



**Australian Government**

**Department of Health**



An Australian Government Initiative

# Primary Health Network Needs Assessment Reporting Template – Core Flexible

**Name of Primary Health Network**

***Adelaide PHN***

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

***Submitted 15 November 2017***

# Section 1 – Narratives

*This section provides brief narratives on the process and key issues relating to the update to the Adelaide PHN (APHN) Baseline Needs Assessment (BNA) Update for the Core & Flexible Funding submitted in November 2016.*

## **Needs Assessment process and issues**

The Adelaide Primary Health Network (PHN) acknowledge the Kaurna peoples who are the Traditional Custodians of the Adelaide Region. We pay tribute to their physical and spiritual connection to land, waters and community, enduring now as it has been throughout time. We pay respect to them, their culture and to Elders past, present and future.

The term “Aboriginal” is used respectively in this document as an all -encompassing term for Aboriginal and Torres Strait Islander people and culture. The term “Indigenous” is used in this document in line with how the data is presented to Adelaide PHN.

An iterative engagement and consultation process forms the basis to the Adelaide PHN (APHN) ethos. Our membership group model comprising our geographically aligned clinical and community advisory councils and seven Health Priority Groups (Mental Health, Aboriginal Health, Consumers and Carers, Disability, Childhood and Youth, Older People and Aged Care, and Palliative Care) are essential to this process. Together with our Board, they bring together a diverse range of experience and knowledge informing our evidence based planning process to determine the local needs and priorities of our catchment area.

The Baseline Needs Assessments (BNA) Update submitted in November 2016 collated consultations including dedicated workshops on Mental Health and Alcohol & Other Drugs (AOD), alongside community workshops and input from our Clinical and Community Advisory Councils and Health Priority Groups. The November 2016 BNA Update (template) included both the Mental Health and Suicide Prevention and AOD BNA Updates. The four strategic priorities identified by the APHN membership groups: (1) Timely Access and Equity, (2) Health Literacy and Education, (3) Care Coordination, Integration and Navigation, and (4) Mental Health, Alcohol & Other Drugs and Physical co-morbidities, have been incorporated into the BNA Updates and as key issues in this reporting template.

Using the BNA Update template as a reference document, Primary Health Networks (PHNs) have been tasked to develop three separate Needs Assessments; (i) Core Flexible (Commonwealth Department of Health PHN funding schedule name), (ii) Mental Health and Suicide Prevention and (iii) AOD, for submission in November 2017. Additionally, PHNs are to analyse (any new) information and or trends since submitting the November 2016 assessment and update the identified needs and priorities accordingly.

This template is called the **2017/18 Adelaide PHN Core Flexible Needs Assessment Update**. Any *new* information in Sections 2 to 4 of the template are highlighted in **red front**. The APHN has also taken this opportunity to refine the information, specifically the outcomes of the health and service needs analysis, by articulating clearly the key issue and identified need to (better) reflect each Needs Assessments template. Nevertheless, the APHN BNA Update process (consultations, health and service needs analysis and priorities setting) was extensive and comprehensive.

The APHN established an internal working group to oversee the methodology and completion of the Needs Assessment Update (NA Update). The (triangulation) process has identified **no**

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**new** priorities for the 2017/18 APHN Core Flexible NA Update. The previously reported **twenty-eight (28) priorities** from the BNA Update have been deemed warranted as they encapsulate new information (both quantitative and qualitative) presented in this NA Update. In addition to this, the APHN has been actively involved in several State and research institution based projects and initiatives to understand the health needs of the community and work in partnership to improve the health and wellbeing of vulnerable population in our region. One example is working collaboratively with Country SA PHN, SA Health and Health Performance Council in developing a South Australian version of the Grattan Institute report to identify (potentially preventable hospitalisations) hotspots of health inequality in both PHNs. Another is being an active member of the South Australia Aboriginal Chronic Disease Consortium in developing a common road map in addressing disparities in chronic disease focusing specifically on diabetes, cancer and heart and stroke in Aboriginal people in South Australia. Finally, in strong and mutual partnership with Country SA PHN and SA Health, the APHN will be implementing HealthPathways across South Australia to support consistent care by using a standardised approach to the management of health conditions to ensure patients receive consistent, accessible, quality and timely care.

The APHN will be working collaboratively with our stakeholders and partners including commissioned service providers to refine and improve service delivery to reflect the identified needs and priorities through our commissioning, monitoring and evaluation processes.

### **Additional Data Needs and Gaps**

Most of the data available on the Commonwealth's PHN website provided sufficient base reference for the APHN to analyse the health and service needs of its catchment. Important for effective commissioning of localised programs and initiatives to meet the needs of identified vulnerable populations requires a lower level data granularity (geographic and population/demographic). At a geographic level, Statistical Area Level 2 data is preferred, and while the Commonwealth provides (MBS/PBS) data by Statistical Area Level 3, for in-depth service mapping e.g. access to After-hours services, we require MBS (all item numbers including psychiatry services) and PBS data for both client location and provider location.

Further access to data specific to Aboriginal and Torres Strait Islander people and Culturally and Linguistically Diverse (CALD) people will provide additional insight into the needs of the Adelaide metropolitan community.

Access to after-hours deputising service data (e.g. time of visits, type of diagnosis, location of patients and referral and follow-up pathways to primary and acute health care services) will provide further insight in understanding the health and service gap to provide targeted services in our region.

### **Additional comments or feedback**

Nil

## Section 2 – Outcomes of the health needs analysis

*Since submitting the (Core Flexible Funding) Baseline Needs Assessment (BNA) Update in November 2016, the APHN has analysed relevant recent quantitative data and undertaken consultations with stakeholders to further investigate and refine the health needs. The following health needs (in red font) refine and or supplement previously identified needs from the BNA Update.*

Outcomes of the health needs analysis			
Identified Need	Key Issue	Description of Evidence	Source
<b>Chronic conditions</b>			
High rates of chronic conditions and poorer health outcomes in Northern, Western and Southern regions of the APHN.	Variations in prevalence at sub-regional levels and with types of chronic conditions across the APHN region.	<p>Approximately 25% of the APHN population had two or more chronic conditions, and 16% had three or more (BEACH, 2016). These rates were consistent with the prevalence of chronic condition multi-morbidity in Other Australian Capital Cities and the prevalence nationally.</p> <p>Between April 2011 and March 2015 approximately 60 out of every 100 encounters with General Practitioners in APHN were for chronic conditions, a higher rate compared with Other Australian Capital Cities (52 per 100) and the national rate (56 per 100) (BEACH, 2016).</p> <p>Substantial geographical variation in chronic disease prevalence and health outcomes is evident across the APHN region.</p> <p><i>Respiratory system disease</i></p> <p>Rates of respiratory system diseases are highest in the Local Government Areas (LGAs) of Playford, Salisbury, Tea Tree Gully, Mitcham and Onkaparinga. For Asthma, the prevalence was highest in the LGAs of Playford, Tea Tree Gully, Marion and Onkaparinga. Playford also had the highest prevalence of people with Chronic Obstructive Pulmonary Disease (COPD), with high rates of premature mortality caused by COPD in Playford, Salisbury, Port Adelaide Enfield, Norwood-Payneham-St Peters, Adelaide and Onkaparinga (PHIDU, 2015).</p> <p>Geographical variation was also evident for the 2014-15 rates of potentially preventable hospitalisations for COPD, with rates being markedly higher</p>	<p><i>Bettering the Evaluation and Care of Health (BEACH), 2016, Family Medicine Research Centre, School of Public Health, The University of Sydney, customised report for Adelaide Primary Health Network, unpublished.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2015, Social Health Atlas of Australia.</i></p> <p><i>Australian Commission on Safety and Quality in Health Care and Australian</i></p>

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	<p>than the South Australian (259 per 100,000) and national (244 per 100,000) rates in the northern, western and southern Statistical Areas Level 3 (SA3s) of Playford (498 per 100,000), Salisbury (376), Port Adelaide - West (343), Onkaparinga (323) and Marion (317) (ACSQHC, 2017).</p> <p><i>Diabetes</i></p> <p>Estimated diabetes prevalence is also high in the LGAs of Port Adelaide Enfield, Playford, Charles Sturt, Salisbury, Norwood-Payneham-St Peters and Campbelltown (PHIDU, 2015). Diabetes was reported as the third most frequent chronic problem managed in general practice, 4.6 per 100 encounters in the APHN region, significantly higher compared to Other Australian Capital Cities (3.6 per 100) (BEACH, 2016).</p> <p>Geographical variation was also evident for the 2014-15 rates of potentially preventable hospitalisations for diabetes complications, with rates being markedly higher than the South Australian (190 per 100,000) and national (173 per 100,000) rates in the northern and western SA3s of Playford (299 per 100,000), Salisbury (259) and Port Adelaide - West (245) (ACSQHC, 2017).</p> <p>Between 2010 to 2014, premature mortality from Diabetes was over twice the national rate in Playford LGA and 59% higher than the national rate in Port Adelaide Enfield LGA (PHIDU, 2017a).</p> <p><i>Circulatory system disease</i></p> <p>Rates of circulatory system diseases were fairly similar across the APHN region, and consistent with national prevalence rates (PHIDU, 2015). However, rates of premature mortality from circulatory system disease varied across the region with rates in Playford and Port Adelaide Enfield LGAs being substantially higher than the national rate between 2010 to 2014 (50% and 37% respectively) (PHIDU, 2017a).</p> <p>Geographical variation was also evident for the 2014-15 rates of hospitalisations for acute myocardial infarction and potentially preventable</p>	<p><i>Institute of Health and Welfare, 2017, The Second Australian Atlas of Healthcare Variation. Sydney: ACSQHC.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2015, Social Health Atlas of Australia.</i></p> <p><i>Bettering the Evaluation and Care of Health (BEACH), 2016, Family Medicine Research Centre, School of Public Health, The University of Sydney, customised report for Adelaide Primary Health Network, unpublished.</i></p> <p><i>Australian Commission on Safety and Quality in Health Care and Australian Institute of Health and Welfare, 2017, The Second Australian Atlas of Healthcare Variation. Sydney: ACSQHC.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2017a, Social Health Atlas of Australia.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2015, Social Health Atlas of Australia.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2017a, Social Health Atlas of Australia.</i></p>

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	<p>heart failure, with rates being markedly higher than the South Australian and national rates in the northern and western SA3s of Playford, Port Adelaide - West and Salisbury (ACSQHC, 2017).</p> <p>Hypertension was reported as the most frequent problem managed by General Practitioners in the APHN region, 8.7 encounters per 100, consistent with Other Australia Capital Cities (BEACH, 2016).</p> <p><i>Musculoskeletal system disease</i></p> <p>Rates of musculoskeletal system disease prevalence were similar across the APHN region, and the APHN rate was consistent with national prevalence rate of 27.7 (PHIDU, 2017a). Prevalence rates for arthritis were significantly higher than the national rate (14.8 per 100) in the LGA of Playford, 17.4 per 100 people (PHIDU, 2017a). While the rate of hospitalisation for musculoskeletal system diseases was highest in the southern regions of Onkaparinga and Marion LGAs.</p> <p><i>Cancer</i></p> <p>With the exceptions of lymphoma (17% higher), melanoma (26% lower), thyroid cancer in women (40% lower) and head and neck cancer in men (14% lower), the 2006-2010 average age-standardised cancer incidence rates for the APHN region were consistent with (or not markedly different from) the Australian age-standardised incidence rates for colorectal, leukaemia, lung, pancreas, kidney, bladder, ovary, cervical, breast, uterus stomach cancers, and all cancers combined (AIHW, 2016a).</p> <p>Clear variations in incidence rates were evident across the APHN for a number of cancer types. Compared to the Australian age-standardised rate, the incidence rates for all cancers combined were lower in the SA3s of Burnside and Unley (14% and 11% lower respectively), but conversely had higher rates of breast cancer incidence (17% and 15% respectively)</p>	<p><i>Australian Commission on Safety and Quality in Health Care and Australian Institute of Health and Welfare, 2017, The Second Australian Atlas of Healthcare Variation. Sydney: ACSQHC.</i></p> <p><i>Bettering the Evaluation and Care of Health (BEACH), 2016, Family Medicine Research Centre, School of Public Health, The University of Sydney, customised report for Adelaide</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2017a, Social Health Atlas of Australia.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2016a. Cancer Incidence and Mortality Across Regions (CIMAR) books: Primary Health Network (PHN), 2006–2010. Canberra: AIHW. &lt;<a href="http://www.aihw.gov.au/cancer-data/CIMAR-books">http://www.aihw.gov.au/cancer-data/CIMAR-books</a>&gt;</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2016b, Cancer Incidence and Mortality Across Regions (CIMAR) books: Statistical Area Level 3 (SA3), 2006–2010. Canberra: AIHW.</i></p>

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Outcomes of the health needs analysis		
	<p>(AIHW, 2016b). The SA3s of Marion and Tea Tree Gully also has higher breast cancer incidence, (15% and 13% respectively), compared to the Australian average. For colorectal cancer, rates were lower in Mitcham (16%), Burnside (15%) and Marion (17%), whereas as for prostate cancer, incidence rates were higher in Marion (14%), Adelaide City (12%) and Mitcham (10%) (AIHW, 2016b). The most substantial variation in incidence rates across the region was for lung cancer, ranging from 51% and 45% lower in Burnside and Adelaide City respectively (compared to the Australian rate), to 53% and 31% higher in the SA3s of Playford and Port Adelaide-West (AIHW, 2016b).</p> <p>As with incidence, the 2009-2013 APHN average age-standardised mortality rates for most cancers were consistent with the Australian rates with the exceptions of lymphoma (20% higher) and melanoma (26% lower) (AIHW, 2016a). For women, mortality rates in the APHN were 21% higher for cervical cancer but a low rate of 2.2 per 100,000. For males, mortality rates were 24% lower for head and neck cancers, 22% lower for prostate cancer and 21% higher for kidney cancer (AIHW, 2016a).</p> <p>With the exception of lung cancer, mortality rates did not reflect patterns of cancer incidence across the region. The 2009-2013 age-standardised rates for all cancers combined indicate that people living in the SA3s of Playford and Port Adelaide-West had substantially higher mortality rates from cancer compared to the people living in other SA3s in the APHN, and the Australia (26% and 23% respectively) (AIHW, 2016b). For breast cancer, mortality rates were highest in Salisbury (30% higher than Australian average), Port Adelaide-West (22%) and Playford (19%) (AIHW, 2016b). For colorectal cancer, Port Adelaide-West had the highest rate in the region, 27% above the Australian rate, followed by Playford and Tea Tree Gully (both 17%) (AIHW, 2016b). As with incidence, the most substantial variation in mortality rates across the region was for lung cancer, ranging from 43% and 42% lower in Holdfast Bay and Burnside respectively (compared to the Australian rate), to 65% and 52% higher in the SA3s of Playford and Port Adelaide-West, with rates 31% higher in Salisbury (AIHW, 2016b).</p>	<p><a href="http://www.aihw.gov.au/cancer-data/CIMAR-books">http://www.aihw.gov.au/cancer-data/CIMAR-books</a></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2016a. Cancer Incidence and Mortality Across Regions (CIMAR) books: Primary Health Network (PHN), 2006–2010. Canberra: AIHW. <a href="http://www.aihw.gov.au/cancer-data/CIMAR-books">http://www.aihw.gov.au/cancer-data/CIMAR-books</a></i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2016b, Cancer Incidence and Mortality Across Regions (CIMAR) books: Statistical Area Level 3 (SA3), 2006–2010. Canberra: AIHW. <a href="http://www.aihw.gov.au/cancer-data/CIMAR-books">http://www.aihw.gov.au/cancer-data/CIMAR-books</a></i></p>



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Outcomes of the health needs analysis			
Child & Youth Health			
<p>Areas of low childhood immunisation coverage rates across the APHN region for children 5 year and under, particularly for Aboriginal and Torres Strait Islander and CALD children.</p>	<p>Childhood immunisation</p>	<p>As of June 2017, the 94% immunisation coverage rates for 1- and 5-year-old children living in the APHN region were close to reaching the national aspirational immunisation coverage target of 95% (DOH, 2017a). The immunisation coverage for 2-year-olds living in the APHN region was lower, at 90% (DOH, 2017a). However, these coverage rates were not consistent across APHN.</p> <p>For 1-year-old children coverage rates are lowest in the SA3s of Adelaide City (85%), Holdfast Bay (88%), Port Adelaide – West (90%) (DOH, 2017b). The rates in Campbelltown (91%), Prospect – Walkerville (92%), Mitcham (92%), Port Adelaide – East (93%), West Torrens (93%) and Playford (93%) are also lower than the APHN average rate (DOH, 2017b).</p> <p>For 2 year olds coverage rates are lowest in the SA3s of Adelaide City (76%), Campbelltown (86%), Unley (87%) and Charles Sturt (87%) (DOH, 2017b). The rates in Holdfast Bay (88%), Salisbury (88%), Norwood - Payneham - St Peters (88%), Port Adelaide – West (88%) and Burnside (89%) are also lower than the APHN average rate (DOH, 2017b).</p> <p>For 5 year olds coverage rates are lowest in the SA3s of Adelaide City (70%), Prospect – Walkerville (86%), Unley (89%), and Holdfast Bay (90%) (DOH, 2017b). The rates in Norwood - Payneham - St Peters (91%) and Campbelltown (92%), Charles Sturt (93%), Mitcham (93%) and Port Adelaide – West (93%) are also lower than the APHN average rate (DOH, 2017b).</p> <p>Immunisation coverage for Aboriginal and Torres Strait Islander children living in the APHN region varies by age cohort. Coverage rates for 5-year-olds are high at 95%, which is in line with the national aspirational target (DOH, 2017c). However, coverage rates for 1-year-olds and 2-year-olds are notably lower at 86% and 83% respectively (DOH, 2017c).</p> <p>The Aboriginal Health Health Priority Group identified immunisation as an issue within maternal, child and youth health.</p>	<p><i>Department of Health, 2017a, Current PHN immunisation coverage data for all children, Current quarter: June 2017, <a href="#">Immunise Australia website</a>, accessed October 2017</i></p> <p><i>Department of Health, 2017b, Current SA3 immunisation coverage data for all children, Current quarter: June 2017, <a href="#">Immunise Australia website</a>, accessed October 2017</i></p> <p><i>Department of Health, 2017c, Current PHN immunisation coverage data for Aboriginal and Torres Strait Islander children, Current quarter: June 2017, <a href="#">Immunise Australia website</a>, accessed October 2017</i></p> <p><i>Health Priority Groups, priority setting workshops, 2016</i></p>



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		<p>Additionally, analysis of the Australian Immunisation Register (AIR) indicates that children from culturally and linguistically diverse backgrounds have lower coverage rates (AIR, 2016).</p> <p><i>Australian Immunisation Register (AIR), 2016, childhood immunisation records, APHN extracted, unpublished.</i></p>
<p>Higher prevalence of overweight and obese children in the north of the APHN region, and rates of obesity and overweight are higher for Aboriginal children compared to non-Aboriginal children</p>	<p>Childhood Obesity</p>	<p>Around a quarter (23.0%) of non-Aboriginal children aged 5-17 years in South Australia were overweight or obese, slightly lower the national average of 24.8% (HPCSA, 2016), but still a growing concern given it is above the 2025 target of 21.6% for 5-11 year olds (AHPC, 2016). The AHPC data also indicates a growing concern for young people – nearly one in three (29.5%) are overweight or obese. The 2025 target for 12-17 year olds is 28.3% (AHPC, 2016).</p> <p>For Aboriginal children, over a third (37.6%) aged 5-17 years in South Australia were overweight or obese. This percentage is higher when compared to non-Aboriginal children and to the national average for Aboriginal children (32.8%) (HPCSA, 2016). Compared to other states and territories, South Australia is ranked second highest (HPCSA, 2016). The AHPC national data indicated that unhealthy weight in childhood is a significant issue for Aboriginal children and young people (AHPC, 2016).</p> <p>The Aboriginal Health HPG identified the need to focus on prevention of obesity, as it can contribute to health issues such as diabetes and hypertension.</p> <p>Although the 2014-15 APHN average rate for children or young people aged 2-17 years who are obese or overweight (24.1 per 100 children) is consistent with the Capital Cities rate (26.3 per 100), rates are higher than the APHN average in the northern sub-region of the APHN. The highest rates are found in the LGAs of Port Adelaide Enfield (27.0), Playford (26.1) and Salisbury (25.6) (AHPC, 2017).</p> <p>The Northern Adelaide Clinical Council, raised their concerns on the increasing rates in childhood and the fact that the condition progresses into adulthood. They suggested that education, patterns of behaviour, technology use and not being able to play outside safely were causal factors.</p> <p><i>Australian Health Policy Collaboration (AHPC), 2016, Australia's Children and Young People Health Tracker.</i></p> <p><i>Health Performance Council of South Australia, 2016, State of Our Health Report.</i></p> <p><i>Australian Health Policy Collaboration (AHPC), 2016, Australia's Children and Young People Health Tracker.</i></p> <p><i>Health Priority Groups, priority setting workshops, 2016.</i></p> <p><i>Australian Health Policy Collaboration (AHPC), 2017, Australia's Health Tracker.</i></p> <p><i>Clinical Council, priority setting workshops, 2016</i></p>

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<p>Young people in the southern and western APHN regions have higher rates of drinking at risky level when compared to APHN and State averages.</p>	<p>Alcohol consumption</p>	<p>Recent secondary analysis of the 2013 national Drug Strategy Household Survey reported that the highest prevalence of monthly risky drinking occurred in Statistical Area Level 4 (SA4) areas of Adelaide-South (29%) and Adelaide-West (33%) within APHN region. The prevalence rate of Adelaide-West SA4 region exceeded the APHN (26%), State (28%) and national (26%) averages (Roche et al., 2016). Previous DASSA analysis reported that high rates of risky alcohol use are also present in the Western and Southern Metropolitan regions (DASSA, 2013).</p> <p>Among the 12-17 year old school students, highest prevalence of risky drinking in the past fortnight occurred in Adelaide-South (22%) and exceeded the APHN and State averages (Roche et al., 2016).</p> <p>The Southern Community Advisory Council identified that there is a high level of substance abuse (alcohol and drugs, in particular methamphetamine) in the southern region of Adelaide requiring timely services and education for young people.</p>	<p><i>Roche, A.M., Fischer, J., Nicholas, R., Kostadinov, V. 2016, Alcohol &amp; Other Drugs Use in South Australia: Adelaide Primary Health Network Patterns and Prevalence, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.</i></p> <p><i>Drug and Alcohol Services South Australia (DASSA), 2013, Alcohol consumption and related harm in South Australia.</i></p> <p><i>Community Advisory Council, priority setting workshops, 2016.</i></p>
<p>Young people across the APHN region have significant rates of illicit drug use</p>	<p>Illicit drug use</p>	<p>Prevalence of lifetime illicit drug use among 12-17 year olds ranged from 8% (Adelaide-Central SA4), to 18% (Adelaide-South SA4). Adelaide-North had the second highest at 14% followed by Adelaide-West at 13%. APHN and state-wide, the prevalence of illicit drug use (ever) among 12-17 year olds was 14% for both regions (Roche et al., 2016).</p> <p>For APHN region, one in ten (10%) 12-17 year olds have used cannabis in the past 12 months. The prevalence ranged from 6% in Adelaide-Central SA4 to 23% in Adelaide-South SA4. Among 16-17 year olds, prevalence ranged from 13% (Adelaide-Central) to 24% (Adelaide-South) (Roche et al., 2016).</p> <p>Among South Australian secondary school students residing in APHN, 1% had used ecstasy in the last 12 months (Roche et al., 2017). Among 16-17 year olds in APHN, 3% had used ecstasy in the last 12 months (Cancer Council Victoria secondary analysis, 2016).</p>	<p><i>Roche, A.M., Fischer, J., Nicholas, R., Kostadinov, V. 2016, Alcohol &amp; Other Drugs Use in South Australia: Adelaide Primary Health Network Patterns and Prevalence, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.</i></p> <p><i>Roche, A.M., Fischer, J., McEntee A., Pidd K., 2017, Drug and Alcohol Use Among Select South Australian At-Risk Groups, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.</i></p>

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		<p>The Southern Community Advisory Council identified that there is a high level of substance abuse (alcohol and drugs, in particular methamphetamine) in the southern region of Adelaide requiring timely services and education for young people.</p>	<p><i>Cancer Council Victoria. (2016). Australian secondary school students' use of tobacco, alcohol and over-the-counter and illicit substances in 2014. Melbourne: Cancer Council Victoria.</i></p> <p><i>Community Advisory Council, priority setting workshops, 2016.</i></p>
<p>Young people living in the APHN region have significant mental health issues</p>	<p>Mental health</p>	<p><i>Suicide ideation and intentional self-harm</i></p> <p>A review of Australian and International studies by Nock et al. (2008) identified that between 12% and 26% of adolescents (ages 12–17 years) reported having had thoughts about suicide in the previous year. For the APHN, this equates to between 9,648 and 20,905 people aged 12-17 years old potentially experiencing suicidal ideation in the past 12 months (ABS, 2017a)</p> <p>In 2016, intentional self-harm was the leading cause of death for South Australians aged 15-24 years old (ABS, 2017b). In this age group the number of deaths by intentional self-harm were 3 times higher in males compared to females (ABS, 2017b).</p> <p>In Greater Adelaide from 2012-2016, 18 children, 12 males and 6 females, aged 5-17 years died from intentional self-harm (ABS, 2017b).</p> <p><i>Mental health-related medicines</i></p> <p>The pattern of mental health-related PBS prescription dispensing for people 17 years and under varied across the APHN region. In 2013-14 the highest rate and number of prescriptions dispensed for antidepressant medications were in Onkaparinga SA3, 3,581 prescriptions equating to a rate of 9,334 prescriptions per 100,000 population (ACSQHC, 2015). The SA3s of Mitcham and Prospect-Walkerville had the next highest rates with 6,588 per 100,000 and 6,584 per 100,000 respectively (ACSQHC, 2015).</p>	<p><i>Nock, M., Borges, G., Bromet, E. et al., 2008, Suicide and suicidal behavior. Epidemiological Reviews, 30(1). 133-154</i></p> <p><i>Australian Bureau of Statistics (ABS), 2017a, Census of Population and Housing 2016, compiled by profile.id and presented in Adelaide Primary Health Network community profile</i></p> <p><i>Australian Bureau of Statistics (ABS), 2017b, 3303.0 Causes of Death, Australia, 2016.</i></p> <p><i>Australian Commission on Safety and Quality in Health Care and National Health Performance Authority, 2015, Australian Atlas of Healthcare Variation. Sydney: ACSQHC.</i></p>

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Outcomes of the health needs analysis			
		<p>Rates of dispensing for antipsychotic medication in people aged 17 years and under varied across the APHN, with the highest rates and number of prescriptions dispensed correlated with areas of lower socioeconomic status. In 2013-14 the highest rates were SA3s of Playford (2,916 per 100,000), Onkaparinga (2,524 per 100,000) and Salisbury (2,458 per 100,000) (ACSQHC, 2015).</p> <p>Although rates of PBS dispensing for attention deficit hyperactivity disorder in people 17 years and under were lower in South Australia compared to other states and territories, a wide variation was evident across the APHN. In 2013-14 rates and numbers of ADHD prescriptions were substantially higher in the SA3s of Playford (2,248 prescriptions, a rate of 10,432 per 100,000), Onkaparinga (3,240 prescriptions, 8,541 per 100,000) and Salisbury (2,265 prescriptions, 7,648 per 100,000) (ACSQHC, 2015). The APHN notes that based on the available data, it is not possible to determine the extent to which antidepressant and antipsychotic medicines were prescribed for conditions other than mental health.</p>	
<p>Access to services and management of conditions influencing children and youth presenting at ED and admissions with potentially preventable conditions.</p>	<p>Potentially preventable hospital presentations and admissions for children and youth</p>	<p>In 2016, for the APHN region, young people (10-19 years) comprised 12% of the PHN population however they represented 13% of AOD Emergency Department (ED) presentations (2015/16), 13% AOD hospital separations (2015/16), 15% of specialist AOD treatment episodes (2014/15) and 8% of Alcohol and Drug Information Service (ADIS) calls (2015) (for callers aged 24 years or under) (Roche et al., 2017).</p> <p>National figures indicate that in 2015-16 six percent of presentations to the emergency department for people aged 15-24 years were mental health-related compared to the national average of four percent (AIHW, 2017a). People aged 15-24 years comprised 22% of mental health-related presentations, compared to 14% of total emergency department presentations (AIHW, 2017a).</p> <p>Analysis of data (2012/13 – 2014/15) from SA health have shown increasing concern for specific potentially preventable conditions - Ear, Nose and Throat infections, Asthma, Dental conditions, Urinary tract infections and Diabetes complications, among the child and youth presenting at Emergency Departments in APHN region (SA Health, 2016a).</p>	<p><i>Roche, A.M., Fischer, J., McEntee A., Pidd K., 2017, Drug and Alcohol Use Among Select South Australian At-Risk Group, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.</i></p> <p><i>Australian Institute of Health and Welfare, 2017a, Mental health services in Australia—Services provided in public emergency departments</i></p> <p><i>SA Health, 2016a, Potentially Preventable Admissions data, 2012/13 – 2014/15, unpublished.</i></p>

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Outcomes of the health needs analysis			
		<p>The Aboriginal Health HPG identified ear health and access to screening and treatment for children as a need.</p> <p>More than half (52%) of the almost 24,500 Dental Caries potentially preventable hospitalisations (PPHs) in the past seven years (2007-08 to 2013-14) were for children aged under ten years old (SA Health, 2015a).</p> <p>Between July 2012 and June 2014, a total of 12,037 South Australians were admitted to hospital for acute preventable dental conditions, making dental conditions the leading cause of PPHs. Young children have the highest rates of preventable hospitalisation due to dental conditions (SA Health, 2015a).</p> <p>The burden of poor oral health is not evenly distributed across the population with Aboriginal children experiencing more than 50 per cent tooth decay than non-Aboriginal children. Furthermore, children in the lowest socio-economic areas have 50 to 70 per cent more tooth decay compared to those in the highest socio-economic areas, and untreated tooth decay is 70 per cent more prevalent in the most disadvantaged children. However 18 to 27 per cent of children in the highest socio-economic groups also had untreated tooth decay (SA Health, 2015a).</p>	<p><i>Aboriginal Health HPG, priority setting workshops 2016.</i></p> <p><i>SA Health, 2015a, SA Dental Service, Understanding possible preventable hospital separation data for dental, Evaluation and Research Unit, Service Quality &amp; Performance Improvement, August 2015, unpublished.</i></p>
<b>Healthy Ageing</b>			
Older adults living in the APHN region have wide-ranging and complex multi-morbidity, high prevalence of chronic disease and associated risk factors.	Healthy ageing	South Australia has an 'aged' population, with a higher proportion of older people than the national average (Roche et al, 2017). The Office for the Ageing states that for South Australia over the next 10 years it is expected that the percentage of the population living beyond the age of 65 years will rise from the current figure of 15% to 22% (OFTA, 2014).	<p><i>Roche, A.M., Fischer, J., McEntee A., Pidd K., 2017, Drug and Alcohol Use Among Select South Australian At-Risk Group, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.</i></p> <p><i>Office for the Ageing (OFTA), 2014, Prosperity through longevity: South</i></p>

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	<p>In 2013 there were 190,842 people aged 65 years and over, including 29,921 people aged 85 years and over, living in the APHN region (PHIDU, 2014). <b>In 2016, this has increased to 205,706 people aged 65 years and over (17.3% of the APHN population) including 32,128 people aged 85 years and over (ABS, 2017a).</b></p> <p>A South Australian survey of older people found that 92% of survey respondents selected health and wellbeing as an important aspect of growing older. The results also indicated a decline in self-rated health with age, with approximately 40% of those aged 70-79 years, and more than 50% of those aged over 80 years rated their health as fair or poor. The health issues that most affected daily activities were vision (22%) and mobility (19%) (OFTA, 2014).</p> <p>In the APHN region, there were 23,430 people (14%) aged 65 years and over living in the community with a profound or severe disability, which was consistent with the national rate of 14% for other capital cities (PHIDU, 2014).</p> <p>The risk of developing dementia increases with age (CAHML, 2015). In South Australia, the 2016 estimate of dementia prevalence is 30,500 people (11,400 males, 19,100 females). This is expected to increase to 33,500 people by 2020. (AIHW, 2012). The most common type of dementia is Alzheimer's disease, which accounts for around 75% of all dementia diagnoses.</p> <p>Multimorbidity of chronic conditions increases with age. In South Australia in 2014, 29% of males and 35% of females aged 65-74 years old, and 39% of males and 47% of females aged 75 years and over lived with two or more chronic health conditions (diabetes, asthma, cardiovascular disease, arthritis, osteoporosis and/or a mental health condition). These proportions were double the state averages of 16% for males and 19% females aged 16 years and over (HPCSA, 2016).</p>	<p><i>Australia's ageing plan, our vision 2014-2019.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2014, Social Health Atlas of Australia.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2017a, Census of Population and Housing 2016, compiled by profile.id and presented in Adelaide Primary Health Network community profile</i></p> <p><i>Office for the Ageing (OFTA), 2014, Prosperity through longevity: South Australia's ageing plan, our vision 2014-2019.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2014, Social Health Atlas of Australia.</i></p> <p><i>Central Adelaide and Hills Medicare Local (CAHML), 2015, Health Profile: a population health needs assessment of the Central Adelaide and Hills region, 2015.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2012, Dementia in Australia. Cat. no. AGE 70. Canberra: AIHW.</i></p> <p><i>Health Performance Council of South Australia (HPCSA), 2016, State of Our Health (online report), accessed April 2016.</i></p>

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Outcomes of the health needs analysis		
	<p>In 2014, more than half of all South Australian males (55%) and females (58%) aged 75 years and over were living with two or more of the following health risk factors: high blood pressure, high cholesterol, no physical activity, obesity, smoking, alcohol risk, and/or insufficient consumption of fruit and vegetables. For 65-74 year olds, 44% of both males and females were living with two or more of the health risk factors. (HPCSA, 2016)</p> <p>Falls represent a significant health issue among older people, with 2011-12 data showing that across Australia, 96,385 people aged 65 years and over required hospitalisation as a result of a fall. Twice as many women as men were hospitalised for a fall, and the number of falls cases increased with age (CAHML, 2015). People aged 85 years and over comprised 42.8% of falls cases requiring hospitalisation. The most commonly recorded cause of fall injury was falling on the same level from slipping, tripping and stumbling, which accounted for 33% of falls (CAHML, 2015).</p> <p>In 2012-13, the estimated number of serious injuries due to falls in people aged 65 and older was 98,704. Females accounted for most of these fall injury cases, and rates of cases were higher for females than for males for all age groups (AIHW, 2017b).</p> <p>Age-standardised rates of hospitalised fall injury cases increased over the 11 years to June 2013 (3% per year). There were more than 24,000 extra fall injury cases for people aged 65 and older in 2012-13 than there would have been if the rate of falls had remained stable since 2002-03 (AIHW, 2017b).</p> <p>The largest proportion (26%) of fall injury cases for people aged 65 and older in 2012-13 were injuries to the hip and thigh. Fractures of the neck of the femur (also commonly called hip fractures) accounted for the majority of these injuries (74%). Injuries to the head were the second most common outcome of a fall (22%). There was a decrease in the rate of hip fractures due to falls (-2% per year) between 2002-03 and 2012-13. In contrast, falls resulting in head injuries increased at a particularly high rate (7% per year) (AIHW, 2017b).</p>	<p><i>Health Performance Council of South Australia (HPCSA), 2016, State of Our Health (online report), accessed April 2016.</i></p> <p><i>Central Adelaide and Hills Medicare Local (CAHML), 2015, Health Profile: a population health needs assessment of the Central Adelaide and Hills region, 2015.</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2017b, Trends in hospitalisations due to falls by older people, Australia 2002-03 to 2012-13. Injury research and statistics series no. 106. Cat. no. INJCAT 182. Canberra: AIHW.</i></p> <p><i>ibid.</i></p>



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Outcomes of the health needs analysis			
		<p>Increases in the rate of fall injury cases and fall-related head injury were most apparent for residents of Major cities (4% and 8% per year, respectively). Around 72% of fall injury cases in 2012–13 were recorded as having occurred in either the home or a residential aged care facility. The age-standardised rate of falls in the home for older people living in the community was 1,655 per 100,000 population while the rate of falls for older people living in residential aged care was 9,037 per 100,000 population. These rates are likely to be underestimated because of missing information on the places in which falls occurred (AIHW, 2017b).</p> <p>In 2012-13, there were more than 120,000 other fall-related hospital separations (mainly for rehabilitation care) for people aged 65 and older. The length of stay in hospital as a result of an injurious fall takes into account time spent in hospital following transfers after the initial hospitalisation and for fall-related rehabilitation and related care. In total, there were 1.4 million days of patient care over the year, with the average total length of stay per fall injury case estimated to be 14.0 days. Overall, one in every 10 days spent in hospital by a person aged 65 or older in 2012–13 was attributable to an injurious fall. The days of patient care attributable to fall-related injury rose from 0.8 million patient days in 2002–03 to 1.4 million patient days in 2012–13 (AIHW, 2017b).</p>	<p><i>Ibid.</i></p> <p><i>Ibid.</i></p>
Aboriginal Health			
<p>Aboriginal and Torres Strait Islander South Australians higher prevalence of nearly all health conditions, compared to non-Aboriginal South Australians.</p>	<p>Health inequalities in health and wellbeing of Aboriginal people</p>	<p>The recently released <i>Aboriginal and Torres Strait Islander Health Performance Framework 2017</i> report for South Australia lists the following concerns for the State:</p> <ul style="list-style-type: none"> <li>• The age-standardised proportion of Indigenous women that smoked during pregnancy was 48%, this was 3 times the rate for non-Indigenous women (15%) in 2014;</li> <li>• A smaller proportion of Indigenous women accessed antenatal care services in the first trimester of pregnancy (53%) compared with for non-Indigenous women (78%) in 2014;</li> <li>• Age-standardised death rates for some chronic diseases in 2011–2015 were higher for Indigenous Australians than for non-Indigenous Australians: more than 4 times as high for diabetes (74 compared</li> </ul>	<p><i>Australian Institute of Health and Welfare (AIHW), 2017c, Aboriginal and Torres Strait Islander Health Framework 2017 report: South Australia, AIHW, Canberra.</i></p>

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Outcomes of the health needs analysis			
		<p>with 18 per 100,000); and twice as high for digestive diseases (46 compared with 21 per 100,000);</p> <ul style="list-style-type: none"> <li>• The incidence rate for Indigenous Australians with end-stage kidney disease increased from 24 per 100,000 in 1997, to 40 per 100,000 in 2014; and</li> <li>• Indigenous Australians had a higher age-standardised rate of hospitalisation for injury from July 2013 to June 2015 compared with non-Indigenous Australians (47 compared with 24 per 1,000). The most common injuries resulting in hospitalisation were: assaults (22%), falls (19%), and complications of medical and surgical care (14%) of all hospitalisations (AHIW, 2017c).</li> </ul> <p>Recent analysis of health conditions, health-related behaviours and social determinants undertaken by Gibson et al. (2017) identified that Aboriginal and Torres Strait Islander South Australians have higher prevalence of nearly all health conditions, compared to non-Aboriginal South Australians.</p> <p>The Aboriginal Health HPG reported that people are presenting late with cancer, leading to high mortality rates and there is a lack of early detection of cancer. The HPG also reported that social determinants of health such as affordable housing, available transport, financial barriers as impacting on health outcomes.</p> <p>The Northern Adelaide Clinical Council reported that accessible services and transport were issues for the delivery of effective Aboriginal health services in the north. The Council also raised the importance of delivering services in a manner that is culturally safe. The Southern Adelaide Clinical Council reported that health services in its area were limited in their cultural sensitivity. The Southern Council also reported that transport was an issue for their communities with the nearest clinic being in the city.</p> <p><i>Children &amp; young people</i></p> <p>Although the immunisation rates for Aboriginal and Torres Strait Islander children living in the APHN region have significantly increased since 2013-14, Aboriginal and/or Torres Strait Islander children still have a lower rates</p>	<p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017. South Australian Aboriginal Health Needs and Gaps Report: Women's and Children's Health Network, 2017. Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.</i></p> <p><i>Health Priority Group priority setting workshops, 2016.</i></p> <p><i>Clinical Council priority setting workshops, 2016.</i></p> <p><i>National Health Performance Authority (NHPA), 2015a, Australian Childhood</i></p>

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Outcomes of the health needs analysis		
	<p>of fully immunised children at 1-, and 2-years of age, compared to non-Aboriginal and/or Torres Strait Islander children in the region (NHPA, 2015a). As of June 2017, immunisation coverage rates for 5-year old for Aboriginal and Torres Strait Islander children living in the APHN region were at 95%, which is in line with the national target (DOH, 2017c).</p> <p>The prevalence of self-reported asthma among Aboriginal children aged 0-14 years was 1.8 times higher than among non-Aboriginal 0-14 year olds; Aboriginal children were also more likely to be hospitalised (Gibson et al, 2017).</p> <p>Infant mortality rates were also substantially higher, with 7.6 deaths per 1,000 live births from 2012-2014 for Aboriginal and Torres Strait Islander populations in South Australia, compared to 2.6 deaths per 1,000 live births for the state as a whole (ABS, 2015).</p> <p><i>Health risk factors, health status &amp; outcomes</i></p> <p>Aboriginal and Torres Strait Islander population smoking rates in metropolitan Adelaide are three times those of the non-Indigenous residents, 37% compared to 12% in 2014-15 (ABS, 2016a).</p> <p>Rates of high or very high psychological distress in Aboriginal and Torres Strait Islander population are 2.5 times those of non-Indigenous South Australians, 34% compared to 14% (HPCSA, 2016).</p> <p>The prevalence rates for a number of chronic conditions are substantially higher for Aboriginal and Torres Strait Islander people in South Australia compared to the prevalence for all persons. For example, in 2012-13, asthma rates were almost double (19.7% compared to 10.8%), as were rates of diabetes (8.9% compared to 4.6%). Cardiovascular disease rates were also substantially higher, 12.5% compared to 4.5% (HPCSA, 2016).</p> <p>The all-cause mortality rate was also higher for Aboriginal and Torres Strait Islander populations in South Australia compared to the population as a whole, 8.3 deaths per 1,000 population compared to a rate of 5.7 deaths</p>	<p><i>Immunisation Register statistics 2014–15.</i></p> <p><i>Department of Health, 2017c, Current PHN immunisation coverage data for Aboriginal and Torres Strait Islander children, Current quarter: June 2017, Immunise Australia website, accessed October 2017</i></p> <p><i>Gibson O, Peterson K, McBride K, Shtangey V, Xiang J, Eltridge F, Keech W. 2017. South Australian Aboriginal Health Needs and Gaps Report: Women’s and Children’s Health Network, 2017. Wardliparingga Aboriginal Research Unit, SAHMRI, Adelaide, unpublished.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2015, Infant mortality rates, Indigenous status, Selected states and territories-2002-2004 to 2012-2014.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2016a, National Aboriginal and Torres Strait Islander Social Survey, 2014–15.</i></p> <p><i>Health Performance Council of South Australia (HPCSA), 2016, State of Our Health Report, (based on ABS 2013, Australian Aboriginal and Torres Strait Islander health survey: 2012-13).</i></p>

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Outcomes of the health needs analysis			
		<p>per 1,000 from 2010-2014 (PC-ROGS, 2016). Data on the underlying causes of death for Aboriginal and Torres Strait Islander populations in APHN are currently not available; however, in 2016 the leading causes of death at the state level were ischaemic heart diseases, diabetes, chronic lower respiratory diseases, malignant neoplasm of trachea, bronchus and lung, cirrhosis and other diseases of liver, and intentional self-harm (suicide) (ABS, 2017b). Age-standardised rates for diabetes were almost six times the non-Indigenous rate, chronic lower respiratory was three times, and intentional self-harm was twice the non-Indigenous rate (ABS, 2016b).</p> <p>Age standardised rates of hospitalisations for Aboriginal and Torres Strait Islander people living in Greater Adelaide were substantially higher in 2012/13 compared the annual average rate for all-persons in Greater Adelaide. Per 100,000 population rates were 43% higher for all admissions, 174% higher for mental health related conditions, 36% higher for respiratory system diseases, and 25% higher for injuries, poisoning and other external causes (PHIDU, 2016).</p>	<p><i>Productivity Commission – Report on Government Services (PC-ROGS), 2016, Volume E: Health, Overview, Age standardised all-cause mortality rate and rate ratios, by Indigenous status, 2010-2014.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2017b, Causes of Death, Australia, 2016.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2016, Aboriginal and Torres Strait Islander Social Health Atlas of Australia.</i></p>
Early Intervention and Prevention through Primary Health Care			
Limited understanding of health conditions and navigating the primary health care system	Low levels of health literacy skills	<p>Consultations facilitated with the membership groups of the APHN identified that health literacy was a main issue for community members that required addressing in a coordinated manner.</p> <p>The APHN Clinical Councils identified the need to provide better education to consumers and professionals across the health sector to improve and encourage the take-up and application of preventative measures and reduce unwarranted variation in care by improving health literacy and education.</p> <p>The Community Advisory Councils prioritised the need for:</p> <ul style="list-style-type: none"> <li>Better education for consumers and professionals across the health sector to improve and encourage the take-up and application of preventative measures.</li> <li>Consumers to be empowered and involved in their own care.</li> </ul>	<p><i>Membership Groups Priority Setting workshops 2016.</i></p>

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Outcomes of the health needs analysis			
		<ul style="list-style-type: none"> <li>Community members and service providers to better inform themselves about services available throughout the primary health care sector and how to access those services, by improving health literacy and education.</li> </ul> <p>The Health Priority Groups overall prioritised the need to invest in early intervention; prevention and education strategies for community and primary health care providers. This will enable community members to make informed decisions; understand health conditions and have awareness where to access appropriate services.</p> <p>Australian research indicates that health literacy is limited in a significant proportion of the general Australian population is limited (Barber et al., 2009). In 2006, 59% of South Australians aged 15-74 years had low health literacy levels indicating they may not have the health literacy skills needed to navigate and understand health information and services (ABS, 2006). While dated, this is the latest health literacy data from the ABS. More recent research by Adams et al. (2009) suggest that 45% of South Australians were 'at risk' or 'of high likelihood' of having low functional health literacy.</p>	<p><i>Barber MN, Staples M, Osborne RH, Clerehan R, Elder C, Buchbinder, R. (2009). <u>Up to a quarter of the Australian population may have suboptimal health literacy depending upon the measurement tool: Results from a population-based survey.</u> Health Promotion International, 24(3), 252-261.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2006, Adult Literacy and Life Skills Survey, accessed October 2017.</i></p> <p><i>Adams RJ, Appleton SL, Hill CL, Dodd M, Findlay C, Wilson DH. (2009). <u>Risks associated with low functional health literacy in an Australian population.</u> Medical Journal of Australia, 191(10), 530-534.</i></p>
High prevalence of health risk factors (including poor nutrition, physical inactivity and smoking) at sub-regional levels, particularly	Management of risk factors	The APHN membership groups recognise the link between behavioural and lifestyle factors and the effect of these on health. The Southern Community Advisory Council identified that the following lifestyle factors which may impact a person's health: smoking; inadequate nutrition; unemployment; lack of exercise; lack of skills to cook health foods;	<i>Community Advisory Council, Results Based Accountability workshops, 2017.</i>

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Outcomes of the health needs analysis			
<p>in Local Government Areas (LGAs) of Playford, Salisbury, Port Adelaide Enfield and Onkaparinga.</p>		<p>education level on understanding of good health, healthy lifestyles, impact of junk food. The Northern Adelaide Clinical Council raised concerns about levels of obesity and the impacts on chronic disease and ultimately on use of resources. They expressed concern that obesity was related to choices about behaviour including food choices and exercise. Lack of education was raised as an issue.</p> <p><i>Smoking</i></p> <p>Estimates from the 2011-13 Australian Health Survey highlight that when compared to other LGAs in the APHN region, there was a higher proportion of both male and female smokers in the LGAs of Playford, Salisbury, Port Adelaide Enfield and Onkaparinga (PHIDU, 2015).</p> <p>In the two years from 2012 to 2014, the average proportion of females smoking during pregnancy was higher in APHN compared to other Capital Cities, 11.4% compared to 9.3% respectively (PHIDU, 2017a). Rates of smoking during pregnancy were highest in the Local Government Areas of Playford (24%), Salisbury (16%), Onkaparinga (15%), Tea Tree Gully (10%) and Charles Sturt (10%) (PHIDU, 2017a).</p> <p><i>Physical inactivity</i></p> <p>In 2015, approximately half of all South Australians aged between 18-64 years and one-third of South Australians aged 65+ years undertook physical activity in line with recommended national levels, and these proportions have remained unchanged in the thirteen years between January 2003 to December 2015 (SA Health, 2015b). The SA3s within the APHN region with the highest rates of physical inactivity between 2012-2104 were Playford, Port Adelaide – East, Salisbury, Port Adelaide – West, Onkaparinga and Campbelltown (SA Health, 2015c).</p> <p><i>Unhealthy weight</i></p> <p>In 2015, 6 in every 10 South Australians aged 18 years and over (62%) were overweight or obese, and this proportion has increased from 54% since July 2002 (SA Health, 2015d). The SA3s within the APHN region with the highest proportion of residents with unhealthy weight between 2012-2014 were Playford, Salisbury, Port Adelaide – West, Tea Tree Gully and Onkaparinga (SA Health, 2015c).</p>	<p><i>Clinical Council, priority setting workshops, 2016.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2015, Social Health Atlas of Australia.</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2017a, Social Health Atlas of Australia</i></p> <p><i>SA Health, South Australian Monitoring &amp; Surveillance System (SAMSS), 2015b, Trends at a glance: Physical Activity trends in South Australian adults, January 2003 to December 2015.</i></p> <p><i>SA Health, South Australian Monitoring &amp; Surveillance System (SAMSS), 2015c, South Australian Health and Risk Factors by SA3 regions, July 2012 to June 2014, December.</i></p>

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Outcomes of the health needs analysis			
		<p><i>Inadequate fruit and vegetable intake</i></p> <p>As well as having a higher proportion of physically inactive, and overweight and obese residents, the SA3s of Salisbury, Playford, Onkaparinga, Port Adelaide – East and Port Adelaide – West also have high proportions of residents with inadequate fruit and vegetable consumption (SA Health, 2015c).</p>	<p>SA Health, South Australian Monitoring &amp; Surveillance System (SAMSS), 2015d, Trends at a glance: Unhealthy weight trends in South Australian adults, July 2002 to December 2015.</p>
<p>Lower rates of Breast, Cervix and Bowel screening participation among Aboriginal and Torres Strait Islander and CALD population groups and people in low socio-economic areas in APHN region</p>	<p>Breast, Cervix and Bowel screening participation rates</p>	<p><i>Bowel cancer screening</i></p> <p>In 2015-2016, APHN had the 3<sup>rd</sup> highest rate of participation in the national bowel cancer screening program, 46.5% of 50-74 year olds, with Country SA PHN 2<sup>nd</sup> highest at 48.1%; the national rate was 40.9% (AIHW, 2017d). The 2015-2016 participation rate for APHN is a slight increase from 45.8% in 2014-2015 (AIHW, 2016c).</p> <p>Participation in the program varies across the APHN region, with the lowest rates of participation in the SA3s of Playford (37.5%), Port Adelaide-West (40.6%), Adelaide City (40.8%), Salisbury (42.4%) and Port Adelaide-East (43.8%) (AIHW, 2017d).</p> <p>The Northern Adelaide Clinical Council suggested that the lower rates of bowel screening in the northern APHN region are likely attributed to levels of education and literacy.</p> <p><i>Breast cancer screening</i></p> <p>In 2015-2016, APHN had the 2<sup>nd</sup> highest rate of participation in the national breast cancer screening program (BreastScreen), 59.4% of 50-74 year old women, with Country SA PHN 3<sup>rd</sup> highest at 59.1%; the national rate was 54.8% (AIHW, 2017d). The 2015-2016 participation rate for APHN increased from 57.8% in 2014-2015 (AIHW, 2016c).</p> <p>Participation in the program increased with age, ranging from 53.8% of 50-54 year olds to 64.5% of 65-69 year olds, then declining to 57.3% in 70-74 year olds (AIHW, 2017d).</p> <p>The 2015-2016 participation rates also varied by APHN sub-regions. The lowest rates of participation in the SA3s of Playford (51.7%), Port Adelaide-</p>	<p><i>Australian Institute of Health and Welfare (AIHW), 2017d, Participation in Australian cancer screening programs in 2015-2016</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2016c, Participation in Australian cancer screening programs in 2014-2015</i></p> <p><i>Clinical Council, priority setting workshops, 2016</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2017d, Participation in Australian cancer screening programs in 2015-2016</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2016c, Participation in Australian cancer screening programs in 2014-2015</i></p>



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Outcomes of the health needs analysis			
		<p>East (52.4%), Port Adelaide-West (55.7%), and Salisbury (56.5%) (AIHW, 2017d).</p> <p><i>Cervical cancer screening</i></p> <p>In 2015-2016, APHN had the 8th highest rate of participation in the national cervical cancer screening program, 57.5% of 20-69 year olds, with Country SA PHN 10<sup>th</sup> highest at 57.0%; the national rate was 55.4% (AIHW, 2017). The 2015-2016 participation rate for APHN is consistent with the 2014-2015 rate of 58.0% (AIHW, 2016c).</p> <p>Participation in the program increased with age, ranging from 42.0% of 20-24 year olds to 63.7% of 50-54 year olds, then declining to 56.9% for 65-69-74 year olds (AIHW, 2017d).</p> <p>The 2015-2016 participation rates also varied by APHN sub-regions. The lowest rates of participation in the SA3s of Adelaide City (45.0%), Playford (46.8%), Port Adelaide-East (53.6%), West Torrens (54.4%) and Port Adelaide-West (54.5%) (AIHW, 2017d).</p> <p>These patterns of geographical variation across the APHN are consistent with the 2014-15 participation rates in the three national screening programs; residents of the northern, western and city areas of the APHN having much lower participation rates compared to both the APHN and national rates (AIHW, 2016c).</p> <p>There appears to be a correlation between areas of low cancer screening participation and socio-economic status with three of these regions, Playford, Salisbury and Port Adelaide, having the lowest Index of Relative Socio-Economic Disadvantage (IRSD) scores in the APHN region (PHIDU, 2017a). Further, the SA3s of Playford, Salisbury, Port Adelaide – West, Port Adelaide – East, West Torrens and Adelaide City, have higher proportions of both Aboriginal and Torres Strait Islander and culturally and linguistically diverse populations in the target screening age groups compared to other regions of the APHN. Feedback from and data provided by the South Australian Cancer Screening Network indicate that these</p>	<p><i>Australian Institute of Health and Welfare (AIHW), 2017d, Participation in Australian cancer screening programs in 2015-2016</i></p> <p><i>Australian Institute of Health and Welfare (AIHW), 2016c, Participation in Australian cancer screening programs in 2014-2015</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2017a, Social Health Atlas of Australia.</i></p> <p><i>SA Health, 2016b, BreastScreen SA screening participation, unpublished.</i></p>

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Outcomes of the health needs analysis			
		specific population groups are participating in screening at substantially lower rates than the wider population (SA Health, 2016b).	
Refugees and Culturally and Linguistically Diverse communities			
High prevalence of health risk factors (including poor nutrition, physical health, diabetes, mental health and AOD)	Refugees and new arrivals and Culturally Diverse Communities' Health and Wellbeing	<p><i>Demographics</i></p> <p>Data from the 2011 Census of Population and Housing indicate that 16% of APHN residents were born in predominately non-English speaking countries (NESC) (PHIDU, 2015); <b>this has increased to 18% based on the 2016 Census data (ABS, 2017a).</b></p> <p>In 2016, the top 10 birthplaces of people from Non-English Speaking Countries in the APHN were: <b>India, China, Italy, Vietnam, Philippines, Greece, Germany, Malaysia, Afghanistan, and Poland (ABS, 2017a).</b></p> <p>The largest changes in birthplace countries in the APHN region between 2011 and 2016 were for those born in India (+8,630 persons), China (+8,427 persons), United Kingdom (-5,689 persons) and Afghanistan (+2,856 persons) (ABS, 2017a).</p> <p>The SA3s of Port Adelaide-East (22.1% of the population), Campbelltown (22.0%), Salisbury (17.5%), Charles Sturt (17.2%) and Port Adelaide-West (17.1%) had the highest proportion of people born in NESC and resident for longer than five years (PHIDU, 2017b).</p> <p>Whereas the SA3s with the highest proportion of people born in NESC and resident for less than five years (recent arrivals) were Adelaide City (21.9% of the population), Port Adelaide–East (8.5%), West Torrens (7.6%), Norwood-Payneham-St Peters (6.8%), and Burnside (5.9%) (PHIDU, 2017b).</p> <p><i>Language and literacy</i></p> <p>In 2016, the top 10 languages other than English spoken at home for people living in the APHN region were: <b>Mandarin, Italian, Greek, Vietnamese, Persian/Dari, Cantonese, Arabic, Punjabi, Filipino/Tagalog, and Hindi (ABS, 2017a).</b></p> <p>The SA3s with the highest proportion of people born overseas reporting poor proficiency in English were Port Adelaide-West (6.0%), Port Adelaide-</p>	<p><i>Public Health Information Development Unit (PHIDU), 2015, Social Health Atlas of Australia.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2017a, Census of Population and Housing 2016 (Enumerated), compiled by profile.id and presented in Adelaide Primary Health Network community profile</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2017b, Social Health Atlas of Australia: Supplementary Release of 2016 Census Data.</i></p> <p><i>Australian Bureau of Statistics (ABS), 2017a, Census of Population and Housing 2016 (Enumerated), compiled by profile.id and presented in Adelaide Primary Health Network community profile</i></p> <p><i>Public Health Information Development Unit (PHIDU), 2017b, Social Health Atlas of Australia: Supplementary Release of 2016 Census Data.</i></p>

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Outcomes of the health needs analysis		
	<p>East (5.9%), Salisbury (5.6%), Adelaide City (4.8%), Campbelltown (4.4%) and Charles Sturt (4.3%) (PHIDU, 2017b).</p> <p>Nationally in 2006, of those born overseas in a mainly non-English speaking country, only 26% achieved literacy levels of 3 or above, the 'minimum required for individuals to meet the complex demands of everyday life and work'. Additionally, 74% of those born overseas in a mainly non-English speaking country have less than adequate levels of literacy and health literacy. This means that they may not be able to effectively exercise their choice or voice when making healthcare decisions (ABS, 2006). While dated, this is the latest health literacy data from the ABS.</p> <p><i>Inequities in health outcomes and access to services</i></p> <p>Consultations undertaken with APHN's membership groups identified culturally and linguistically diverse (CALD) and new and emerging communities' health as one of the target population groups for the APHN (Clinical Councils, CACs, HPGs, 2016). <i>Wider community consultations identified that the health needs of CALD communities particularly mental health and AOD should be an area of concern for the APHN (MHAOD consultations, 2016).</i></p> <p>Research by Principe (2015) reported that many older people from CALD backgrounds have higher levels of disadvantage and other risk factors compared to older Anglo-Australians. These risk factors include socioeconomic disadvantage, cultural translation difficulties, lack of exposure to Australian services and systems, and lower rates of access to services. Older people from CALD backgrounds have a higher risk of mental health issues than and tend to present at later stages of illness compared to other older people in Australia. Those who migrated to Australia at an older age or who are from refugee background, face a higher risk of mental and physical health issues. Older migrants, in particular women, are recognised as ageing prematurely and experiencing social isolation (Principe, 2015). <i>Australian research has also identified that CALD communities particularly from Asia and the Pacific are disproportionately affected by Hepatitis B (ASHM, 2015).</i></p>	<p><i>Australian Bureau of Statistics (ABS), 2006, Adult Literacy and Life Skills Survey, accessed October 2017.</i></p> <p><i>Clinical Councils, Community Advisory Councils, Health Priority Groups, priority setting workshops, 2016.</i></p> <p><i>APHN Mental Health and Alcohol and Other Drugs (MHAOD) reform community consultations, 2016.</i></p> <p><i>Principe, I., 2015, <a href="#">Issues in Health Care in South Australia for People from Culturally and Linguistically Diverse Backgrounds – A Scoping Study for the Health Performance Council SA</a>, assessed February 2016.</i></p> <p><i>Australasian Society for HIV Medicine (ASHM), 2015, Hepatitis B Mapping Project: Estimates of chronic hepatitis diagnosis, monitoring and treatment by Medicare Local, 2013/14 – National Report.</i></p>

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		In South Australia, the three population groups with the highest inequality ratio of Quintile 5 (most disadvantaged) to 1 (least disadvantaged), by proportion of the South Australian population, are people born in Vietnam, the Philippines and India (Principe, 2015).	

## Section 3 – Outcomes of the service needs analysis

*Since submitting the (Core Flexible Funding) Baseline Needs Assessment (BNA) Update in November 2016, the APHN has analysed relevant recent quantitative data and undertaken consultations with stakeholders to further investigate and refine the service needs. The following service needs (in red font) refine and or supplement previously identified needs from the BNA Update.*

Outcomes of the service needs analysis			
Identified Need	Key Issue	Description of Evidence	Source
Accessing appropriate primary health care services for vulnerable population groups	Timely access and equity to primary health care services and care	<p><i>Clinical Councils</i></p> <p>Priority setting workshops with the Southern Adelaide Clinical Council (CC) prioritised the importance of improving and increasing timely access to health services.</p> <p>During the priority setting workshops, the Central Adelaide CC prioritised the need to map and coordinate implementation of current strategies and develop solutions to current gaps for End of life care.</p> <p>The Northern Adelaide CC prioritised the need to improve coordination and access to primary health care services and programs and build the capacity of the primary health care workforce (incl. GPs) to meet the needs of at risk and vulnerable people. They also identified a need for better pathways for consumers to enable navigation through the primary health care system (particularly for the socially isolated, at risk families, mental health, and vulnerable populations).</p> <p><i>Community Advisory Councils</i></p> <p>The Central Community Advisory Council (CAC) prioritised that the importance to identify the barriers including cost to accessing health services despite the availability of quality and quantity of chronic disease services. Additionally, the Council identified access and affordability as important as health literacy, coordination and facilitation of care and mental health and comorbidity.</p> <p>During the priority setting workshops, the Northern CAC prioritised that health service providers need to inform themselves to address and cater for the needs of vulnerable individuals – Aboriginal and Torres Strait Islander people, CALD, elderly, youth, and others. Additionally,</p>	<p><i>Clinical Council, priority setting workshops, 2016.</i></p> <p><i>Community Advisory Council, priority setting workshops, 2016.</i></p>

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	<p>they stressed that people need to be able to access pathways that are culturally and/or linguistically appropriate and sensitive and nonjudgmental with consideration of the social determinants.</p> <p><i>Health Priority Groups</i></p> <p>The Disability HPG prioritised the need to review the current provision of disability health services to maintain and enable access to primary health services across disability, health and community.</p> <p>The Childhood &amp; Youth HPG prioritised the need to build the capacity of families using sound community development practices which empower minority groups and build trust. Services need to be accessible, appropriate and timely.</p> <p>The Mental Health HPG prioritised the need to ensure a coordinated approach between services that focuses on the whole person and their circumstances, including coexisting physical health needs and complex social factors which interact with mental health.</p> <p>In the priority setting workshops, our Palliative Care HPG prioritised that capacity needs (to be built) at the primary care level to maximise care and support for people in the community when they are dying. They emphasised that GPs and palliative care nurses are critical to the whole system working.</p> <p>The Aboriginal Health HPG prioritised the need to ensure that commissioned services are culturally safe for Aboriginal people.</p> <p><i>Community consultations</i></p> <p>Members of the Aboriginal community identified lack of respect and sensitivity from service providers, poor support, communication and coordination between services and long wait times and follow through as the top 3 irritants from their experience of health service use.</p> <p>The Aboriginal Engagement workshops identified the following top 3 factors they would like to have in service delivery to make it better:</p> <ul style="list-style-type: none"> <li>• Being treated with dignity and respect and without prejudice</li> <li>• Easy access to services when they are needed</li> <li>• Well-coordinated holistic approach to services</li> </ul>	<p><i>Health Priority Groups, priority setting workshops, 2016.</i></p> <p><i>APHN Aboriginal Engagement workshops, 2017</i></p>

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<p><b>Improved:</b></p> <ul style="list-style-type: none"> <li>• Access to culturally appropriate health services</li> <li>• Health workforce capacity</li> <li>• System integration, to ensure refugees and new arrivals, and culturally diverse communities have timely access to primary health care services in APHN region.</li> </ul>	<p><b>Refugees and new arrivals and diverse communities timely access to primary health care services</b></p>	<p>Consultations undertaken with APHN's membership groups identified Culturally and Linguistically Diverse (CALD) and new and emerging communities' health as one of the target population groups for the APHN (Clinical Councils, CACs, HPGs, 2016). <b>The service needs of CALD communities were raised as areas of concern particularly their ability to access mental health, alcohol and other drug and primary health care services in our region (Mental Health HPG; MHAOD consultations).</b></p> <p>Research undertaken by the Health Performance Council SA identified people from CALD backgrounds are among the population groups missing out on accessing suitable services or gaining equitable health care outcomes (Principe, 2015). Analysis of patient data between 2011-15 reported that 8.2% of patients visiting General Practices were of CALD backgrounds in the APHN region when compared to 13.2% for other capital cities and 8.9 nationally (BEACH, 2016).</p> <p>The CALD Scoping Study for the Health Performance Council SA have identified: inclusion and empowerment; access and equity; quality and capacity building as key principles of care for persons from CALD backgrounds arising from consultations and other relevant research (Principe, 2015).</p> <p><b>The APHN conducted a number of RANA consultations with key stakeholders representing the multicultural sector, primary health care and research which identified the following areas required addressing:</b></p> <ul style="list-style-type: none"> <li>• health literacy for refugees and new arrivals to make informed decisions about their health and health care. Refugee and new arrival populations have limited understanding of the Australian health system and access to appropriate and timely primary health care services</li> <li>• capacity building for primary health workers supporting the health of refugees and new arrivals. Primary health care providers, including general practice don't have the support, training and capacity to deliver culturally safe and culturally appropriate services to refugee and new arrival populations.</li> </ul>	<p><i>Community Advisory Council, priority setting workshops, 2016.</i></p> <p><i>Community Advisory Council, priority setting workshops, 2016.</i></p> <p><i>Health Priority Groups, priority setting workshops, 2016.</i></p> <p><i>APHN Mental Health and Alcohol and Other Drug (MHAOD) service reform consultation, 2016</i></p> <p><i>Principe I., 2015, <a href="#">Issues in Health Care in South Australia for People from Culturally and Linguistically Diverse Backgrounds – A Scoping Study for the Health Performance Council SA</a>, assessed February 2016.</i></p> <p><i>Bettering the Evaluation and Care of Health (BEACH), 2016, Family Medicine Research Centre, School of Public Health, The University of Sydney, customised report for Adelaide Primary Health Network, unpublished.</i></p> <p><b><i>Refugees and New arrivals (RANA) consultation and co-design workshops, August 2017.</i></b></p>



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		<ul style="list-style-type: none"> <li>system integration of primary health care services for refugees and new arrivals. The migrant health sector and primary health care services are not integrated due to the lack of formalised partnerships and referral pathways that increase and improve access and delivery of culturally appropriate and sensitive primary care services to new arrival and refugee populations (RANA consultation and co-design workshops, August 2017).</li> </ul>
Increase the health workforce capacity to work with vulnerable population groups with high health needs to improve access to primary health care services and health literacy	Health Workforce	<p><i>Clinical Councils</i></p> <p>The priority setting workshops with the Northern Adelaide CC prioritised the need to provide better education to consumers and professionals across the health sector to improve and encourage the take-up and application of preventative measures (particularly in relation to the socially isolated, at risk families, mental health, health ownership, advanced care planning and vulnerable populations).</p> <p>The Southern Adelaide CC prioritised the need to reduce unwarranted variation in care by improving health literacy and education.</p> <p>The Central Adelaide CC prioritised in the quality use of medicines – the need to be embedded as a principle in the implementation of all APHN programs and focus is specific national priorities including opiate and antibiotic prescribing by improving health literacy and education.</p> <p><i>Community Advisory Councils</i></p> <p>The Northern CAC prioritised the need better education for consumers and professionals across the health sector to improve and encourage the take-up and application of preventative measures.</p> <p>The Central CAC prioritised the need for consumers to be empowered and involved in their own care, to use plain language, access to transparent information about fees and reasons for particular referral pathways, enable more online patient reviews of primary health services, and for general practices to have up to date and accessible websites.</p> <p>The Southern CAC prioritised that community members and service providers need to better inform themselves about services available</p>

*Clinical Council, priority setting workshops, 2016.*

*Community Advisory Council, priority setting workshops, 2016.*

Outcomes of the service needs analysis			
		<p>throughout the primary health care sector and how to access those services, by improving health literacy and education.</p> <p><i>Health Priority Groups</i></p> <p>The Older People &amp; Aged Care HPG prioritised the need for awareness of services and case coordination for those who do not have access or skills to use the internet. They also identified the need for advocacy for older people by health professionals. The Older People &amp; Aged Care HPG also stressed the importance of building the capacity of health professionals and GPs to undertake mental health assessments, support older people with advance care and palliative care needs better and address overprescribing of medications (falls risk) by providing support, training and education.</p> <p>The Aboriginal HPG prioritised the need more focus on early intervention and health literacy in the community and increased access to culturally safe services, including specialist services, for chronic diseases. They emphasised the need to improve the uptake of the Aboriginal health check. The Aboriginal HPG also identified the need for training and education (particularly in loss and grief) across the community and workforce empowering Aboriginal communities and addressing real and perceived racism. They reported on the need to increase the number of Aboriginal Health Workers and Aboriginal Health Practitioners and provide integrated bi-cultural training in order to have culturally appropriate services.</p> <p>The Palliative Care HPG prioritised the need to promote end-of-life and advanced care planning in primary care; encourage and support GPs with an interest in the field, and expand the GP shared care model. They also identified the need to raise awareness in the community, and recognise the role the aged care sector can play in providing palliative care.</p> <p>The Childhood and Youth HPG prioritised health literacy of the community in relation to healthy child development and developmental behaviours; whilst upskilling practitioners in the impacts of trauma on children's health and development was a priority. There was also concern that there is a lack of knowledge by primary health practitioners</p>	<p><i>Health Priority Groups, priority setting workshops, 2016.</i></p>

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		<p>(including GPs) in paediatrics; especially developmental and behavioural issues.</p> <p>The Mental Health HPG prioritised the need to invest in early intervention and prevention with inclusive criteria which facilitates access to services. The Disability HPG prioritised improving health literacy and education by providing training in disability and the health needs of people with disabilities for GPs, nurses, allied health, support workers, planners and case managers.</p>
<p>Lack of integration, pathways and care coordination along the health continuum for people in our community and particularly vulnerable population groups.</p>	<p>Care coordination, integration and navigation</p>	<p><i>Clinical Councils</i></p> <p>The priority setting workshops with our Central Adelaide CC identified system integration (–development of improved and standardised access and integration processes between primary care and both public and private hospital services), as a priority need for (improving) care coordination, integration and navigation. The Southern Adelaide CC prioritised increasing integration through coordination and communication between services and practitioners. Similarly, the Northern Adelaide CC prioritised integrated approach as the key need for (improving) care coordination, integration and navigation. <b>The Northern Adelaide Clinical Council reported that there was limited knowledge of what services are available for people experiencing chronic pain. They also reported a lack of coordination and integration of these services.</b></p> <p><i>Community Advisory Councils</i></p> <p>In the workshops, the Central CAC prioritised the need for less fragmentation and more cooperation and linkages both within the primary health care sector and between primary and intermediate care settings. The Northern CAC prioritised the need to coordinate pathways to primary health care. Additionally, they reported that the health system is way too complex for consumers and users in navigate it properly – consequently the inability to access information or programs pertinent to them. The Southern CAC prioritised the coordination of care and systems and staff to be adequately trained.</p>

*Clinical Council, priority setting workshops, 2016.*

*Community Advisory Council, priority setting workshops, 2016.*

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	<p>This will enable timely, affordable and accessible services where health providers communicate and share information about patients in minimising the duplication of information.</p> <p><i>Health Priority Groups</i></p> <p>The Disability HPG prioritised the need for a primary health care service model for people with disabilities which is interagency and interdisciplinary.</p> <p>During the priority setting workshops, the Palliative Care HPG prioritised the need to shift focus from the acute system to the role of GPs and the navigation issues from the perspective of consumer, clinician and service provider. Additionally, they identified that pathways need to be simple and easy to access – a stepped model of care that is responsive and timely with one person, a case manager / coordinator, to help sort care when needed will improve care coordination, integration and navigation.</p> <p>The Consumers &amp; Carers HPG prioritised that the (health) system needs to be inclusive of and supportive of formalised carers and care coordinators. They reported that there is a lack of a unified / interfacing communication system and culture of care coordination. The Consumers &amp; Carers HPG also stressed the importance of consumers and carers knowing about services and how to access them. The HPG reported that the primary health system is not responsive – conditions need to escalate before able to access services, and currently there is a lack of holistic discharge planning and limited availability of primary health services and community-based after- hours services.</p> <p>The Childhood &amp; Youth HPG prioritised the need to improve the (current) disjointed service delivery models which present multiple barriers to the provision of services being child-focussed. The HPG also reported there is a lack of identified care coordinators for families with complex needs and a lack of funding / workforce/ quality which affects the level of care coordination and collaboration.</p>	<p><i>Health Priority Groups, priority setting workshops, 2016.</i></p>

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		<p>The Older People &amp; Aged Care HPG prioritised the need to improve case management, care coordination and advocacy on behalf of consumers by health professionals, and increase incentives to encourage collaboration and integration across aged care, acute and primary care sectors.</p> <p>The Mental Health HPG prioritised the need to improve the experience of entry to and navigation of the stepped care and broader service system.</p> <p><i>Community workshops</i></p> <p>The Aboriginal Engagement workshops identified poor support, communication and coordination between services, long wait times and poor follow through as top irritants experienced in health service use.</p>	<p><i>APHN Aboriginal Engagement Workshops, 2017.</i></p>
<p>Access to appropriate and timely services are pivotal in reducing avoidable Emergency Department presentations and hospital (re)admissions.</p>	<p>High rates of preventable hospitalisations by sub-regional levels and age groups in APHN region</p>	<p>In 2013-14 the age-standardised rate of potentially preventable hospitalisations (PPH) in the APHN was 2,446 hospitalisations per 100,000 people, consistent with the Australian average rate (NPHA, 2015b).</p> <p>Approximately six percent of hospitalisations were for vaccine preventable conditions. Acute conditions, primarily dental conditions, kidney and urinary tract infections, cellulitis and ear, nose and throat infections, accounted for 47% of PPH. Chronic conditions also accounted for 47% of PPH, with the highest rates for chronic obstructive pulmonary disease (COPD), congestive heart failure, diabetes complications, iron deficiency anaemia and angina (NHPA, 2015b).</p> <p>The top five conditions (out of 22 conditions) contributed to approximately half of the total PPH in the region and almost two-thirds of total bed days. Heart failure contributed to the highest proportion of bed days with 16.3% (and 9.1% of PPH), followed by COPD, 14.8% bed days (10.7% of PPH), kidney and urinary tract infections 13.1% (11.7% of PPH), diabetes complications 10.1% bed days (7.2% of PPH) and cellulitis 9.7% of bed days (8.9% of PPH) (NHPA, 2015b).</p> <p>Age-standardised rates of PPH varied across the APHN region (NHPA, 2015b). Rates for Total PPH were highest in the north and north-west</p>	<p><i>National Health Performance Authority 2015b, Healthy Communities: Potentially preventable hospitalisations in 2013–14.</i></p> <p><i>National Health Performance Authority 2015b, Healthy Communities: Potentially preventable hospitalisations in 2013–14.</i></p> <p><i>National Health Performance Authority 2015b, Healthy Communities: Potentially preventable hospitalisations in 2013–14.</i></p>

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		<p>areas of the APHN, specifically the Statistical Area Level 3s of Playford, Port Adelaide – West, Salisbury and Port Adelaide – East. Rates were lowest in Burnside, Unley and Prospect – Walkerville.</p> <p>The same four SA3s (Playford, Port Adelaide – West, Salisbury and Port Adelaide – East) as well as Onkaparinga in APHN's south, had the highest rates of PPH for Chronic conditions (NHPA, 2015b).</p> <p>There was less variation in the PPH rates for Acute and Vaccine-preventable across the region, but they were highest in the SA3s of Playford, Adelaide City, Port Adelaide – East, Salisbury, Tea Tree Gully, Marion and West Torrens (NHPA, 2015b).</p> <p>The rates of PPH in the region generally increased with age, with people 85 years and older with the highest rates. The exception to this is the 0-4 year olds and 5-9 year olds, who for total, vaccine-preventable, and acute conditions had PPH rates comparable to people aged 60 to 69 years old (SA Health 2016c).</p>	<p><i>National Health Performance Authority 2015b, Healthy Communities: Potentially preventable hospitalisations in 2013–14.</i></p> <p><i>National Health Performance Authority 2015b, Healthy Communities: Potentially preventable hospitalisations in 2013–14.</i></p> <p><i>National Health Performance Authority 2015b, Healthy Communities: Potentially preventable hospitalisations in 2013–14.</i></p> <p><i>SA Health, 2016c, PPA Data for Adelaide Primary Health Network (PHN), unpublished.</i></p>
<p>Increase utilisation of specific MBS item numbers by General Practitioners for Aboriginal and Torres Strait Islander people/patients.</p>	<p>Primary health care for Aboriginal and Torres Strait Islanders</p>	<p>Analysis of Medicare Benefits Statistics on item number 715 by PHN (AIHW, 2016d) and analysis of Medicare Benefits Statistics by PHN and by SA3 highlighted that Aboriginal Health Assessments are lower in the APHN when compared to other PHNs, and at sub-regional levels particularly in Statistical Area Level 3 (SA3) of Playford, Port Adelaide-East and West, Salisbury, Onkaparinga, and Charles Sturt (DoH, 2016).</p> <p>During the Priority setting workshops, the Aboriginal HPG emphasised the need to improve the uptake of the Aboriginal (children and adult) health check.</p>	<p><i>Australian Institute of Health and Welfare (AIHW), 2016d, analysis of Department of Human Services Medicare Benefits Statistics, 2011/12 to 2013/14.</i></p> <p><i>Department of Health (DoH), 2016, Medicare Benefits Schedule, 2013/14 – 2014/15, unpublished.</i></p> <p><i>Health Priority Groups, priority setting workshops, 2016.</i></p>
<p>Improving access to and effectiveness of primary health care services for older persons</p>	<p>Healthy ageing</p>	<p>The Older Persons &amp; Aged Care HPG identified the following issues as priority needs for the HPG:</p> <ul style="list-style-type: none"> <li>• loneliness (social isolation),</li> <li>• quality use of medications leading to increased mortality, morbidity and falls,</li> <li>• lack of access to primary mental health care services (for older people),</li> </ul>	<p><i>Health Priority Group, priority setting workshops, 2016.</i></p>

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		<ul style="list-style-type: none"> <li>• Lack of care coordination and pathways between acute, primary health care and aged/social care services,</li> <li>• raising awareness of health professionals to the early warning signs of dementia , and</li> <li>• palliative care (e.g. communication of end of life transition, knowledge in workforce about palliative care referral pathways, use of Advanced Care Plans).</li> </ul> <p>The Aboriginal Health HPG identified access to services for older people as an issue, including support for activities such as equipment provision, transport (including transport back home for people requiring palliative care.) Perceptions about aged care can also be a barrier to access as is a lack of knowledge of available services.</p> <p>The Central Adelaide Clinical Council reported that there are currently no palliative care beds in the South Australian community. They reported a lack of standardised documentation of clinical instructions, a lack of knowledge of health care providers available, poor understanding and lack of access to palliative medicines and a lack of out-of-hours continuity of care.</p> <p>The Northern Adelaide Clinical Council also reported that there was a need for good palliative care for people with comorbidities and mental health support.</p> <p><i>Mental health-related medication</i></p> <p>In 2013-14, for people aged 65+ years, the highest rates of dispensing of antidepressant medications in the APHN region was in the Statistical Area Level 3 (SA3) of Playford with 244,017 prescriptions per 100,000 people; the South Australian rate was 206,606 per 100,000 (ACSQHC, 2015). Rates for antidepressant dispensing were also high in Onkaparinga (217,803), Tea Tree Gully (217,739), Salisbury (216,313), and Norwood-Payneham-St Peters (216,138) (ACSQHC, 2015).</p> <p><i>Clinical Councils, priority setting workshops, 2016.</i></p> <p><i>Australian Commission of Safety and Quality in Health Care (ACSQHC) and the National Health Performance Authority, 2015, Australian Atlas of Healthcare Variation.</i></p>

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	<p>Playford SA3 had the 2<sup>nd</sup> highest rate of PBS prescriptions dispensed for anxiolytic (anti-anxiety) medicines in Australia for people aged 65 years and over with 74,380 per 100,000 people, twice the Australian rate (ACSQHC, 2015). Rates for anxiolytic dispensing were also high in Port Adelaide - West (59,011), Salisbury (58,342), Tea Tree Gully (54,215), and Marion (52,324) (ACSQHC, 2015).</p> <p>The highest rates of antipsychotic medicines dispensing for people aged 65 years and over occurred in the SA3s of Port Adelaide - West (33,404), Norwood-Payneham-St Peters (32,932), Adelaide City (31,730), Playford (31,364), and Unley (31,002) (ACSQHC, 2015).</p> <p>Rates of PBS prescriptions dispensed for anticholinesterase medicines, which are used to treat Alzheimer's, in people aged 65 years and over were notably higher in the SA3s of Charles Sturt (21,369), Port Adelaide - West (19,923), Adelaide City (18,004), and Playford (17,666) compared to the Australian rate, 12,650 prescriptions per 100,000 people (ACSQHC, 2015).</p> <p>While there is a correlation between areas of lower socioeconomic status particularly in the north of the APHN region, and higher rates of mental health-related PBS prescriptions dispensing to people aged 65 years, the patterns may also reflect the distribution of older residents and the density of aged care facilities across the APHN region. The APHN also notes that based on the available data, it is not possible to determine the extent to which antidepressant and antipsychotic medicines were prescribed for conditions other than mental health.</p> <p><i>Hospitalisations</i></p> <p>In South Australia, people aged 65 years and over take up a disproportionately large amount of overnight stays in hospital, with people aged between 65-75 years of age twice as likely as the rest of the population to be admitted to hospital. In particular, despite being only 4.9% of the population, people aged 80 and over take up more than 25% of overnights stays, with those aged over 85 years are more than five times as likely to be admitted to hospital (OFTA, 2014).</p>	<p><i>Office for the Ageing (OFTA), 2014, Prosperity through longevity: South Australia's ageing plan, our vision 2014-2019.</i></p>



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Outcomes of the service needs analysis		
	<p>In 2015-16 people aged 65+ years and living in the APHN region made up 48% of potentially preventable hospitalisations in South Australian hospitals; people aged 85 years and over made up 14% (SA Health, 2017). The rates of potentially preventable hospitalisations in the region generally increased with age, with people 80 years and older with the highest rates. In 2015/16 the four most common conditions leading to a 'potentially preventable' hospitalisation in people aged 65 years and older were chronic obstructive pulmonary disease, congestive cardiac failure, urinary tract infections, and diabetes complications (SA Health, 2017).</p> <p>Feedback from the Central Adelaide Clinical Council reported that one in four people over age 75 have an unplanned hospital admission due to a medication related problem.</p> <p>At the APHN level, older people residing in APHN accounted for 9% of AOD-related hospital separations. However, they comprised higher proportions of separations for alcohol (15%) and opioids (16%) (Roche et al., 2017).</p> <p>The number of fentanyl-related deaths in Australia increased between 2002/03 and 2010/11. While fentanyl prescriptions were most prevalent among females over 80 years, fentanyl-related deaths most commonly occurred among males aged 30-49 years (Roxburgh et al., 2011).</p> <p><i>Primary health care services</i></p> <p>Community consultations conducted by the former Medicare Locals in the APHN region reported a number of issues for older adults including access to transport, social isolation, coordination of health and social services, capacity to navigate the health system and coordination of end of life and palliative care (CAHML, 2015; SAFKIML 2015; NAML 2015). Barriers to access, particularly for older CALD communities</p>	<p>SA Health, 2017, PPA Data for Adelaide Primary Health Network (PHN), unpublished</p> <p>Central Adelaide Clinical Council priority setting workshops, 2016</p> <p>Roche, A.M., Fischer, J., McEntee A., Pidd K., 2017, Drug and Alcohol Use Among Select South Australian At-Risk Group, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, South Australia, unpublished.</p> <p>Roxburgh, A., Bruno, R., Larance, B., &amp; Burns, L. (2011). Prescription of opioid analgesics and related harms in Australia. Medical Journal of Australia, 195(5), 280-284.</p> <p>Central Adelaide and Hills Medicare Local (CAHML), 2015, Health Profile: a population health needs assessment of the Central Adelaide and Hills region, 2015; Southern Adelaide Fleurieu Kangaroo Island Medicare Local (SAFKIML), 2015, Comprehensive</p>

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		include language, the reliance on online information and registration for services, and changes to and within community support agencies (Principe, 2015).	<p><i>Needs Assessment Report; Northern Adelaide Medical Local (NAML), 2015, Comprehensive Needs Assessment Report.</i></p> <p><i>Principe, I., 2015, <a href="#">Issues in Health Care in South Australia for People from Culturally and Linguistically Diverse Backgrounds – A Scoping Study for the Health Performance Council SA</a>, assessed February 2016.</i></p>
After-Hours			
<p>Lack of awareness amongst both the community and healthcare providers about the after-hours services available in their regions, and a lack of access to appropriated after-hours services</p> <p>A possible after-hours service gap exists in the northern fringes (Angle Vale) and south-eastern areas (McLaren Vale and Willunga) of the APHN region.</p>	After-hours services	<p>The Southern Adelaide Clinical Council reported during a planning workshop that young people in crisis do not always receive help in a timely manner. The Central Adelaide Clinical Council also reported that there is a lack of available psychiatric services and the Northern Adelaide Clinical Council raised the issue that mental health services were 9 to 5 and an extended hour 'walk in clinic' was needed in the North.</p> <p>APHN analysis of SA Health data indicated that approximately two-fifths of all unplanned Emergency Department (ED) presentations in the 2013/14 and 2014/15 financial years occurred in the after-hours period, and two-fifths of these presentations were triaged as semi-urgent or non-urgent (SA Health, 2015d). Approximately two-thirds of these presentation were self-, relative- or friend-referrals. The Local Government Areas of Playford, Onkaparinga, Adelaide and Walkerville had the highest presentation rates in this period. Approximately 1 out of every 10 presentations was for a potentially preventable-type condition. <b>Ear, Nose, Throat infections, Cellulitis, Urinary Tract infections, Dental conditions and Asthma are potentially preventable conditions presenting at EDs in the after-hours period in APHN region especially the LGAs of Playford and Onkaparinga.</b></p>	<p><i>Clinical Council, priority setting workshops, 2016.</i></p> <p><i>SA Health, 2015d, Emergency Department Presentations, 2013/14 – 2014/15, unpublished analysis undertaken by APHN.</i></p>

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Outcomes of the service needs analysis		
	<p>Approximately 16,000 episodes were triaged to the <i>healthdirect</i> After-Hours GP Helpline in the 2014/15 financial year; approximately 20% of all calls made by APHN residents to the <i>healthdirect</i> Nurse Triage Helpline (HealthDirect Australia 2016).</p> <p>While there are currently a number of Medical Deputising Services operating in the after-hours period across the APHN, analysis of their service boundaries show that there are pockets within in the north of the Playford LGA, and south-eastern region of the Onkaparinga LGA that are not being serviced (APHN, 2016).</p> <p>Between 2012/13 and 2014/15, non-urgent after-hours attendances by general practitioners increased by 23%, and urgent after-hours attendances by 26% in the same period (DOH, 2015). Data provided by the National Health Performance Agency (NHPA, 2016) indicated that in the 2013/14 financial year the average number of after-hours GP attendances per person (age-standardised) was highest in the SA3 of Playford (0.98 attendances), followed by Adelaide City and Port Adelaide – West (both 0.71), all higher than the PHN average of 0.55 attendances per person (NHPA 2016).</p> <p>Data provided by the National Health Performance Agency (NHPA, 2016) indicate that in the 2013/14 financial year, the SA3s with the highest average number of unplanned, non-urgent, semi-urgent and urgent after-hours ED attendances in the APHN region were Playford (137 attendances per 1,000 people), Onkaparinga (126 attendances) and Adelaide City (117 attendances). These rates are markedly higher than the APHN average of 93 attendances per 1,000 people (NHPA, 2016).</p> <p>Community consultations conducted by the former Medicare Locals in the APHN region raised a number of issues including limited understanding of the available after-hours services in the metropolitan</p>	<p><i>HealthDirect Australia, 2016, HealthMap data 2014/15, unpublished, assessed September 2016.</i></p> <p><i>Adelaide Primary Health Network (APHN), 2016, analysis of Medical deputising service provider websites (National Home Doctor Service, MedVisit, Australian Family Home Doctor, Doctor To You, Call The Doctor, Western Suburbs After Hours, My Doctor Now), unpublished, assessed August 2016.</i></p> <p><i>Department of Health (DOH), 2015, Medicare Benefits Schedule, 2013/14 – 2014/15, analysis undertaken by APHN, unpublished.</i></p> <p><i>National Health Performance Authority (NHPA), 2016, Healthy Communities: Use of emergency department and GP services in 2013-14.</i></p> <p><i>National Health Performance Authority (NHPA), 2016, Healthy Communities: Use of emergency department and GP services in 2013-14.</i></p> <p><i>Central Adelaide and Hills Medicare Local (CAHML), 2015, Health Profile: a population health needs assessment of the Central</i></p>

## 2017/18 Adelaide PHN Core Flexible Needs Assessment Update

Outcomes of the service needs analysis		
		<p>region, especially in the outer northern and southern metropolitan suburbs and for those residing in aged care facilities. There was also concern that a lack of appropriate after-hours health care services, e.g. mental health, crisis support, leading to preventable hospital presentations (CAHML, 2015; SAFKIML, 2015; NAML, 2015).</p>
		<p><i>Adelaide and Hills region, 2015; Southern Adelaide Fleurieu Kangaroo Island Medicare Local (SAFKIML), 2015, Comprehensive Needs Assessment Report; Northern Adelaide Medical Local (NAML), 2015, Comprehensive Needs Assessment Report.</i></p>

## Section 4 – Opportunities, priorities and options

*This section summarises APHN new priorities arising from the Needs Assessment by triangulating new Health Needs and Service Needs Analysis with consultations undertaken with our membership groups, stakeholders and community.*

*Any new priorities listed below (in red font) are additional to the 28 priorities reflected in the Needs Assessment Update relating to Core Flexible Funding completed in November 2016. Please see following page for the priorities.*

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
No new priorities identified	•	•	•	•

## 2017/18 Adelaide PHN Core Flexible Needs Assessment Update

<i>Priorities identified in the APHN Baseline Needs Assessment Update (APHN BNA Update) submitted in November 2016 relating to Core Flexible Needs Assessment</i>
<i>1. Immunisation rates for Aboriginal and Torres Strait Islander children are lower than non- Aboriginal and Torres Strait Islander children.</i>
<i>2. Aboriginal and Torres Strait Islander South Australian people are more likely to have a range of chronic conditions (respiratory, diabetes, circulatory system disease, chronic kidney disease) than non- Aboriginal and Torres Strait Islander people.</i>
<i>3. The CALD community are disproportionately affected by Hepatitis B.</i>
<i>4. Accessibility to and appropriateness of primary health care services, particularly for CALD and new and emerging communities, Aboriginal and Torres Strait Islander people, LGBTIQ and older people.</i>
<i>5. Identified areas of the APHN region have childhood immunisation rates below the national average.</i>
<i>6. Selected areas of the APHN region have high rates of smoking which correlates with areas of high prevalence of COPD.</i>
<i>7. Selected areas of the APHN region have high rates of obesity and overweight and correlate with areas of low physical activity and poor nutrition.</i>
<i>8. Selected APHN LGAs have higher rates of a range of chronic conditions (respiratory disease, diabetes, circulatory system disease, chronic kidney disease, musculoskeletal) and multi-morbidities.</i>
<i>9. Services for people living with persistent pain are limited with long delays to access hospital-based services.</i>
<i>10. Higher rates of multimorbidity among the aged population lead to increased utilisation of health care services.</i>
<i>11. Lack of community awareness about appropriate after-hours health care services leading to increased potentially preventable hospitalisations.</i>
<i>12. RACFs have a low capacity to support their residents in the afterhours setting leading to increased transportation to emergency departments and medical deputising services.</i>
<i>13. Selected APHN regions have higher rates of PPH resulting from a range of chronic (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, diabetes complications, angina, iron deficiencies) and acute conditions (dental issues, urinary tract infections, cellulitis).</i>
<i>14. Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations.</i>
<i>15. Early screening of selected cancers (cervix, bowel, breast) can assist in intervention measures which can help reduce mortality as part of a wider cancer control strategy.</i>
<i>16. A need to increase the ease of navigation and visibility of the health care system in selected APHN regions, population groups and for particular health issues.</i>
<i>17. Lack of easily understood and accessible referral pathways across systems and settings.</i>
<i>18. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.</i>
<i>19. Lack of community awareness about existing health care services for different population groups, consumers and providers.</i>
<i>20. Lack of person-centred care and responsiveness to individual circumstances, including co-morbidities.</i>
<i>21. Need to improve provision of education to consumers and professionals across the health sector to encourage the take-up and application of preventative health measures.</i>
<i>22. Need to improve the aptitude/attitude and consistency of empathic responses of a variety of health care staff across a range of sectors and settings as well as increase workforce capacity.</i>
<i>23. Minimise instances of poor quality and unwarranted variations of care and follow up.</i>
<i>24. Prevention and early intervention strategies for childhood and youth health conditions</i>
<i>25. Accessibility to primary health services for Aboriginal and Torres Strait Islander people</i>
<i>26. Access and information to Breast, Cervix and Bowel cancer screening services for Aboriginal and Torres Strait Islander people, CALD, and those in low socio-economic areas</i>
<i>27. Awareness of timely access to appropriate services (including after-hours services) for vulnerable population groups particularly, Aboriginal and Torres Strait Islander people, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers</i>
<i>28. A coordinated approach to improve navigation and pathways for patients to manage their conditions</i>

## Section 5 - Checklist

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