Australian Government
Department of Health

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An Australian Government Initiative

Primary Health Network

Needs Assessment Reporting Template - Core

This template must be used to submit the Primary Health Network's (PHN's) Needs Assessment report to the Department of Health (the Department) by **November 2020** as required under Item E.5 of the Standard Funding Agreement with the Commonwealth.

Name of Primary Health Network

South Eastern Melbourne

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.

Section 2 – Outcomes of the health needs analysis

This section summarises the findings of the health needs analysis in the table below. For more information refer to Table 1 in '5. Summarising the findings in the Needs Assessment Guide on www.health.gov.au/PHN. Additional rows may be added as required.

Outcomes of the CORE health needs analysis		
Priority Area	**Key Issue**	**Description of evidence**
Demographic profile	Total SEMPHN population (2020): • Casey: 363,512 • Greater Dandenong: 174,770 • Mornington Peninsula 165,822 • Kingston: 169,278 • Glen Eira: 160,300 • Frankston: 146,305 • Stonnington: 121,956 • Port Phillip: 117,920 • Bayside: 108,612 • Cardinia: 117,469 SEMPHN: 1,651,836	Population Health Information Development Unit (PHIDU). Social Health Atlas of Australia: Primary Health Networks (online). At: http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks (accessed 29th October 2020).
	Projected annual population growth (2014-2024): • Cardinia 4.4% • Casey 2.7% • Port Phillip 1.8% • Stonnington 1.7% • Greater Dandenong 1.6% • Mornington Peninsula 1.3% • Kingston 1.0%	Department of Health and Human Services (DHHS). 2015 Local Government Area (LGA) Statistical Profiles (online). At: https://www2.health.vic.gov.au/about/reporting-planning-data/gis-and-planning-products/geographical-profiles (accessed 12 October 2017). *Estimate calculated using annual growth rate

Outcomes of the CORE health needs analysis		
	• Glen Eira 0.8% • Frankston 0.8% • Bayside 0.8%	
	Estimated population in 2026*: • Casey 390,672 • Greater Dandenong 178,206 • Mornington Peninsula 176,369 • Kingston 167,228 • Glen Eira 152,559 • Frankston 145,269 • Cardinia 144,785 • Stonnington 122,897 • Port Phillip 120,562 • Bayside 105,140	
	High proportion of children aged 0-4 years in 2019 in: • Cardinia: 8.1% • Casey: 7.9% SEMPHN: 6.2%	PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks (accessed 29th October 2020).
	Highest proportion of children aged 5-9 years in 2019 in: • Cardinia: 7.9% • Casey: 7.9% SEMPHN: 6.3%	
	Highest proportion of children aged 10-14 years in 2019 in: • Bayside 7.3% • Cardinia 7.1% • Casey 7.0% SEMPHN: 5.9%	

Outcomes of the CORE health needs analysis		
	Highest proportion of youth aged 15-24 years in 2018 in: • Greater Dandenong 14.2% • Casey 13.9% • Stonnington 13.9% • Glen Eira 13.1%	PHIDU. LGA data - Census 2018 (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 25 October 2019).
	Highest proportion of people aged 25-64 years in 2018 in: • Port Phillip 66.8% • Stonnington 59.0%	
	High proportion of people aged 65-84 years in 2018 in: • Mornington Peninsula 21.2% • Bayside 15.5% • Kingston 14.3%	
	High proportion of people aged over 85 years in 2018 in: • Bayside 3.5% • Mornington Peninsula 3.2% • Glen Eira 2.8% • Kingston 2.7%	
	Relatively higher proportion of Aboriginal and Torres Strait Islander population in 2017 in: • Frankston 1.2%	
	High proportion of people born in predominantly non-English speaking countries in 2016 in: • Greater Dandenong: 54.2% SEMPHN: 23.8%	PHIDU. LGA data - Census 2016 (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 12 October 2017).
	Highest proportion of refugee arrivals between 2016-17 initially settled in: • Casey 50.7%	Department of Social Services (DSS). Historical Settlement Reports (online). At: https://data.gov.au/dataset/settlement-reports (accessed 27 October 2017).

Outcomes of the CORE health needs analysis		
	• Greater Dandenong 42.8%	
• Casey is the most populated LGA in the SEMPHN region, with over 360,000 residents in 2020 • Bayside, Cardinia and Casey have the highest proportion of youth aged 10-14 years • Cardinia and Casey have the largest proportion of young children aged 0-4 years in the SEMPHN region • Mornington Peninsula and Bayside have the highest proportion of people aged over 65 years in the SEMPHN region • Frankston had the highest proportion of Aboriginal and/or Torres Strait Islander people in the SEMPHN region • Cardinia and Casey are projected to have the highest annual population growth rate in the SEMPHN region over the next decade • Over half the population in Greater Dandenong were born in a predominantly non-English speaking country • Casey and Greater Dandenong receive nearly 94% of all refugee arrivals in the SEMPHN region		
Social determinants of health	High level of disadvantage (IRSD) in 2016 (based on Australian score of 1,000): • Greater Dandenong: 895 • Frankston: 1,001 • Casey: 1,004 SEMPHN: 1,024	PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks (accessed 29th October 2020).
	High rate of people who left school at year 10 or below (ASR per 100) in 2016 in: • Cardinia: (33.8) • Greater Dandenong: (32.9) • Casey: (30.7) • Frankston: (30.2) SEMPHN: 24.2 Victoria: 26.0	PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 12 October 2017).
	High proportion of unemployment, 2019 • Greater Dandenong: 7.7%	PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://phidu.torrens.edu.au/social-health-

Outcomes of the CORE health needs analysis		
	• Frankston: 5.4% • Casey: 5.4% • Cardinia: 5.0% SEMPHN: 4.6% Victoria: 4.8%	atlases/data#social-health-atlas-of-australia-primary-health-networks (accessed 29th October 2020).
	High proportion of people experiencing high/very high levels of social isolation 2014: • Greater Dandenong: 25.9% • Casey: 21.2% • Port Phillip: 20.5% • Cardinia: 20.1%	DHHS. Victorian Population Health Survey (2014). At: https://www2.health.vic.gov.au/public-health/population-health-systems/health-status-of-victorians/survey-data-and-reports/victorian-population-health-survey (accessed 31 October 2018).
	School leaver participation in higher education, 2016 • Mornington Peninsula: 27.3% • Cardinia: 28.6% • Frankston: 31.4% SEMPHN: 43.0% Victoria: 39.3%	PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 12th October 2018).
	Full time participation in secondary school education at age 16, 2016 low in: • Casey: 86.0% • Greater Dandenong: 85.3% • Mornington Peninsula: 84.4% • Frankston: 83.7% • Cardinia: 83.1% SEMPHN: 87.2 Victoria: 86.1	

Outcomes of the CORE health needs analysis		
	Low median weekly equivalised household income in 2016 in: • Greater Dandenong $659	Australian Bureau of Statistics. 1410 - Data by Region, 2011-16 (online). At http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/141020 11-16?OpenDocument (accessed 30 October 2017).
	High rate of people who had government support as their main source of income, for longer than 12 months in the last two years (2014) (ASR/100): • Greater Dandenong: 27.5 • Frankston: 20.5	PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 31 October 2018).
	High rate of homelessness within SEMPHN per 1000 people are: • Greater Dandenong 12.8 (1,942 people) • Port Phillip 11.2 (1,127 people) • Casey 4.3 (1,280 people) SEMPHN: 4.8 Victoria: 6.0	Source: Census of Population and Housing, 2016.
	High proportion of dwellings with households requiring extra bedrooms 2016: • Greater Dandenong: 10.8%	PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 31 October 2018).
	Care givers providing unpaid child**care** to own child: • Cardinia: 25.5% • Casey: 24.6% • Bayside: 22.4% SEMPHN: 20.5% Victoria: 19.8%	CIS Summary Report. Inner South Community Health Service October 2016 Public Health Information Development Unit (PHIDU, 2018). Social Health Atlas of Australia: Primary Health Networks (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (Published October 2018).

Outcomes of the CORE health needs analysis		
	Women twice as likely to be caregivers as men. Dependent children who are unsafe reported by 6% of caregivers. Discussion with key stakeholders has also reported that women who are full time carers of children find it difficult to access and comply with treatment programs that are generally only available during the day. 15% of women presenting for assessment in Bayside between January and June 2016 had dependent children.	
	High mortgage stress 2016 in: • Greater Dandenong: 18.2% • Casey: 13.5 % • Cardinia: 10.6% SEMPHN: 10.11% Victoria: 10.2%	Mortgage and rental stress is comprised of households in the bottom 40% of income distribution spending more than 30% of income on either mortgage repayments or rent. Public Health Information Development Unit (PHIDU, 2018). Social Health Atlas of Australia: Primary Health Networks (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (Published October 2018).
	High rental stress 2016 in: • Greater Dandenong (32.8%) • Mornington Peninsula (32.6%) • Frankston (31.2%) SEMPHN – 24.8% Victoria – 27.2%	PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (Published October 2018).
	High proportion of people experiencing severe gambling-related problems in 2016 in: • Greater Dandenong 5.0%	City of Greater Dandenong. Estimated prevalence of severe gambling problems (online). At: http://www.greaterdandenong.com/document/18464/statistical-data-for-victorian-communities (accessed 1 November 2017).
	High gaming machine losses per person aged 18+ 2019 in: • Greater Dandenong $898 • Kingston $656	Victorian Commission for Gambling and Liquor Regulation

Outcomes of the CORE health needs analysis		
	• Mornington Peninsula $625 • Glen Eira $609 • SEMPHN – $485	https://www.vcglr.vic.gov.au/resources/data-and-research/gambling-data/population-density-and-gaming-expenditure 2019. (accessed November 2019).
	High crime rate per 1,000 population in the year ending June 2019 in: • Port Phillip: 88.0 • Greater Dandenong: 87.0 • Frankston: 79.0	Crime Statistics Agency. Data tables - Offence Visualisation LGA Offence Rate Offence Type - year ending June 2017 (Online). At: https://www.crimestatistics.vic.gov.au/crime-statistics/latest-crime-data/download-data-4 (Accessed September 2019).

Identified Needs – Social determinants of health:

- Very high rates of homelessness in Dandenong and Port Phillip
- The area of Greater Dandenong, Mornington Peninsula and Frankston have populations impacted by high levels of life complexity and social determinants.
- Greater Dandenong is the most disadvantaged LGA in the SEMPHN region, with high rates of early school leavers, high unemployment, high rates of mortgage and rental stress, low household income, high rates of homelessness and the highest rates of gaming machine losses.
- High rates of crime in Port Phillip, Greater Dandenong and Frankston.
- Dependence on government assistance – There were 40,923 people receiving unemployment benefits across the catchment at June 2016, 66% of unemployment recipients were from the areas of Greater Dandenong, Frankston, Mornington Peninsula and Casey.
- Homelessness – There were 6,916 people classified as homeless in the SEMPHN catchment. The areas of Greater Dandenong, Port Phillip and Casey have 63% of homeless persons within SEMPHN. Homeless housing includes persons living in 'severely' crowded dwellings, supported accommodation, boarding houses and improvised dwellings.
- School retention – Participation in higher education is low in Mornington Peninsula, Cardinia, Frankston and the number of students leaving at Year 10 is high in Cardinia, Casey, Frankston and Greater Dandenong.

Evidence[1] suggests that the influence of environment including social, cultural, economic and physical environment contribute to the drug use behaviour of individuals. The areas identified above include the highest areas of disadvantage within the catchment and treatments targeting individuals may only have a partial impact if the social determinants of drug use behaviour are not addressed as part of the overall response.

[1] Spooner C (2004) Social Determinants of Drug Use

Outcomes of the CORE health needs analysis		
Injury and lower urgency care	Lower Urgency Care in the after hours, high rates of presentation per 1000 in (2018–19):* • Mornington Peninsula: 41.7 • Cardinia: 40.4 • Frankston: 40.0 • Port Phillip: 39.0 SEMPHN: 36.8	PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks (accessed 29th October 2020). Lower urgency care defined as: presentations to emergency departments that could be treated within the community. Including pain management, wound care, sprains, fractures and infections. *After hours from 6-11pm weeknights, Saturday afternoon. Weeknights from 11pm, Saturday evenings all day Sunday and Public Holiday.
	Lower Urgency Care in-hours, high rates of presentation per 1000 population in (2018-19): • Cardinia: 47.0 • Mornington Peninsula: 46.5 • Port Phillip: 43.3 • Frankston: 40.3 SEMPHN: 36.9	
Behavioural risk factors	The smoking rate (ASR per 100) in 2017-18 was high in: • Greater Dandenong: 18.9 • Frankston: 18.1 • Cardinia: 17.0 • Mornington Peninsula: 16.3 • Casey: 15.1 SEMPHN: 14.6	PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks (accessed 29th October 2020).
	Harmful use of alcohol (ASR per 100) in 2017-18 was high in: • Mornington Peninsula: 21.3 • Bayside: 19.5 • Port Phillip: 19.0 SEMPHN: 14.4	

Outcomes of the CORE health needs analysis		
	Obesity (ASR per 100) in 2017-18 was high in: • Cardinia: 36.7 • Frankston: 34.6 • Casey: 34.1 • Mornington Peninsula: 29.8 SEMPHN: 28.7	
	High rate of people who undertook no or low exercise in the previous week (ASR per 100) in 2014-15 in: • Greater Dandenong: 78.2 • Casey: 73.6 • Frankston: 68.1 • Cardinia: 67.7 SEMPHN: 64.5	
	High proportion of people with low fruit and vegetable consumption in (2014): • Greater Dandenong 55.0% • Glen Eira 54.8% • Casey 53.7%	DHHS. 2015 Local Government Area (LGA) Statistical Profiles (online). At: https://www2.health.vic.gov.au/about/reporting-planning-data/gis-and-planning-products/geographical-profiles (accessed 12 October 2017).
	High proportion of people who consumed sugar-sweetened soft drinks daily in (2014): • Casey 15.9% • Frankston 15.4% • Cardinia 14.7%	
	Low proportion of people who saw a GP in the previous 12 months in 2013-14 in: • Port Phillip 81.2% • Stonnington 81.3%	

Outcomes of the CORE health needs analysis		
Identified needs – Health behaviours • Lower urgency presentations for treatment within emergency departments were highest in Mornington Peninsula, Cardinia, Frankston and Port Phillip. • Greater Dandenong has the highest rate of current smokers in the SEMPHN region as well as the highest rate of people with low fruit and vegetable consumption, as well as the lowest rate of exercise in the SEMPHN region. • Frankston has one of the highest rates of current smokers, rates of obesity and people who report drinking a sugar sweetened beverage every day. • Smoking is a major factor that influences health outcomes. High smoking rates are seen across much of the SEMPHN region. • Mornington Peninsula, Bayside and Port Phillip have high rates of people who consume alcohol at risky levels. • Cardinia has the highest rate of obesity in the SEMPHN region, as well as high rates of smoking and consumption of sugar sweetened soft drinks		
Health status and outcomes	High rate of fair or poor self-assessed health (ASR per 100) in 2017-18 in: • Greater Dandenong: 15.9 SEMPHN: 12.7	PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks (accessed 29th October 2020).
	High rate of high psychological distress (ASR per 100) in 2014-15 in: • Greater Dandenong: 17.5 • Casey: 13.8 • Cardinia: 13.7 • Frankston: 13.2 SEMPHN: 12.7	
	High proportion of people with a profound or severe disability in 2016 in: • Greater Dandenong 6.6% • Mornington Peninsula 5.8% • Frankston 5.8%	
	High rate of avoidable mortality (ASR per 100,000) between 2013-17 in:	

Outcomes of the CORE health needs analysis		
	• Frankston: 128.2 • Greater Dandenong: 117.1 • Port Phillip: 107.9 SEMPHN: 92.4	
	High rate of youth (15-24 years) mortality (ASR per 100,000) between 2013-17 in: • Frankston: 45.4 • Mornington Peninsula: 35.7 • Cardinia: 35.6 SEMPHN: 27.7	
	Leading underlying causes of death, number and age-standardised death rates (deaths per 100,000 population) (2018): • Coronary heart disease • Dementia including Alzheimer disease • Cerebrovascular disease • Lung cancer • Chronic obstructive pulmonary disease • Colorectal cancer • Diabetes • Prostate cancer • Heart failure and complications and ill-defined heart disease • Influenza and pneumonia	PHIDU. Deaths in Australia (online). At: https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia/data (accessed 27 October 2020).
	Key areas of need identified by stakeholders: 1. General, oral and physical health (AOD, homeless, MH) 2. Intravenous use among AOD users	SEMPHN stakeholder engagement, 2017

Outcomes of the CORE health needs analysis		
	3. Support for clients between initial contact and actual treatment (e.g. counselling, non-residential withdrawal for AOD use) 4. Provision of crisis housing 5. Pharmaceutical misuse and elder abuse among seniors 6. Family violence 7. Community safety, for example, school programs to targeted males at a developmental age and promote positive behaviour towards women 8. Sexually Transmitted Infections among especially young men, sex workers and prisoners 9. Managing social isolation through infrastructure (e.g. social support drop-in centres)	
Identified needs – Health status and outcomes • Frankston, Mornington Peninsula and Cardinia have high rates of youth mortality. • Greater Dandenong and Frankston had high proportions of people with poor health and health outcomes across most metrics. • Greater Dandenong has relatively high rates of psychological distress. • Mornington Peninsula had a high proportion of people with a profound or severe disability.		
Chronic disease prevalence and avoidable mortality	Prevalence of chronic disease and comorbidity was higher among: • People aged over 65 years • Women • People living in socioeconomically disadvantaged areas • People living in regional and remote areas Most common chronic conditions in 2014-15: • Cardiovascular disease	AIHW. (2016). Australia's health 2016. Australia's health series no. 15. Cat. No. AUS 199. Canberra: AIHW.

Outcomes of the CORE health needs analysis		
	• Mental health conditions • Back pain and problems • Arthritis • Asthma	
	High prevalence of diabetes mellitus (ASR per 100) in 2017-18 in: • Greater Dandenong: 7.6 • Casey: 6.1 SEMPHN: 4.7	PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks (accessed 29th October 2020).
	High prevalence of high blood cholesterol (ASR per 100) in 2011-12 in: • Mornington Peninsula: 35.7	
	High prevalence of circulatory system diseases (ASR per 100) in 2014-15 in: • Greater Dandenong: 20.5 • Casey: 20.2 • Cardinia: 19.9 • Frankston: 19.1 • Kingston: 18.5 • Mornington Peninsula: 18.4	
	High prevalence of respiratory system diseases (ASR per 100) in 2014-15 in: • Greater Dandenong: 33.9 • Casey: 33.5 • Cardinia: 32.6 • Frankston 32	
	High prevalence of asthma (ASR per 100) in 2017-18 in: • Cardinia: 14.1	

	• Frankston: 14.0 • Mornington Peninsula: 12.9 • Casey: 11.4 SEMPHN: 10.6	
	High rate of avoidable mortality from diabetes (ASR per 100,000) between 2013-17 in: • Greater Dandenong: 7.8 • Glen Eira: 5.6 • Port Phillip: 5.6 • Frankston: 5.0 SEMPHN: 4.7	
	High rate of avoidable mortality from circulatory system diseases (ASR per 100,000) between 2013-17 in: • Greater Dandenong: 43.3 • Frankston: 35.3 SEMPHN: 29.4	
	High rate of avoidable mortality from chronic obstructive pulmonary diseases (ASR per 100,000) between 2013-17 in: • Frankston: 13.0 • Cardinia: 9.8 • Port Phillip: 9.7 SEMPHN: 7.3	
	High rate of avoidable mortality from respiratory system diseases (ASR per 100,000) between 2013-17 in: • Frankston: 13.4 • Cardinia: 10.2 • Port Phillip: 9.8	

Outcomes of the CORE health needs analysis		
	SEMPHN: 7.8	
Identified needs – Chronic disease • Greater Dandenong had very high rates of prevalence and avoidable mortality from diabetes and had the highest rates of prevalence and avoidable mortality from circulatory and respiratory system diseases. • Frankston had high rates of avoidable mortality from diabetes, circulatory and respiratory system diseases, but relatively low rates of prevalence of diabetes mellitus. • Casey had high rates of prevalence of respiratory system diseases. • Cardinia had high rates of prevalence of circulatory system diseases and the highest rates of asthma.		
Cancer screening, incidence and mortality	Under screened groups: [1, 2] • Aboriginal and Torres Strait Islanders • Culturally and linguistically diverse communities • Socioeconomically disadvantaged groups • Males	[1] Oliver, I., Marine, F., & Grogan, P. (2011). Disparities in cancer care in Australia and the Pacific. The oncologist, 16(7), 930-934. [2] Javanparast, S., Ward, P. R., Carter, S. M., & Wilson, C. J. (2012). Barriers to and facilitators of colorectal cancer screening in different population subgroups in Adelaide, South Australia. The Medical Journal of Australia, 196(8), 521-523.
	Lowest participation in the National Bowel Screening Program among people aged 50-74 years in 2016-17 in: • Casey – South 36.2% • Stonnington – West 38.0% • Dandenong 38.6% SEMPHN: 40.7%	AIHW. National cancer screening programs participation data. https://www.aihw.gov.au/reports/cancer-screening/national-cancer-screening-programs-participation/contents/national-bowel-cancer-screening-program (Accessed October 2019).
	Low participation in the Breastscreen Australia program among women aged 50-74 years in 2016-17 in: • Stonnington – West: 44.8% • Port Phillip: 46.6%	AIHW. Cancer screening in Australia by small geographic areas 2015/16 (online). At: https://www.myhealthycommunities.gov.au/primary-health-network/phn203#_ (accessed October 2018).

Outcomes of the CORE health needs analysis		
	• Casey – South: 47.2% • Frankston: 47.4% SEMPHN: 51.9% Relatively low participation in the National Bowel Cancer Screening Program among people aged 50-74 years in the SEMPHN region (51.3%) and across Australia (55.1%) in 2015-16.	
	Low participation rates in the Cervical Screening Program among women aged 20-69 years in 2015-16 in: • Casey – South: 50.8% • Dandenong: – 51.1% Relatively high participation rates in the National Cervical Cancer Screening Program among people aged 20-69 years in the SEMPHN region (57.7%) and Victoria (56.6%) in 2015-16Frankston 52.9%.	
	High rate of avoidable mortality from colorectal cancer (ASR per 100,000) between 2013-17 in: • Frankston: 11.8 • Port Phillip: 10.2 • Glen Eira: 10.0 SEMPHN: 9.3	PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks (accessed 29th October 2020).
	High rate of avoidable mortality from breast cancer (ASR per 100,000) among females between 2013-17 in: • Cardinia: 20.5 • Glen Eira: 19.9	

Outcomes of the CORE health needs analysis		
	• Frankston: 19.0 • Casey: 18.9 SEMPHN: 16.7	
Identified needs – Cancer screening, incidence and mortality • High rates of avoidable deaths from colorectal cancer in Frankston, Port Phillip and Glen Eira. • High rates of avoidable deaths from breast cancer in Kingston, Cardinia, Glen Eira, Frankston and Casey. • Low rates of participation in screening for bowel cancer in Casey South, Stonnington West and Dandenong. • Low rates of participation in screening for breast cancer in Stonnington – West, Port Phillip, Casey – South and Frankston. • Low rates of participation in the cervical screening program in Casey- South, Dandenong and Frankston.		
Immunisation	Under-immunised groups[1, 2]: • Aboriginal and Torres Strait Islanders • Migrants and refugees • High and low socioeconomic status groups	[1] Hull, B. P., McIntyre, P. B., & Sayer, G. P. (2001). Factors associated with low uptake of measles and pertussis vaccines—an ecologic study based on the Australian Childhood Immunisation Register. Australian and New Zealand journal of public health, 25(5), 405-410. [2] Haynes, K., & Stone, C. (2004). Predictors of incomplete immunisation in Victorian children. Australian and New Zealand journal of public health, 28(1), 72-79.
	Immunisation coverage at 12-15 month at June 2020 lowest coverage in: • Casey North 93.5% • Stonnington - West: 93.5% • Mornington Peninsula 93.9% SEMPHN:95.4%	Australian Immunisation Register - Coverage Report (Annualised 1 July 2019 – June 2020).
	Immunisation coverage at 24-27 month at June 2020 lowest coverage in: • Stonnington West 87.3%	

Outcomes of the CORE health needs analysis		
	• Port Phillip 89.5% • Bayside 90.4 SEMPHN: 93.9%	
	Immunisation coverage at 60-63 month at June 2020 lowest coverage in: • Stonnington West 88.4% • Bayside 93.4% • Port Phillip 91.2% SEMPHN: 95.5%	
	40 immunisation providers have been identified across the SEMPHN region with high numbers of children who are not fully immunised, through an analysis of AIR data. Targeting these providers could bring immunisation rates across SEMPHN above national targets.	Australian Immunisation Register - Coverage Report (30/12/2016).
	Immunisation coverage for Aboriginal and Torres Strait Islander children: • 12-15 months 92.82% • 24-27 months 88.37% 60-63 months 97.87%	Australian Immunisation Register - Coverage Report (Annualised 1 July 2018 – June 2019).
	Relatively high rates of HPV vaccine coverage among boys (72.7%) and girls (77.8%) aged 15 years in the SEMPHN region in 2015-16.	Australian Immunisation Register - Coverage Report (Annualised 1 July 2018 – June 2018).

Identified needs – Immunisation

- The local government areas of Stonnington are below the catchment average across all age groups.
- Lower rates of immunisation coverage among Aboriginal and non-Aboriginal children aged 24-27-month-old in the SEMPHN region compared to other age groups.

Outcomes of the CORE health needs analysis		
Infectious diseases	Higher prevalence of infectious disease among: • International travellers • Migrants and refugees • Aboriginal and Torres Strait Islanders • LGBTI community • Injecting drug users • People experiencing homelessness People at risk of serious complications from influenza: • People aged over 65 years • Aboriginal and Torres Strait Islanders • Pregnant women People with: • Heart disease • Chronic lung disease • Chronic neurological conditions • Impaired immunity • Haemoglobinopathies • Diabetes • Kidney disease	[1] O'Brien, D. P., Leder, K., Matchett, E., Brown, G. V., & Torresi, J. (2006). Illness in returned travellers and immigrants/refugees: the 6-year experience of two Australian infectious diseases units. Journal of travel medicine, 13(3), 145-152. [2] Heywood A, Zwar N, Forssman B, et al. The contribution of travellers visiting friends and relatives to notified infectious diseases in Australia: state-based enhanced surveillance. Epidemiology and Infection. 2016;144(16):3554-3563. doi:10.1017/S0950268816001734. [3] Naidu, L., Chiu, C., Habig, A., Lowbridge, C., Jayasinghe, S., Wang, H., ... & Menzies, R. (2013). Vaccine preventable diseases and vaccination coverage in Aboriginal and Torres Strait Islander people, Australia 2006-2010. Communicable diseases intelligence quarterly report, 37, S1-95. [4] Grulich, A. E., Visser, R. O., Smith, A., Risse, C. E., & Richters, J. (2003). Sex in Australia: Sexually transmissible infection and blood-borne virus history in a representative sample of adults. Australian and New Zealand journal of public health, 27(2), 234-241. [5] Kermode, M., Crofts, N., Miller, P., Speed, B., & Streeton, J. (1998). Health indicators and risks among people experiencing homelessness in Melbourne, 1995–1996. Australian and New Zealand Journal of Public Health, 22(4), 464-470. [6] Better Health Channel. Flu (influenza) – immunisation (online). At: https://www.betterhealth.vic.gov.au/health/healthyliving/flu-influenza-immunisation (accessed 15 November 2017).
	High rates of blood borne viruses per 100,000 in 2018 in: • Greater Dandenong: 124.3	DHHS. Infectious diseases surveillance – daily summaries (online). At: https://www2.health.vic.gov.au/public-health/infectious-

Outcomes of the CORE health needs analysis		
	• Port Phillip: 64.5 SEMPHN: 50.3	diseases/infectious-diseases-surveillance/infectious-diseases-surveillance-daily-summaries (accessed October 2020).
	High rates of hepatitis B per 100,000 in 2019 in: • Greater Dandenong: 68.3 SEMPHN: 22.7	
	High rates of hepatitis C per 100,000 in 2019 in: • Greater Dandenong: 392.5 • Port Phillip: 33.2 SEMPHN: 18.4	
	High rates of gonococcal infections per 100,000 in 2019 in: • Stonnington: 288.5 • Port Phillip: 292.9 SEMPHN: 105.2	
	High rates of chlamydia infections per 100,000 in 2018 in: • Port Phillip: 1025.3 • Stonnington: 996.4 SEMPHN: 428.2	
	Very high rates of Syphilis infections per 100,000 in 2018 in: • Port Phillip: 105.9 • Stonnington: 93.2 SEMPHN: 24.6	
	Low rates of influenza per 100,000 in 2020(YTD) in: • Cardinia: 97.5 • Casey: 83.6 SEMPHN: 88.7	
	High rates of tuberculosis per 100,000 in 2018 in: • Greater Dandenong: 18 SEMPHN: 8.3	

Outcomes of the CORE health needs analysis		
Identified needs – Infectious diseases • Influenza rates 1334 cases to date in 2020 compared to 18,259 confirmed cases 2019. Cardinia and Casey reported the highest rates. • Blood borne disease rates in Greater Dandenong are twice the SEMPHN average. • Hepatitis B rates in Greater Dandenong are three times higher than the SEMPHN average. • Very High rates Hep C in Stonnington, Port Phillip and Glen Eira. • Sexually transmissible infection rates very high in Stonnington and Port Phillip. • The rate of Tuberculosis is high in Greater Dandenong.		
Priority Populations	Priority groups identified by stakeholders: • People aged over 65 years • Culturally and linguistically diverse communities (CALD) (particularly those of a low socio-economic status) • People experiencing homelessness • People identifying as LGBTI • People experiencing end of life care • Clients with a dual diagnosis of MH and AOD • People at risk of or bereaved due to suicide • Parents of very young children (particularly early parenting support) • Sex workers	SEMPHN stakeholder consultations, 2017.
Priority populations - Children and Youth	Women who smoke during pregnancy 2014-16: • Frankston 19.6% • Cardinia 18.7% • Mornington Peninsula 16.0%	AIHW. My Healthy Community (online). At: https://www.myhealthycommunities.gov.au/primary-health-network/phn203# (accessed 12 October 2018).
	High incidence of low birth weight babies between 2014-16 in: • Greater Dandenong 6.5%	PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://phidu.torrens.edu.au/social-health-

Outcomes of the CORE health needs analysis		
	High proportion of children who are developmentally vulnerable on one or more domains in 2018 in: • Greater Dandenong: 27.7% • Casey: 20.4% SEMPHN: 18.5%	atlases/data#social-health-atlas-of-australia-primary-health-networks (accessed 29th October 2020).
	Low rate of children who consumed the recommended amount of fruits (ASR per 100) in 2014-15 in: • Greater Dandenong: 61.1	
	High rate of childhood obesity among 2-17-year old (ASR per 100) in 2017-18 in: • Cardinia: 9.0 • Greater Dandenong: 8.6 • Frankston: 8.6 • Casey: 8.5 SEMPHN: 7.3	
	High rate of child protection substantiations per 1,000 population in 2014-15 in: • Frankston: 23.6 • Greater Dandenong: 20.3	
	High rate of youth (15-24 years) mortality (ASR per 100,000) between 2013-17 in: • Frankston: 45.4 • Mornington Peninsula: 35.7 • Cardinia: 35.6 SEMPHN: 27.7	
Identified needs – Children and youth • Greater Dandenong has a large proportion of children and youth who are developmentally vulnerable on one or more domains.		

Outcomes of the CORE health needs analysis		
• Frankston had very high rates of youth mortality. • Frankston had high rates of child protection substantiations, as well as a high rate of youth mortality. • Cardinia, Casey, Frankston and Mornington Peninsula had a large proportion of mothers who reported smoking during pregnancy.		
Priority populations – Older people	Top five diseases causing burden in people aged 65 years and over: • Coronary heart disease • Dementia • Chronic Obstructive Pulmonary Disease (COPD) • Stroke • Lung cancer	AIHW. Older Australia at a glance (online). At: https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/health-and-functioning/burden-of-disease (accessed 15 November 2017).
	Top five leading causes of premature death among people aged 65-74 years in 2016-18: • Lung cancer • Coronary heart disease • COPD • Cerebrovascular disease • Colorectal cancer	AIHW. (2016). Deaths (online). At: https://www.aihw.gov.au/reports/life-expectancy-death/deaths/data (accessed October 2020).
	Type of care received in hospital for people aged over 65 years in 2013-14: • Acute medical 57% • Acute surgical 22% • Acute (other) 12% • Rehabilitation 6% • Palliative care 1%	AIHW. (2016). Australia's health 2016. Australia's health series no. 15. Cat. No. AUS 199. Canberra: AIHW.

Outcomes of the CORE health needs analysis		
	High proportion of people aged over 65 years with a profound or severe disability in 2016 in: • Greater Dandenong 20.4%	PHIDU. LGA data - Census 2016 (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 12 October 2018).
	High proportion of people over 75 years who live alone in 2011 in: • Port Phillip 45.7%	DHHS. 2015 Local Government Area (LGA) Statistical Profiles (online). At: https://www2.health.vic.gov.au/about/reporting-planning-data/gis-and-planning-products/geographical-profiles (accessed 12 October 2017).
	Low rate of residential aged care places per 1,000 population aged over 70 years in 2016 in: • Stonnington: 67.4	PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 12 October 2017).
	Number of people on Home Care Packages as at 20 March 2019 in Southern Metro Victoria: • Level 1 Basic care needs: 248 • Level 2 Low level care needs: 3,113 • Intermediate care needs: 758 • High level care needs: 1,229 SEMPHN: 5,348	My Aged Care. At: https://www.myagedcare.gov.au/ (accessed 8th November 2019) Home care packages provide a program that supports older Australians with complex needs to remain living at home through a coordinated package of care and services to meet the individual needs of people.
	Number of residential aged care services (as at 30 June 2018): • 158 Number of home care services (as at 30 June 2018): • 133	AIHW. GEN Aged Care Data (online). At: https://www.gen-agedcaredata.gov.au/My-aged-care-region (Accessed 28th October 2020).
	High rate of dementia per 1,000 population in 2017 in: • Mornington Peninsula: 24.3 • Bayside: 22.8	Dementia statistics for Victoria 2017. At: https://www.dementia.org.au/statistics/vic (accessed 8th November 2019).

Outcomes of the CORE health needs analysis		
	Dementia is the single greatest cause of disability in older Australians (aged 65 years or older) and the third leading cause of disability burden overall. People with dementia account for 52% of all residents in residential aged care facilities.	Dementia Statistics. Key facts and statistics (online). At: https://www.dementia.org.au/statistics (accessed 28th October 2020).
	High rate of overnight hospitalisations for dementia (ASR per 100,000) in 2014-15 in: • Frankston: 71	PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 12 October 2017).
Identified needs – Older people • Within the SEMPHN catchment there are high rates of disability, sole living and rising rates of dementia which impacts individuals' ability to self-manage their activities of daily living and access to appropriate health care • Greater Dandenong had a high proportion of older people with a severe disability • Port Phillip had a high proportion of people who live alone • Mornington Peninsula and Bayside had high rates of dementia		
Priority populations - Aboriginal and Torres Strait Islander people	Key health issues: [1, 2] • Cardiovascular disease • Cancer – particularly lung and cervical • Type 2 diabetes • Mental illness and suicide • Renal disease • Respiratory system diseases • Infectious diseases • Eye health • Ear disease and hearing loss • Dental caries and periodontal diseases	[1] Thomson, N., MacRae, A., Burns, J., Catto, M., Debuyst, O., Krom, I., ... & Urquhart, B. (2010). Overview of Australian Indigenous health status April 2010. Perth, WA: Australian Indigenous HealthInfoNet. [2] Vos, T., Barker, B., Begg, S., Stanley, L., & Lopez, A. D. (2009). Burden of disease and injury in Aboriginal and Torres Strait Islander Peoples: the Indigenous health gap. international Journal of Epidemiology, 38(2), 470-477. [3] Davy, C., Harfield, S., McArthur, A., Munn, Z., & Brown, A. (2016). Access to primary health care services for Indigenous

Outcomes of the CORE health needs analysis		
	• Disability Health risk factors: [1, 2] • High rates of smoking • High rates of alcohol and drug related harm • Poor nutrition • Low physical activity • High rates of obesity • Lower immunisation rates Barriers to accessing services: [3, 4] • Poor health literacy • Different attitudes towards health and wellbeing • Financial barriers • Lack of culturally appropriate services and information • Transport barriers • Lack of trust • Familial relationships between Aboriginal clinic staff and clients	peoples: A framework synthesis. International journal for equity in health, 15(1), 163. [4] Isaacs, A. N., Pyett, P., Oakley-Browne, M. A., Gruis, H., & Waples-Crowe, P. (2010). Barriers and facilitators to the utilization of adult mental health services by Australia's Indigenous people: seeking a way forward. International journal of mental health nursing, 19(2), 75-82.
	High proportion of Aboriginal mothers who reported smoking during pregnancy between 2012-14 in: • Mornington Peninsula (50.8%) High unemployment rate among Aboriginal people in 2016 in: • Greater Dandenong (IARE): 21.2% • Cranbourne – Narre Warren (IARE): 13.2% SEMPHN: 11.6%	PHIDU. Aboriginal & Torres Strait Islander Social Health Atlas of Australia (online). At: http://phidu.torrens.edu.au/social-health-atlases/data#aboriginal-torres-strait-islander-social-health-atlas-of-australia (accessed 28th October 2020). IARE – are based on Aboriginal & Torres Strait Islander areas set by ABS.

Outcomes of the CORE health needs analysis		
	High proportion of Aboriginal people with a profound or severe disability in 2011 in: • Mornington Peninsula (IARE) 8.1% • Greater Dandenong (IARE) 7.4% • Frankston (IARE) 6.8%	
	High rate of hospital admissions of Aboriginal people (ASR per 100,000) in 2012-13 in: • Greater Dandenong (IARE): 46,450 • Cranbourne – Narre Warren (IARE): 28,091 • Melbourne – Port Phillip (IARE): 27,393 SEMPHN: 23,939	
	High rate of ambulatory case sensitive hospitalisations of Aboriginal people (ASR per 100,000) in 2012-13 in: • Greater Dandenong (IARE): 4,225	
Identified needs – Aboriginal and Torres Strait Islander people • Greater Dandenong (IARE) had a large proportion of Aboriginal residents with high needs including high rates of unemployment, high proportion of people with disability high rates of hospital admissions.		
Priority Populations Refugees and people from culturally and linguistically diverse communities	Top 10 ethnic groups among refugees who arrived in the SEMPHN region between 2007-2016: • Hazara • Karen • Tamil • Pashtun • Tajik • Iraqi • Burmese	Department of Social Services (DSS). Historical Settlement Reports (online). At: https://data.gov.au/dataset/settlement-reports (accessed 27 October 2017).

	• African (NFD) • Afghan • Oromo	
	Overall, first generation migrants to Australia generally experience better health status and outcomes than the Australian born population (with the exception of type 2 diabetes). [1, 2] This is referred to as the 'healthy migrant effect', whereby people in good health are more likely to meet Australia's health requirements and are also more willing to migrate. [3] Key health issues for refugees: [4, 5, 6] • Mental health issues • Nutritional deficiencies • Infectious diseases • Under-immunisation • Poor dental and optical health • Poorly managed chronic diseases • Delayed growth and development in children • Physical consequences of torture Barriers to accessing services: [7, 8, 9] • Financial barriers – low income and unemployment • Cultural barriers – different beliefs and attitudes towards health • Language difficulties • Under-trained workforce – lack of awareness of needs specific to refugee health	[1] Anikeeva, O., Bi, P., Hiller, J. E., Ryan, P., Roder, D., & Han, G. S. (2010). The health status of migrants in Australia: a review. Asia Pacific Journal of Public Health, 22(2), 159-193. [2] Abouzeid, M., Philpot, B., Janus, E. D., Coates, M. J., & Dunbar, J. A. (2013). Type 2 diabetes prevalence varies by socio-economic status within and between migrant groups: analysis and implications for Australia. BMC Public Health, 13(1), 252. [3] Strong, K., Trickett, P., & Bhatia, K. (1998). The health of overseas-born Australians, 1994-1996. Australian Health Review, 21(2), 124-133. [4] Milosevic, D., Cheng, I. H., & Smith, M. M. (2012). The NSW Refugee Health Service: Improving refugee access to primary care. Australian family physician, 41(3), 147 [5] Davidson, N., Skull, S., Chaney, G., Frydenberg, A., Isaacs, D., Kelly, P., ... & Smith, M. (2004). Comprehensive health assessment for newly arrived refugee children in Australia. Journal of paediatrics and child health, 40(9-10), 562-568. [6] Johnston, V., Smith, L., & Roydhouse, H. (2012). The health of newly arrived refugees to the Top End of Australia: results of a clinical audit at the Darwin Refugee Health Service. Australian Journal of Primary Health, 18(3), 242-247. [7] Murray, S. B., & Skull, S. A. (2005). Hurdles to health: immigrant and refugee health care in Australia. Australian Health Review, 29(1), 25-29.

Outcomes of the CORE health needs analysis		
	• Legal barriers • Distrust of government services	[8] Davidson, N., Skull, S., Burgner, D., Kelly, P., Raman, S., Silove, D., ... & Smith, M. (2004). An issue of access: delivering equitable health care for newly arrived refugee children in Australia. Journal of paediatrics and child health, 40(9-10), 569-575. [9] Lamb, C. F., & Smith, M. (2002). Problems refugees face when accessing health services. New South Wales public health bulletin, 13(7), 161-163.
Priority populations – people experiencing homelessness	Sub-groups [1] • Males experienced higher rates of homelessness • Aboriginal and Torres Strait Islander people experienced higher rates of homelessness • Children: almost one in six Victorians who were counted as homeless on census night in 2011 was a child aged under 12 years (3,638 children) • Youth: about 6,130 Victorians aged 12–25 years had nowhere to call home on census night in 2011, comprising about one-quarter of all homeless Victorians Key health issues [2, 3] • Mental health issues[1] • Alcohol and drug dependence[1] • Infectious diseases[2] Barriers to accessing services [4, 5] • Financial hardship • Lack of transportation to medical facilities • Lack of identification or Medicare card • Difficulty maintaining appointments or treatment regimes	[1] ABS. 2049.0 - Census of Population and Housing: Estimating homelessness, 2011 (online). At: http://www.abs.gov.au/ausstats/abs@.nsf/mf/2049.0 (accessed 10 November 2017).Fazel, S., Khosla, V., Doll, H., & Geddes, J. (2008). [2] The prevalence of mental disorders among the homeless in western countries: systematic review and meta-regression analysis. PLoS medicine, 5(12), e225. [3] Raoult, D., Foucault, C., & Brouqui, P. (2001). Infections in the homeless. The Lancet infectious diseases, 1(2), 77-84. [4] Australian Human Rights Commission. Homelessness is a Human Rights Issue (online). At: https://www.humanrights.gov.au/publications/homelessness-human-rights-issue (accessed 14 November 2017). [5] North and West Metropolitan Local Area Service Network. North and West Metropolitan Region LASN Client Focus Group 3 Report (online). At: http://www.nwhn.net.au/Resources.aspx (accessed 10 November 2017).

Outcomes of the CORE health needs analysis		
	• Lack of awareness of support services • Assessment process is repetitive and lacks sensitivity to client circumstances	
Priority populations - LGBTQI Community	Key health issues • Stigma and discrimination is a major factor that impacts on the health and wellbeing of LGBTI communities and individuals[1] • Poor mental health: higher rates of mental health disorders, including depression, anxiety disorders, and suicidal thoughts, plans and attempts, compared to the general population[2] • Illicit drug use: higher rates of smoking and illicit drug use, than the general population[3] • Sexual health: higher rates of STIs, particularly HIV among gay men[4] • Homelessness: particularly among transgender people[5] Barriers to accessing services [6] • Majority of LGBTI people reported experiencing homophobia from health professionals • Difficulties communicating with medical professionals because of the fear that they may need to 'come out' during the consultation and risk receiving less favourable treatment as a result • Reluctant to have their sexuality recorded in their histories due to the fear that others may gain access to their records	[1] Rosenstreich, G., Comfort, J., & Martin, P. (2011). Primary health care and equity: the case of lesbian, gay, bisexual, trans and intersex Australians. Australian Journal of Primary Health, 17(4), 302-308. [2] Lea, T., de Wit, J., & Reynolds, R. (2014). Minority stress in lesbian, gay, and bisexual young adults in Australia: Associations with psychological distress, suicidality, and substance use. Archives of sexual behaviour, 43(8), 1571-1578. [3] Roxburgh, A., Lea, T., de Wit, J., & Degenhardt, L. (2016). Sexual identity and prevalence of alcohol and other drug use among Australians in the general population. International Journal of Drug Policy, 28, 76-82. [4] Stenger, R., Baral, S., Stahlman, S., Wohlfeiler, D., Barton, E., & Peterman, T. (2016). As through a glass, darkly: the future of sexually transmissible infections among gay, bisexual and other men who have sex with men. Sexual health, 14(1), 18-27. [5] McNair, R., Andrews, C., Parkinson, S., & Dempsey, D. (2017). Stage 1 Report LGBTI Homelessness: Preliminary findings on risks, service needs and use. At: http://www.lgbtihomeless.com/wp-content/uploads/2017/01/LGBTI-Homelessness-Stage-1-Report-Preliminary-findings-on-risks-service-needs-and-use.pdf (accessed 14 November 2017). [6] Better Health. Gay and lesbian discrimination (online). At: https://www.betterhealth.vic.gov.au/health/healthyliving/gay-and-lesbian-discrimination (accessed 14 November 2017).

Section 3 – Outcomes of the service needs analysis

This section summarises the findings of the service needs analysis in the table below. For more information refer to Table 2 in '5. Summarising the Findings' in the Needs Assessment Guide on www.health.gov.au/PHN.

Additional rows may be added as required.

Outcomes of the CORE service needs analysis		
Priority Area	**Key Issue**	**Description of Evidence**
Access to services	High rate of people who reported experiencing a financial barrier to accessing healthcare when they needed it in the previous 12 months (ASR per 100) in 2014 in: • Greater Dandenong: 2.5	PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 12 October 2017).
	High rate of people who often have difficulty or cannot get to places with transport (ASR per 100) in 2014 in: • Greater Dandenong: 5.6	
	Low proportion of population who reside near public transport in 2015 in: • Cardinia: 43.3% • Mornington Peninsula: 46.1% • Casey: 62.4%	DHHS. 2015 Local Government Area (LGA) Statistical Profiles (online). At: https://www2.health.vic.gov.au/about/reporting-planning-data/gis-and-planning-products/geographical-profiles (accessed 12 October 2017).
	Main barriers to access: • Lack of affordable medical services: 69% • Lack of awareness of existing services 61% • Lack of affordable transport 59% • Shortage of allied health services 52%	PHN Stakeholder engagement survey November 2016 Pricewaterhouse Coopers 2018: Chronic Disease Service Mapping Project for SEMPHN.

Outcomes of the CORE service needs analysis		
	• Gaps in health literacy 50% • Distance to health care services 42% • Lack of available after-hours appointments 35% • Poor past experiences 35% • Lack of available appointments 30% • Shortage of culturally appropriate services 21% • Shortage of GPs 19% • Concerns related to privacy 19% • Shortage of Aboriginal health workers 14% • Lack of accommodation during treatment 14% • Communication difficulties (e.g. experiences of people with hearing difficulties or intellectual disabilities) 11% • Barriers to accessing allied health • Gaps in general practice after hours services including catchment wide gaps particularly on Sundays	
Identified needs – Access to health services • Greater Dandenong has a high proportion of people who experience financial barriers to accessing health services as well as transport barriers • Less than half the population in Cardinia and Mornington Peninsula reside near public transport.		
Core	Low rate of general practices per 1,000 population in 2015 in: • Cardinia: 0.2 • Casey: 0.2 • Kingston: 0.2	DHHS. 2015 Local Government Area (LGA) Statistical Profiles (online). At: https://www2.health.vic.gov.au/about/reporting-planning-data/gis-and-planning-products/geographical-profiles (accessed October 2017).

Outcomes of the CORE service needs analysis		
	Low rate of general practitioners per 1,000 population in 2017 in: • Cardinia: 7.2 • Casey: 10.6 • Port Phillip: 11.5 • Kingston: 14.8 • Mornington Peninsula: 16.9	DOH Health Workforce Data https://hwd.health.gov.au/datatool.html (accessed October 2019).
	Low rate of pharmacies per 1,000 population in 2015 in: • Kingston: 0.1	DHHS. 2015 Local Government Area (LGA) Statistical Profiles (online). At: https://www2.health.vic.gov.au/about/reporting-planning-data/gis-and-planning-products/geographical-profiles (accessed October 2017).
	Low rate of allied health service sites per 1,000 population in 2015 in: • Casey: 0.4 • Cardinia: 0.5 • Kingston: 0.5	

Identified needs – Availability of primary health care services

- There is relatively less access to General Practitioners in Mornington Peninsula, Cardinia, Casey and Kingston in comparison to other parts of the SEMPHN catchment. Areas of good access are situated closer to the inner suburbs and CBD areas (and in higher socioeconomic regions) and in commercial centres of LGAs (for example Frankston central).
- Cardinia, Casey and Kingston had a low rate of availability of primary health care services.
- Cardinia, Casey and Kingston had a low rate of availability of allied health care services.
- There is relatively less access to bulk billing services for those who require it (e.g. Healthcare or Pension card holders) in Mornington Peninsula, the northern areas of Cardinia, Casey and some areas of Frankston and Kingston.
- Many people who do not speak English can access general practice consultations in their own language, however, they are likely to travel beyond their LGA boundaries for this. There are notable gaps in LOTE general practice services for specific population groups in each LGA[2].

[2] PwC SEMPHN Service Mapping Project

Outcomes of the CORE service needs analysis		
Health service utilisation	Frequent GP attenders were more likely to: • Be older • Live in the socioeconomically disadvantaged areas • Have one or more long-term health conditions • Have arthritis or osteoporosis • Rate their health as fair or poor	AIHW. Healthy Communities: Frequent GP attenders and their use of health services in 2012–13 (online). At: https://www.myhealthycommunities.gov.au/our-reports/frequent-gp-attenders-use-health-services/march-2015 (accessed 15 November 2017).
	High rate of GP attendances per person (age-standardised) in 2016-17 in: • Casey – South: 7.4 • Cardinia: 7.0 • Frankston: 7.0	AIHW. Web update: Medicare Benefits Schedule GP and specialist attendances and expenditure in 2016–17 (online). At: https://www.myhealthycommunities.gov.au/our-reports/gp-and-specialists-attendances-and-expenditure/august-2017/explore-the-data (accessed 30 October 2018).
	High rates of specialist attendances per person (age-standardised) in 2016-17 in: • Stonnington – East: 1.3 • Stonnington – West: 1.3	
	GP attendances in residential aged-care facilities South Eastern Melbourne 2017-18: • Attendances: 306,675 • Residential aged care places: 16,608 • GP attendances per aged-care patient: 18.5	Residential aged-care patients refers to the number of patients who received at least one Medicare-subsidised GP attendance in a residential aged care facility, not the number of people who live in residential aged care facilities. ABS (Australian Bureau of Statistics) 2016. Australian Statistical Geography Standard (ASGS): Volume 1—Main structure and greater capital city statistical areas, July 2016, ABS cat. no. 1270.0.55.001. Canberra: ABS. Viewed 21 November 2019, <http://www.abs.gov.au/ausstats/abs@.nsf/mf/1270.0.55.001>.

Outcomes of the CORE service needs analysis		
Identified needs – GP attendances • Casey reported very high rates of GP attendances, despite having lower numbers of general practitioners in the area creating barriers to access.		
After-hours care	The rate of providers who claimed GP After Hours/Emergency Attendance per 1,000 population was lowest in: • Cardinia: 0.6 • Casey South: 0.7 • Dandenong: 0.8	Department of Health. MBS data by Statistical Area 3 - MBS Item and Reporting Group, 2012-13 to 2015-16 (online). At: http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-MBS_Data (accessed 3 October 2017). Rate calculated using census 2016 URP.
	High rate of after-hours GP attendances per 100 in: • Casey: 45.5 • Frankston: 32.0 • Cardinia: 32.0 • Dandenong: 30.4 SEMPHN: 27.5	Medicare-subsidised GP, allied health, diagnostic imaging and specialist health care, by Primary Health Network (PHN) area, 2013–14 to 2017–18. PHIDU. Social Health Atlas of Australia: Primary Health Networks (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 12 October 2019).
	After Hours Lower Urgency Emergency Department Presentations in 2019-20: • Frankston: 21.6% • Greater Dandenong: 17.4% • Casey: 16.4%	Hospitals with the highest number of Emergency Department presentations in the afterhours. VEMD accessed via POLAR 29 –10-2020.
	High rate of after-hours emergency department presentations (per 1,000 ASR) in 2015-16 in: • Frankston: 91	Australian Institute of Health and Welfare. Web update: Use of emergency department and GP services in 2015–16 (online). At: http://www.myhealthycommunities.gov.au/our-reports/ed-gp-attendances-update/august-2017/explore-the-data (accessed 30 October 2017).

Outcomes of the CORE service needs analysis	
	In 2017, SEMPHN undertook an after-hours needs analysis, to identify areas of need within the region. The analysis factored in key social determinants, priority populations, indicators of health status and outcomes, utilisation of after-hours primary health care, hospital and emergency department services, as well as after-hours service availability. The results of the analysis were used to rank the 12 SA3s within the region based on need (from highest to lowest need): • Cardinia • Casey - South • Dandenong • Frankston • Mornington Peninsula • Kingston • Casey - North • Glen Eira • Bayside • Stonnington – West • Stonnington – East • Port Phillip
	In 2017, SEMPHN carried out a study exploring consumer behaviours and experiences of accessing after hours services. The recommendations from the study are presented below: • Emphasis on health literacy, focused on appropriate use of available after-hours services - Targeted education aimed at increasing consumers knowledge and confidence in relation to symptom identification and management - Creating a culture where using an appropriate alternative service depending on the level of urgency of the condition is normalised - Expanding the range of ancillary services (e.g. diagnostic imaging, pathology and pharmacy) offered by after-hours services • Need to build workforce capacity - Gaining awareness of the key factors that consumers identify as contributing to poor quality care

Outcomes of the CORE service needs analysis		
	• Promoting the uptake and application of the key elements that are perceived to contribute to high quality care	
Identified needs – After-hours • There are high rates of lower urgency Emergency Department presentations in Frankston, Greater Dandenong and Casey. • There is less access to after-hours general practice in the northern area of Cardinia, the southern area of Casey and some small areas of other LGAs when compared with the rest of SEMPHN[3]. • There are high rates of after-hours GP attendances in Casey, Frankston, Cardinia and Dandenong.		
Emergency Department Presentations	Key drivers of ED visits: • Multiple long-term health conditions • Cost barriers to seeing a GP • Limited afterhours access • Service mix of available general practitioners	AIHW. Healthy Communities: Use of emergency department and GP services in 2013–14 (online). At: https://www.myhealthycommunities.gov.au/our-reports/ed-gp-attendances/april-2016 (accessed 27 November 2019). Outcome Health POLAR Explorer September 2019.
	High rate of ED presentations per 100,000 population in 2017-18 in: • Frankston: 5,735 • Cardinia: 4,381 • Casey: 4,272 • Mornington Peninsula: 4,013 • Greater Dandenong: 3,771	AIHW. http://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks (accessed 28th October 2020).
	Alcohol related ED presentations 2013-14 per 10,000: • Frankston (26.0) • Greater Dandenong (22.5) • Port Phillip (20.3) • Mornington Peninsula (18.3) Victoria: 13.8	

[3] PwC SEMPHN Chronic Disease Service Mapping Report 2018

Outcomes of the CORE service needs analysis		
	Illicit drug related ED presentations 2013-14 per 10,000: • Port Phillip (4.5) • Greater Dandenong (3.9) Victoria: 2.1	Turning point AOD Stats 2013-14 at http://www.aodstats.org.au/ (accessed October 2016).
	High rate of Lower Urgency ED presentations per 1,000 population in 2015-16 to 2017-18 in: • Cardinia 92.2 • Mornington Peninsula 87.4 • Bayside 84.1 • Port Phillip 84.1 SEMPHN: 77.2	AIHW Use of Emergency Departments for lower urgency care: 2015-16 to 2017-18 At: https://www.aihw.gov.au/reports-data/health-welfare-services/hospitals/data(accessed 27 November 2019).
	High rate of annual increase in ED presentations between 2004-05–2014-15: • Cardinia 9.6% • Casey 8% • Greater Dandenong 5.5%	DHHS. 2015 Local Government Area (LGA) Statistical Profiles (online). At: https://www2.health.vic.gov.au/about/reporting-planning-data/gis-and-planning-products/geographical-profiles (accessed 12 October 2017).
	High rate of projected annual increase in ED presentations between 2014-15–2026-27 in: • Cardinia 5.4% • Casey 4.1% • Greater Dandenong 3.5%	
Hospital admissions	High rate of inpatient separations per 1,000 population in 2014-15 in: • Mornington Peninsula: 557.1 • Bayside: 513.2 • Frankston: 495.7	DHHS. 2015 Local Government Area (LGA) Statistical Profiles (online). At: https://www2.health.vic.gov.au/about/reporting-planning-data/gis-and-planning-products/geographical-profiles (accessed 12 October 2017).

Outcomes of the CORE service needs analysis		
	High rate of annual increase in inpatient separations between 2004-05 and 2014-15 in: • Cardinia: 8.5% • Casey: 6.3%	
	High rate of projected annual increase in inpatient separations between 2014-15–2026-27 in: • Cardinia: 5.3% • Casey: 4.7%	
	Top three chronic conditions which contributed to the highest age standardised potentially preventable hospitalisations and bed days: • Congestive heart failure • Chronic obstructive pulmonary disease (COPD) • Diabetes complication	AIHW. My Healthy Communities (online). At: https://www.aihw.gov.au/reports-data/indicators/healthy-community-indicators/potentially-preventable-hospitalisations (accessed November 2019).
	High rate of potentially preventable hospitalisations (per 100,000 ASR) in 2017-18 in: • Casey South 3,264 • Frankston 3,222 • Casey North 3,092 • Cardinia 2,892 SEMPHN 2,697	
	High rate of potentially preventable hospitalisations for chronic conditions (per 100,000 ASR) in 2017-18 in: • Casey South 1,762 • Casey North 1,558 • Frankston 1,530	

Outcomes of the CORE service needs analysis		
	• Dandenong 1,393 SEMPHN 1,260	
	High rate of potentially preventable hospitalisations for COPD (per 100,000 ASR) in 2017-18 in: • Frankston 357 • Casey South 349 • Port Phillip 288 • Casey North 282 SEMPHN 231	
	High rate of potentially preventable hospitalisations for diabetes complications (per 100,000 ASR) in 2017-18 in: • Casey South 269 • Frankston 255 • Casey North 210 • Mornington Peninsula 189 SEMPHN 171	
	High rate of potentially preventable hospitalisations for iron deficiency anaemia (per 100,000 ASR) in 2017-18 in: • Casey South 483 • Casey North 402 SEMPHN 338	
	High rate of potentially preventable hospitalisations for acute conditions (per 100,000 ASR) in 2017-18 in: • Frankston 1,479 • Mornington Peninsula 1,432 • Cardinia 1,315	

Outcomes of the CORE service needs analysis		
	SEMPHN 1,195	
	High rate of potentially preventable hospitalisations for dental conditions (per 100,000 ASR) in 2017-18 in: • Mornington Peninsula 424 • Frankston 339 • Port Phillip 258 • Stonnington West 256 SEMPHN 245	
	High rate of potentially preventable hospitalisations for cellulitis (per 100,000 ASR) in 2017-18 in: • Cardinia 293 • Casey South 275 • Casey North 268 • Frankston 249 SEMPHN 223	
	High rate of potentially preventable hospitalisations for other vaccine preventable conditions (per 100,000 ASR) in 2016-17 in: • Dandenong 294 • Casey North 141 SEMPHN 107	

Identified needs – Hospital admissions overall and potentially preventable hospital admissions

- There are high rates of ED presentations in Frankston, Cardinia and Casey.
- The outer areas of Casey South, Casey North, Frankston, Cardinia, Mornington Peninsula and Dandenong have high rates of Potentially Preventable Hospitalisations (PPH) overall for 2017-18 and the highest rates of PPH for both chronic and acute conditions.
- Dandenong reported high rates of PPHs for vaccine preventable conditions and separations for total PPH.

Outcomes of the CORE service needs analysis	

Residential Aged Care GP Forum Engagement 2019	Outcomes from the Forum:
	• Administrative reforms
	  ○ Impress
	  ○ Consistent advance care planning
	  ○ Falls
	  ○ Infection
	  ○ Psychotropic medications
	• Increasing knowledge base of GPs and RACFs
	• A more organised approach to case conferences
	• An improved, funded after-hours service
	  ○ Based on geography – use local practices
	  ○ Use nurse practitioners
	  ○ More collaborations
	• Services for those other than the aged in residential care
	• Funded psychological services for clients in aged care – communication to GPs and facilities
	• Conversation with VicHealth about collaboration between the aged care sector and acute sector
	• Technical solutions for nursing home/GP communication – use of secure email vs fax, and enabling one set of notes in multiple places

Service Mapping Project	Summary of how the current chronic disease system compares to the principles in the SEMPHN Optimal Model of Care Framework[4] Service Mapping Outcomes: Overall: • The SEMPHN has a mix of private and public health services across the primary and secondary care systems.

[4] Appendix 2: SEMPHN Optimal Model of Care Framework

Outcomes of the CORE service needs analysis	
	• There are gaps identified in service provision for some health service types including after hours, allied health, community-based rehabilitation, care coordination, and dietetics • There are gaps identified in areas of SEMPHN where access to health services may be difficult without private transport including parts of Dandenong, Frankston, Cardinia, Mornington Peninsula and Kingston • There are gaps in low or no fee services (particularly for allied health) Enablers: • Co-location or close proximity of health providers • Clear guidelines for referrals into public outpatient specialist clinics • Sufficient clinical staff with ability to care for patients with chronic conditions • Patient motivation and self-management Barriers: • Very few care and support coordinator roles • Transport for some patients (particularly the elderly) • Few (if any) low or no cost allied health services in the system • Lack of patient compliance Chronic Disease Management (CDM) Plans (particularly care from allied health and home-based behaviour change recommendations) • Lack of attendance at general practice appointments is an ongoing challenge • Limited (if any) home-based care services (either through general practice or through the home nursing services) • Very long waiting lists for outpatient specialist clinics at public hospitals • MBS rebates for CDM are insufficient • Current practice software does not allow easy 'tracking' of complex patients Patient experiences: • People experience the health care system differently – even when managing the same chronic condition • Positive patient centered interactions with health providers are important to patients • The system is complex and difficult to navigate. Someone needs to coordinate care and services • Maintaining connection to employment has financial and non-financial importance for people • Health literacy is fundamental for patients to self-manage their conditions well • Digital technology can enable patient self-management and accountability

Outcomes of the CORE service needs analysis	
SEMPHN model of care framework	• Costs of health services are a major barrier to access for allied health and medical specialists • There is a lack of information about out of pocket costs • Private health insurance allows for 'choice' • Waiting times in the public system are long • Time taken for diagnosis impacts treatment and pathways. Diagnosis and treatment is complicated by co-morbid mental health conditions • The flow of patient and care information is often a problem. People must 'keep track' of their information • Social disadvantage and vulnerability have a major impact on experience **Populations with specific risks** There is evidence that some populations are not able to access effective and appropriate chronic disease care. These population groups include people with multiple complex chronic conditions and have other socioeconomic vulnerabilities such as: • Elderly people who live alone • People with significant housing instability/homelessness • People with multiple complex and chronic conditions who also have limited social supports • People with comorbid mental health conditions • Recent migrants and refugees • People with a history of trauma A model of care framework is a set of guiding principles for the organisation and coordination of care within the health system and within health services. The aim of having an Optimal Model of Care Chronic Disease Framework at SEMPHN is to have the health system organised in a way that: • Improves the lives and health outcomes of all people • Enhances people's access to, and experiences of health care • Improves the working lives of the health care workforce • Reduces unnecessary costs and maximises value for money of health care

Outcomes of the CORE service needs analysis	
	A review of best practice models of care for chronic disease found: • There is no one model that has strong evidence of improved outcomes across populations, diseases or services • There are common elements (or principles) of best practice models • There are common enablers and barriers to successful implementation of chronic disease programs ***The SEMPHN optimal model of care framework*** The SEMPHN Framework: • Describes 12 key best practice principles of a health care system • Is based on common elements of best practice chronic disease models of care, both internationally and in Australia • Applies to all chronic diseases • Does not prescribe a particular program, intervention or initiative to be implemented • Allows for innovation in local service design and delivery to achieve these principles • Can help guide SEMPHN activities and commissioning
SEMPHN stakeholder consultation, 2017 and 2018	**Need to adopt a more collaborative, integrated and streamlined approach to care** Respondents spoke about the need for: • Better collaboration: to improve relationships, communication and promote knowledge and skill transfer across sectors (e.g. AOD and primary health care) Integration and streamlining of services, using strategies such as: • A “wrap around” approach with links to other services (e.g. MH, AOD, primary health care, housing, education and employment) • Co-located services- “simplify a complicated system. Requires fewer sources of information - one-stop-shop”. For example, detox, withdrawal and rehabilitation services while receiving care for an acute condition in hospital • Sharing of assessment tools, information across services • PHN to play a proactive role in the health sector, encouraging the uptake of these elements through: • A “community of practice” approach • Providing platforms to network and share information

Outcomes of the CORE service needs analysis	
	• The 2018 consultation with service providers and consumer representatives in the refugee health space identified additional needs relevant to this theme as follows: (note: additional feedback from these consultations have been presented under the relevant themes within this section) • Clear pathways to "*identify and access relevant services" (e.g. mental health and family violence support services)* • Integrated services with improved communication and capacity for coordination across service elements Adopting a collaborative, integrated and streamlined approach to care, would result in: • More streamlined and efficient referral pathways • Enhanced clarity on "who is responsible for each aspect of treatment/care" • Greater continuity of care including staff who remain involved as a patient's point of contact throughout the disease trajectory • Fewer assessments undertaken and less burden on clients and staff when client information is shared across the system
	Need for targeted and client centred services Several respondents spoke about the need for client centred approaches to service delivery, which included several elements. Incorporating these elements into service models has been reportedly known to result in better engagement with the system, less dropouts and fewer ED presentations. The elements noted were: • A single point of entry to facilitate seamless, supportive assessment and treatment for dual diagnosis • A "*client directed*" approach to care which provided opportunities for family inclusive practice • Avoiding the use of "professional jargon" within service delivery Additionally, respondents highlighted the need to: • Provide more flexibility to address client needs such as affordability, transport issues, and appointment "no shows" • Provide translators, services and information in multiple languages • Providing infrastructure and facilities to enable access. For example, childcare so parent can access a service. Access for carers to transport options • Holistic assessment of MH of AOD clients to ensure "*one health element is not overlooked at the expense of the other"*

Outcomes of the CORE service needs analysis	
	• Adopt place based, assertive outreach approach to engage with hard to reach clients and address health needs (e.g. residents of public housing estates) As previously noted, consultations in 2018 with service providers and consumer representatives in the refugee health space identified additional needs to be addressed: • Appropriate mental health services to deal with the specific needs of the cohort • Availability of case workers with the skills to take on complex clients • Available and accessible translated resources which are specifically targeting a cohort with low health literacy and limited knowledge of the health system • High quality patient centred care to ensure patient understanding of health condition(s) and treatment plan(s) • Addressing these elements were further stressed on given the cohort's backdrop of limited English and communication skills, financial issues and lack of or limited knowledge of "*the full extent of their rights*"
	Need for capacity building: Workforce and infrastructure Staffing shortages, especially a lack of skilled staff such as registered nurses and home visiting doctors in the aged care sector was highlighted as a need to be addressed. The 2018 consultations with service providers in the chronic disease space have highlighted inadequacies in resourcing, which have resulted in challenges collecting and reporting mandated patient data, and the provision of quality care coordination to patients. A similar thread followed in the 2018 consultation with service providers and consumer representatives in the refugee health space. Respondents identified the challenges service providers were dealing with due to time pressures and resourcing inadequacies within the sector. In general practice, providers noted that a lack of time limits the use of interpreter services. Consumer consultations highlighted the challenges faced by this cohort when accessing services if no interpreter services is available. In such instances, service providers pointed out that "*case workers are often required to assist with communication, particularly with complex clients*", alongside needing to follow "*complex billing processes for those without Medicare*", further adding to their workload. Respondents highlighted the need to build workforce capacity through: • Training and information sessions for clinicians and management • Training focused on the needs of clients with complex health issues (e.g. dual diagnosis, pain management in palliative care) • Attendance at regular forums involving multi-agency representation • Support and facilitate cultural shift to increase uptake of AOD and MH clients for "*screening and brief interventions*" by general practice. For example, education to reduce stigma surrounding AOD users

Outcomes of the CORE service needs analysis	
	• Provision of training to staff including nurses, clinicians, and management. For example, in relation to working within the National Disability Insurance Scheme (NDIS) model and palliative care • Continuous professional development • Knowledge sharing events • Support with accreditation • Competitive pay structures • Quality improvement processes implemented at a practice level For example, training relevant to family-centred practices, peg tube care, catheterisation, diabetes and heart diseases was highlighted. Training opportunities relevant to the assessment and treatment of dual diagnosis clients was also noted. Similarly, education and knowledge-sharing events to increase staff knowledge on assisting their clients to navigate the system, identify existing services and access points, such as in relation to the new National Disability Insurance Scheme (NDIS), was noted. The 2018 consultation providers of CDM services further highlighted a need to build clinician skills in care coordination. This was especially pointed out as a need in the context of providing care to priority population groups who require more intensive assistance and support in managing a chronic condition. Feedback suggested the implementation of quality improvement processes at a practice level would contribute towards ongoing enhancement of practice functioning and service delivery. For example, a focus on policies and procedures, ongoing training for staff, improvements to IT infrastructure (e.g. client + Respondents spoke about the need to build infrastructure, such as: • A single data system which can be used by all service providers across multiple systems. As noted by providers of CDM services, this will result in "*continuity of information to follow the continuity of care*" • Technology which will enable better communication across settings, and promote e-health initiatives • Resources to promote health literacy among consumers Improving quality systems including confidentiality agreement and a standardised privacy agreement (AOD)
	Need for more appropriate funding and funding structures Many respondents spoke about funding related issues, including: • Burden on sector to manage high demand (e.g. long waiting lists) and complex consumer needs with limited resources

Outcomes of the CORE service needs analysis	
	• Lack of certainty due to short-term funding affects resourcing including recruitment and retention of skilled staff. This was also highlighted in the 2018 feedback provided by providers of chronic disease management services. This poses challenges to the achievement and evaluation of long-term outcomes • Joint funding for multi-service models should be integrated from the onset. For example, "*MH, AOD, homelessness joint funding from the onset. It forces the existence of consortiums. Simplified and streamlined reporting process while working with multiple funding bodies affects the ability to be manage budgets and service types. It promotes and supports service coordination, addressing fragmentation of the system and supports consumers to navigate the system more effectively*" • Concerns over eligibility to access the NDIS for clients currently accessing community MH support services • Need for funding an in-home carer respite service to address carer burnout and the financial and practical burdens faced • Need for funding for community palliative care to employ a full-time specialist palliative care nurse to provide service delivery in residential aged care Respondents spoke about the need for the PHN to: • Understand the impact of short-term funding on the sector and client outcomes • Commission services which enable greater certainty of service delivery for providers and service access for consumers Funded consumer participation program (as opposed to an advisory group). This will help services implement robust feedback, consumer review forums, co-design and be involved in funded PHN programs.
	Need to raise awareness Respondents highlighted the need to raise awareness among consumers and service providers about: • Existing services • Pathways to access • Changing laws • New programs • Eligibility criteria • Value of evidence-based practice • Navigating the health system (eligibility and pathways to access services, referral pathways, cost etc.) • Health literacy

Outcomes of the CORE service needs analysis	
	For example, awareness raising by the PHN on community health referral pathways which can be accessed by private service providers was noted. This was also evident in the 2018 consultations with consumer representatives and service providers in the refugee health space. Feedback provided pointed to promoting the use of community groups as a platform for health promotion initiatives due to the cohort's "*close connections to their community*". Raising awareness would help, by: • Reducing the duplication of services • Promoting and providing opportunities for inter-sectoral integration and collaboration • Promoting health literacy, by targeting prevention and early intervention that is focused on a proactive rather than reactive approach and "*getting to people before they become severe*" • Reducing ED presentations. For example, admissions can be avoided when early intervention is provided for palliative patients requiring pain management, and people needing psychosocial support Respondents spoke about the PHN's role in: • Advocacy. For example, "*for alternative support options for people not eligible for NDIS services who are presently receiving, and have received psychosocial support services for many years*" Health literacy initiatives. For example, "*promoting the benefits of physical activity to combat obesity and social isolation*", as well as information on eligibility criteria for palliative care which includes "*non-malignant chronic conditions such as dementia, COPD and stroke*". Similarly, to "*promote an awareness of palliative care among clinicians and consumers in the Health Care Homes and other commissioned CDM projects*".
	Patient Experience As part of the Chronic Disease Service Mapping Project, PwC partnered with the Consumers Health Forum of Australia to conduct ten in-depth case studies of people with multiple complex chronic diseases. The CHF used their validated 'Real People Real Data' methodology. Experience wheels were developed for each case study. A focus was made on how people access services within the SEMPHN. • People experience the health care system differently – even when managing the same chronic condition • Positive patient centered interactions with health providers are important to patients • The system is complex and difficult to navigate. Someone needs to coordinate care and services • Maintaining connection to employment has financial and non-financial importance for people

Outcomes of the CORE service needs analysis	
	• Health literacy is fundamental for patients to self-manage their conditions well • Digital technology can enable patient self-management and accountability • Costs of health services are a major barrier to access allied health and medical specialists • There is a lack of information about out of pocket costs • Private health insurance allows for 'choice' • Waiting times in the public system are long • Time taken for diagnosis impacts treatment and pathways. Diagnosis and treatment is complicated by co-morbid mental health conditions • The flow of patient and care information is often a problem. People must 'keep track' of their information • Social disadvantage and vulnerability have a major impact on experience