7
NxIH2	Higher rates of chronic disease amongst First Nations people	2
NxIH3	Reduced access to health services for First Nations people	7
NxIH4	Lack of integration, flexibility and cultural appropriateness of mental health and drug and alcohol services	4
NxIH5	A low proportion of First Nations people having a 715-health assessment	1
NxIH6	Lack of culturally safe workplaces for First Nations workforce	2
NxIH7	Closing The Gap for First Nations People	6
NxIH8	First Nations Child Maternal and Family Health	4
NxIH9	Lack of men's health services for First Nation's men	4

FIRST NATIONS HEALTH OPPORTUNITIES AND OPTIONS					
Possible Activities	**Expected Outcome**	**Possible Performance Indicators**	**Data Source**	**Potential Lead**	**Need/s**
Commission the Integrated Team Care activity to facilitate access to clinical support and chronic disease management for Aboriginal and Torres Strait Islander people	Improved health outcomes for Aboriginal and Torres Strait Islander people	*Output indicators* – Proportion of the regional Aboriginal and Torres Strait Islander population receiving PHN-commissioned Aboriginal Health services Proportion of the regional Aboriginal and Torres Strait Islander population having a 715-health assessment *Outcome indicators* – Clinical outcomes for people receiving PHN-commissioned Aboriginal Health services Rate of potentially preventable hospitalisations, by Aboriginality Patient experience of care	HNECC AIHW NSW HealthStats	HNECC	NxIH1 NxIH2 NxIH3 NxIH5 NxIH7 NxIH8
Provide peer support, professional guidance and mentoring to the Aboriginal workforce delivering the Integrated Team Care activity	Improved cultural safety of workplaces and primary care services. Improved health outcomes for Aboriginal and Torres Strait Islander people.	*Outcome indicators* – Patient experience of care Health worker experience of care Cultural safety of services	HNECC	HNECC	NxIH6 NxIH7
Partner in key Aboriginal Health Partnerships, including: The Hunter Aboriginal Health and Wellbeing Alliance; and the Central Coast Aboriginal Partnership Agreement	Improved integration and coordination of services. Increased access to health services for Aboriginal and Torres Strait Islander people.	*Process indicator* – HNECC actively participates in all relevant activities associated with each of the partnerships	HNECC	HNECC CCLHD HNELHD ACCHOs	NxIH1 NxIH3 NxIH4 NxIH7 NxIH8 NxIH9

Alcohol and Other Drug Treatment Priority Needs

ALCOHOL AND OTHER DRUG TREATMENT PRIORITY NEEDS		
Code	**Need**	**# opt**
NxAOD1	Higher rates of alcohol misuse	10
NxAOD2	High levels of illicit drug use	10
NxAOD3	Reduced access to drug and alcohol treatment services for the general population	10
NxAOD4	Reduced access to drug and alcohol treatment services for First Nations people	4
NxAOD5	Reduced access to drug and alcohol treatment services for pregnant women and/or those with young children	1
NxAOD6	Reduced access to drug and alcohol treatment services for youth	1
NxAOD7	Reduced access to drug and alcohol treatment services for people exiting the criminal justice system	1
NxAOD8	Reduced access to drug and alcohol treatment services for people with co-occurring substance misuse and mental illness	1
NxAOD9	Alcohol, Other Drugs and Comorbidities	6
NxAOD10	Lack of drug and alcohol rehabilitation services	0

Alcohol and Other Drug Treatment Opportunities and Options

ALCOHOL AND OTHER DRUG TREATMENT OPPORTUNITIES AND OPTIONS					
Possible Activities	Expected Outcome	Possible Performance Indicators	Data Source	Potential Lead	Need/s
Commission drug and alcohol treatment services in response to local need	Increased access to drug and alcohol treatment services	*Output indicator* – Proportion of regional population receiving PHN-commissioned drug and alcohol treatment services *Outcome indicators* - Clinical outcomes for people receiving PHN-commissioned drug and alcohol treatment services Proportion of people aged 16 years+ consuming alcohol at level posing long-term risk to health Rate of mental health hospitalisations for drug and alcohol use Rate of alcohol-attributed deaths Rate of methamphetamine-related hospitalisations Rate of active patients with a record of drug misuse	HNECC NSW HealthStats AIHW PAT CAT	HNECC	NxAOD1 NxAOD2 NxAOD3 NxAOD4 NxAOD9
Continue to support a GP and Practice Nurse Clinical Mentoring Programs delivered by a multidisciplinary team of drug and alcohol experts	Increased routine screening and evidence-based treatment within General Practice	*Outcome indicator* – Change in practice reported by GPs and Practice Nurses	HNECC	HNECC	NxAOD1 NxAOD2 NxAOD3 NxAOD9
Support the delivery of the Drug and Alcohol First Aid Programs	Increased capacity to recognise and respond to substance misuse	*Output indicator* – Increase in confidence of participants in recognising and responding to substance misuse	HNECC	HNECC	NxAOD1 NxAOD2 NxAOD3 NxAOD9

ALCOHOL AND OTHER DRUG TREATMENT OPPORTUNITIES AND OPTIONS

Possible Activities	Expected Outcome	Possible Performance Indicators	Data Source	Potential Lead	Need/s
Support Regional Drug and Alcohol forums targeting General Practice, Community Pharmacy and Psychologists and the administration of addiction medicines, S8 prescription monitoring, collaborative care arrangements and clinical pathways	Improved service integration	*Process indicator* – Evidence of effective partnerships between service providers to support integrated collaborative care *Outcome indicator* – Patient experience of care	HNECC	HNECC	NxAOD1 NxAOD2 NxAOD3 NxPH41 NxAOD9
Support the Psychology Drug and Alcohol Clinical Mentoring Project, delivering clinical supervision and mentoring to psychologists in primary health care	Increased number of drug and alcohol-specialist psychologists in primary health care	*Output indicator* - Increase in confidence of participants in providing drug and alcohol treatment *Outcome indicator* – Number of drug and alcohol-specialist psychologists in primary health care	HNECC	HNECC	NxAOD1 NxAOD2 NxAOD3 NxAOD9 NxMH23
Develop a training package to support GPs in the treatment of chronic pain using psychotherapy and self-management rather than opioid substitution	Increased non-pharmacological treatment of chronic pain	*Output indicator* - Increase in confidence and likelihood of participants in providing non-pharmacological treatment *Outcome indicator* – Change in practice reported by GPs and/or through practice software	HNECC PAT CAT	HNECC	NxAOD1 NxAOD2 NxAOD3
Develop a drug and alcohol referral and service navigation resource	Improved referral pathways for drug and alcohol services, and increased access to drug and alcohol treatment services	*Process indicator* – Referral and service navigation resource is developed *Output indicator* – Referral pathways are improved *Outcome indicator* – Patient experience of care	HNECC	HNECC	NxAOD1 NxAOD2 NxAOD3 NxAOD9

ALCOHOL AND OTHER DRUG TREATMENT OPPORTUNITIES AND OPTIONS

Possible Activities	Expected Outcome	Possible Performance Indicators	Data Source	Potential Lead	Need/s
Facilitate a clinical placement program for GPs in LHD drug and alcohol specialist services	Increased GP skills and knowledge in prescribing S8 medications, and awareness of clinical pathways	*Process indicator* – Clinical placement program is established *Output indicators* – Number of GPs completing the program Increase in knowledge of participants *Outcome indicator* – Patient experience of care	HNECC	HNECC	NxAOD1 NxAOD2 NxAOD3
Support drug and alcohol partnership networks in the HNECC PHN region	Improved regional coordination and improved sector capacity	*Process indicator* – Drug and alcohol partnership networks are established *Output indicators* – Networks include representation from all services in the sector Evidence of effective partnerships between service providers Strategies for improving regional coordination and sector capacity are developed Strategies are executed *Outcome indicator* – Patient experience of care	HNECC	HNECC	NxAOD1 NxAOD2 NxAOD3
Utilise partnerships and sector engagement opportunities to identify emerging workforce capacity and development needs	Increased capacity of primary care clinicians and services to respond to drug and alcohol needs of the region. Increased access to drug and alcohol treatment services	*Process indicator* - Activities utilise a program logic approach to demonstrate alignment between need, input, output and outcome *Output indicator* – Workforce capacity and development activities are targeted to identified areas of need	HNECC	HNECC	NxAOD1 NxAOD2 NxAOD3

ALCOHOL AND OTHER DRUG TREATMENT OPPORTUNITIES AND OPTIONS

Possible Activities	Expected Outcome	Possible Performance Indicators	Data Source	Potential Lead	Need/s
Commission drug and alcohol treatment services targeted at Aboriginal and Torres Strait Islander people, including priority groups: pregnant women and/or those with young children; youth; people exiting the criminal justice system; and people with co-occurring substance use and mental illness.	Increased access to drug and alcohol treatment services for Aboriginal and Torres Strait Islander people	*Output indicator* – Proportion of the population receiving PHN-commissioned drug and alcohol treatment services who are Aboriginal and Torres Strait Islander people *Outcome indicators* - Clinical outcomes for Aboriginal and Torres Strait Islander people receiving PHN-commissioned drug and alcohol treatment services Rate of active Aboriginal and Torres Strait Islander patients with a record of drug misuse	HNECC PAT CAT	HNECC	NxAOD4
Collaborate in the NSW PHN Aboriginal Drug and Alcohol Best Practice Guidelines development, evaluation and training	Increased access to drug and alcohol treatment services for Aboriginal and Torres Strait Islander people	*Output indicators* – Guidelines are developed Guidelines are implemented Use of the guidelines is evaluated *Outcome indicator* – Patient experience of care	NSW PHNs HNECC	NSW PHNs	NxAOD4
Utilise partnerships and sector engagement opportunities to identify emerging Aboriginal and Torres Strait Islander workforce development needs	Increased capacity of the Aboriginal and Torres Strait Islander workforce and increased access to drug and alcohol treatment services for Aboriginal and Torres Strait Islander people	*Process indicator* - Activities utilise a program logic approach to demonstrate alignment between need, input, output and outcome *Output indicator* – Workforce capacity and development activities are targeted to identified areas of need	HNECC	HNECC	NxAOD4

ALCOHOL AND OTHER DRUG TREATMENT OPPORTUNITIES AND OPTIONS

Possible Activities	Expected Outcome	Possible Performance Indicators	Data Source	Potential Lead	Need/s
Commission drug and alcohol treatment services targeted at: - pregnant women and/or those with young children - youth - people exiting the criminal justice system - people with co-occurring substance misuse and mental illness	Increased access to drug and alcohol treatment services for each of the target population groups	*Output indicator* – Proportion of the population receiving PHN-commissioned drug and alcohol treatment services within each target cohort *Outcome indicator* - Clinical outcomes for each target cohort receiving PHN-commissioned drug and alcohol treatment services Rate of mental health hospitalisations for drug and alcohol use	HNECC AIHW	HNECC	NxAOD5 NxAOD6 NxAOD7 NxAOD8

REFERENCE LIST

1. *Australian Bureau of Statistics (ABS), National Health Survey: Health literacy, 2018 (Accessed 2021).*
2. *Australian Institute of Health and Welfare (AIHW), Health Literacy, 2020. (Accessed 2021).*
3. *Clinical Council and Community Advisory Committees Recommendations & Outcomes Report, 2018-2021*
4. *HNECC PHN Internal Staff Survey, 2021*
5. *Have Your Say Stakeholder Survey, 2021*
6. *Have Your Say Community Survey, 2021*
7. *Proportion of persons aged 15 years and above assessing their health as 'fair' or 'poor' 2017-18; 2014-15 Hunter New England and Central Coast Primary Health Network (PHIDU, 2021).*
8. *National Aboriginal and Torres Strait Islander Health Survey 2018-19, Australian Institute of Health and Welfare (AIHW) (2021).*
9. *People aged 15 and over living in households, self-assessed health status by disability status, disability group and age group, 2017–18 from People with disability in Australia: health status of people with disability supplementary data tables (ABS National Health Survey 2017–18)*
10. *Number of people with a profound or severe disability (includes people in long-term accommodation), all ages, 2016; assistance to people with a disability, unpaid, 2016 (PHIDU 2019).*
11. *Life expectancy (Centre for Epidemiology and Evidence, HealthStats NSW, NSW Ministry of Health, 2021).*
12. *Medical Journal of Australia (2018) Homeless health care: meeting the challenges of providing primary care*
13. *Blakely T., Hales, S., & Woodward, A. (2004). Poverty: assessing the distribution of health risks by socioeconomic position at national and local levels. Geneva: World Health Organisation. Turrell, G., & Mathers C.D. (2000). Socioeconomic status and health in Australia. The Medical Journal of Australia, 172(9), 434-438.*
14. *Relative Socioeconomic Outcomes Index, 2016, Hunter New England and Central Coast Primary Health Network; Local Government Areas (PHIDU, 2021).*
15. *Indigenous Relative Socioeconomic Outcomes Index, 2016, Aboriginal and Torres Strait Islander Social Health Atlas of Australia, Data by Indigenous Area (PHIDU, 2021).*
16. *Federation of Ethnic Communities' Councils of Australia (FECCA) 2015. Review of Australian research on older people from culturally and linguistically diverse backgrounds (PDF). Canberra: DSS.*
17. *Considine, R (primary author). HNECC PHN Mental Health Regional Plan 2020-2025 Incorporating Suicide Prevention (2020). (Accessed 2021)*
18. *Proportion (%) of people aged 65 years and over, ERP 2020; Proportion (%) of people aged 65 years and over population projections ERP 2020; 2025; 2030, Hunter New England and Central Coast Primary Health Network; Local Government Areas (PHIDU, 2021).*
19. *New South Wales State and Local Government Area population projections, 2016 (NSW Department of Planning and Environment, 2016).*
20. *Influenza and pneumonia hospitalisations, persons aged 65+ and all ages, Hunter New England*

and Central Coast PHN, NSW 2001-01 to 2018-19; Falls-related hospitalisations, persons of all ages and 65 years and over, Hunter New England and Central Coast PHN, NSW 2001-02 to 2018-19; Centre for Epidemiology and Evidence, HealthStats NSW, NSW Ministry of Health, 2021).

21. *Stroke hospitalisations, Hunter New England and Central Coast PHN, NSW 2001-02 to 2018-19; coronary heart disease hospitalisations, Hunter New England and Central Coast PHN, NSW 2001-02 to 2018-19 (Centre for Epidemiology and Evidence, HealthStats NSW, NSW Ministry of Health, 2021).*

22. *Rates per PPH condition, COPD; for 65 years and over; under 65 years; total bed days for 65 years and over, 2017-18, Hunter New England and Central Coast Primary Health Network, Australian Institute of Health and Welfare (AIHW) (2021).*

23. *My aged care region tool (AIHW, 2021).*

24. *Social Health Atlas of Australia: Primary Health Networks, Australian born population 2016; People born in predominantly NES countries 2016; People born overseas reporting poor proficiency in English 2016; Top ten non-English speaking countries, 2016, Hunter New England and Central Coast Primary Health Network; Local Government Areas (PHIDU 2021).*

25. *Consultation with key stakeholder groups.*

26. *People from culturally and linguistically diverse backgrounds, The Department of Health, 2006 (Australian Government; Department of Health, 2018).*

27. *NSW Plan for Healthy Culturally and Linguistically Diverse Communities 2019-2023. NSW Health.*

28. *Percentage of fully immunised 1-, 2-, and 5-year-old children, by Primary Health Network, for Hunter New England and Central Coast (NSW) 2021 (Australian Government Department of Health).*

29. *NSW Childhood immunisation coverage data by SA3, June 2021 annualised data (2021). Australian Government Department of Health.*

30. *Current Coverage data tables for Aboriginal and Torres Strait Islander Children fully immunised at one, two and five years, 2021. Department of Health, NSW Government (2021).*

31. *HPV Coverage, females and males aged 15 years, Hunter New England and Central Coast Primary Health Network; 2017 (PHIDU, 2021).*

32. *Smoking during pregnancy (%), 2016; 2017; 2018; 2019, Hunter New England and Central Coast Primary Health Network; Local Government Areas (Centre for Epidemiology and Evidence, HealthStats NSW, NSW Ministry of Health, 2021).*

33. *Number of deaths among infants and young children aged less than 5 years per 1,000 live births, by Statistical Area Level 3 (SA3), Child and maternal health in 2014-2016, Myhealthycommunities, AIHW, 2018 (Accessed 2021).*

34. *HNE Rural Clinical Council First Quarter Regional Meeting Summaries, 2021*

35. *Maternal characteristics-including risk factors and demographic information based on the mother's usual residence, National perinatal mortality data collection, Hunter New England and Central Coast PHN, 2017-18. Australian Institute of Health and Welfare (AIHW) (2021).*

36. *Early childhood development: AEDC Developmentally vulnerable on one or more domains, 2018, Hunter New England and Central Coast PHN, including local government area components (PHIDU 2021).*

37. *Proportion of population aged 15-24 years, 2010 ERP; Learning or earning at ages 15 to 24, 2016; Youth unemployment beneficiaries 16 to 24 years, 2020 (PHIDU, 2021).*

38. *Intentional self-harm hospitalisations, persons of all ages and 15-24 years, Hunter New England and Central Coast PHN, NSW 2018-19 (Centre for Epidemiology and Evidence, HealthStats NSW, NSW Ministry of Health, 2021).*

39. *Intentional self-harm hospitalisations & Indigenous Australians, Suicide and self-harm monitoring, 2019-20. Australian Institute of Health and Welfare (AIHW) (2021).*

40. *National Coronial Information System. Intentional self-harm fatalities in the Hunter, New England and Central Coast Region 2000-2013. 2016 (Accessed 2021).*

41. *Australian Standard Geographical Classification—Remoteness Areas (ASGC-RA); National data on lifestyle risk factors regional/remote compared to urban populations (AIHW 2021).*

42. *Social Health Atlas of Australia, Data by Primary Health Network, Published 2021: May 2021. 2019 ERP, Low birthweight babies 2016-2018, Estimated number of people aged 15 years and over with fair or poor self-assessed health (modelled estimates) 2017-18, Estimated number of people with diabetes mellitus 2017-18. ABS (2018b) Cat. 1270.0.55.005, Australian Statistical Geography Standard (ASGS): Volume 5 - Remoteness Structure, July 2016. Australian Bureau of Statistics, Canberra.*

43. *Final Report Rural Communities Project Evaluation, 2021*

44. *Number of people with a profound or severe disability (includes people in long-term accommodation), all ages, 2016; assistance to people with a disability, unpaid, 2016, Hunter New England and Central Coast Primary Health Network; Local Government Areas (PHIDU 2021).*

45. *Gloucester Local Community Plan and Hunter New England Rural Community Advisory Committee Second Quarter Regional Meeting Summaries 2021*

46. *Dementia prevalence data 2018-2058; Australian Commonwealth Electoral Divisions (Dementia Australia, 2021).*

47. *Aboriginal and Torres Strait Islander people and dementia: A review of the research (Alzheimer's Australia, 2014) (Accessed 2021).*

48. *Australian Bureau of Statistics (ABS) Causes of Death, Australia, 2019 (cat. no. 3303.0) (2021).*

49. *Dementia prevalence data 2018-2058 (Deloitte Access Economics, Dementia Australia, 2018). NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI).*

50. *Rate of hospitalisations for dementia as a principal diagnosis or as a comorbidity, hospitalisations, persons aged 65 and over, 2001-03 to 2018-19, Hunter New England and Central Coast Primary Health Network, HealthStats NSW (Centre for Epidemiology and Evidence, NSW Ministry of Health, 2021).*

51. *Australian Institute of Health and Welfare 2018, Australia's Health 2018, Dementia. (AIHW) (Accessed 2021).*

52. *Australian Institute of Health and Welfare 2021. Dementia in Australia 2021: Summary report. Cat. no. DEM 3. Canberra: (AIHW) (2021).*

53. *Overweight or obese adults, persons, Hunter New England and Central Coast PHN, NSW 2002 to 2019; Overweight or obese adults, persons New South Wales, 2002 to 2019 (Centre for Epidemiology and Evidence, HealthStats NSW, NSW Ministry of Health, 2021).*

54. *Blueprint for the Management of Overweight and Obesity in the Mining Industry 2016.*

55. *Overweight persons aged 2-17 years, 2017-18; Obese persons, aged 2-17 years, 2017-18, Hunter New England and Central Coast Primary Health Network; Local Government areas (PHIDU 2021).*

56. *People aged 2 and over with disability living in households, Body Mass Index (BMI) by disability group, age and sex 2017–18; People aged 18 and over and over living in households, Body Mass Index (BMI) by disability status and sex, 2017–18 (ABS 2019. Microdata: National Health Survey, 2017–18. Canberra: ABS. Findings based on AIHW analysis of the main unit record file (MURF)).*

57. *NSW Population Health Survey data for 2014–17 cited in NSW Plan for Healthy Culturally and Linguistically Diverse Communities 2019-2023. NSW Health. 2019*

58. *Central Coast Clinical Council Discussion Notes Preventative Health Strategy, 2021*

59. *National Obesity Prevention Strategy 2022-2023, DoH (Draft)*

60. *Fruit and vegetables: recommended daily consumption by Primary Health Network, percentage of persons aged 16 years and over, NSW 2019; Insufficient physical activity by Primary Health Network, persons aged 16 years and over, NSW 2019 (Centre for Epidemiology and Evidence, HealthStats NSW, NSW Ministry of Health, 2021).*

61. *People aged 18 and over living in households, whether met guidelines for physical activity in the last week by disability status, age group, disability group and sex, 2017–18 (ABS 2019. Microdata: National Health Survey, 2017–18. Canberra: ABS. Findings based on AIHW analysis of the main unit record file (MURF)).*

62. *World Health Organization, Prevention Cancer (WHO) 2021.*

63. *Current smoking in adults, by Primary Health Network, NSW, 2019; Current smoking in adults by Aboriginality, NSW 2018-19; Current smoking in adults by remoteness from service centres and sex, NSW 2019 (Centre for Epidemiology and Evidence, HealthStats NSW, NSW Ministry of Health, 2021).*

64. *Tobacco in Australia, Prevalence of smoking in other high-risk subgroups of the population (The Cancer Council, 2018); Smoking and mental illness: A guide for health professionals (Australian Government Department of Health and Ageing, 2017).*

65. *People aged 18 and over with disability living in households, current daily smoker status by age, disability status, sex and disability group, 2017–18 (ABS 2019. Microdata: National Health Survey, 2017–18. Canberra: ABS. Findings based on AIHW analysis of the main unit record file (MURF).*

66. *Reporting for Better Cancer Outcomes Performance Report 2019; Hunter New England and Central Coast Primary Health Network, Cancer Institute NSW, 2019 (Accessed 2021).*

67. *Percentage of adults who reported having a long-term health condition, 2019-20 (Australian Institute of Health and Welfare, 2021).*

68. *AIHW analysis of 2016 National (insulin-treated) Diabetes Register (AIHW 2021).*

69. *Diabetes or high blood glucose by age and sex, persons aged 16 years and over, 2019; Diabetes deaths by Local Government Area: Diabetes-related deaths (total underlying + selected associated), NSW 2018 to 2019; Diabetes as a principal diagnosis: Hospitalisations by Primary Health Network, NSW 2018-19; Diabetes hospitalisations by Local Government Area and type of diabetes: Type 1, NSW 2018-19; ; Diabetes hospitalisations by Local Government Area and type of diabetes: Type 2, NSW 2018-19 (Centre for Epidemiology and Evidence, HealthStats NSW, NSW Ministry of Health, 2021).*

70. *Asthma status by Primary Health Network, children aged 2-15 years, NSW 2018-19; COPD deaths by Primary Health Network, All ages, NSW, 2017-18; COPD hospitalisations by Local Government Area, persons of all ages, NSW 2017-18 to 2018-19 (Centre for Epidemiology and Evidence, HealthStats NSW, NSW Ministry of Health, 2021).*

71. *Circulatory disease by Primary Health Network, All circulatory disease's NSW 2017-18; deaths from circulatory diseases by Primary Health Network, 2017-18; (Centre for Epidemiology and Evidence, HealthStats NSW, NSW Ministry of Health, 2021).*

72. *Reporting for Better Cancer Outcomes Performance Report 2018, Hunter New England and Central Coast Primary Health Network, Cancer Institute NSW, 2018 (Accessed 2021).*

73. *HNECC PAT CAT data, 2021.*

74. *NSW Population Health Survey data for 2014–17 and Girgis S and Colagiuri R (2009) cited in NSW Plan for Healthy Culturally and Linguistically Diverse Communities 2019-2023. NSW Health. 2021*

75. *Cancer Institute NSW, Cancer statistics NSW, Cancer Incidence rate; Cancer mortality rate, Hunter New England and Central Coast Primary Health Network, 2017 (NSW Government, 2021).*

76. *Reporting for Better Cancer Outcomes Performance Report 2020, Hunter New England and Central Coast Primary Health Network, Cancer Institute NSW, 2020 (Accessed 2021).*

77. *Participation in NBCSP, persons, Hunter New England and Central Coast Primary Health Network, 2016-17; Cervical screening participation, females aged 20 to 69 years; 2015-16, Hunter New England and Central Coast Primary Health Network (PHIDU 2021).*

78. *Cancer Institute NSW, Cancer Statistics NSW, Breast Screening Participation, Hunter New England and Central Coast Primary Health Network, 2019-20 (NSW Government, 2021).*

79. *Cancer council, NSW Cancer Plan 2022-2026, Cancer Council NSW submission (2021).*

80. *Consultation with key stakeholder group from Department of Communities and Justice, NSW Government.*

81. *Australian Bureau of statistics (ABS), Census of Population and Housing; Estimating homelessness in Australia, 2016 (Accessed 2021).*

82. *Newcastle Registry Week Report, St Vincent de Paul Society, 2021*

83. *Hunter Manning Community Advisory Committee, 2021*

84. *Private Lives 3: The health and wellbeing of LGBTIQ people in Australia, Australian Research Centre in Sex, Health and Society, La Trobe University, 2020*

85. *Australian Government, National Recovery and Resilience Agency, Local area profiles, Disaster recover in your local area (2021).*

86. *Australian bushfires 2019-20, exploring the short-term health impacts, Australian Institute of Health and Welfare (AIHW) (2021).*

87. *Australia's health 2020, Natural environment and health, 2020, Australian Institute of Health and Welfare (AIHW) (2021).*

88. *NSW Government, Covid-19 vaccination in NSW (Accessed November 2021).*

89. *Australian Bureau of Statistics, One year of COVID-19: Aussie Jobs, business and the economy. A timeline of significant COVID-19 events and statistical and economic insights over the last year (ABS, 2021).*

90. *Social Health Atlases of Australia: Hunter New England and Central Coast Primary Health Network, JobSeeker unemployment beneficiaries, June 2021 (PHIDU) (2021).*

91. *HNECC PHN Market Mapping Insight, July 2021*

92. *Social health atlas of Australia Data by Primary Health Network (incl. local government areas); Estimated number of people aged 18 years and over with high or very high psychological distress, based on the Kessler 10 Scale (K10) (modelled estimates) 2017-18, (PHIDU 2021).*

93. *Intentional self-harm fatalities in the Hunter, New England and Central Coast Region, 2000 (National Coronial Information System, 2021).*

94. *Intentional self-harm hospitalisations, persons of all ages and 15-24 years, Hunter New England and Central Coast PHN (incl. local government areas), NSW 2001-02 to 2018-19 (Centre for Epidemiology and Evidence, HealthStats NSW, 2021).*

95. *Suicide, Hunter New England and Central Coast PHN (incl. local health districts), NSW, 2017 (Centre for Epidemiology and Evidence, HealthStats NSW, 2021).*

96. *Suicide by Aboriginality, NSW 2006-2010 to 2014-18. Suicide by Remoteness, NSW 2001-2018, Suicide persons aged: all ages, NSW (Centre for Epidemiology and Evidence, HealthStats NSW, 2021).*

97. *Central Coast Clinical Council Discussion on the National Preventative Health Strategy, 2021*

98. *National Coronial Information System Suicide Data by PHN, 2016. Melbourne: National Coronial Information System, 2016.*

99. *People aged 18 and over living in households, K10 score(a) by disability status, disability group and age group, 2017–18 ABS 2019. Microdata: National Health Survey, 2017–18. Canberra: ABS. Findings based on AIHW analysis of the main unit record file (MURF).*

100. *Mental Health Commission of NSW, 2014, Living Well: A Strategic Plan for Mental Health:2014-2024, Mental Health Commission, Sydney cited in NSW Plan for Healthy Culturally and Linguistically Diverse Communities 2019-2023. NSW Health. 2019*

101. *Harry Minas, Ritsuko Kakuma, Lay San Too, Hamza Vayani, Sharon Orapeleng, Rita Prasad-Ildes, Greg Turner, Nicholas Procter, Daryl Oehm (2013) Mental health research and evaluation in multicultural Australia: Developing a culture of inclusion. (Accessed 2021).*

102. *4326.0 - National Survey of Mental Health and Wellbeing: Summary of Results, 2007 Table 5 12-month mental disorders, by selected population characteristics Australian Bureau of Statistics (ABS) 2021.*

103. *Final Report Rural Communities Project Evaluation, 2021*

104. *Intentional self-harm hospitalisations by Primary Health Network, persons of all ages and 15-24 years, NSW 2018-19; HealthStats (Centre for Epidemiology and Evidence, 2021).*

105. *Considine, R (primary author). HNECC PHN Mental Health Regional Plan 2020-2025 Incorporating Suicide Prevention (2021).*

106. *Mendelson J, Kelehear B, Wallace K, Morris K, White S, Rigby K, Considine R, Davies K, Handley T, Rich J. Hunter New England Central Coast Primary Health Network, Mental health and Suicide Prevention Needs Assessment Report 2017; pg 19, 21, 23, 96.*

107. *Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, Zubrick SR (2015) The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Department of Health, Canberra.*

108. *2017-18 FACS Annual Report Highlights. Sydney: NSW Family and Community Services, 2018.*

109. *Clinical Council and Community Advisory Committees Recommendations & Outcomes Report, 2018-2021*

110. *Beyond Blue, Statistics- Men, 2019 (Accessed 2021).*

111. *Australian Institute of Health and Welfare, Suicide and self-harm monitoring, deaths by suicide over time (AIHW) (2021).*

112. *Social health atlas of Australia Data by Primary Health Network (incl. Indigenous areas) Proportion of Aboriginal and Torres Strait Islander population, 2016, Hunter New England and Central Coast Primary Health Network (PHIDU, 2021).*

113. *Stakeholder consultations (2017).*

114. *Hospitalisations by cause and Aboriginality, NSW; 2018-19; Intentional self-harm hospitalisations by Aboriginality, persons of all ages and 15-24 years, NSW 2018-19 (Centre for Epidemiology and Evidence, HealthStats NSW, 2021).*

115. *Australian Institute of Health and welfare, Indigenous Health and wellbeing: Australia's Health, 2020 (AIHW) (2021).*

116. *Australian Institute of Health and Welfare, suicide and self-harm monitoring, Deaths by suicide amongst Indigenous Australians, 2020 (AIHW) (2021).*

117. *Social Health Atlas of Australia, data by Primary Health Network, Indigenous Areas, 2021. Admissions for mental health conditions, by Aboriginal persons, 2018-19 (PHIDU, 2021).*

118. *Aboriginal Health Needs Survey, 2019*

119. *Dudgeon P, Bray A, Ring I & McPhee R 2021. Beyond evidence-deficit narratives in Indigenous suicide prevention. Produced for the Indigenous Mental Health and Suicide Prevention Clearinghouse. Cat. no. IMH 6. Canberra: AIHW.*

120. *Dudgeon P, Blustein S, Bray A, Calma T, McPhee R & Ring I 2021. Connection between family, kinship and social and emotional wellbeing. Produced for the Indigenous Mental Health and Suicide Prevention Clearinghouse. Cat. no. IMH 4. Canberra: AIHW.*

121. *HNECC PHN – Taree and surrounding communities. Aboriginal and Torres Strait Islander Healing Forum, 2021*

122. *HNECC PHN – Cessnock, Kurri Kurri and surrounding communities. Aboriginal and Torres Strait Islander Healing Forum, 2021*

123. *National Ageing Research Institute. (2009). beyondblue depression in older age: a scoping study. Final Report. Melbourne: National Ageing Research Institute (2021).*

124. *Rosenstreich G. LGBTI People Mental Health and Suicide. Revised 2nd Edition. Sydney: National LGBTI Health Alliance, 2013. Table 21: Profile of Headspace clients by population group, Q1-Q3 2016/17.*

125. *LGBTIQ+ Health Australia, Snapshot of Mental Health and Suicide Prevention Statistics for LGBTIQ+ People, April 2021.*

126. *Private Lives 3: The health and wellbeing of LGBTIQ people in Australia, Australian Research Centre in Sex, Health and Society, La Trobe University, 2020*

127. *Estimated number of people with mental and behavioural problems 2017-18 (modelled estimates), Estimated number of males with mental and behavioural problems 2017-18 (modelled estimates), Estimated number of females with mental and behavioural problems 2017-18 (modelled estimates). Social health atlas of Australia Data by Primary Health Network (incl. local government areas) (PHIDU, 2021).*

128. *Consultation with key stakeholder groups (National Psychosocial Support measure needs assessment).*

129. *PSS Evaluation Report, 2021*

130. *SANE Australia, A Life without Stigma, A SANE report 2006; pg 5 (2021).*

131. *Proportion of Aboriginal and Torres Strait Islander people (%) ERP, 2016; Indigenous relative socioeconomic index scores by Aboriginality, 2016, Hunter New England and Central Primary Health Network (including Indigenous areas) (PHIDU, 2021).*

132. *Life Expectancy of Aboriginal and Torres Strait Islander People (AIHW, 2021); Contribution of chronic disease to the gap in adult mortality between Aboriginal and Torres Strait Islander and other Australians (AIHW, 2010).*

133. *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, 2021).*

134. *Indigenous health check (MBS 715) data tool (AIHW, 2021).*

135. *Australian Institute of Health and Welfare, Indigenous health check (MBS 715) data tool, 2017 (AIHW) 2021.*

136. *Australian Bureau of Statistics (ABS). (2018-19). National Aboriginal and Torres Strait Islander Health Survey: Statistics about long-term health conditions, disability, lifestyle factors, physical harm and use of health services (2021).*

137. *Potentially preventable hospitalisations by category and Aboriginality, Hunter New England and Central Coast PHN, NSW 2006-07 to 2016-17; Chronic obstructive pulmonary disease hospitalisations by Aboriginality, persons of all ages and 65 years and over, NSW, 2006-07 to 2018-19; Hospitalisations by cause and 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, 2021).*

138. *Hunter New England and Central Coast Primary Health Network, First Nations Health- Close the Gap Information Session Presentation, Aboriginal Health Access Team, 2021.*

139. *NSW Aboriginal Health Plan, 2013-2023*

140. *Closing The Gap NSW Community Engagement Report, 2021*

141. *HNECC PHN – Taree and surrounding communities, Aboriginal and Torres Strait Islander Healing Forum, 2021*

142. *HNECC PHN – Cessnock, Kurri Kurri and surrounding communities. Aboriginal and Torres Strait Islander Healing Forum, 2021*

143. *Maternal characteristics-including risk factors and demographic information based on the mother's usual residence, National perinatal mortality data collection, Hunter New England and Central Coast PHN, 2017-18. Australian Institute of Health and Welfare (AIHW) (2021).*

144. *Smoking at all during pregnancy by PHN, among Aboriginal and non-Aboriginal mothers, 2021; Low birth weight babies by mother's Aboriginality and Primary Health Network, 2021 (Centre for Epidemiology and Evidence, HealthStats NSW, NSW Ministry of Health, 2018). Australian Government Department of the Prime Minister and Cabinet, Closing the Gap – Prime Minister's Report 2016, Canberra.*

145. *Alcohol consumption at levels posing long-term risk to health by PHN, persons aged 18 years and over, NSW 2017-18 (AIHW, 2021)*

146. *Alcohol consumption at levels posing immediate risk to health by PHN, persons aged 16 years and over, NSW, 2019; Alcohol drinking frequency in adults by sex, by PHN, NSW 2018-19; Alcohol attributable deaths by PHN, NSW, 2015-16;2016-17;2017-18; Alcohol attributable hospitalisations by LGA, NSW 2013-14 to 2018-19 (Centre for Epidemiology and Evidence, HealthStats NSW, NSW Ministry of Health, 2021).*

147. *HNECC Regional Drug & Alcohol Networks Service Mapping Survey Report (HNECC PHN, HNE LHD, CC LHD, & NADA, 2017).*

148. *Drug use by main language spoken at home, people aged 14 and over, 2010 to 2016 (Alcohol, tobacco and other drug use in Australia, 2019, Populations, Supplementary data tables, AIHW, September 2019)*

149. *Evaluation of commissioned AoD services, Grosvenor, 2021*

150. *Methamphetamine-related hospitalisations and persons hospitalised, persons aged 16 years and over, by PHN, NSW 2010-11 to 2018-19; Opioid-related emergency department presentations (selected drugs), NSW 2011-12 to 2018-19. (Centre for Epidemiology and Evidence, HealthStats NSW, NSW Ministry of Health, 2021).*

151. *HNECC Regional Drug & Alcohol Networks Service Mapping Survey Report (HNECC PHN, HNE LHD, CC LHD, & NADA, 2017).*

152. *Estimated number of people aged 18 years and over who consumed more than two standard alcoholic drinks per day, 2017-18, Hunter New England and Central Coast Primary Health Network (incl. local government areas) (Phidu, 2021).*

153. *Alcohol think again, Alcohol and Mental Health (2021).*

154. *Australian Institute of Health and Welfare, Mental health services in Australia, 2019 (AIHW, 2021).*

155. *Consultation with key stakeholder groups, including HNECC Clinical Councils and Community Advisory Committees.*

156. *Central Coast Local Health District, Palliative Care and End of Life Care Review (CCLHD, 2017).*

157. *HNECC PHN Allied Health Strategy - Allied Health, health information and clinical systems survey report (2020).*

158. *Patient experiences in Australia by small geographic areas in 2018-2019. Australian Institute of Health and Welfare (AIHW, 2021).*

159. *Clinical Council, Community Advisory Committees Recommendations and Outcomes 2018-2021*

160. *Clinical Councils Regional Meeting Summaries, 2021*

161. *Consultation with general practices and other key stakeholder groups, including HNECC Clinical Councils and Community Advisory Committees.*

162. *HNECC Internal Data, 2021.*

163. *Australian Institute of Health and Welfare, National Health Workforce Dataset (NHWDS) (AIHW) (2021).*

164. *Health Demand and Supply Utilisation Patterns Planning Tool (HeaDS UPP) (2021).*

165. *HNECC PHN COVID-19 Impact Survey, 2020 (2021)*

166. *HNECC PHN After-Hours Primary Care Needs Assessment, 2020 (2021).*

167. *Recommendations and Outcomes 2018-2021*

168. *Clinical Councils 2021 Regional Meeting Summaries*

169. *HNECC PHN Allied Health Strategy - Allied Health, health information clinical systems survey report (2020) (Accessed 2021).*

170. *Incorporating Telehealth into the Future of Australian Primary Healthcare. NSW and ACT PHNs (2020) (Accessed 2021).*

171. *Potentially preventable hospitalisations by condition, Hunter New England and Central Coast PHN, NSW 2018-19 (PHIDU 2021).*

172. *Reducing Potentially Preventable Hospitalisations in the HNECC Primary Health Network Region Report, Primary Health Network, December 2020 (2021).*

173. *Percentage of adults who saw a dentist, hygienist or dental specialist in the preceding 12 months, 2019-20; Percentage of adults who did not see or delayed seeing a dentist, hygienist or dental specialist due to cost in the preceding 12 months (Australian Institute of Health and Welfare, 2021).*

174. *Central Coast Clinical Council, 2021*

175. *Clinical Council and Community Advisory Committee Regional Meeting Summaries, First Quarter 2021*

176. *Clinical Council and Community Advisory Committee Recommendations and Outcomes, 2018-2021*

177. *Potentially preventable hospitalisations by category, Primary Health Network and Year, 2018-19; Potentially preventable hospitalisations by condition, Primary Health Network and Year, 2018-19; Potentially preventable hospitalisations by category Aboriginality Primary Health Network and Year, 2016-17; Potentially preventable hospitalisations total NSW 2018-19 by Socioeconomic status; Potentially preventable hospitalisations total NSW 2018-19 by remoteness area; Potentially preventable hospitalisations total NSW 2018-19 by Aboriginality (Centre for Epidemiology and Evidence, NSW Health, 2021).*

178. *Australian Institute of Health and Welfare, potentially preventable hospitalisations in Australia by national, state, PHN, age groups and small geographic areas, 2017–18. Cat. No. HPF 36. Canberra: (AIHW) (2021).*

179. *Clinical Epidemiology & Health Service Evaluation Unit. Potentially preventable hospitalisations: a review of the literature and Australian Policies-Final report. 2009. Victoria: Royal Melbourne Hospital.*

180. *Australian Institute of Health and Welfare, The Health and Welfare of Australia's Aboriginal and Torres Strait Islander peoples, 2015. Canberra (AIHW) (2021).*

181. *Australian Institute of Health and Welfare, Admitted patient care 2016-17: Australian hospital statistics, Canberra (AIHW) (2021).*

182. *Australian Institute of Health and Welfare, Potentially Preventable Hospitalisations in Australia by small geographic areas, 2018. Canberra (AIHW) (2021).*

183. *Australian Institute of Health and Welfare, Australia's Health 2018. Australia's health series no. 16. AUS 221. Canberra; (AIHW) (2021).*

184. *Consultation with key stakeholder groups, including GPs and Practice Nurses.*

185. *GP coverage; female GP coverage; and number and location of practice nurses who have completed the Well Women's Screening course.*

186. *Cancer Institute NSW, Reporting for Better Cancer Outcomes Program (RBCO Report), 2020 (2021).*

187. *Australian Institute of Health and Welfare, National Bowel Cancer Screening Program: Monitoring report 2021 (AIHW, 2021).*

188. *Consultation with key stakeholder groups, including Karuah and Tilligerry Peninsula community members and service providers.*

189. *Number of after-hours GP attendances per person, 2016-17; Percentage of adults who saw a GP after hours in the preceding 12 months, 2016-17 (AIHW, 2018).*

190. *Use of Emergency Departments for lower urgency care, 2015-16 to 2018-19; Medicare-subsidised GP, allied health and specialise health care across local areas, 2013-14 to 2017-18 (AIHW, 2021)*

191. *Stakeholder consultation HNECC PHN Urgent and After-Hours Care Survey. (2019).*

192. *Social Health Atlas: Primary Health Networks: Emergency department presentations: Total presentations; semi-urgent presentations; non-urgent presentations, HNECC PHN 2019-20, PHIDU (2021).*

193. *Australian Institute of Health and Welfare, Emergency department care 2019-20, Australian hospital statistics (AIHW, 2021).*

194. *Social Health Atlas: Primary Health Networks, Persons, 65 years and over, 2020 ERP, Hunter New England and Central Coast Primary Health Network, PHIDU (2021).*

195. *Australian Standard Geographical Classification—Remoteness Areas (ASGC-RA); National data on access to health services regional/remote compared to urban populations (AIHW 2014).*

196. *Social Health Atlas of Australia, Data by Primary Health Network, Published 2021: May 2021.*

197. *1270.0.55.005, Australian Statistical Geography Standard (ASGS): Volume 5 - Remoteness Structure, July 2016. Australian Bureau of Statistics, Canberra.*

198. *Consultation with local resettlement organisations, the Local Health District, General Practitioners and other primary care staff, Department of Human Services, The Primary Health Network, NDIS, Renu Armidale (Town revival & renewal group) and Armidale Sanctuary Humanitarian support*

199. *Gloucester Local Community Plan, 2021*

200. *Social health atlas of Australia Data by Primary Health Network (incl. local government areas), Estimated number of people aged 18 years and over who often have a difficulty or cannot get to places needed with transport, including housebound (modelled estimates), 2014, Hunter New England and Central Coast Primary Health Network (PHIDU, 2021).*

201. *Percentage of people who delayed or did not see a medical specialist, GP, due to cost in the last 12 months, 2019-20; percentage of adults who delayed or avoided filling a prescription due to cost in the preceding 12 months, 2019-20; Patient experiences in Australia 2019-20 (AIHW, 2021).*

202. *Consultation with key stakeholder groups, including HNECC Clinical Councils and Community Advisory Committees and St Vincent de Paul.*

203. *Table 6.1 and 6.2 ALL HOMELESS PERSONS, by place of enumeration, Local Government Area, 2016 and 2011. 2049.0 - Census of Population and Housing: Estimating homelessness, 2016 (2021)*

204. *NewsGP Overcrowding leads to poorer health outcomes for Aboriginal and Torres Strait Islander peoples 19 February 2018*

205. *Medical Journal of Australia (2018) Homeless health care: meeting the challenges of providing primary care (2021).*

206. *ACON, Sexuality and Gender Diverse Community Needs, 2021*

207. *Snoswell, C.L., Caffery, L.J., Taylor, M.L., Haydon, H.M., Thomas, E., Smith, A.C. Centre for Online Health, The University of Queensland. Telehealth and coronavirus: Medicare Benefits Schedule (MBS) activity in Australia (2021).*

208. *Australia Bureau of statistics (ABS) Patient Experiences in Australia: Summary of Findings 2020-2021 (ABS, 2021).*

209. *The Fourth Australian Atlas Health Care Variation, Australian Commission on Safety and Quality in Health Care, 2021*

210. *Australian Institute of Health and Welfare, Mental Health Overnight Hospitalisations (AIHW) 2021.*

211. *2020-21 Primary Mental Health Care Minimum Data Set (PMHC-MDS) (Accessed 2021).*

212. *Australian Institute of Health and Welfare, Medicare-subsidised GP, allied health and specialist health care across local areas: 2020-21 (AIHW). 2021.*

213. *Australian Institute of Health and Welfare, Medicare-subsidised GP, allied health and specialist health care across local areas: 2020-2021, (AIHW) (2021).*

214. *Consultations with key stakeholder groups, including Tilligerry Peninsula community members and services.*

215. *Admissions for mental health related conditions, all hospitals, 2018-19 by Hunter New England and Central Coast Primary Health Network (incl local government area components (PHIDU, 2021).*

216. *Suicide, Hunter New England and Central Coast Primary Health Network, NSW 2001 to 2018 (Centre for Epidemiology and Evidence, NSW HealthStats, 2021).*

217. *Potentially preventable hospitalisations by category and Aboriginality, Hunter New England and Central Coast PHN, NSW 2006-07 to 2016-17 (Centre for Epidemiology and Evidence, NSW Health, 2018).*

218. *NSW Aboriginal Health Plan 2013-2023*

219. *NSW Implementation Plan for Closing the Gap, 2021*

220. *HNECC PHN – Taree and surrounding communities. Aboriginal and Torres Strait Islander Healing Forum, 2021*

221. *HNECC PHN – Cessnock, Kurri Kurri and surrounding communities. Aboriginal and Torres Strait Islander Healing Forum, 2021*

222. *HNECC PHN – Inverell and surrounding communities. Aboriginal and Torres Strait Islander Healing Forum, 2021*

223. *Dudgeon P, Bray A, Ring I & McPhee R 2021. Beyond evidence-deficit narratives in Indigenous suicide prevention. Produced for the Indigenous Mental Health and Suicide Prevention Clearinghouse. Cat. no. IMH 6. Canberra: AIHW.*

224. *NADA Member Needs Assessment, 2020*

225. *Cultural safety in health care for indigenous Australians: monitoring framework (2021 release), patient experience of health care, Australian Institute of Health and Welfare (AIHW) (2021).*

226. *Australian Institute of Health and Welfare (AIHW). (2021). Indigenous health check (MBS 715) data tool. Retrieved from:* https://www.aihw.gov.au/reports/indigenous-health-welfare-services/indigenous-health-check-mbs-715-data-tool/report-editions

227. *HNECC Regional Drug & Alcohol Networks Service Mapping Survey Report (HNECC PHN, HNE LHD, CC LHD, & NADA, 2017).*

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