Primary Health Network Needs Assessment Reporting Template (2016/17 Update)

Name of Primary Health Network

Adelaide PHN

This template was used to submit the Primary Health Network's (PHN's) Baseline Needs Assessment update to the BNA submitted in March 2016. To streamline reporting requirements, the updates to the Initial Drug and Alcohol Treatment Needs Assessment Report (awaiting Commonwealth approval for publication) and Mental Health and Suicide Prevention Needs Assessment Report is also included in this template.

It is noted that the Baseline Needs Assessment from March 2016 (available on the Adelaide PHN website) is to be read in conjunction with the Needs Assessment updated November 2016 (this version).

Submitted 15 November 2016

2016/17 Adelaide PHN Baseline Health Needs Assessment – Update

Section 1 – Narrative

This section provides narratives on the process and key issues relating to the update to the Adelaide PHN (APHN) Baseline Needs Assessment (BNA) submitted in March 2016.

Needs Assessment process and issues

An iterative engagement and consultation process forms the basis to the 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 (See Appendix A for more information). 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 BNA submitted in March 2016 collated consultations including dedicated workshops on Mental Health and Alcohol and Other Drugs, alongside community workshops and input from our Clinical and Community Advisory Councils, the results of which were used to inform our health and service needs analysis. However, the results of our in-depth consultations undertaken with our seven Health Priority Groups throughout the year, were not able to be included in our original BNA submission. Hence, this update aligns this information with our existing BNA submission and consolidates the identified health and service needs of our community from all of our membership groups. Together with new quantitative data for example, from the Commonwealth Department of Health, Australian Institute of Health and Welfare, SA Health (hospital activities), Public Health Information Development Unit, all ongoing consultations with our stakeholders and partners have been incorporated into the triangulation process.

Importantly in June 2016, the APHN Membership Advisory Council (MAC) comprising of a representative from each of our 13 membership groups (three Clinical Councils, three Community Advisory Councils and seven Health Priority Groups) identified four strategic priorities that they believe were key considerations in the provision of coordinated, effective and efficient primary health care services which focus on the whole person and their circumstances of everyday life, based on their experience and perspectives.

The four strategic priorities are: (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. These priorities form the basis of the APHN strategic direction and consequently have allowed us to refine our priority setting process. These four strategic priorities have been incorporated into this update to the APHN BNA.

Using this further insight and direction, the APHN will continue to develop local innovative solutions to address the health and service needs of our community underpinned by the iterative engagement and consultation process with our stakeholders, partners and community described here. This update has identified five new priorities – this is in addition to the 32 priorities already reflected in the Baseline Needs Assessment completed in March 2016. Please see Section Four for more information.

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. However, 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 data by 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.

More recently, we have held discussions with the Australian Health Policy Collaboration (AHPC) with regards to the (Australia's) Health Tracker. The data and forthcoming Tracker by Area (particularly by Local Government Area) has potential benefits for all PHNs in understanding the needs of their population and importantly track/monitor targets by bringing together a suite of databases. It is hoped that the Commonwealth will consider integrating the database/dashboard into its data portal/dashboard for PHNs. In any event, we intend to interrogate the AHPC data for its region and triangulate the findings in the priority setting process for the Comprehensive Needs Assessment in November 2017.

In providing general practices with clinical auditing tool (i.e. PenCS CAT4), we have recently established data sharing agreements with general practices in our region. This will supplement other sources of information when analysing the needs of a population within a defined catchment. Additionally, we will work in close partnership with our practices in understanding their patient needs and implement clinical interventions.

We have worked in strong partnership with SA Health in analysing potentially preventable hospitalisations (PPH) and continue to work collaboratively with our State health department to further investigate PPH. Recognising that there are some remaining gaps in the required knowledge to inform service delivery across the region, we continue to gather information on service needs by strengthening relationships with our general practices, pharmacies, allied health and importantly our commissioned service providers. This will ensure a more detailed understanding of particular health issues in localities across our catchment and ensure appropriate planning and delivery of services.

Together with SA Health, the APHN has been collaborating with the Local Government Association in regards to our health promotion strategies and the Local Councils' Public Health Plans. From December 2016, the APHN will be meeting with the following Local Councils: Playford, Salisbury, Port Adelaide Enfield and Onkaparinga, to discuss the synergies and collaborative opportunities between the priorities identified in their Public Health Plans and the APHN priorities arising from our Needs Assessment process. All ongoing consultations from this sector will be analysed and included in the Comprehensive Needs Assessment report in November 2017.

With specific regard to the commissioning of Alcohol and Other Drugs (AOD) treatment services, the APHN and Country SA PHN have together commissioned the National Centre for Education and Training in the Addictions (NCETA) to provide specific AOD prevalence and treatment information for both metropolitan and country SA areas. This will provide insight into the needs of the South Australian community and will allow for further refinement of AOD

models for implementation across the state by commissioned service providers. The findings from this report will incorporated in the Comprehensive Needs Assessment.

The APHN is also gathering valuable information through active engagement with the local AOD sector. This has included monthly meetings at the executive level between the Adelaide PHN and the state government AOD treatment provider - Drug and Alcohol Services South Australia (DASSA) - and participating in AOD service modelling. We also meet regularly with the peak non-government organisation representing the AOD treatment services sector in SA, and regularly participates in community and stakeholder consultations and forums.

The AOD treatment services to be commissioned by the APHN will form a network that will gather and respond to information directly from consumers. All these services will have commenced by 1st January 2017. All ongoing consultations from the sector will be analysed and included in the Comprehensive Needs Assessment report in November 2017.

Additional comments or feedback

The APHN commends the Commonwealth for moving the deliverable dates of the Needs Assessment and subsequent Work Plans. This will allow PHNs adequate timeframe to enable efficient commissioning of services to align with the Commonwealth Schedules. For the Comprehensive Needs Assessment, the APHN expects that the Commonwealth will provide timely information and guidance on the expectations and template (if any).

Section 2 – Outcomes of the health needs analysis

Since submitting the Baseline Needs Assessment in March 2016, the APHN has undertaken consultations with its membership groups and stakeholders to further analyse the needs and thematically prioritise them. The following are outcomes of the consultation process in refining previously identified and new needs.

Outcomes of the health needs analysis			
Identified Need	Key Issue	Description of Evidence	Source
HN1. Mental Health	Data from the Health Needs Assessment shows disparity in prevalence of mental health conditions at a sub-regional level, specifically in Local Government Areas of Playford, Port Adelaide Enfield and Onkaparinga, and for specific population groups. Concern for specific population groups and those in lower socio economic areas.	The estimated prevalence of mental health issues is higher in the APHN compared to the average of other Australian capital cities with long term mental and behavioural problems 8% higher, and psychological distress 11% higher (PHIDU, 2014). Within the APHN region prevalence varies geographically with rates of psychological distress up to 55% higher in Population Health Areas in the North and Southern areas of the region compared to the PHN average (PHIDU, 2015). Certain populations living in the APHN region are disproportionately affected by mental health issues; 34% of South Australian Aboriginal and Torres Strait Islanders aged 18 years and over are estimated to have high to very high levels of psychological distress compared to 14% of non-Indigenous South Australians (ABS, 2016). Furthermore, 28% of South Australians with a profound or severe activity limitation had a mental or behavioural disorder (ABS, 2014) compared to 15% of all South Australians (PHIDU, 2014). Illicit drug users living in South Australia also reported high levels of psychological distress, at more than twice the APHN average rate (NDARC, 2014).	*Public Health Information Development Unit (PHIDU), 2014, Social Health Atlas of Australia.* *Public Health Information Development Unit (PHIDU), 2015, Social Health Atlas of Australia.* *Australian Bureau of Statistics (ABS), 2016, National Aboriginal and Torres Strait Islander Social Survey, Australia, 2014–15* *Australian Bureau of Statistics (ABS), 2015, Disability, Ageing and Carers, Australia: Summary of Findings, 2012* *Public Health Information Development Unit (PHIDU), Social Atlas of Health, 2014.* *National Drug and Alcohol Research Centre (NDARC), 2014, SA Drug Trends,*

Outcomes of the health needs analysis			
HN2. Suicide Prevention	Increasing concern for specific population groups, specifically Aboriginal and Torres Strait Islanders, youth, males and LGBTIQ (Lesbian, Gay, Bisexual, Transgender, Intersex, and Questioning), and at sub-regional level, specifically in Local Government Areas of Playford, Adelaide City, Onkaparinga and Charles Stuart.	In Greater Adelaide, which includes all of the APHN region, rates of deaths from intentional self-harm have increased by 19% in the five years from 2010 to 2014 (PHIDU, 2014). Deaths from suicide and self-inflicted injuries were 23% higher in APHN compared to the average rate for all other Australian capital cities. In South Australia, the rates of deaths from intentional self-harm were over three times higher for males than females across all age groups (PHIDU, 2014). Suicide accounted for a higher proportion of deaths among Aboriginal and Torres Strait Islanders populations, 4.2%, compared to non-Indigenous South Australians, 1.6% of deaths (ABS, 2016). Substantial geographical variation is evident across APHN, with Elizabeth/ Smithfield - Elizabeth North in the north, Adelaide City in the centre, Christie Downs/ Hackham West - Huntfield Heights in the south and West Lakes in the west of the region, having almost double the rates of death from suicides and self-inflicted injuries compared to the Metropolitan average (PHIDU, 2014).	*Public Health Information Development Unit (PHIDU), 2014, Social Health Atlas of Australia.* *Public Health Information Development Unit (PHIDU), 2014, Social Health Atlas of Australia.* *Australian Bureau of Statistics (ABS), 2016, National Aboriginal and Torres Strait Islander Social Survey, Australia, 2014–15* *Public Health Information Development Unit (PHIDU), 2014, Social Health Atlas of Australia.*
HN3. Alcohol and Other Drugs	*Awaiting Commonwealth approval for publication*	*Awaiting Commonwealth approval for publication*	*Awaiting Commonwealth approval for publication*
HN4. Chronic Conditions	Data from the Health Needs Assessment shows variations in prevalence at sub-regional levels and with types of conditions across the APHN region.	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. 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	*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.*

Outcomes of the health needs analysis			
		Capital Cities (52 per 100) and the National rate (56 per 100) (BEACH, 2016).	
		Substantial geographical variation in chronic disease prevalence is evident across the APHN region. Rates of respiratory system diseases are highest in the 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).	*Public Health Information Development Unit (PHIDU), 2015, Social Health Atlas of Australia.*
		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).	*Public Health Information Development Unit (PHIDU), 2015, Social Health Atlas of Australia.*
		Rates of circulatory system diseases are fairly similar across the APHN region, and consistent with National prevalence rates (PHIDU, 2015). 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).	*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.*
HN5. Child and Youth Health	Wide variation in childhood immunisation rates across the APHN region for 1-year-old, 2 year olds and 5 year olds, particularly	Childhood immunisation rates varies across the APHN region with lower rates for 1-year-old children in SA3s of: Unley, Prospect-Walkerville, Port Adelaide-West, Port Adelaide-East, Campbelltown, Norwood-Payneham-St Peters, West Torrens, Playford, Charles Sturt, Holdfast Bay and Adelaide City.	

Outcomes of the health needs analysis			
	for Aboriginal and Torres Strait Islander and CALD children.	For 2 year olds: Norwood-Payneham-St Peters, Onkaparinga, Marion, Playford, West Torrens, Campbelltown, Port Adelaide-East, Port Adelaide-West, Burnside, Charles Sturt, Holdfast Bay and Adelaide City. For 5 year olds: Marion, Tea Tree Gully, Onkaparinga, Port Adelaide-West, Burnside, Campbelltown, Mitcham, Prospect-Walkerville, Holdfast Bay, Charles Sturt, Unley, West Torrens, Port Adelaide-East, Norwood-Payneham-St Peters, and Adelaide City (NHPA 2015). Additionally, analysis of the Australian Childhood Immunisation Register (ACIR) indicates lower rates for Aboriginal and Torres Strait Islander and CALD children (ACIR, 2016).	*National Health Performance Authority (NHPA), 2015, Australian Childhood Immunisation Register statistics 2014–15.* *Australian Childhood Immunisation Register (ACIR), 2016, childhood immunisation records, APHN extracted, unpublished.*
	Increasing concern for childhood obesity rates impacting on health and wellbeing at adulthood.	Around a quarter (23.0%) of non-Aboriginal children aged 5-17 years in South Australia were overweight or obese. While this is slightly lower the national average of 24.8% (HPCSA, 2016), it is still a growing concern given the recent AHPC children overweight and obesity national data of 25.6% (AHPC, 2016). The 2025 target is 21.6%. The AHPC data also indicates a growing concern for young people – nearly one in 3 (29.5%) are overweight or obese. The 2025 target is 28.3% (AHPC, 2016). 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%). Compared to other states and territories, South Australia is ranked second highest (HPCSA 2016). The AHPC national data indicates significant issue for Aboriginal children and young people, 32.8% and 36.3% respectively (AHPC, 2016). Analysis of data (2012/13 – 2014/15) from SA health have shown increasing concern for specific potentially preventable conditions	*Health Performance Council of South Australia, 2016, State of Our Health Report.* *Australian Health Policy Collaboration (AHPC), 2016, Australia's Children and Young People Health Tracker.*

Outcomes of the health needs analysis			
	Increasing concern for specific potentially preventable conditions among the child and youth presenting at Emergency Departments.	(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, 2016).	*SA Health, 2016, Potentially Preventable Admissions data, 2012/13 – 2014/15, unpublished.*
HN6. Aboriginal Health	Data from the Health Needs Assessment identifies significant health inequalities across a number of health and wellbeing indicators. For this reason, this population's health needs have been identified as a priority area.	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 of fully immunised children at 1-, 2- and 5-years of age, compared to non- Aboriginal and/or Torres Strait Islander children in the region (NHPA, 2015). 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). 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). 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). 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	*National Health Performance Authority (NHPA), 2015, Australian Childhood Immunisation Register statistics 2014–15.* *Australian Bureau of Statistics (ABS), 2016a, National Aboriginal and Torres Strait Islander Social Survey, 2014–15.* *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).* *Productivity Commission – Report on Government Services (PC-ROGS), 2016, Volume E: Health, Overview, Age*

Outcomes of the health needs analysis			
		compared to a rate of 5.7 deaths per 1,000 from 2010-2014 (PC-ROGS, 2016). Data on the underlying causes of death for South Australian Aboriginal and Torres Strait Islander populations are currently not available; however the leading causes of death at the national level are ischaemic heart diseases, diabetes, chronic lower respiratory diseases, malignant neoplasm of trachea, bronchus and lung, and intentional self-harm (suicide) (ABS, 2016b). 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). 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). 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).	*standardised all-cause mortality rate and rate ratios, by Indigenous status, 2010-2014.* *Australian Bureau of Statistics (ABS), 2016b, Causes of Death, Australia, 2014.* *Australian Bureau of Statistics (ABS), 2015, Infant mortality rates, Indigenous status, Selected states and territories-2002-2004 to 2012-2014.* *Public Health Information Development Unit (PHIDU), 2016, Aboriginal and Torres Strait Islander Social Health Atlas of Australia.*
HN7. Early Intervention and Prevention	Early intervention and prevention through primary health care could avert unnecessary strain on the health care/hospital system. Analysis of data has identified unsatisfactory levels of health risk	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, and high proportion of females smoking during pregnancy in	*Public Health Information Development Unit (PHIDU), 2015, Social Health Atlas of Australia.*

Outcomes of the health needs analysis			
	factors (including poor nutrition, physical inactivity and smoking) at sub-regional levels, particularly in Local Government Areas (LGAs) of Playford, Salisbury, Port Adelaide Enfield and Onkaparinga. Analysis of various cancer screening databases and consultations with cancer screening agencies have identified low socio economic areas and Aboriginal and Torres Strait Islander and CALD population groups as key focus areas/groups to increase Breast, Cervix and	Playford, Salisbury, Onkaparinga and Port Adelaide Enfield LGAs (PHIDU, 2015). 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, 2015a). 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, 2015b). 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, 2015c). 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, 2015b). 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, 2015b). The most recently available cancer screening participation data indicates that residents of the northern, western and city areas of the APHN had much lower participation rates compared to both the APHN and national rates between 01 January 2014 and 31 December 2015 (AIHW, 2016). These areas, which include the SA3s Playford, Salisbury, Port Adelaide – West, Port Adelaide –	*SA Health, South Australian Monitoring & Surveillance System (SAMSS), 2015a, Trends at a glance: Physical Activity trends in South Australian adults, January 2003 to December 2015.* *SA Health, South Australian Monitoring & Surveillance System (SAMSS), 2015b, South Australian Health and Risk Factors by SA3 regions, July 2012 to June 2014, December.* *SA Health, South Australian Monitoring & Surveillance System (SAMSS), 2015c, Trends at a glance: Unhealthy weight trends in South Australian adults, July 2002 to December 2015.* *SA Health, South Australian Monitoring & Surveillance System (SAMSS), 2015b, South Australian Health and Risk Factors by SA3 regions, July 2012 to June 2014.*

Outcomes of the health needs analysis			
	Bowel screening participation rates.	East, Charles Sturt, West Torrens and Adelaide City, also 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 specific population groups are participating in screening at substantially lower rates than the wider population (SA Health, 2016).	*Australian Institute of Health and Welfare (AIHW), 2016, Analysis state and territory cervical screening register data.* *SA Health, 2016, BreastScreen SA screening participation, unpublished.*
HN8. After-Hours Health Care	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. While there are some variations at sub-regional levels, the LGAs of Playford and Onkaparinga have highest presentation rates for potentially preventable-type conditions in the after-hours period.	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, 2015). 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. Approximately 16,000 episodes were triaged to the *healthdirect* After-Hours GP Helpline in the 2014/15 financial year; approximately 20% of all calls made by APHN residents to the *healthdirect* Nurse Triage Helpline (HealthDirect Australia 2016).	*SA Health, 2015, Emergency Department Presentations, 2013/14 – 2014/15, unpublished analysis undertaken by APHN.* *HealthDirect Australia, 2016, HealthMap data 2014/15, unpublished, assessed September 2016.*

Section 3 – Outcomes of the service needs analysis

Since submitting the Baseline Needs Assessment in March 2016, the APHN has undertaken consultations with its membership groups and stakeholders to further analyse the needs and thematically prioritise them. The following are outcomes of the consultation process in refining previously identified and new needs.

Outcomes of the service needs analysis			
Identified Need	Key Issue	Description of Evidence	Source
SN1. Mental Health and Suicide Prevention	A maldistribution of mental health services is evident across the region. Regions in the north, south and west of the APHN have high rates of hospitalisations and PBS subsidized mental health-related prescription medication dispensing. In the west and north-western region there is comparatively low service provision and low rates of people referred to MBS funded psychological services in the same areas Other key issues that were highlighted through extensive community consultations include: • the inability of services to focus on the whole person and their circumstances, particularly social factors and physical comorbidities;	Service mapping identified that approximately two-thirds of providers of psychological services, and two-thirds of mental health services are located in the centre of the APHN region (NHSD, 2015). Analysis of MBS data showed that the central SA3s of Adelaide City and Unley had the highest rates of Mental Health Treatment Plan preparation and review, and along with Playford, had the highest rates of GP mental health consultations (DoH 2016). With regards to psychological management, the BEACH study reported that the APHN had significantly higher psychological counselling management action rate (29.4 encounters) per 100 psychological problem contacts when compared to Other Capital cities (24.5) and nationally (24.0) (BEACH, 2016). The APHN had a lower referral management action rate (13.0) per 100 psychological problem contacts when compared to Other Capital cities (16.3) and nationally (15.7) (BEACH 2016). There is a strong correlation between areas of lower socioeconomic status, particularly in the north of the region, and higher rates of mental health-related PBS prescriptions dispensing within the APHN; the exception to this is antidepressant medication in people aged 17 years and under and antipsychotic medicines in adults,	*APHN analysis of National Health Services Directory (NHSD), November 2015.* *Department of Health (DoH), 2016, APHN analysis of Medicare Benefits Schedule data by Statistical Area Level 3, 2014/15* *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.* *Australian Commission of Safety and Quality in Health Care (ACSQHC) and the National Health Performance Authority, 2015, Australian Atlas of Healthcare Variation.*

Outcomes of the service needs analysis			
	• a lack of culturally appropriate services, and services targeted to at-risk populations; • poor integration, coordination and collaboration between service providers; and • inadequate early intervention, and access to and knowledge of preventative health measures.	where rates are also high in more socioeconomic advantaged areas of APHN (ACSQHC, 2015). The Statistical Area Level 3s (SA3s) of Playford and Onkaparinga had the highest rates of dispensing of antidepressants across all age groups in 2013-14 (ACSQHC, 2015). For anti-anxiety medications, Playford had the fourth highest rate in Australia for people aged 18-64 years, and the 2nd highest rate in Australia for people aged 65 years and over (ACSQHC, 2015). High rates of anti-psychotic medicines dispensing occurred in the Playford, Salisbury, Adelaide City, Onkaparinga, Port Adelaide-West and Norwood-Payneham-St Peters across varying age groups (ACSQHC, 2015). Onkaparinga, Playford and Salisbury had highest rates of dispensing for attention deficit hyperactivity disorder medicines for people aged 17 years and under in 2013-14 (ACSQHC, 2015).	*Australian Commission of Safety and Quality in Health Care (ACSQHC) and the National Health Performance Authority, 2015, Australian Atlas of Healthcare Variation.*
		While the APHN's average age-standardised rate of mental health hospitalisations 849 hospitalisation per 100,000 people was consistent with the national average (911 per 100,000 people), some areas of the APHN region had exceptionally high rates (AIHW, 2016). The SA3s of Adelaide City had the highest rate in Australia, with 2,179 hospitalisations per 100,000 people. Port Adelaide – East and Holdfast Bay SA3s had the next highest rates of 1,170 and 1,028 respectively (AIHW, 2016). Schizophrenia and delusional disorders, and bipolar and mood disorders were the primary groups of conditions with the highest admission rated for specialised care. Drug and alcohol use conditions had the highest rates of admission for non-specialised care (AIHW, 2016). Adelaide City also had high rates of hospitalisation due to intentional self-harm 228 hospitalisation per 100,000 people, notably higher	*Australian Institute of Health and Welfare (AIHW), 2016, Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2013–14*

Outcomes of the service needs analysis			
		than the APHN average of 154. Rates were also high in Playford (209), Marion (200), Holdfast Bay (194) and Onkaparinga (190) (AIHW, 2016).	
		Priority setting workshops with the Central Community Advisory Council (CAC) prioritised the importance in the simplification of mental health services and integration with drug and alcohol services.	*Community Advisory Council, priority setting workshops, 2016.*
		Priority setting workshops with the Southern CAC prioritised that mental health cannot be seen in isolation to a person's wellbeing. Additionally, the CAC highlighted that primary health care workers need to be equipped to address the needs of people experiencing social and mental health related issues. We need to ensure mental health services and programs are sustainable and developed to meet the needs of individuals with a focus on early intervention and recovery programs.	
		The Mental Health Priority Group (HPG) prioritised that a holistic service delivery approach is needed that focusses on the whole person and their circumstances	*Health Priority Groups, priority setting workshops, 2016.*
		During the priority setting workshops, the Aboriginal HPG prioritised that mental health, loss and grief are underlying issues that impact on other health issues. The HPG highlighted that it is important that these are addressed in culturally effective and safe ways. Additionally, they mentioned the stigma associated with the label of "mental illness/health" so the first contact with mental health services is critical along with early intervention across the life span.	
		The Childhood & Youth HPG prioritised the lack of coordination / screening / capacity in the system to meet the multiple and complex	

Outcomes of the service needs analysis			
		needs of children and young people living in difficult social situations, domestic violence and poverty.	
SN2. Alcohol and Other Drugs (AOD)	*Awaiting Commonwealth approval for publication*	*Awaiting Commonwealth approval for publication*	*Awaiting Commonwealth approval for publication*
SN3. Timely Access and Equity to Health Services and Care	Lack of appropriate services and timely access to health services for vulnerable population groups, particularly Aboriginal and Torres Strait Islanders, Children and Youth, people with a disability, Older people, Palliative Care patients, and their carers.	Priority setting workshops with the Southern Adelaide Clinical Council (CC) prioritised the importance of improving and increasing timely access to health services. 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. The Northern Adelaide CC prioritised the need to improve coordination and access to primary health care services and programs for consumers, and 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). The Central 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. 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, they stressed that people need to be able to access pathways that are culturally and/or linguistically appropriate and	*Clinical Council, priority setting workshops, 2016.* *Community Advisory Council, priority setting workshops, 2016.*

Outcomes of the service needs analysis			
		sensitive and nonjudgmental with consideration of the social determinants. 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. The Childhood & 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. In the priority setting workshops, our Palliative Care HPG prioritised the 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.	*Health Priority Groups, priority setting workshops, 2016.*
SN4. Health Literacy and Education	Training and education is available for health professionals to increase skills in culturally appropriate integrated service delivery and enable appropriate care to patients and advice to carers Increase awareness of appropriate services (including after-hours services) with an increased focus on prevention and early intervention programs to vulnerable population groups.	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). The Southern Adelaide CC prioritised the need to reduce unwarranted variation in care by improving health literacy and education. 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.	*Clinical Council, priority setting workshops, 2016.*

Outcomes of the service needs analysis			
		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. The Central CAC prioritised during the workshops on 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. The Southern CAC prioritised that community members and service providers need 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.	*Community Advisory Council, priority setting workshops, 2016.*
		The Older people & Aged Care HPG prioritised the need for awareness of services and where to go for what (including for those who do not have access or skills to use the internet). They also identified the need to advocacy for older people by health professionals. The Older People & Aged Care HPG also stressed the importance to build the capacity of health professionals and GPs to understand the issues for older people by providing support, training and education. 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)	*Health Priority Groups, priority setting workshops, 2016.*

Outcomes of the service needs analysis			
		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. 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. 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.	
SN5. Care Coordination, Integration and Navigation	Gaps in communication and coordination of care along the health continuum for patients, particularly vulnerable population groups, Aboriginal and Torres Strait Islanders, CALD, Children and Youth, Disabled, Older people, Palliative Care patients, and their carers.	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.	*Clinical Council, priority setting workshops, 2016.*

Outcomes of the service needs analysis			
	Improve the navigation and pathways for patients to Primary Health Care. Concern in the unwarranted variation of care and quality use of medicines at sub-regional levels in the APHN.	Similarly, the Northern Adelaide CC prioritised integrated approach as the key need for (improving) care coordination, integration and navigation. 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 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. This will enable timely, affordable and accessible services where health providers communicate and share information about patients in minimising the duplication of information. The Disability HPG prioritised the need for a Primary Health Care service model for people with disabilities which is interagency and interdisciplinary. 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.	*Community Advisory Council, priority setting workshops, 2016.* *Health Priority Groups, priority setting workshops, 2016.*

Outcomes of the service needs analysis			
		The Consumers & 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 & 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 we are 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. Childhood & 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. The Older People & 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. The Mental Health HPG prioritised the need to improve the experience of entry to and navigation of the stepped care and broader service system.	
SN6. Preventable Hospitalisations	Disparity in rates of preventable hospitalisation across the APHN region with higher rates of PPH in the north and north-western regions	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, 2015a).	*National Health Performance Authority, 2015a, Adelaide Primary Health Network Potentially*

Outcomes of the service needs analysis			
	of APHN, which correlate to areas of lower socioeconomic status. The management of chronic conditions and access to appropriate and timely services in these regions are pivotal in avoidable Emergency Department presentations and hospital (re)admissions.	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). 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, 2015a). Age-standardised rates of PPH varied across the APHN region (NHPA, 2015b). Rates for Total PPH were highest in the north and north-west 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. 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). 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).	*preventable hospitalisations (PPH), 2013–14: user generated report.* *National Health Performance Authority 2015b, Healthy Communities: Potentially preventable hospitalisations in 2013–14.* *National Health Performance Authority, 2015a, Adelaide Primary Health Network Potentially preventable hospitalisations (PPH), 2013–14: user generated report.* *National Health Performance Authority 2015b, Healthy Communities: Potentially preventable hospitalisations in 2013–14.*

Outcomes of the service needs analysis			
		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 2016).	*SA Health, 2016, PPA Data for Adelaide Primary Health Network (PHN), unpublished.*
SN7. Aboriginal Health	Increasing concern for disparity in the utilisation of specific MBS item numbers by General Practitioners for Aboriginal and Torres Strait Islander people/patients.	Analysis of Medicare Benefits Statistics on item number 715 (AIHW 2016) by PHN (AHIW, 2016) and analysis of Medicare Benefits Statistics by PHN and by SA3 (DoH, 2016). Aboriginal Health Assessment (MBS 715) low 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 (associated with HN6). During the Priority setting workshops, the Aboriginal HPG emphasised the need to improve the uptake of the Aboriginal (children and adult) health check.	*Australian Institute of Health and Welfare (AIHW), 2016, analysis of Department of Human Services Medicare Benefits Statistics, 2011/12 to 2013/14.* *Department of Health (DoH), 2016, Medicare Benefits Schedule, 2013/14 – 2014/15, unpublished.* *Health Priority Groups, priority setting workshops, 2016.*
SN8. Healthy Aging	An ageing population has implications for the health system especially increased co-morbidity, Emergency Department presentations, hospital (re)admissions and potential need for residential aged care facilities. For this reason, this population's health needs have been identified as a priority area. When compared to other capital cities, the APHN has a higher	In 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). 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). 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	*Office for the Ageing (OFTA), 2014, Prosperity through longevity: South Australia's ageing plan, our vision 2014-2019.* *Public Health Information Development Unit (PHIDU), 2014, Social Health Atlas of Australia.* *Office for the Ageing (OFTA), 2014, Prosperity through longevity: South Australia's ageing plan, our vision 2014-2019.OfOffice for the Ageing (OFTA), 2014, Prosperity through longevity: South Australia's ageing plan, our vision 2014-2019.*

Outcomes of the service needs analysis			
	proportion of the elderly population and particularly in Local Government Areas of Campbelltown, Burnside, Walkerville and Holdfast Bay, when compared to the APHN average. The health issues for older adults are wide-ranging and complex, and include complex multi-morbidity, high prevalence of chronic disease and associated risk factors, mental health issues and psychological distress, dementia, palliative care and falls risk.	as fair or poor. The health issues that most affected daily activities were vision (22%) and mobility (19%) (OFTA, 2014). In the Adelaide PHN 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). 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. 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). 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)	*Public Health Information Development Unit (PHIDU), 2014, Social Health Atlas of Australia.* *Central Adelaide and Hills Medicare Local (CAHML), 2015, Health Profile: a population health needs assessment of the Central Adelaide and Hills region, 2015.* *Australian Institute of Health and Welfare (AIHW), 2012, Dementia in Australia. Cat. no. AGE 70. Canberra: AIHW.* *Health Performance Council of South Australia (HPCSA), 2016, State of Our Health (online report), accessed April 2016.* *Health Performance Council of South Australia (HPCSA), 2016, State of Our Health (online report), accessed April 2016.*

Outcomes of the service needs analysis			
		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). 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). The rates of PPH in the region generally increased with age, with people 85 years and older with the highest rates. In 2014/15 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 influenza and pneumonia (SA Health, 2016). 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 include language, the reliance on online	*Central Adelaide and Hills Medicare Local (CAHML), 2015, Health Profile: a population health needs assessment of the Central Adelaide and Hills region, 2015.* *Office for the Ageing (OFTA), 2014, Prosperity through longevity: South Australia's ageing plan, our vision 2014-2019.* *SA Health, 2016, PPA Data for Adelaide Primary Health Network (PHN), unpublished* *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 Needs Assessment Report; Northern Adelaide*

Outcomes of the service needs analysis			
		information and registration for services, and changes to and within community support agencies (Principe, 2015).	*Medical Local (NAML), 2015, Comprehensive Needs Assessment Report.* *Principe Iolanda, 2015, Issues in Health Care in South Australia for People form Culturally and Linguistically Diverse Backgrounds – A Scoping Study for the Health Performance Council SA, assessed February 2016.*
SN9. Culturally and Linguistically Diverse (CALD) and New and emerging communities Health	Concern on pre-arrival experiences of refugees and language/cultural differences of new and settled migrants producing (continued) roadblocks in the navigation of the primary health care sector leading to avoidable Emergency Department presentations, hospital (re)admissions and high rates of Hepatitis B. For this reason, this population's health needs have been identified as a priority area.	Data from the 2011 Census of Population and Housing indicate that 16% of APHN residents were born in predominately non-English speaking countries (NESC). The Local Government Areas of Adelaide city, Campbelltown, Port Adelaide Enfield and West Torrens had the highest proportion of people born in NESC while those resident for less than five years (or recent arrivals) are in Adelaide city, West Torrens, Prospect and Port Adelaide Enfield (PHIDU, 2015). The top 10 birthplaces of people from Non-English Speaking Countries in the APHN are: Italy, India, China, Vietnam, Greece, Germany, Philippines, Malaysia, Poland and Netherlands, with Port Adelaide Enfield LGA having the majority of residents from these countries (PHIDU, 2015). The top 10 languages spoken by people from NESC in the APHN are: Italian, Greek, Mandarin, Vietnamese, Cantonese, Arabic, Polish, German, Spanish and Hindi with Port Adelaide Enfield and Marion having the majority of residents who speak these languages (PHIDU, 2015). CALD communities particularly from Asia and the Pacific are disproportionately affected by Hepatitis B (ASHM, 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 (BEACH, 2016).	*Public Health Information Development Unit (PHIDU), 2015, Social Health Atlas of Australia.* *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.* *Bettering the Evaluation and Care of Health (BEACH), 2016, Family Medicine Research Centre, School of Public Health, The University*

Outcomes of the service needs analysis			
		The Mental Health and AOD community workshops have identified CALD as one of the priority target population groups for the APHN. The Priority Setting Workshops with our membership groups have identified CALD and new and emerging communities' health (and their accessibility to health services) as one of the target population groups for the APHN. 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). Research undertaken by the Health Performance Council SA have identified people from CALD backgrounds are among the population groups missing out on accessing suitable services or gaining equitable health care outcomes (Principe, 2015). Research have found 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. It found that 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).	*of Sydney, customised report for Adelaide Primary Health Network, unpublished.* *Community workshops, 2016.* *Clinical Councils, Community Advisory Councils, Health Priority Groups, priority setting workshops, 2016.* *Principe Iolanda, 2015, Issues in Health Care in South Australia for People form Culturally and Linguistically Diverse Backgrounds – A Scoping Study for the Health Performance Council SA, assessed February 2016.*

Outcomes of the service needs analysis			
		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).	
SN10. After-Hours Service Delivery	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 Increasing concern for areas with the highest average number of after-hours GP attendances per person in the APHN region, which also have the highest rates of ED-presentations in the after-hours period. A possible after-hours service gap exists in the northern fringes (Angle Vale) and south-eastern areas (McLaren Vale and Willunga) of the PHN region.	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 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). 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). 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	*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 Needs Assessment Report; Northern Adelaide Medical Local (NAML), 2015, Comprehensive Needs Assessment Report.* *Department of Health (DOH), 2015, Medicare Benefits Schedule, 2013/14 – 2014/15, analysis undertaken by APHN, unpublished.* *National Health Performance Authority (NHPA), 2016, Healthy Communities: Use of emergency department and GP services in 2013-14.* *National Health Performance Authority (NHPA), 2016, Healthy Communities: Use of emergency department and GP services in 2013-14.*

Outcomes of the service needs analysis			
		markedly higher than the APHN average of 93 attendances per 1,000 people. 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).	*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.*

Section 4 – Opportunities, priorities and options

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

The five new priorities listed below are additional to the 32 priorities already reflected in the Baseline Needs Assessment completed in March 2016. The 32 priorities are listed thereafter for reference.

Opportunities, priorities and options	
Priority	Possible Options
33.Prevention and early intervention strategies for childhood and youth health conditions	• Targeting commissioning of programs to tackle key childhood and youth health issues (e.g. childhood obesity, chronic conditions, developmental delay, disability potentially preventable Emergency Department presentations) • Coordinated approach with partners and stakeholders to educate and promote health prevention strategies to health professionals and consumers
34. Accessibility to primary health services for Aboriginal and Torres Strait Islander people	• Partner with organisations and stakeholders to provide education, awareness and support programs delivered to primary care providers specific to Aboriginal Health • Foster and support integration and collaboration between mainstream and Aboriginal health sectors with the aim to improve health pathways • Strengthen and support the Integrated Care Program to increase accessibility to primary care services for Aboriginal and Torres Strait Islander people • Commission the delivery of cultural learning to support APHN programs and to build capacity of mainstream practices to deliver appropriate services. • Coordinate an approach with primary care to increase registration of PIP IHI, the uptake of 715 and Aboriginal specific MBS items • Identify service gaps and work with all partners across the health system to improve the patient journey for Aboriginal and Torres Strait Islander people

Opportunities, priorities and options	
Priority	Possible Options
	• Identify and commission innovative services that are patient centred and based on Aboriginal and Torres Strait Islander population health needs • Support and commission programs that contribute to the development of the Aboriginal health workforce • Partner with bodies such as SAHMRI, SAAHP, SA health, CSAPHN in support of research translation, and to implement recommendations from the chronic condition plans specific to Aboriginal and Torres Strait Islander communities. • Coordinated approach with partners and stakeholders to promote culturally appropriate health prevention strategies to Aboriginal and Torres Strait Islander people • Coordinated approach with health professionals to increase awareness of PIP IHI and Aboriginal specific MBS item numbers • Programs aimed at increasing workforce capacity in providing culturally appropriate care and information for Aboriginal and Torres Strait Islander people • Strengthening the Integrated Care Program to increase accessibility to primary health services for Aboriginal and Torres Strait Islander people
35. 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	• Work collaboratively with partners and stakeholders to assist the implementation of the recommendations from the South Australian Aboriginal Cancer Control Plan • Collaborative involvement in the South Australian Cancer Control Plan • A coordinated approach with partners and stakeholders to educate and promote cancer screening services for Aboriginal and Torres Strait Islander people, CALD, and those residing in low socio economic areas • Programs aimed at increasing access to cancer screening services and primary healthcare services for targeted population and in specific sub-regional levels in APHN
36. 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	• Increased promotion of alternative after-hours service options in areas of service gaps • Culturally appropriate and easy-to-understand community awareness resources and information to vulnerable population groups • Innovative programs aimed at increasing access to 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

Opportunities, priorities and options	
Priority	Possible Options
37. A coordinated approach to improve navigation and pathways for patients to manage their conditions	• Promotion of established clinical referral and management guidelines and pathways at education events focussed on chronic condition management [where appropriate and relevant] • Work collaboratively with the Care Connections practices to navigate/develop local pathways of care to support chronic condition management • Promotion of templates and resources to support coordinated chronic condition management

Priorities identified in the APHN Baseline Needs Assessment submitted in March 2016
1. High prevalence of mental health/behavioural issues and psychological distress in selected areas across the region.
2. Provision of psychological services comparatively low in areas of highest need.
3. Comparatively high numbers of people attempting to access psychological services in areas with minimal psychological service provision.
4. Disproportionate quantities of mental health related medicines prescribed in women, disadvantaged areas and population groups such as people aged 75 and over.
5. Difficulty in identifying and accessing appropriate mental health treatment services.
6. Greater prevalence of intentional self-harm and suicide in selected areas and specific population groups across the region including Aboriginal and Torres Strait Islander people.
7. Alcohol is the most common principal drug of concern in particular areas of the APHN region and for population group including Aboriginal and Torres Strait Islander people.
8. Significantly less South Australians with AOD problems access counselling as a treatment than the Australian average.
9. Higher prevalence of illicit drug use in selected areas and specific population groups, particularly Aboriginal and Torres Strait Islander populations.
10. Immunisation rates for Aboriginal and Torres Strait Islander children are lower than non- Aboriginal and Torres Strait Islander children.
11. 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.
12. The CALD community are disproportionately affected by Hepatitis B.
13. 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.
14. Identified areas of the APHN region have childhood immunisation rates below the national average.
15. Selected areas of the APHN region have high rates of smoking which correlates with areas of high prevalence of COPD.
16. Selected areas of the APHN region have high rates of obesity and overweight and correlate with areas of low physical activity and poor nutrition.
17. 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.
18. Services for people living with persistent pain are limited with long delays to access hospital-based services.
19. Higher rates of multimorbidity among the aged population lead to increased utilisation of health care services.
20. Lack of community awareness about appropriate after hours health care services leading to increased potentially preventable hospitalisations.
21. RACFs have a low capacity to support their residents in the afterhours setting leading to increased transportation to emergency departments and medical deputising services.
22. 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).
23. Medication misadventure including poor quality use of medicines contributes greatly to the burden of potentially preventable hospitalisations.
24. 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.
25. 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.
26. Lack of easily understood and accessible referral pathways across systems and settings.

27. A need to increase communication and collaboration between service providers including hospitals to improve clinical handover.
28. Lack of community awareness about existing health care services for different population groups, consumers and providers.
29. Lack of person-centred care and responsiveness to individual circumstances, including co-morbidities.
30. 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.
31. 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.
32. Minimise instances of poor quality and unwarranted variations of care and follow up.