PRIMARY HEALTH NETWORK

# Core Needs Assessment

## SUMMARY VERSION

2022 — 2025

phn
HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

THEPHN.COM.AU

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

We acknowledge First Nations peoples are the first peoples of Australia, each with their own culture, language, beliefs and practices. There is a growing preference the terminology used for First Nations Australians to be recognised as First Nations people as a more encompassing term, acknowledging the diversity of Australia's First Peoples. To mirror this preference, the PHN have changed where appropriate, terminology to First Nations people within the CNA 2022-2025. However, it should be noted, the data collected reflects the terminology that the data was sourced from and therefore there is a mix of other terminology for First Nations peoples used throughout this document such as: Indigenous Australians, Aboriginal Australians, and Aboriginal and/or Torres Strait Islander people.

Please note: First Nations people should be aware that this document may contain images of deceased persons in photographs.

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## ACKNOWLEDGEMENTS

The PHN would like to thank the project team for their work and commitment to the success of the Core Needs Assessment 2022-2025. We would like to extend this gratitude and thanks to the valuable suggestions, ideas and commitment to success from all PHN staff, partners, internal and external stakeholders and community members involved in this process.

| ABBREVIATIONS | |
|---|---|
| **ABS** | Australian Bureau of Statistics |
| **AOD** | Alcohol and Other Drugs |
| **CALD** | Culturally and Linguistically Diverse |
| **CC** | Clinical Council |
| **CAC** | Community Advisory Committee |
| **CNA** | Core Needs Assessment |
| **COPD** | Chronic Obstructive Pulmonary Disease |
| **DPA** | Distribution Priority Area |
| **ED** | Emergency Department |
| **ERP** | Estimated Resident Population |
| **GP** | General Practitioner |
| **HPV** | Human papillomavirus |
| **LGA** | Local Government Area |
| **LGBTIQA+** | Lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual |
| **LHD** | Local Health District |
| **MERIT** | Magistrates Early Referral into Treatment Program |
| **MBS** | Medicare Benefits Schedule |
| **NADA** | The Network of Alcohol and other Drugs Agencies |
| **NDIS** | National Disability Insurance Scheme |

| ABBREVIATIONS | |
|---|---|
| **NGO** | Non-government Organisations |
| **NSW** | New South Wales |
| **PHN** | Primary Health Network |
| **PPH** | Potentially Preventable Hospitalisation |
| **RACF** | Resident Aged Care Facility |
| **RN** | Registered Nurse |

| GLOSSARY OF TERMS | |
|---|---|
| **715 Health Check** | The 715 Health check is a specific health check available for Aboriginal and Torres Strait Islander people. A 715 Health Check is a health assessment that helps to ensure that Aboriginal & Torres Strait Islander people receive primary health care matched to their needs, by encouraging early detection, diagnosis and intervention for common and treatable conditions that cause morbidity and early mortality. |
| **Circulatory disease** | A group of diseases of the heart and blood vessels. |
| **Cultural respect** | Cultural respect can be defined as the recognition, protection and continued advancement of the inherent rights, cultures and traditions of a particular culture. At work, this means everyone, regardless of culture, need to be treated with respect, inclusion, and transparent management and health and safety policies. |
| **Cultural safety** | Cultural safety is about creating a workplace where everyone can examine their own cultural identities and attitudes and be open-minded and flexible in our attitudes towards people from cultures other than our own. It also requires everyone to understand that their own values or practices are not always or only the best way to solve workplace problems. |
| **Comorbidities** | The simultaneous presence of two or more diseases or medical conditions in a patient. |
| **Clinical Councils** | Clinical Councils are GP-led and include members from other primary health care professions who assist us to develop local strategies to improve the operation of the health care system for patients. The role of the Clinical Councils is to provide the Board of the Primary Health Network with locally relevant perspectives on clinical issues that impact on the unique needs of our local communities. |
| **Clinical Governance** | Clinical governance is the set of relationships and responsibilities established by a health service organisation between its state or territory department of health, governing body, executive, workforce, patients, consumers and other stakeholders to ensure good clinical outcomes. |
| **Community Advisory Committees** | The Community Advisory Committees are made up of members with active community networks who can provide the advice, feedback, community perspective and context which helps to shape our funding of programs and services. |
| **Diabetes** | A disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood. There are two forms of diabetes. Type 1 diabetes, also known as Insulin-Dependent Diabetes Mellitus, is characterised by hyperglycaemia due to an absolute deficiency of the insulin hormone produced by the pancreas. Type 2 diabetes, also known as noninsulin-dependent diabetes mellitus, is characterised by hyperglycaemia due to a defect in insulin secretion usually with a contribution from insulin resistance |

| GLOSSARY OF TERMS | |
|---|---|
| **First Nations People** | Aboriginal and Torres Strait Islander peoples are the first peoples of Australia. 'Indigenous Australian' is a very general term that covers two very distinct cultural groups: Aboriginal and Torres Strait Islander peoples. These terms of grouping are umbrella terms, within which sits a large array of different nations, each with their own culture, language, beliefs and practices. It's important to acknowledge that there is great diversity within these two broad terms. There is a growing preference for First Nations Australians as a more encompassing term, because while it also is broad, it acknowledges the diversity of Australia's First Peoples. |
| **Healing programs** | For Aboriginal and Torres Strait Islander people, healing is a holistic process, which addresses mental, physical, emotional and spiritual needs and involves connections to culture, family and land. Healing works best when solutions are culturally strong, developed and driven at the local level, and led by Aboriginal and Torres Strait Islander people. |
| **Health Inequalities** | Health inequities are systematic differences in the health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. These inequities have significant social and economic costs both to individuals and societies. |
| **Health literacy** | Health literacy is about how people understand information about health and health care, and how they apply that information to their lives, use it to make decisions and act on it. |
| **Indigenous Relative Socioeconomic Outcomes Index** | The Indigenous Relative Socioeconomic Outcomes index (IRSEO) is an Indigenous specific index derived by the Centre for Aboriginal Economic Policy Research (CAEPR) from the 2016 Census of Population and Housing. The IRSEO is composed of 9 socioeconomic outcomes of the usual resident population. These are: Population 15 years and over employed; Population 15 years and over employed as a manager or professional; Population 15 years and over employed full-time in the private sector; Population 15 years and over who have completed Year 12; Population 15 years and over who have completed a qualification; Population 15 to 24 years old attending an educational institution; Population 15 years and over with an individual income above half the Australian median; Population who live in a house that is owned or being purchased; and Population who live in a house with at least one bedroom per usual resident. The IRSEO reflects relative advantage or disadvantage at the Indigenous Area level, where a score of 1 represents the most advantaged area and a score of 100 represents the most disadvantaged area. |
| **Intersectional/ intersectionality** | 'Intersectionality' refers to the ways in which different aspects of a person's identity can expose them to overlapping forms of discrimination and marginalisation. Aspects of a person's identity can include social characteristics such as: Aboriginality; gender; sex; sexual orientation; gender identity; ethnicity; colour; nationality; refugee or asylum seeker background; migration or visa status; language; religion; ability; age; mental health; socioeconomic status; housing status; geographic location; medical record; and criminal record. |

| GLOSSARY OF TERMS | |
|---|---|
| **Intentional self-harm** | Self-harm is any behaviour that involves the deliberate causing of pain or injury to oneself. Self-harm can include behaviours such as cutting, burning, biting or scratching the skin, pulling out hair, hitting oneself, or repeatedly putting oneself in dangerous situations. It can also involve abuse of drugs or alcohol, including overdosing on prescription medications. |
| **Local Government Area** | A spatial unit which represents the whole geographical area of responsibility of an incorporated Local Government Council. New South Wales local government areas vary in size and character, and can consist of a group of suburbs, a town or a rural area. |
| **Magistrates Early Referral into Treatment Program** | The Magistrates Early Referral Into Treatment (MERIT) program is a voluntary, pre-plea program for adults in the Local Court who have issues related to their alcohol and other drug use. MERIT provides access to a wide range of alcohol and other drug treatment services for 12 weeks while court matters are adjourned. MERIT aims to improve the health and well-being and reduce offending for adults who have issues related to their alcohol and other drug use and are in contact with the criminal justice system. |
| **Mental health promotion and prevention** | Promotion is defined as intervening to optimize positive mental health by addressing determinants of positive mental health before a specific mental health problem has been identified, with the ultimate goal of improving the positive mental health of the population. Mental health prevention is defined as intervening to minimize mental health problems by addressing determinants of mental health problems before a specific mental health problem has been identified in the individual, group, or population of focus with the ultimate goal of reducing the number of future mental health problems in the population. |
| **My Aged Care** | An Australian Government-funded aged care service, providing information and support to understand, access and navigate the aged care system. |
| **National cancer screening** | Cancer is one of the leading causes of illness and death in Australia. Some cancers can be detected through screening, which allows for early detection, intervention and treatment. Australia has 3 national cancer screening programs: Breast Screen Australia. National Cervical Screening Program (NCSP) National Bowel Cancer Screening Program (NBCSP). |
| **Potentially Preventable hospitalisations** | A Potentially Preventable Hospitalisation (PPH) is an admission to hospital for a condition whereby the hospitalisation could potentially have been prevented through early disease management and the provision of appropriate individualised preventative health interventions. These interventions are typically delivered in primary care and community-based care settings, including those by general practitioners (GPs), medical specialists, nurses, dentists and allied health professionals. PPHs are commonly classified into three groups: Vaccine-preventable, Chronic conditions and Acute conditions. |
| **Polypharmacy** | Polypharmacy refers to the use of multiple medications. A 'polypharmacy patient' then, is one who has been prescribed and is taking multiple medications for multiple conditions. This includes over the counter, prescription and/ or traditional and complementary medicines used by a patient. |

| GLOSSARY OF TERMS | |
|---|---|
| **Postvention** | Postvention, by definition, is the support conducted after the loss of a loved one from suicide. This includes counselling (including suicide grief-specific counselling), support groups, support from family and friends, and many more. Postvention directly supports those who affected by a suicide. |
| **Recommended Daily Intake** | A Recommended Dietary Intake (RDI), sometimes referred to as recommended daily intake, is the average daily intake level of a particular nutrient that is likely to meet the nutrient requirements of 97-98% of healthy individuals in a particular life stage or gender group. |
| **Respiratory disease** | Diseases of the airways and other structures of the lung. Some of the most common are chronic obstructive pulmonary disease (COPD), asthma, occupational lung diseases and pulmonary hypertension |
| **Rural and remote locations** | The term 'rural and remote' encompasses all areas outside Australia's Major cities. Using the Australian Standard Geographical Classification System, these areas are classified as Inner regional, Outer regional, Remote or Very remote. |
| **Rural Communities Project** | The Rural Communities Project is focused on the unique health issues facing the Tenterfield and Glen Innes communities (and villages in each local government area). |
| **Socio-economic Indexes for Areas (SEIFA)** | Socio-economic Indexes for Areas (SEIFA) measures have been created from Census information. Each index summarises a different aspect of the socio-economic conditions in an area, and therefore summarises a different set of social and economic information. The indexes can be used to explore different aspects of socio-economic conditions by geographic areas. For each index, every geographic area in Australia is given a SEIFA number which shows how relatively 'disadvantaged' that area is compared with other areas in Australia. |
| **Suicidal Ideation** | Suicidal ideations (SI), often called suicidal thoughts or ideas, is a broad term used to describe a range of contemplations, wishes, and preoccupations with death and suicide. |
| **Telehealth** | Telehealth is having a consultation with a healthcare provider by phone or video call. |
| **The Australian Early Development Census (AEDC)** | The Australian early development census (AEDC) is a population-based measure of how children in Australia have developed by the time they start their first year of full-time school. The AEDC involves the collection of data across five developmental domains including: physical health and wellbeing; social competence; emotional maturity; language and cognitive skills (school-based); and communication skills and general knowledge. |
| **Yarning circles** | Yarning is about building respectful relationships. The use of a yarning circle (or dialogue circle) is an important process within Aboriginal culture and Torres Strait Islander culture. The yarning circle has been used by Indigenous peoples from around the world for centuries to learn from a collective group, build respectful relationships, and to preserve and pass on cultural knowledge. |

# BACKGROUND

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

## WHAT IS THIS CORE NEEDS ASSESSMENT SUMMARY VERSION?

This document is a summary of the 2022 to 2025 Core Needs Assessment completed in December 2021. Within this document we have presented the health needs and service gaps for our region which are grouped under nine overarching themes:

- Health and Wellbeing of First Nations People
- Maternal, Child and Youth Health
- Older Persons Health
- Priority Populations
- Primary Mental Health Care and Suicide Prevention
- Alcohol and Other Drugs
- Health Workforce and Service Capacity
- Socioeconomic Impacts
- Disease Focus

We have included summarised descriptions of the identified needs and presented this document in an easy to read and visually appealing format. If you would like to view the entirety of the Core Needs Assessment with its full descriptions of evidence for each need, please see our Core Needs Assessment 2022 to 2025 Academic Report on our website.

## WHAT IS THE CORE NEEDS ASSESSMENT?

A Needs Assessment is a process used to identify unmet health and healthcare needs of a population, and present options for work that can be done to address these needs and improve the health of the population. The Core Needs Assessment (CNA) is the first step in the PHN commissioning framework. It provides the basis of the PHN's understanding of the health needs of people living in our region and is used to inform the way the PHN plans and commissions services.

## WHY IS THE CORE NEEDS ASSESSMENT IMPORTANT?

The Needs Assessment is used to:

- Gain a better understanding of, and insight into, the health needs and service gaps across our region, including differences experienced by population groups such as First Nations people, people living in rural areas and Culturally and Linguistically Diverse (CALD) populations;
- Identify opportunities and options for actions that can be taken to address the identified needs and service gaps with the intention of improving the health needs of our region;
- Inform the development of our Annual Plan, and decisions about health service planning and delivery;
- Engage with partner organisations to ensure corresponding effort and investment to improve the health of our communities.

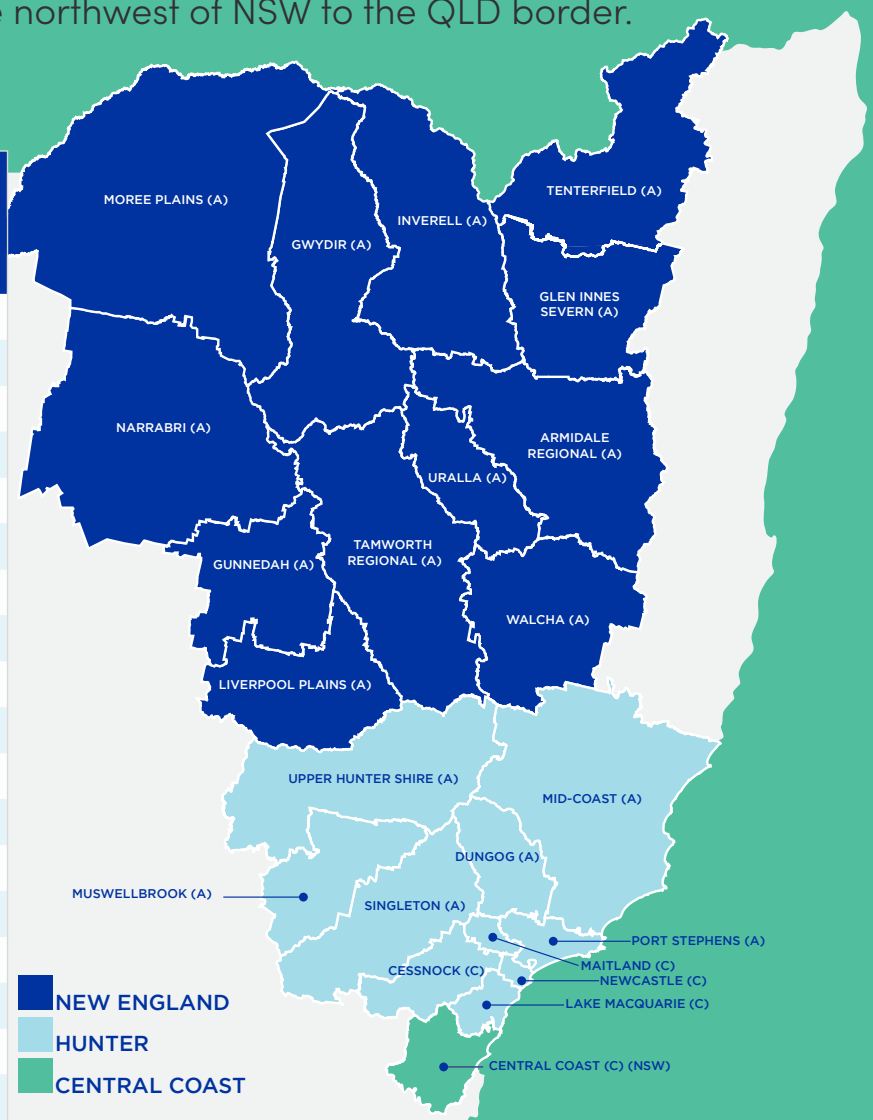
## HOW DO WE PREPARE THE CORE NEEDS ASSESSMENT?

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

## HUNTER NEW ENGLAND AND CENTRAL COAST PRIMARY HEALTH NETWORK (THE PHN) DEMOGRAPHICS

The HNECC PHN is the second largest PHN in NSW, covering an area of 133 812km$^2$. Our region spans across 23 Local Government Areas (LGAs) and has a mix of metropolitan, regional and rural areas. It reaches from just north of Sydney, across the northwest of NSW to the QLD border.

| LOCATION (LOCAL GOVERNMENT AREA) | POPULATION SIZE (ERP 2020) |
|---|---|
| HNECC PHN | 1,288,568 |
| Armidale Regional (A) | 29,704 |
| Central Coast (C) | 345,809 |
| Cessnock (C) | 61,256 |
| Dungog (A) | 9,664 |
| Glen Innes Severn (A) | 8,873 |
| Gunnedah (A) | 12,690 |
| Gwydir (A) | 5,299 |
| Inverell (A) | 17,780 |
| Lake Macquarie (C) | 207,775 |
| Liverpool Plains (A) | 7,853 |
| Maitland (C) | 87,395 |
| Mid-Coast (A) | 94,395 |
| Moree Plains (A) | 13,077 |
| Muswellbrook (A) | 16,355 |
| Narrabri (A) | 13,049 |
| Newcastle (C) | 167,363 |
| Port Stephens (A) | 74,506 |
| Singleton (A) | 23,380 |
| Tamworth Regional (A) | 62,545 |
| Tenterfield (A) - part a | 6,470 |
| Upper Hunter Shire (A) | 14,167 |
| Uralla (A) | 5,944 |
| Walcha (A) | 3,105 |
| *Key: (C) city; (A) area. | |



## LIFE EXPECTANCY AT BIRTH

In 2018

| HNECC PHN | NSW |
|---|---|
| Males 79.3 | 81.5 |
| Females 83.3 | 85.7 |
| Persons 81.5 | 83.6 |

## POPULATION PREDICTIONS

Based on the 2016 population of 1,247,661, the population is predicted to increase by 18.5% by 2036 to 1,478,930 (NSW 28.2%).

## AGE BREAKDOWN

- In 2019, 12.1% of the population of the HNECC PHN region were aged 15-24 years (NSW 12.8%).
- 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%).

## SERVICES

There are 2 Local Health Districts, 387 General Practices, 9 Aboriginal Medical Services, 318 Pharmacies and 44 Public Hospitals within our region.

## CULTURALLY AND LINGUISTICALLY DIVERSE COMMUNITIES (CALD)

- 82.3% of the population were born in Australia (NSW 65.5%).
- Our region has a lower proportion of people from non-English Speaking backgrounds (5.2%) than the state (NSW 21.0%).
- The top two nationalities from people born in non-English speaking countries were 0.5% born in the Philippines (Australia 1.0%) and 0.4% of the population born in China (Australia 2.2%).

## DISABILITY

75,884 people have a profound or severe disability this is 6.6% of the population (NSW 5.6%).

## HOMELESSNESS

There were an estimated 3,751 homeless people in the HNECC PHN in 2016, which represents an increase of 18.10% since 2011.

## FIRST NATIONS PEOPLE

79,405 of people in our region identify as Aboriginal and/or Torres Strait Islander. This is 6.4% of the population (NSW 3.4%).

## RURAL AND REMOTE

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.

## HAVE YOUR SAY COMMUNITY AND STAKEHOLDER 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.

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.

### 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

# Identified Priority Areas

Health & Wellbeing of First Nations People

Maternal, Child & Youth Health

Older Persons Health

Priority Populations

Primary Mental Health Care & Suicide Prevention

Alcohol & Other Drugs Misuse

Health Workforce & Service Capacity

Socioeconomic Impacts

Disease Focus

IDENTIFIED PRIORITY AREA

# Health & Wellbeing Of First Nations People

## HEALTH & WELLBEING OF FIRST NATIONS PEOPLE

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
|---|---|---|
| **NxIH1** | Poorer health outcomes for First Nations People | 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.<br><br>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%.<br><br>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). 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. 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. |
| **NxIH2** | High 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%). |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
|---|---|---|
| **NxIH7** | 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.<br><br>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. 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. |
| **NxIH8** | 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:<br>- Disconnection from culture and country and the impact this has on identity and wellbeing for children and young people<br>- Racism makes it difficult for children to identify and connect to culture<br>- High levels of child removals from local families causing children to be removed from kinship structures<br>- Families that are living off country are living in isolation with housing policies exacerbating family isolation<br>- 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.<br>- Lack of cultural safety for children in care and child protection and the need for genuine trauma aware and healing informed care for children |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
|---|---|---|
| **NxMH5** | Mental health, suicide prevention and trauma informed needs of First Nations people | 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).<br><br>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).<br><br>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. |
| **NxIH3** | 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. |
| **NxAOD4** | Reduced access to drug and alcohol treatment services for First Nations people | 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. |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
|---|---|---|
| **NxIH4** | 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. 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.<br><br>Community and stakeholder engagement identified the following mental health service needs for First nations people:<br>- The whole person needs to be considered, including history, support and follow up<br>- First Nations mental health training for service providers and primary care clinicians is needed<br>- Increased Aboriginal health workers to accompany First Nations people to mental health appointments<br>- First Nations led mental health and healing programs and for primary care organisations to increase cultural training to understand the impacts of generational trauma<br><br>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%). |
| **NxIH5** | 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%). |
| **NxIH6** | 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. |
| **NxIH9** | 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. |

IDENTIFIED PRIORITY AREA

# Maternal Child & Youth Health

## MATERNAL, CHILD & YOUTH HEALTH

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
|---|---|---|
| **NxPH30** | 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.<br><br>Community consultation identified several needs relating to early intervention services for children and youth including:<br>- Excessively long wait lists for early childhood developmental assessment and treatment, with children starting school before any help has been accessed<br>- Lack of early intervention and preventative services for the 0-12 age group<br><br>Difficulties in accessing paediatricians and allied health services for early childhood intervention services within the rural and remote region of the PHN |
| **NxPH7** | 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.<br><br>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).<br><br>By mid-2017, in the HNECC PHN region human papillomavirus (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). |
| **NxPH8** | 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 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. |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxPH9** | Poor health and devel-opmental 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. 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). Further 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.<br><br>The Australian Early Development Census (AEDC) 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%).<br><br>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. |
| **NxPH10** | 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%). 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).<br><br>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). |

IDENTIFIED PRIORITY AREA

# Older Persons Health

# OLDER PERSONS HEALTH

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
|---|---|---|
| **NxPH5** | Health needs of an ageing population | 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%).<br><br>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 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).<br><br>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).<br><br>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).<br><br>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); and 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). |
| **NxPH33** | 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. 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.<br><br>Stakeholder consultation identified several needs related to services for older people.<br><br>- A need for a PHN and Local Health District (LHD) partnership prioritising aged care and ageing population as a dedicated workstream<br>- Strategies for mental health support for Resident Aged Care Facility (RACF) residents<br>- Workforce issues within aged care need to be highly prioritised, including General Practitioner (GP) shortages in visiting RACFs and that Register Nurses (RNs) and Nurse Practitioners can play a role in supporting aged care.<br>- A need for novel models of care for older people including telehealth and assistant therapy models<br>- A need for staff skills to be increased within RACFs to manage behaviourally challenging residents |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxMH4** | Mental health and suicide prevention needs of males aged over 80 years | 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. 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 |
| **NxMH6** | Mental health and suicide prevention needs of older people residing in aged care facilities | 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. 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. |

IDENTIFIED PRIORITY AREA

# Priority Populations

## PRIORITY POPULATIONS

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
|---|---|---|
| **NxPH29** | 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 National Disability Insurance Scheme (NDIS) include need that is currently not visible and 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; lack of capacity and skilled workforce in the Non-government organisations (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. |
| **NxPH12** | 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%).<br><br>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. |
| **NxPH6** | Poorer health outcomes for Culturally and Linguistically diverse (CALD) 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. 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%).<br><br>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. |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxPH39** | Reduced access to services for Culturally and Linguistically Diverse (CALD) populations | Stakeholder consultation identified several challenges for culturally and linguistically diverse (CALD) populations in being able to access health services including:<br>- People who speak English as a second language less likely to go to public health services such as Diabetes management education or a dietician<br>- A lack of cultural awareness of health professionals<br>- A lack of interpreters used consistently in primary care services<br>- A lack of translated resources on health topics<br>- Inadequate support and lack of available time for mainstream primary care services to better support CALD populations<br>The challenges in accessing health services for CALD populations has been further highlighted during the COVID-19 pandemic.<br>A lack of a bilingual service directory for health services<br>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. |
| **NxPH37** | 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. In 2019-20, 12,582 people were recorded as accessing specialist homelessness services within the HNECC PHN region (NSW 63, 283). Consultation 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. |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxPH19** | Poorer health outcomes for people experiencing homelessness | People experiencing homelessness are among Australia's most socially and economically disadvantaged. 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. 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.<br><br>According to stakeholders, 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. Mental health is a high need for people experiencing homelessness. Further in the recent Have Your Say Stakeholder Survey, 2021, those who are homeless and have severe mental illness have difficulty in accessing services. |
| **NxPH34** | Reduced access to services in rural and 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.<br><br>Clinical Councils, Community Advisory Committees, community and service provider stakeholders highlighted several issues regarding rural and remote access to services including:<br>- A lack of transport and accessibility in rural areas has an impact on vulnerable individuals within communities<br>- Geographic distribution of GPs is an issue for the rural and remote communities<br>- Quality of medical care was flagged as lacking compared to medical care within the cities<br>- Access to majority of health services is limited within the Glen Innes region with high wait lists and books closed to new patients<br>- Limited physiotherapists within rural and remote regions, often resulting in high wait lists<br>- Severe shortage of doctors and mental health services including suicide prevention services<br>- Limited after-hours access |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
|---|---|---|
| **NxPH11** | 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. 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.<br><br>The Rural Communities Project delivered in Glenn Innes Severn and Tenterfield LGAs identified through the project evaluation that both LGAs experienced:<br>- High levels of socioeconomic disadvantage<br>- An aging population<br>- A higher proportion of people with disabilities and care and chronic disease in comparison to NSW average<br>- Lack of engagement with preventative health measures such as breast and bowel cancer screening<br>- High rates of health risk factors such as obesity and alcohol misuse and low levels of health literacy<br>- Very high rates of moderate to severe mental illness<br>- Higher than average rates of Indigenous disadvantage<br><br>In the recent "Have Your Say Community Survey, 2021" community members ranked rural health issues as the **third highest health concern** for the community. |

IDENTIFIED PRIORITY AREA

# Primary Mental Health Care & Suicide Prevention

## PRIMARY MENTAL HEALTH CARE & SUICIDE PREVENTION

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxMH1** | 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.<br><br>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:<br>- Mental Health area<br>- Moderate-severe mental illness<br>- People impacted by trauma<br>- People at risk of mental illness<br>- People with chronic disease<br>- People with eating disorders<br>- Mental Health Target Groups:<br>- Children and young people<br>- Aboriginal people<br>- People in rural and remote areas<br>- Vulnerable population groups e.g., males aged 25-65 years<br>- People aged 80 years and older<br><br>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). 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:<br><br>Suicide Prevention Challenges:<br>- Follow-up support for those with suicidal ideation<br>- Follow up support after presentation for suicide attempt<br>- Evidence based approaches to suicide prevention<br>- Intersectoral commitment to suicide prevention<br>- Community capacity to address suicide<br>- Evidence based approaches to postvention |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxMH1 cont.** | High rates of mental illness, intentional self-harm and suicide cont. | Suicide Prevention Target Groups:<br>- Young People<br>- Aboriginal People<br>- Males 25-65 years<br>- People from vulnerable population groups<br>- People from rural and remote areas<br>- Older males 80 years and over<br>All workshops identified young people as the highest priority for suicide prevention target groups. 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. |
| **NxMH2** | Mental health and suicide prevention needs of youth aged 12-25 years | 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.<br>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. |
| **NxMH3** | 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. 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). |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxMH7** | 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:<br><br>Compared to the general population, LGBTIQ+ young people aged 16-17 years old were almost three times more likely to have attempted suicide in the past 12 months<br><br>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<br><br>LGBTIQ+ people are nearly six times more likely to experience and be diagnosed with depression<br><br>Transgender and gender diverse people aged 14-25 years old are over seven times more likely to experience and be diagnosed with depression<br><br>40.5% of LGBTQI+ young people aged 14-21 years reported being diagnosed with generalised anxiety disorder<br><br>LGBTQI+ 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.<br><br>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. 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. |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxMH8** | 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. 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.<br><br>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. |
| **NxMH32** | 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. |
| **NxMH9** | 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. 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. |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxMH10** | 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).<br><br>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. Further there is 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. |
| **NxMH11** | 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. Service providers indicated that their decisions about referral were often made on knowledge about service costs rather than on care needs. |
| **NxMH12** | 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. |

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| **NxMH13** | 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. 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%).<br><br>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. |

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| **NxMH14** | 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.<br><br>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. |

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| **NxMH15** | 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 Medicare Benefits Schedule (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.<br><br>Stakeholder consultation identified the following issues as reduced access to psychiatrists:<br><br>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<br><br>Rural and remote access to psychiatrists is difficult with long wait times and often no to limited psychiatrists within the rural and remote regions<br><br>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<br><br>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. |
| **NxMH18** | 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).<br><br>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. |

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| **NxMH20** | 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 |
| **NxMH21** | 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.<br><br>The results of priority setting workshops determined the rank -order for perceptions of suicide prevention target groups and challenges across the region:<br><br>Target Groups:<br>- Young people<br>- Aboriginal people<br>- Males 25-65 years<br>- People from vulnerable population groups<br>- People from rural and remote areas<br>- Older males 80+ years<br><br>Suicide Prevention Challenges:<br>- Follow up support for those with suicidal ideation<br>- Follow up support after presentation for suicide attempt<br>- Evidence based approaches to suicide prevention<br>- Community capacity to address suicide<br>- Evidence based approaches to postvention<br><br>Further to this, stakeholder consultation identified the following needs for suicide prevention and postvention strategies and services for the region:<br>- 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.<br>- Suicide patients discharged too soon and actively deteriorating young people rejected access to specialist mental health services despite multiple referrals<br>- Youth suicide an issue in Maitland and surrounding areas |

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| **NxMH22** | 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. |

IDENTIFIED PRIORITY AREA

# Alcohol & Other Drug Misuse

## ALCOHOL & OTHER DRUG MISUSE

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxAOD1** | Higher rates of alcohol misuse | Alcohol misuse is a concern across the HNECC PHN region. 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%).<br><br>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%). 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. |
| **NxAOD9** | Alcohol, Other Drugs and Comorbidities | Comorbidity is the presence of two or more physical or mental disorders (or diseases) in one person at the same time. 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. Findings from the recent HNECC PHN Alcohol and Other Drugs Evaluation suggested that there is a need for continuum of care across mental health and Alcohol and Other Drugs comorbidities. Mental health and Alcohol and Other Drugs comorbidities were also raised as a health need from stakeholder consultation. |
| **NxAOD2** | High levels of illicit drug use | Illicit drug use is an increasing concern for stakeholders across 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). 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).<br><br>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 |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxAOD3** | 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 Alcohol and Other Drug (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. Service providers indicate that the following factors need to be in place to improve outcomes across the region: people do not understand the signs and symptoms of drug and alcohol misuse and are delaying help-seeking, due in part to stigma; 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; 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. |
| **NxAOD5** | 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. |
| **NxAOD6** | 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.<br><br>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. |

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| **NxAOD7** | 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. Furthermore, stakeholders highlight 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. |
| **NxAOD8** | Reduced access to drug and alcohol treatment services for people with co-occurring substance misuse and mental illness | 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. |
| **NxAOD10** | Lack of drug and alcohol rehabilitation services | 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, the Network of Alcohol and other Drugs Agencies (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:<br><br>There is a lack of detoxification beds, especially for the youth population (13–16-year-olds)<br><br>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<br><br>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. |

IDENTIFIED PRIORITY AREA

# Health Workforce & Service Capacity

## HEALTH WORKFORCE & SERVICE CAPACITY

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxPH20** | 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.<br><br>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%).<br><br>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:<br><br>Lack of service integration and coordination between GPs and allied health professionals<br><br>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.<br><br>Further collaboration is required between services already available and operating within the community.<br><br>An increase in care navigators and coordination in practices<br><br>Services available but are not linked up and supported<br><br>Integrated services between GPs, allied health, NGOs and the LHDs, need to be able to be accessed by a variety of people<br><br>Agile in how care can be delivered in an integrated way that is non-siloed |

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| **NxPH21** | 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).<br><br>There is an identified need to minimise workforce vulnerability in communities across the HNECC PHN region. Key contributors include:<br><br>An ageing GP workforce leading to workforce shortages across the region, highlighting the need for succession planning to ensure continuity of care.<br><br>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.<br><br>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.<br><br>An expansion of corporate general practices often requiring additional support for non-vocationally recognised doctors.<br><br>A lack of reliable, regular locum support.<br><br>Challenges in relation to after hours and on-call hospital rostering.<br><br>Reduced networking opportunities in rural areas.<br><br>Changes to Distribution Priority Areas (DPAs) affect the capacity to employ overseas trained doctors; and<br><br>Lack of suitable mentoring programs for GPs and nurses in rural areas.<br><br>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. |

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| **NxPH22** | 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:<br>Ongoing Regional Continuing Professional Development advisory groups.<br>Greater education for GPs, Practice Managers and Nurses, and administrative staff.<br>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<br>Investigation into alternative methods of education via webinars, live streaming, focused groups and small group learning<br>GP education of the recognition of people experiencing homelessness and their needs (e.g., mental health, drug and alcohol, diabetes)<br>Allied health providers to be included in further CPD opportunities provided by the PHN as an opportunity to network and engage with other providers<br>Grant writing workshops would be beneficial for local health service providers who require additional support. |
| **NxPH23** | 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:<br>- Continuing Quality Improvement<br>- Practice data extraction and analysis<br>- Practice management<br>- Practice Nurse optimisation<br>- Education and professional development<br>- Digital Health<br>- Accreditation<br>- Chronic disease management<br>- Preventative health and models of care<br>- Workforce capacity and capability<br>- Immunisation<br>- Pathways<br>- General Practice Quality Planning<br>- MBS item number and Practice Incentive Payment changes awareness<br>- Model of care development and support<br>- Workforce planning |

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| **NxPH26** | Lack of prevention and early intervention services | Ongoing, targeted health promotion and prevention is required to maintain and improve health outcomes. Community consultation identified several needs relating to early intervention services (for children) including:<br><br>Excessively long wait lists for early childhood developmental assessment and treatment, with children starting school before any help has been accessed<br><br>Lack of early intervention and preventative services for the 0-12 age group<br><br>Difficulties in accessing paediatricians and allied health services for early childhood interventions services within the rural and remote region of the PHN<br><br>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:<br>- Advocate for an updated national nutritional policy<br>- Further education for clinician education in constructive conversations for overweight patients<br>- 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<br>- Increased health and food literacy programs for youth<br>- Increase in preventative health programs for the aged care sector<br>- An increased need for dietitians and exercise physiologists<br>- Increase in physical activity health promotion programs<br>- 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.<br>- Consideration into early intervention for alcohol misuse and domestic violence were also raised by council members, particularly because of COVID-19 lockdown measures.<br>- Preventative services identified as a need by community consultation included:<br>- Further funding needed for community health and wellness programs<br>- More training for health care staff on preventative measures for chronic disease<br>- An increased need for further preventative and health promotion activities within the region |

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| **NxPH28** | Barriers to cancer screening in primary care | 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. 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. 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. 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. |
| **NxPH41** | 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.<br><br>Stakeholder consultation highlighted several needs relating to Pharmacy including:<br>- A stronger role for Pharmacy for primary care service delivery reducing the demands on GPs<br>- Increase in chronic pain medication management reviews<br>- Increase in medication reviews to reduce the inappropriate use of medication and incorrect interpretation of medication use<br>- Stronger integration and partnerships between pharmacy and other health services<br><br>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. |

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| **NxPH40** | 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:<br><br>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.<br><br>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<br><br>Strong support for the continuation of telehealth medicine and to provide a community awareness campaign on options available when seeking healthcare including telehealth<br><br>A need to provide continuing education for GPs on communication methods when utilising telehealth<br><br>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 |
| **NxPH31** | 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.<br><br>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).<br><br>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.<br><br>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. |

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| **NxPH32** | High proportions of semi-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.<br><br>Over the whole HNECC region, which covers two Local Hospital Districts 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%). |
| **NxMH16** | 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.<br><br>According to stakeholders in the recent "Have Your Say Stakeholder Survey, 2021" allied health services was the **most important health service area** needing improvement. |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxMH17** | Limited availability of early intervention services | Early intervention includes to prevent the 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.<br><br>Early intervention and prevention services were raised in community and stakeholder consultation, in particular early intervention mental health services for children and youth.<br><br>Lack of preventative and early intervention mental health services for the 0-12 age group was identified as a high need<br><br>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<br><br>A need to empower communities and focus on prevention and early intervention in all areas including mental health |
| **NxMH19** | Limited capacity of services to develop and implement an approach to quality | 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.<br><br>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 |

IDENTIFIED PRIORITY AREA

# Socio-economic Impacts

## SOCIOECONOMIC IMPACTS

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
|---|---|---|
| **NxPH1** | 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.<br><br>In 2018, in Australia the Australian Bureau of Statistics (ABS) Health Literacy Survey reported:<br>- 12.4% of people aged 18 years and over found it 'difficult' in their ability to find good health information<br>- 7.8% of people aged 18 years and over found it 'difficult' in understanding health information well enough to know what to do<br><br>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). |
| **NxPH2** | 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). 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. |
| **NxPH4** | Socio-economic 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 Socio-economic Indexes for Areas (SEIFA) score for the area in which they reside.<br><br>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%). |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxPH3** | 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. Cessnock LGA (81.0) was the only LGA with a lower average life expectancy than the HNECC PHN region average. |
| **NxPH35** | 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.<br><br>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:<br>- limited bus services during the weekdays and often none on the weekend<br>- transport limitations often a major barrier to accessing specialist services<br>- limited to no public transport options for residents in Gloucester, resulting in the reliance of neighbourhood group transport services<br>- Referral services are difficult to access for people in rural and remote regions with long distances to travel to access the service |
| **NxPH36** | 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.<br><br>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%). |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxPH38** | 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.<br><br>**COVID-19 Pandemic**<br><br>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. With the significant events and economic impacts of COVID-19 on Australian jobs, industry and the economy. 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%).<br><br>**Drought**<br><br>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 reported among males living in rural areas.<br><br>**Bush fires**<br><br>The 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). 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.<br><br>**NSW Storms and Floods**<br><br>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. |

IDENTIFIED PRIORITY AREA

# Disease Focus

## DISEASE FOCUS

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxPH14** | 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. 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%). 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%).<br><br>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. |
| **NxPH15** | High rates of physical inactivity and poor nutrition | 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. 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 (2017; 46.3%).<br><br>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. |
| **NxPH16** | 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. In 2019, 17.9% of adults in the HNECC PHN region were current smokers (NSW 15.5%). 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). |

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| **NxPH17** | High rates of chronic disease | Chronic diseases are conditions with long lasting and persistent effects. 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%).<br><br>**Diabetes**<br><br>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). 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). 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.<br><br>**Respiratory Disease**<br><br>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). Further 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).<br><br>**Circulatory Disease**<br><br>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). Stakeholders in the New England region have expressed concern about the higher-than-average circulatory disease mortality rates in the Tamworth Regional LGA. |

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| **NxPH18** | High cancer incidence and mortality | **Cancer Incidence and Mortality**<br>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).<br>**Cancer Screening**<br>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%). 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%). 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%, higher than the NSW average (38.3%). |
| **NxPH24** | 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%).<br>A variety of stakeholder consultation noted a need and concerns for dental access and services including:<br>Concern regarding lack of dental/mouth care in Aged Care facilities<br>Lack of publicly funded dental care<br>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 |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxPH25** | 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 carers, 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.<br><br>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.<br><br>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. |
| **NxPH13** | 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. 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. |

| CODE | IDENTIFIED NEED | KEY EVIDENCE |
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| **NxPH27** | High rates of chronic disease hospitalisations | 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 a 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.<br><br>**Indigenous status**<br><br>Aboriginal people tend to be more likely than non-Indigenous people 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. 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 peoples within the HNECC PHN region (2,364.5; and 959.1, respectively).<br><br>**Socioeconomic status**<br><br>For nearly all health measures, people from lower socioeconomic groups in Australia have a lower 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.<br><br>**Remoteness area**<br><br>While PHN level data is not available, in NSW in 2018-19 the rate of chronic PPH conditions per 100,000 population for people living in major cities was 856.2 compared to 1539.1 for people living in remote areas and 1766.1 for people living in very remote areas.<br><br>**People aged 65 years and older**<br><br>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 in comparison to under 65 years (657). 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. Chronic PPHs are the highest priority category of PPHs for older people in the HNECC PHN region. |

## WHAT'S NEXT?

The PHN's Core Needs Assessment is the starting point for The PHNs planning and activity delivery cycle. It will be used as a decision making and prioritisation tool that ensures all PHN work, projects and commitments are addressing the region's health needs.

When planning activities or smaller projects, staff are required to link their project to specific need/s identified in the needs assessment and consider how this need can be addressed and or improved through delivery of their activity. Options suggested in the needs assessment provide context for how an activity can address a need based on available evidence, which in turn helps The PHN to focus its work.

Activities are annually mapped at both a project and activity level through internal PHN and external Department of Health planning and reporting processes. Success of a project or activity, and ultimately the PHN, is measured through outcome measures tied to these activities and whether overtime needs are being improved or met.

**For more information, please contact the PHN at info@thephn.com.au**

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HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

PRIMARY HEALTH NETWORK