

Primary Health Network

Needs Assessment Reporting Template

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 **30 March 2016** 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.

Instructions for using this template

Overview

This template is provided to assist PHNs to fulfil their reporting requirements for a Needs Assessment as required under Item E.5 of the Standard Funding Agreement (Funding Agreement) with the Department.

Further information for PHNs on the development of needs assessments is provided in the *Needs Assessment Guide*, available on the Department's website (www.health.gov.au/PHN).

The key output of needs assessment will be to inform the Activity Work Plan. In addition, the information provided by PHNs in this report may be used by the Department to inform programme and policy development.

Reporting

The Needs Assessment report template consists of the following:

Section 1 – Narrative

Section 2 – Outcomes of the health needs analysis

Section 3 – Outcomes of the service needs analysis

Section 4 – Opportunities, priorities and options

Section 5 – Checklist

PHN reports must be in a Word document and provide the information as specified in Sections 1-5.

Limited supplementary information may be provided in separate attachments if necessary. Attachments should not be used as a substitute for completing the necessary information as required in Sections 1-5.

While the PHN may include a range of material on their website, for the purposes of public reporting the PHN is required to make the tables in Section 2 and Section 3 publicly available on their website.

Submission Process

The Needs Assessment report must be lodged to the Grant Officer via email VicTasPHN@health.gov.au on or before 30 March 2016.

Reporting Period

This Needs Assessment report will cover the period of 1 July 2016 to 30 June 2018 and will be reviewed and updated as needed.

Section 1 – Narrative

This section provides PHNs with the opportunity to provide brief narratives on the process and key issues relating to the Needs Assessment.

Identifying the health needs of our community is the necessary and critical first step to deliver better health outcomes for the population in South Eastern Melbourne. With this in mind, this document identifies the most critical factors contributing to the variation in health outcomes across South Eastern Melbourne and, on this basis, recommends potential activities to address many of these issues.

The South Eastern Melbourne PHN (SEMPHN) serves a highly diverse population of more than 1.4 million people. Populations exist within the catchment that maintain very high standards of living while others endure some of the worst living standards in Australia. This extreme variance is echoed in the health outcomes of the population, with areas such as Greater Dandenong and Frankston exhibiting the poorest health and social outcomes of any region in the broader SEMPHN catchment.

There are also those areas which reflect a hybrid, where generally good population health exists alongside communities with very poor health outcomes. This is best reflected in the City of Port Phillip, where there are both high standards of living and good health outcomes coupled with high rates of homelessness, mental health and drug addiction, contributing to poor health outcomes for pockets of the population.

The region is also representative of areas which experience for example heightened social isolation, coupled with high rates of obesity, psychological distress and child protection substantiations. This is best reflected in the City of Casey and Cardinia Shire respectively. In both areas, associated remoteness coupled with limited availability of services and access to public transport are likely to be strongly correlated to the poor access to services and associated health outcomes reflected in the data.

The significant variability in the health of the SEMPHN community coupled with an economic environment which mandates that PHNs 'do more with less' has shaped this Health Needs Assessment, including the proposed activities. In identifying areas of priority and corresponding activities, this document focuses specifically on areas and cohorts exhibiting the poorest health outcomes, often across a number of domains. By doing so, SEMPHN will be able to improve the health outcomes of our population using the most effective and efficient means.

The areas of priority and corresponding activities are designed to align with four key themes:

- Intelligent Commissioning;
- Co-Design and Patient Centricity;
- Health System Alignment; and
- Enhancing Professional Practice Capacity.

These themes reflect the central features of SEMPHN's organisational strategy, and therefore provide the frame for the organisation's current and future activities.

Process

This third health needs assessment aims to build upon (where applicable) the analysis completed in the two previous needs assessments and provide a deeper, more nuanced understanding of the population profile and health needs of the SEMPHN region.

The majority of this needs analysis relies on a range of secondary data sources including:

- Population Health Information Development Unit (PHIDU)
- Australian Bureau of Statistics (ABS) census data;
- various Department of Health, Victorian Department of Health and Human Services,
- Australian Institute of Health and Welfare (AIHW) and National Health Performance Agency (NHPA) reports;
- Medicare Benefit Schedule and Pharmaceutical Benefit Scheme data; and
- academic research reports and articles.

Where possible, efforts have been made to verify data published in secondary sources, and data custodians have been notified of any errors found. During the course of collecting data for this needs assessment, a few errors were identified in the PHIDU dataset relating to rate calculations and data labels, which were promptly corrected. However, given the size of the dataset, and lack of access to additional data sources that can be used for verification, it is possible that there are errors that haven't been identified. So data obtained from such secondary sources need to be examined alongside relevant data published by other sources.

Data were analysed at the smallest geographical level available. Unfortunately, due to a dearth of local-level statistics, data are sometimes presented at a regional, state or national level. Estimates were then compared to the most relevant comparator possible.

Peer Groups

In previous needs assessments, local areas were compared against each other, and to state and national results. This made it difficult to identify the relative need in SEMPHN and to prioritise between needs. Natural variation between metropolitan and rural and regional areas means comparison with Victorian and Australian should be done with care. These comparisons also do not indicate whether a need ought to be addressed or not with the PHN's limited funding allocation. This year SEMPHN used a process of PHN peer grouping in order to compare against similar areas to help identify key areas of focus for SEMPHN. Peer PHNs from across the country were selected based on the following factors:

- Similar population size/density
- Similar mix of metropolitan and regional areas
- Similar demographic profiles (age, cultural diversity)
- Similar socio-economic profiles (areas of socio-economic advantage as well as areas of relative disadvantage)

Results for each of these PHNs were collated and sorted and a range was determined. Where an area within SEMPHN had a result for a measure that was outside of this peer range it was

determined to be an area of potential concern. For example the peer range for psychological distress was 7.3 to 13.6. The LGAs of Greater Dandenong, Frankston, Casey and Cardinia fell outside this range and as such have been highlighted in this needs assessment.

The peer PHNs:

- Northern Sydney PHN
- Western Sydney PHN
- North Western Melbourne PHN
- Eastern Melbourne PHN
- Brisbane North PHN
- Brisbane South PHN
- Perth North PHN
- Perth South PHN

Where peer results were unavailable, areas were compared against other areas such as the Victorian, regional and national averages.

Consultation Process

The consultation process was aimed at adding an additional layer of richness to this needs assessment. In particular, it aimed to give both internal and external stakeholders an opportunity to have their voices heard, as well as to provide insight into the needs of consumers and the sector. All senior management within SEMPHN, as well as external stakeholders from all ten councils within the catchment, local hospital networks, and service providers across the key priority areas such as mental health (MH), alcohol and other drugs (AOD), chronic disease management (CDM) and palliative care (PC) were invited to participate. Platforms for consultation offered were face-to-face or phone interviews, written responses to the interview questions or completion of an online survey conducted in October 2017. In total, the online survey received 108 responses. There were 12 interviews conducted with MH, AOD, CDM and PC service providers, as well as with internal staff at SEMPHN resulting in a sample of 41 stakeholders being interviewed.

A qualitative study exploring patient experiences accessing after hours services was conducted in February 2017. Face-to-face semi-structured interviews were carried out with a sample of 28 consumers who had accessed an after-hours service within the catchment in the previous six months. The findings from this study have been fed into the needs assessment and inform the section on understanding consumer needs.

Additional Data Needs and Gaps (max 400 words)

Understanding the need for services within the community is challenging and local prevalence is based on synthetic estimates using demand/utilisation data, state and national level surveys, and regional risk factors. These estimates are obfuscated by a number of factors including:

- Data quality and timeliness, particularly at smaller geographies
- Identified challenges with access to services, particularly amongst vulnerable population groups

- Sector capacity to manage and support those with complex and chronic health conditions.

Having access to timely population, health and service usage data at a local geography would allow greater insight into the demographic profile, health needs, and service demands of the region. Further, it would enable the PHN to better commission initiatives that are targeted to populations in greatest need. Limited existence of, or access to, local level data has restricted the detail of analysis completed in the needs assessment. Aggregated data can obscure the impact of SEMPHN activities, particularly pilots or interventions targeted at particular subsets of the population, such as priority populations.

Access to and sharing of linked unit record data would further allow PHNs to follow the patient journey through the health care system and understand key gaps, blockages and challenges, and ultimately allow for improved system design and integration. Regular access to unit record data at the practice, service and patient level from community and primary through to tertiary health care providers would enable the PHN to determine in as near as possible real-time, where to direct programs and to quantify the impact PHN activities are having on health outcomes in the region. SEMPHN has engaged with key regional stakeholders around data sharing and linking. However, this has been challenging and centralised coordination would aid this process.

At present, the majority of data informing the needs assessment are accessed via a variety of organisation specific portals. Each organisation is driven by its own priorities when providing data and not the needs of audiences accessing the data. Therefore, data is often presented at the level of detail directed by the organisation capturing the data, the limitations imposed by the data custodians or previous clients accessing the data. Data are presented at various geographic levels and there are limitations to the data elements available. Data are not refreshed at the same scheduled rate so comparisons must be made between population groups from ranging years.

Different organisations present data on a variety of platforms. Therefore, data is presented through products such as excel, modified SAS tables, dashboards and pdf files. This adds time to the data extraction process and limits the analysis to what can be readily extracted. For example, ascertaining simple data on co-morbidities, length of stay in acute and sub-acute hospital settings is currently not possible. If data were available in a timely manner at the appropriate level, needs assessments would evolve out of routine analysis completed during core business rather than as an additional reporting requirement. Access to quality and timely hospital data presents a key challenge particularly where key PHN outcomes include hospital level performance indicators. Limited access to emergency department and admitted patient data is currently provided through unwieldy dashboards which were not designed with population health planning in mind.

A lack of local level data including, demographics, health conditions and service needs of priority populations makes planning for these groups more difficult. Limited identification creates additional challenges and where possible minimum data sets should include the identification of people within these groups so that services can be better targeted to suit their needs.

Additional comments or feedback (max 500 words)

This is an updated version of the Needs Assessment submitted to the Commonwealth in November 2016. As such, it includes updates where new data were available alongside more in-depth findings which emerged from the stakeholder and consumer consultations. However the majority of needs presented in the previous needs assessment have not changed substantially over the period.

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 health needs analysis		
Priority Area	Key Issue	Description of Evidence
Demographic profile	Total population (2016): <ul style="list-style-type: none"> Casey 299,301 Mornington Peninsula 154,999 Greater Dandenong 152,050 Kingston 151,389 Glen Eira 140,875 Frankston 134,143 Stonnington 103,832 Port Phillip 100,863 Bayside 97,087 Cardinia 94,128 	Population Health Information Development Unit (PHIDU). LGA data - Census 2016 (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 12 October 2017).
	Projected annual population growth (2014-2024): <ul style="list-style-type: none"> Cardinia 4.4% Casey 2.7% Port Phillip 1.8% Stonnington 1.7% Greater Dandenong 1.6% 	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).

Outcomes of the health needs analysis		
	<ul style="list-style-type: none"> Mornington Peninsula 1.3% Kingston 1% Glen Eira 0.8% Frankston 0.8% Bayside 0.8% 	
	<p>Estimated population in 2026*:</p> <ul style="list-style-type: none"> 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 	<p>*Estimate calculated using annual growth rate published in: 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).</p>
	<p>High proportion of children aged 0-4 years in 2016 in:</p> <ul style="list-style-type: none"> Cardinia 8.3% Casey 7.9% 	<p>Population Health Information Development Unit (PHIDU). LGA data - Census 2016 (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 12 October 2017).</p>
	<p>High proportion of people aged 65-84 years in 2016 in:</p> <ul style="list-style-type: none"> Mornington Peninsula 17.4% Bayside 14.8% Kingston 11.9% 	<p>Population Health Information Development Unit (PHIDU). LGA data - Census 2016 (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 12 October 2017).</p>
	<p>High proportion of people aged over 85 years in 2016 in:</p> <ul style="list-style-type: none"> Bayside 3.7% 	<p>Population Health Information Development Unit (PHIDU). LGA data - Census 2016 (online). At:</p>

Outcomes of the health needs analysis		
	<ul style="list-style-type: none"> Mornington Peninsula 3.3% Glen Eira 3.0% 	http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 12 October 2017).
	Relatively high proportion of Aboriginal and Torres Strait Islander population in 2016 in: <ul style="list-style-type: none"> Frankston 1.0% 	Population Health Information Development Unit (PHIDU). LGA data - Census 2016 (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 12 October 2017).
	High proportion of people born in predominantly non-English speaking countries in 2016 in: <ul style="list-style-type: none"> Greater Dandenong 54.2% 	Population Health Information Development Unit (PHIDU). LGA data - Census 2016 (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 12 October 2017).
SEMPHN - Demographic profile <ul style="list-style-type: none"> Casey is the most populated LGA in the SEMPHN region, with nearly 300,000 residents in 2016 Cardinia and Casey are projected to have the highest annual population growth rate in the SEMPHN region over the next decade Cardinia and Casey also 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 Torres Strait Islander people in the SEMPHN region Over half the population in Greater Dandenong was born in a predominantly non-English speaking country 		
Social determinants of health	High level of disadvantage (IRSD) in 2011 in: <ul style="list-style-type: none"> Greater Dandenong 895 	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 left school at year 10 or below (ASR per 100) in 2016 in: <ul style="list-style-type: none"> Cardinia 33.8 Greater Dandenong 32.9 Casey 30.7 	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).

Outcomes of the health needs analysis		
	<ul style="list-style-type: none"> Frankston 30.2 	
	High unemployment rate in June 2016 in: <ul style="list-style-type: none"> Greater Dandenong 12.4% Casey 8.0% Cardinia 7.0% 	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).
	Low median weekly equivalised household income in 2016 in: <ul style="list-style-type: none"> Greater Dandenong \$659 	Australian Bureau of Statistics. 1410 - Data by Region, 2011-16 (online). At http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/14102011-16?OpenDocument (accessed 30 October 2017).
	High rate of homelessness per 1,000 population in 2011 in: <ul style="list-style-type: none"> Port Phillip 15.3 Greater Dandenong 10.3 	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 experiencing severe gambling-related problems in 2016 in: <ul style="list-style-type: none"> 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 rate of gaming machine losses per adult population in 2016/17 in: <ul style="list-style-type: none"> Greater Dandenong \$989 	Victorian Commission for Gambling and Liquor Regulation. Gaming machine expenditure by local government area - current half-year monthly (online). At: https://www.responsiblegambling.vic.gov.au/information-and-reSource/victorias-gambling-environment/gambling-statistics (accessed 27 October 2017) Note: Census 2016 data was used to calculate this rate
	High crime rate per 1,000 population in 2016/17 in: <ul style="list-style-type: none"> Greater Dandenong 126 	Crime Statistics Agency. Data tables - Offence Visualisation LGA Offence Rate Offence Type - year ending June 2017 (Online). At:

Outcomes of the health needs analysis		
	<ul style="list-style-type: none"> Frankston 12,354 Port Phillip 11,463 	https://www.crimestatistics.vic.gov.au/crime-statistics/latest-crime-data/download-data-4 (accessed 9 November 2017).
Identified needs – Social determinants of health <ul style="list-style-type: none"> Greater Dandenong is the most disadvantaged LGA in the SEMPLHN region, with high rates of early school leavers, high unemployment, low household income, high rates of homeless and gambling problems Very high rates of homelessness in Port Phillip Cardinia and Casey have some of the highest rates of early school leavers and unemployment in the SEMPLHN region Frankston is one of the most disadvantaged LGAs in the SEMPLHN region, and has one of the highest rates of early school leavers 		
Behavioural risk factors	The smoking rate (ASR per 100) in 2014-15 was high in: <ul style="list-style-type: none"> Frankston 20.2 Cardinia 18.3 Mornington Peninsula 17.3 Casey 16.9 Greater Dandenong 16.4 	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).
	Harmful use of alcohol (ASR per 100) in 2014-15 was high in: <ul style="list-style-type: none"> Bayside 20.5 Port Phillip 19.6 	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).
	Obesity (ASR per 100) in 2014-15 was high in: <ul style="list-style-type: none"> Cardinia 32.4 Casey 32.2 Frankston 30.8 	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 people with low fruit and vegetable consumption in (2014): <ul style="list-style-type: none"> Greater Dandenong 55.0% Glen Eira 54.8% 	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 health needs analysis		
	<ul style="list-style-type: none"> Casey 53.7% 	
	<p>High proportion of people who consumed sugar-sweetened soft drinks daily in (2014):</p> <ul style="list-style-type: none"> Casey 15.9% Frankston 15.4% Cardinia 14.7% 	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).
	<p>High rate of people who undertook no or low exercise in the previous week (ASR per 100) in 2014-15 in:</p> <ul style="list-style-type: none"> Greater Dandenong 73.4 	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).
	<p>Low proportion of people who saw a GP in the previous 12 months in 2013-14 in:</p> <ul style="list-style-type: none"> Port Phillip 81.2% Stonnington 81.3% 	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).
Identified needs – Health behaviours <ul style="list-style-type: none"> Smoking is a major factor influencing health outcomes with high smoking rates across most of the SEMPHN region Frankston has the highest rate of current smokers in the SEMPHN region, as well as one of the highest rates of obesity and people who report drinking a sugar sweetened beverage every day 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 smoking and consumption of sugar sweetened soft drinks Greater Dandenong had the highest rate of people with low fruit and vegetable consumption, as well as the lowest rate of exercise in the SEMPHN region 		
Health status and outcomes	<p>High rate of fair or poor self-assessed health (ASR per 100) in 2014-15 in:</p> <ul style="list-style-type: none"> Greater Dandenong 20.1 	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).

Outcomes of the health needs analysis		
	<p>High rate of psychological distress (ASR per 100) in 2014-15 in:</p> <ul style="list-style-type: none"> • Greater Dandenong 16.7 • Frankston 15.0 • Casey 14.9 • Cardinia 14.0 	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).
	<p>High proportion of people with a profound or severe disability in 2016 in:</p> <ul style="list-style-type: none"> • Greater Dandenong 6.6% • Mornington Peninsula 5.8% • Frankston 5.8% 	PHIDU. LGA data - Census 2016 (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 12 October 2017).
	<p>High rate of avoidable mortality (ASR per 100,000) between 2010-14 in:</p> <ul style="list-style-type: none"> • Frankston 132.1 	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).
	<p>Leading causes of avoidable mortality (2009-11):</p> <ul style="list-style-type: none"> • Ischaemic heart disease • Lung cancer • Suicide and self-inflicted injuries • Bowel cancer • Stroke • Breast cancer 	AIHW. Healthy Communities: Avoidable deaths and life expectancies in 2009–2011 (online). At: https://www.myhealthycommunities.gov.au/our-reports/avoidable-deaths-and-life-expectancies/december-2013 (accessed 27 November 2017).
	<p>Key areas of need identified by stakeholders:</p> <ul style="list-style-type: none"> • General, oral and physical health (AOD, homeless, MH) • Intravenous use among AOD users • Support for clients between initial contact and actual treatment (e.g. counselling, non-residential withdrawal for AOD use) • Provision of crisis housing 	SEMPHN stakeholder engagement, 2017

Outcomes of the health needs analysis		
	<ul style="list-style-type: none"> • Pharmaceutical abuse and elder abuse among seniors • Family violence • Community safety. For example, school programs to targeted males at a developmental age and promote positive behaviour towards women) • Sexually Transmitted Infections among especially young men, sex workers and prisoners • Managing social isolation through infrastructure (e.g. social support drop-in centres) 	
Identified needs – Health status and outcomes <ul style="list-style-type: none"> • Greater Dandenong and Frankston had high proportions of people with poor health and health outcomes • Casey and Cardinia had 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	<p>Prevalence of chronic disease & comorbidity was higher among:</p> <ul style="list-style-type: none"> • People aged over 65 years • Women • People living in socioeconomically disadvantaged areas • People living in regional & remote areas <p>Most common chronic conditions in 2014-15:</p> <ul style="list-style-type: none"> • Cardiovascular disease • Mental health conditions • Back pain and problems • Arthritis • Asthma 	AIHW,. (2016). Australia's health 2016. Australia's health series no. 15. Cat. No. AUS 199. Canberra: AIHW.

Outcomes of the health needs analysis		
	<p>High prevalence of diabetes mellitus (ASR per 100) in 2011-12 in:</p> <ul style="list-style-type: none"> Greater Dandenong 8.3 	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).
	<p>High prevalence of high blood cholesterol (ASR per 100) in 2011-12 in:</p> <ul style="list-style-type: none"> Mornington Peninsula 35.7 	
	<p>High prevalence of circulatory system diseases (ASR per 100) in 2011-12 in:</p> <ul style="list-style-type: none"> Frankston 17.4 Cardinia 17.3 	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).
	<p>High prevalence of respiratory system diseases (ASR per 100) in 2011-12 in:</p> <ul style="list-style-type: none"> Frankston 33.4 Kingston 33.1 Mornington Peninsula 30.8 	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).
	<p>High prevalence of asthma (ASR per 100) in 2011-12 in:</p> <ul style="list-style-type: none"> Cardinia 13.0 Mornington Peninsula 12.1 Frankston 11.6 Kingston 10.6 	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).
	<p>High rate of avoidable mortality from diabetes (ASR per 100,000) between 2010-14 in:</p> <ul style="list-style-type: none"> Greater Dandenong 7.7 Frankston 6.7 	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).

Outcomes of the health needs analysis		
	<p>High rate of avoidable mortality from circulatory system diseases (ASR per 100,000) between 2010-14 in:</p> <ul style="list-style-type: none"> • Greater Dandenong 43.4 • Frankston 39.6 	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).
	<p>High rate of avoidable mortality from respiratory system diseases (ASR per 100,000) between 2010-14 in:</p> <ul style="list-style-type: none"> • Frankston 13.1 • Greater Dandenong 9.5 	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).
Identified needs – Chronic disease <ul style="list-style-type: none"> • Greater Dandenong had very high rates of prevalence and avoidable mortality from diabetes • Greater Dandenong had the highest rates of avoidable mortality from circulatory and respiratory system diseases, but had relatively lower rates of prevalence • Frankston had very high rates of avoidable mortality from diabetes, as well as circulatory and respiratory system diseases, but had relatively lower rates of prevalence of diabetes mellitus • Kingston and Mornington Peninsula had high rates of prevalence of respiratory system diseases • Cardinia had high rates of prevalence of circulatory system diseases as well as asthma 		
Cancer screening, incidence and mortality	<p>Underscreened groups: ^{1, 2}</p> <ul style="list-style-type: none"> • Aboriginal and Torres Strait Islanders • Culturally and linguistically diverse communities • Socioeconomically disadvantaged groups • Males 	<p>¹ Olver, I., Marine, F., & Grogan, P. (2011). Disparities in cancer care in Australia and the Pacific. The oncologist, 16(7), 930-934.</p> <p>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.</p>
	Relatively low participation in the National Bowel Cancer Screening Program among people aged 50-74 years in the	AIHW. Cancer screening in Australia by small geographic areas 2015-16 (online). At: https://www.aihw.gov.au/reports/cancer-

Outcomes of the health needs analysis		
	SEMPHN region (39.3%) and across Australia (40.9%) in 2015-16.	screening/cancer-screening-in-australia-by-small-geographic/notes (accessed 1 November 2017).
	<p>Low participation in the BreastScreen Australia program among people aged 50-74 years in 2015-16 in:</p> <ul style="list-style-type: none"> Stonnington – West 44.8% Port Phillip 46.6% Casey – South 47.2% Frankston 47.4% 	AIHW. Cancer screening in Australia by small geographic areas 2015-16 (online). At: https://www.aihw.gov.au/reports/cancer-screening/cancer-screening-in-australia-by-small-geographic/notes (accessed 1 November 2017).
	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 2015-16.	AIHW. Cancer screening in Australia by small geographic areas 2015-16 (online). At: https://www.aihw.gov.au/reports/cancer-screening/cancer-screening-in-australia-by-small-geographic/notes (accessed 1 November 2017).
	<p>High rate of avoidable mortality from colorectal cancer (ASR per 100,000) between 2010-14 in:</p> <ul style="list-style-type: none"> Frankston 12.4 Kingston 11.0 Casey 10.7 	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).
	<p>High rate of avoidable mortality from breast cancer (ASR per 100,000) among females between 2010-14 in:</p> <ul style="list-style-type: none"> Kingston 21.7 Cardinia 21.4 Glen Eira 21.1 Mornington Peninsula 20.4 Frankston 18.7 	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 – Cancer screening, incidence and mortality		

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- Low rates of participation in screening for bowel cancer across Australia, which needs to be addressed systematically
- Low rates of participation in screening for breast cancer in the following SA3s: Stonnington – West, Port Phillip, Casey – South and Frankston
- High rates of avoidable deaths from colorectal cancer in Frankston, Kingston and Casey
- High rates of avoidable deaths from breast cancer in Kingston, Cardinia, Glen Eira, Mornington Peninsula and Frankston

Immunisation	Under-immunised groups: ^{1, 2} <ul style="list-style-type: none"> • 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.
	Relatively high immunisation coverage for 12-15 month olds across the SEMPHN region (94.8%) in June 2017.	Australian Immunisation Register - Coverage Report (30/09/2017)
	Relatively low immunisation coverage for 24-27 month olds across the SEMPHN region (91.9%) in June 2017.	Australian Immunisation Register - Coverage Report (30/09/2017)
	Relatively low immunisation coverage for 60-63 month olds in June 2017 in: <ul style="list-style-type: none"> • Port Phillip 89.4% • Stonnington 90.3% 	Australian Immunisation Register - Coverage Report (30/09/2017)
	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 the national target.	Australian Immunisation Register - Coverage Report (30/12/2016)

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	Relatively low rates of immunisation coverage for Aboriginal and Torres Strait Islander children aged 24-27 months in the SEMPHN region (88.0%) in 2015-16.	AIHW. Healthy Communities: Immunisation rates for children in 2015–16 (online). At: myhealthycommunities.gov.au/our-reports/immunisation-rates-for-children/june-2017/explore-the-data (accessed 1 November 2017).
	Relatively high rates of HPV vaccine coverage among boys (68.7%) and girls (77.5%) aged 15 years in the SEMPHN region in 2014-15.	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 - Immunisation <ul style="list-style-type: none"> • High rates of immunisation coverage among 12-15 month olds in the SEMPHN region, compared to other age groups • Low rates of immunization coverage among Aboriginal and non-Aboriginal children aged 24-27 month olds in the SEMPHN region compared to other age groups • Port Phillip and Stonnington had low rates of immunization coverage among 60-63 month olds 		
Infectious diseases	<p>Higher prevalence of infectious disease among:</p> <ul style="list-style-type: none"> • International travellers¹ • Migrants and refugees² • Aboriginal and Torres Strait Islanders³ • LGBTIQ community⁴ • Injecting drug users⁴ • People experiencing homelessness⁵ <p>People at risk of serious complications from influenza: ⁶</p> <ul style="list-style-type: none"> • People aged over 65 years • Aboriginal and Torres Strait Islander people • Pregnant women 	<p>¹ O'Brien, D. P., Leder, K., Matchett, E., Brown, G. V., & Torresi, J. (2006). Illness in returned travelers and immigrants/refugees: the 6-year experience of two Australian infectious diseases units. <i>Journal of travel medicine</i>, 13(3), 145-152.</p> <p>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. <i>Epidemiology and Infection</i>. 2016;144(16):3554-3563. doi:10.1017/S0950268816001734.</p> <p>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</p>

Outcomes of the health needs analysis		
	<ul style="list-style-type: none"> • People with: <ul style="list-style-type: none"> ○ Heart disease ○ Chronic lung disease ○ Chronic neurological conditions ○ Impaired immunity ○ Haemoglobinopathies ○ Diabetes ○ Kidney disease 	<p>people, Australia 2006-2010. Communicable diseases intelligence quarterly report, 37, S1-95.</p> <p>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.</p> <p>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.</p> <p>⁶ Better Health Channel. Flu (influenza) – immunisation (online). At: https://www.betterhealth.vic.gov.au/health/healthyliving/flu-influenza-immunisation (accessed 15 November 2017).</p>
	<p>High rates of blood borne viruses per 100,000 in 2017 in:</p> <ul style="list-style-type: none"> • Greater Dandenong 148.7 • Port Phillip 82.8 	<p>DHHS. Infectious diseases surveillance – daily summaries (online). At: https://www2.health.vic.gov.au/public-health/infectious-diseases/infectious-diseases-surveillance/infectious-diseases-surveillance-daily-summaries (accessed 10 November 2017).</p>
	<p>High rates of hepatitis B per 100,000 in 2017 in:</p> <ul style="list-style-type: none"> • Greater Dandenong 89.8 	<p>DHHS. Infectious diseases surveillance – daily summaries (online). At: https://www2.health.vic.gov.au/public-health/infectious-diseases/infectious-diseases-surveillance/infectious-diseases-surveillance-daily-summaries (accessed 10 November 2017).</p>
	<p>High rates of hepatitis C per 100,000 in 2017 in:</p> <ul style="list-style-type: none"> • Port Phillip 54.2 • Greater Dandenong 54.0 • Frankston 46.9 	<p>DHHS. Infectious diseases surveillance – daily summaries (online). At: https://www2.health.vic.gov.au/public-health/infectious-diseases/infectious-diseases-surveillance/infectious-diseases-surveillance-daily-summaries (accessed 10 November 2017).</p>

Outcomes of the health needs analysis		
	<p>High rates of sexually transmissible infections per 100,000 in 2017 in:</p> <ul style="list-style-type: none"> Stonnington 630.6 Port Phillip 545.7 	DHHS. Infectious diseases surveillance – daily summaries (online). At: https://www2.health.vic.gov.au/public-health/infectious-diseases/infectious-diseases-surveillance/infectious-diseases-surveillance-daily-summaries (accessed 10 November 2017).
	<p>High rates of gonococcal infections per 100,000 in 2017 in:</p> <ul style="list-style-type: none"> Stonnington 457.0 Port Phillip 402.6 	DHHS. Infectious diseases surveillance – daily summaries (online). At: https://www2.health.vic.gov.au/public-health/infectious-diseases/infectious-diseases-surveillance/infectious-diseases-surveillance-daily-summaries (accessed 10 November 2017).
	<p>High rates of influenza per 100,000 in 2017 in:</p> <ul style="list-style-type: none"> Bayside: 1,187.3 Glen Eira 936.3 	DHHS. Infectious diseases surveillance – daily summaries (online). At: https://www2.health.vic.gov.au/public-health/infectious-diseases/infectious-diseases-surveillance/infectious-diseases-surveillance-daily-summaries (accessed 10 November 2017).
	<p>High rates of Tuberculosis per 100,000 in 2017 in:</p> <ul style="list-style-type: none"> Greater Dandenong 23.8 	DHHS. Infectious diseases surveillance – daily summaries (online). At: https://www2.health.vic.gov.au/public-health/infectious-diseases/infectious-diseases-surveillance/infectious-diseases-surveillance-daily-summaries (accessed 10 November 2017).
<p>Identified needs – Infectious diseases</p> <ul style="list-style-type: none"> High rates of blood borne diseases in Greater Dandenong and Port Phillip, particularly hepatitis C Greater Dandenong has high rates of hepatitis B and tuberculosis Stonnington & Port Phillip have high rates of STIs, particularly gonococcal infections Bayside & Glen Eira have high rates of influenza 		

Outcomes of the health needs analysis		
Priority populations	<p>Priority groups identified by stakeholders:</p> <ul style="list-style-type: none"> • Seniors • Culturally and Linguistically Diverse communities (particularly those of a low socio-economic status) • People experiencing homelessness • People identifying as LGBTQI • People experiencing end of life care • Clients with a dual diagnosis of MH and alcohol and other drug issues • People at risk of or bereaved due to suicide • Parents of very young children (early parenting support) • Sex workers • Prisoners 	SEMPHN stakeholder consultations, 2017
Priority populations – Children & youth	<p>High proportion of pregnancies where the mother reported smoking in 2012-14 in:</p> <ul style="list-style-type: none"> • Cardinia 33.6% • Casey 25.7% • Frankston 21.9% • Mornington peninsula 17.5% • Greater Dandenong 11.4% 	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).
	<p>High incidence of low birth weight babies between 2012-14 in:</p> <ul style="list-style-type: none"> • Greater Dandenong 6.9% 	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).
	<p>High proportion of children who are developmentally vulnerable on one or more domains in 2015 in:</p> <ul style="list-style-type: none"> • Greater Dandenong 28.3% 	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).

Outcomes of the health needs analysis		
	<p>Low rate of children who consumed the recommended amount of fruits (ASR per 100) in 2014-15 in:</p> <ul style="list-style-type: none"> Greater Dandenong 61.1 	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).
	<p>High rate of childhood obesity among 2-17 year olds (ASR per 100) in 2014-15 in:</p> <ul style="list-style-type: none"> Greater Dandenong 10.6 Casey 9.3 	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).
	<p>High rate of child protection substantiations per 1,000 population in 2014-15 in:</p> <ul style="list-style-type: none"> Frankston 23.6 Greater Dandenong 20.3 	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).
	<p>High rate of youth (15-24 years) mortality (ASR per 100,000) between 2010-14 in:</p> <ul style="list-style-type: none"> Cardinia 56.5 Frankston 53.0 Port Phillip 47.2 	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).
<p>Identified needs – Children & youth</p> <ul style="list-style-type: none"> Cardinia, Casey, Frankston & Mornington Peninsula had a large proportion of mothers who reported smoking during pregnancy Greater Dandenong has a large proportion of children and youth with high needs Frankston had high rates of child protection substantiations, as well as a high rate of youth mortality Cardinia had very high rates of youth mortality 		
Priority populations – older people	<p>Top five diseases causing burden in people aged 65 years and over:</p> <ul style="list-style-type: none"> Coronary heart disease 	AIHW. Older Australia at a glance (online). At: https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance

Outcomes of the health needs analysis		
	<ul style="list-style-type: none"> • Dementia • COPD • Stroke • Lung cancer 	a-glance/contents/health-and-functioning/burden-of-disease (accessed 15 November 2017).
	<p>Top five leading causes of premature death among people aged 65-74 years in 2012-14:</p> <ul style="list-style-type: none"> • 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-in-australia/contents/leading-causes-of-death (accessed 15 November 2017).
	<p>Type of care received in hospital for people aged over 65 years in 2013-14:</p> <ul style="list-style-type: none"> • 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.
	<p>High proportion of people aged over 65 years with a profound or severe disability in 2016 in:</p> <ul style="list-style-type: none"> • Greater Dandenong 25.7% 	PHIDU. LGA data - Census 2016 (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 12 October 2017).
	<p>High proportion of people over 75 years who live alone in 2011 in:</p> <ul style="list-style-type: none"> • 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).

Outcomes of the health needs analysis		
	<p>Low rate of residential aged care places per 1,000 population aged over 70 years in 2016 in:</p> <ul style="list-style-type: none"> 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).
	<p>High rate of dementia per 1,000 population in 2016 in:</p> <ul style="list-style-type: none"> Mornington Peninsula 25.1 Bayside 23.8 	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).
	<p>High rate of overnight hospitalisations for dementia (ASR per 100,000) in 2014-15 in:</p> <ul style="list-style-type: none"> Frankston 71 	
<p>Identified needs – Older people</p> <ul style="list-style-type: none"> 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	<p>Key health issues: ^{1,2}</p> <ul style="list-style-type: none"> Cardiovascular disease Cancer – particularly lung & cervical Type 2 diabetes Mental illness & suicide Renal disease Respiratory system diseases Infectious diseases Eye health Ear disease & hearing loss 	<p>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.</p> <p>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.</p> <p>³ Davy, C., Harfield, S., McArthur, A., Munn, Z., & Brown, A. (2016). Access to primary health care services for Indigenous peoples: A</p>

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	<ul style="list-style-type: none"> Dental caries and periodontal diseases Disability <p>Health risk factors: ^{1, 2}</p> <ul style="list-style-type: none"> High rates of smoking High rates of alcohol and drug related harm Poor nutrition Low physical activity High rates of obesity Lower immunization rates <p>Barriers to accessing services: ^{3, 4}</p> <ul style="list-style-type: none"> Poor health literacy Different attitudes towards health & wellbeing Financial barriers Lack of culturally appropriate services and information Transport barriers Lack of trust Family relationships to clinic staff, where aboriginal staff are hired 	<p>framework synthesis. International journal for equity in health, 15(1), 163.</p> <p>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.</p>
	<p>High proportion of Aboriginal mothers who reported smoking during pregnancy between 2012-14 in:</p> <ul style="list-style-type: none"> Cranbourne – Narre Warren 48.8% Greater Dandenong (IARE) 48.8% 	<p>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 31 September 2017).</p>
	<p>High unemployment rate among Aboriginal people in 2011 in:</p> <ul style="list-style-type: none"> Greater Dandenong (IARE) 13.3% 	<p>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 31 September 2017).</p>

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	<ul style="list-style-type: none"> Melbourne – Port Phillip 12.4% Frankston (IARE) 12.3% 	atlases/data#aboriginal-torres-strait-islander-social-health-atlas-of-australia (accessed 31 September 2017).
	<p>High proportion of Aboriginal people with a profound or severe disability in 2011 in:</p> <ul style="list-style-type: none"> Mornington peninsula (IARE) 8.1% Greater Dandenong (IARE) 7.4% Frankston (IARE) 6.8% 	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 31 September 2017).
	<p>High rate of hospital admissions of Aboriginal people (ASR per 100,000) in 2012-13 in:</p> <ul style="list-style-type: none"> Melbourne – Port Phillip 34,365 Greater Dandenong (IARE) 33,585 	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 31 September 2017).
	<p>High rate of ambulatory case sensitive hospitalisations of Aboriginal people (ASR per 100,000) in 2012-13 in:</p> <ul style="list-style-type: none"> Greater Dandenong (IARE) 4,225 	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 31 September 2017).
Identified needs – Aboriginal and Torres Strait Islander people <ul style="list-style-type: none"> Greater Dandenong (IARE) had a large proportion of Aboriginal residents with high needs 		
Priority populations – Refugees and people from culturally and linguistically	<p>Top 10 ethnic groups among refugees who arrived in the SEMPHN region between 2007-2016:</p> <ul style="list-style-type: none"> Hazara Karen Tamil Pashtun Tajik 	Department of Social Services (DSS). Historical Settlement Reports (online). At: https://data.gov.au/dataset/settlement-reports (accessed 27 October 2017).

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diverse communities	<ul style="list-style-type: none"> Iraqi Burmese African (NFD) Afghan Oromo 	
	<p>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</p> <p>Key health issues for refugees: ^{4, 5, 6}</p> <ul style="list-style-type: none"> 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 <p>Barriers to accessing services: ^{7, 8, 9}</p> <ul style="list-style-type: none"> Financial barriers – low income & unemployment 	<p>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.</p> <p>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.</p> <p>³ Strong, K., Trickett, P., & Bhatia, K. (1998). The health of overseas-born Australians, 1994-1996. Australian Health Review, 21(2), 124-133.</p> <p>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</p> <p>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.</p> <p>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.</p>

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	<ul style="list-style-type: none"> • Cultural barriers – different beliefs and attitudes towards health • Language difficulties • Under-trained workforce – Lack of awareness of issues specific to refugee health • Legal barriers • Distrust of government services 	<p>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.</p> <p>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.</p> <p>⁹ Lamb, C. F., & Smith, M. (2002). Problems refugees face when accessing health services. New South Wales public health bulletin, 13(7), 161-163.</p>
Priority populations – People experiencing homelessness	<p>Sub-groups ¹</p> <ul style="list-style-type: none"> • Males experienced higher rates of homelessness • Indigenous Australians experienced higher rates of homelessness • Children: almost one in six Victorians 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. <p>Key health issues ^{2,3}</p> <ul style="list-style-type: none"> • Mental health issues¹ • Alcohol and drug dependence¹ • Infectious diseases² 	<p>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).</p> <p>² The prevalence of mental disorders among the homeless in western countries: systematic review and meta-regression analysis. PLoS medicine, 5(12), e225.</p> <p>³ Raoult, D., Foucault, C., & Brouqui, P. (2001). Infections in the homeless. The Lancet infectious diseases, 1(2), 77-84.</p> <p>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).</p> <p>⁵ North and West Metropolitan Local Area Service Network. North and West Metropolitan Region LASN Client Focus Group 3 Report</p>

Outcomes of the health needs analysis		
	<p>Barriers to accessing services ^{4, 5}</p> <ul style="list-style-type: none"> Financial hardship Lack of transportation to medical facilities Lack of identification or Medicare Card Difficulty maintaining appointments or treatment regimes Lack of awareness of support services Assessment process is repetitive and lacks sensitivity to client circumstances 	<p>(online). At: http://www.nwhn.net.au/Resources.aspx (accessed 10 November 2017).</p>
Priority populations – LGBTIQ community	<p>Key health issues</p> <ul style="list-style-type: none"> Stigma & discrimination is a major factor that impacts on the health & wellbeing of LGBTIQ communities and individuals.¹ Poor mental health: Higher rates of mental health disorders, including depression, anxiety disorders, 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 <p>Barriers to accessing services ⁶</p> <ul style="list-style-type: none"> Majority of LGBTIQ people reported experiencing homophobia from health professionals. 	<p>¹ Rosenstreich, G., Comfort, J., & Martin, P. (2011). Primary health care and equity: the case of lesbian, gay, bisexual, trans and intersex Australians. <i>Australian Journal of Primary Health</i>, 17(4), 302-308.</p> <p>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. <i>Archives of sexual behavior</i>, 43(8), 1571-1578.</p> <p>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. <i>International Journal of Drug Policy</i>, 28, 76-82.</p> <p>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. <i>Sexual health</i>, 14(1), 18-27.</p> <p>⁵ McNair, R., Andrews, C., Parkinson, S., & Dempsey, D. (2017). Stage 1 Report LGBTI Homelessness: Preliminary findings on risks,</p>

Outcomes of the health needs analysis		
	<ul style="list-style-type: none"> 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. 	<p>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)</p> <p>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).</p>

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 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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Greater Dandenong 5.6 	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).
	Low proportion of population who reside near public transport in 2015 in: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Lack of affordable medical services 69% Lack of awareness of existing services 61% 	PHN Stakeholder engagement survey November 2016

Outcomes of the service needs analysis		
	<ul style="list-style-type: none"> • Lack of affordable transport 59% • Shortage of allied health services 52% • 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 or intellectual disabilities) 11% 	
Identified needs – Access to health services <ul style="list-style-type: none"> • 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 		
Availability of Primary Health Care services	Low rate of General Practitioners per 1,000 population in 2014 in: <ul style="list-style-type: none"> • Cardinia 0.7 • Kingston 0.7 • Casey 0.9 • Frankston 1.0 	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 GP clinics per 1,000 population in 2015 in:	DHHS. 2015 Local Government Area (LGA) Statistical Profiles (online). At: https://www2.health.vic.gov.au/about/reporting-planning-data/gis-

Outcomes of the service needs analysis		
	<ul style="list-style-type: none"> Cardinia 0.2 Casey 0.2 Kingston 0.2 	and-planning-products/geographical-profiles (accessed 12 October 2017).
	Low rate of pharmacies per 1,000 population in 2015 in: <ul style="list-style-type: none"> 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 12 October 2017).
	Low rate of Allied Health service sites per 1,000 population in 2015 in: <ul style="list-style-type: none"> Casey 0.4 Cardinia 0.5 Kingston 0.5 	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).
Identified needs – Availability of Primary Health Care Services <ul style="list-style-type: none"> Cardinia, Casey and Kingston had a low rate of availability of primary health care services 		
Health service utilisation	Frequent GP attenders were more likely to: <ul style="list-style-type: none"> 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 2015-16 in: <ul style="list-style-type: none"> Casey – South 7.5 	Australian Institute of Health and Welfare. Web update: Medicare Benefits Schedule GP and specialist attendances and expenditure in 2015–16 (online). At: https://www.myhealthycommunities.gov.au/our-

Outcomes of the service needs analysis		
		reports/gp-and-specialists-attendances-and-expenditure/august-2017/explore-the-data (accessed 30 October 2017).
	High rates of specialist attendances per person (age-standardises) in 2015-16 in: <ul style="list-style-type: none"> Stonnington – East 1.3 Stonnington – West 1.3 	Australian Institute of Health and Welfare. Web update: Medicare Benefits Schedule GP and specialist attendances and expenditure in 2015–16 (online). At: https://www.myhealthycommunities.gov.au/our-reports/gp-and-specialists-attendances-and-expenditure/august-2017/explore-the-data (accessed 30 October 2017).
Identified needs – GP attendances <ul style="list-style-type: none"> Casey had very high rates of GP attendances, despite having low rates of GP availability 		
After-hours	The rate of providers who claimed GP After Hours/Emergency Attendance per 1,000 population was lowest in 2015-16 in: <ul style="list-style-type: none"> 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 person (age-standardised) in 2015-16 in: <ul style="list-style-type: none"> Casey – South 1.1 Casey – North 1.0 	Australian Institute of Health and Welfare. Web update: Medicare Benefits Schedule GP and specialist attendances and expenditure in 2015–16 (online). At: https://www.myhealthycommunities.gov.au/our-reports/gp-and-specialists-attendances-and-expenditure/august-2017/explore-the-data (accessed 30 October 2017).
	High rate of after-hours emergency department presentations (per 1,000 ASR) in 2015-16 in: <ul style="list-style-type: none"> 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 service needs analysis

In 2017, SEMPHN also 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 ED 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:

- 1 Cardinia (highest need)
- 2 Casey - South
- 3 Dandenong
- 4 Frankston
- 5 Mornington Peninsula
- 6 Kingston
- 7 Casey - North
- 8 Glen Eira
- 9 Bayside
- 10 Stonnington - West
- 11 Stonnington - East
- 12 Port Phillip (lowest need)

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:

- Need for awareness raising of service availability among consumers and service providers
- 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 alternative after hours services

Outcomes of the service needs analysis		
	<ul style="list-style-type: none"> Need to build workforce capacity <ul style="list-style-type: none"> Gaining awareness of the key factors that consumers identify as contributing to poor quality care Promoting the uptake and application of the key elements that are perceived to contribute to high quality care 	
Identified needs – After-hours <ul style="list-style-type: none"> Casey had relatively high rates of after-hours GP attendances per person, despite having low rates of providers who claimed an after-hours item Cardinia, Casey-South & Dandenong appear to have the highest level of after-hours need in the SEMPHN region 		
Emergency Department presentations	Key drivers of ED visits: <ul style="list-style-type: none"> Multiple long-term health conditions Cost barriers to seeing a GP Older age (60 years and over) People living in outer region, remote and very remote regions 	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 2017).
	High rate of ED presentations per 1,000 population in 2014-15 in: <ul style="list-style-type: none"> Cardinia 299.0 Frankston 292.0 Mornington Peninsula 285.3 Greater Dandenong 273.8 Casey 269.5 	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 annual increase in ED presentations between 2004-05–2014-15: <ul style="list-style-type: none"> 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).

Outcomes of the service needs analysis		
	<p>High rate of projected annual increase in ED presentations between 2014-15–2026-27 in:</p> <ul style="list-style-type: none"> Cardinia 5.4% Casey 4.1% Greater Dandenong 3.5% 	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).
	<p>High rate of primary care type ED presentations per 1,000 population in 2015-15 in:</p> <ul style="list-style-type: none"> Cardinia 116.4 	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).
<p>Identified needs – ED presentations</p> <ul style="list-style-type: none"> Cardinia, Casey and Greater Dandenong have had the highest rates of increase in ED presentations over the previous 10 years, and are predicted to have the greatest increase over the next decade Cardinia had very high rates of ED presentations overall, as well as primary care type ED presentations Frankston had high rates of ED presentations overall, as well as high rates of after-hours ED presentations Mornington Peninsula had relatively high rates of ED presentations 		
Hospital admissions	<p>High rate of inpatient separations per 1,000 population in 2014-15 in:</p> <ul style="list-style-type: none"> 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).
	<p>High rate of annual increase in inpatient separations between 2004-05–2014-15 in:</p> <ul style="list-style-type: none"> Cardinia 8.5% 	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).

Outcomes of the service needs analysis		
	<ul style="list-style-type: none"> Casey 6.3% 	and-planning-products/geographical-profiles (accessed 12 October 2017).
	<p>High rate of projected annual increase in inpatient separations between 2014-15–2026-27 in:</p> <ul style="list-style-type: none"> Cardinia 5.3% Casey 4.7% 	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).
	<p>Top 5 conditions which contributed to the most potentially preventable hospitalisations & bed days:</p> <ul style="list-style-type: none"> Chronic obstructive pulmonary disease (COPD) Diabetes complications Heart failure Cellulitis Kidney and urinary tract infections (UTIs) 	AIHW. Healthy Communities: Potentially preventable hospitalisations in 2013–14. At: https://www.myhealthycommunities.gov.au/our-reports/potentially-preventable-hospitalisations/december-2015 (accessed 30 October 2017).
	<p>High rate of potentially preventable hospitalisations (per 100,000 ASR) in 2015-16 in:</p> <ul style="list-style-type: none"> Casey – South 3,156 Frankston 2,108 Casey – North 2,090 Cardinia 3,077 	AIHW. Web update: Potentially preventable hospitalisations in 2015–16 (online). At: https://www.myhealthycommunities.gov.au/our-reports/potentially-preventable-hospitalisations-update/july-2017/explore-the-data (accessed 30 October 2017).
	<p>High rate of potentially preventable hospitalisations for chronic conditions (per 100,000 ASR) in 2015-16 in:</p> <ul style="list-style-type: none"> Casey – North 1,610 Casey – South 1,567 Frankston 1,519 	AIHW. Web update: Potentially preventable hospitalisations in 2015–16 (online). At: https://www.myhealthycommunities.gov.au/our-reports/potentially-preventable-hospitalisations-update/july-2017/explore-the-data (accessed 30 October 2017).

Outcomes of the service needs analysis		
	<ul style="list-style-type: none"> Cardinia 1,504 Dandenong 1,393 	
	<p>High rate of potentially preventable hospitalisations for chronic obstructive pulmonary disease (per 100,000 ASR) in 2015-16 in:</p> <ul style="list-style-type: none"> Frankston 360 Cardinia 328 Casey – North 300 Casey – South 290 	<p>AIHW. Web update: Potentially preventable hospitalisations in 2015–16 (online). At: https://www.myhealthycommunities.gov.au/our-reports/potentially-preventable-hospitalisations-update/july-2017/explore-the-data (accessed 30 October 2017).</p>
	<p>High rate of potentially preventable hospitalisations for diabetes complications (per 100,000 ASR) in 2015-16 in:</p> <ul style="list-style-type: none"> Casey – North 269 Frankston 264 	<p>AIHW. Web update: Potentially preventable hospitalisations in 2015–16 (online). At: https://www.myhealthycommunities.gov.au/our-reports/potentially-preventable-hospitalisations-update/july-2017/explore-the-data (accessed 30 October 2017).</p>
	<p>High rate of potentially preventable hospitalisations for iron deficiency anaemia (per 100,000 ASR) in 2015-16 in:</p> <ul style="list-style-type: none"> Casey – South 366 Casey – North 353 Bayside 337 Cardinia 329 	<p>AIHW. Web update: Potentially preventable hospitalisations in 2015–16 (online). At: https://www.myhealthycommunities.gov.au/our-reports/potentially-preventable-hospitalisations-update/july-2017/explore-the-data (accessed 30 October 2017).</p>
	<p>High rate of potentially preventable hospitalisations for acute conditions (per 100,000 ASR) in 2015-16 in:</p> <ul style="list-style-type: none"> Frankston 1,462 Mornington Peninsula 1,444 	<p>AIHW. Web update: Potentially preventable hospitalisations in 2015–16 (online). At: https://www.myhealthycommunities.gov.au/our-reports/potentially-preventable-hospitalisations-update/july-2017/explore-the-data (accessed 30 October 2017).</p>

Outcomes of the service needs analysis		
	<ul style="list-style-type: none"> • Cardinia 1,436 	
	<p>High rate of potentially preventable hospitalisations for dental conditions (per 100,000 ASR) in 2015-16 in:</p> <ul style="list-style-type: none"> • Mornington Peninsula 436 	AIHW. Web update: Potentially preventable hospitalisations in 2015–16 (online). At: https://www.myhealthycommunities.gov.au/our-reports/potentially-preventable-hospitalisations-update/july-2017/explore-the-data (accessed 30 October 2017).
	<p>High rate of potentially preventable hospitalisations for cellulitis (per 100,000 ASR) in 2015-16 in:</p> <ul style="list-style-type: none"> • Cardinia 300 	AIHW. Web update: Potentially preventable hospitalisations in 2015–16 (online). At: https://www.myhealthycommunities.gov.au/our-reports/potentially-preventable-hospitalisations-update/july-2017/explore-the-data (accessed 30 October 2017).
	<p>High rate of potentially preventable hospitalisations for ear notes & throat infections (per 100,000 ASR) in 2015-16 in:</p> <ul style="list-style-type: none"> • Cardinia 273 • Casey – North 236 • Casey – South 226 	AIHW. Web update: Potentially preventable hospitalisations in 2015–16 (online). At: https://www.myhealthycommunities.gov.au/our-reports/potentially-preventable-hospitalisations-update/july-2017/explore-the-data (accessed 30 October 2017).
	<p>High rate of potentially preventable hospitalisations for gangrene (per 100,000 ASR) in 2015-16 in:</p> <ul style="list-style-type: none"> • Cardinia 99 • Frankston 97 • Casey – South 78 • Mornington Peninsula 77 • Bayside 68 	AIHW. Web update: Potentially preventable hospitalisations in 2015–16 (online). At: https://www.myhealthycommunities.gov.au/our-reports/potentially-preventable-hospitalisations-update/july-2017/explore-the-data (accessed 30 October 2017).
	<p>High rate of potentially preventable hospitalisations for vaccine preventable conditions (per 100,000 ASR) in 2015-16 in:</p>	AIHW. Web update: Potentially preventable hospitalisations in 2015–16 (online). At: https://www.myhealthycommunities.gov.au/our-reports/potentially-preventable-hospitalisations-update/july-2017/explore-the-data (accessed 30 October 2017).

Outcomes of the service needs analysis		
	<ul style="list-style-type: none"> Dandenong 402 	reports/potentially-preventable-hospitalisations-update/july-2017/explore-the-data (accessed 30 October 2017).
Identified needs – Hospital admissions <ul style="list-style-type: none"> High rates of potentially preventable hospitalisations for COPD and iron deficiency anaemia in the SEMPLHN region Cardinia and Casey have had the highest rates of increase in hospital admissions over the previous 10 years, and are predicted to have the greatest increase over the next decade Casey, Frankston and Cardinia had very high rates of potentially preventable hospitalisations Dandenong had high rates of potentially preventable hospitalisations for chronic conditions and vaccine preventable conditions Mornington Peninsula had very high rates of inpatient separations 		
SEMPHN stakeholder consultation, 2017	Themes identified: <ol style="list-style-type: none"> Need to adopt a more collaborative, integrated and streamlined approach to care Need for targeted and client centred services Need for capacity building: workforce and infrastructure Need for more appropriate funding and funding structures Need to raise awareness 	
	Need to adopt a more collaborative, integrated and streamlined approach to care <p>Respondents spoke about the need for:</p> <ol style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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 	

Outcomes of the service needs analysis

3. The 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

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 through staff remaining involved as the patient’s point of call 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 drop outs and lesser emergency department presentations. The elements noted were:

1. A single point of entry to facilitate seamless, supportive assessment and treatment for dual diagnosis
2. A “*client directed*” approach to care which provided opportunities for family inclusive practice
3. 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/information in multiple languages
- Providing infrastructure/facilities to enable access. For example, childcare so parent can access service. Access for carers and transport options
- Assess MH of AOD clients at assessment to ensure “*one health element is not overlooked at the expense of the other*”
- Adopt place based, assertive outreach approach to engage with hard to reach clients and address health needs (e.g. residents of public housing estates)

Need for capacity building: workforce and infrastructure

Outcomes of the service needs analysis

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.

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 break the stigma surrounding AOD users.
- 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

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 relevant to promoting staff knowledge on assisting clients navigate the system, identify existing services and access points such as in relation to the new National Disability Insurance Scheme (NDIS) was noted.

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

Outcomes of the service needs analysis

- Improving quality systems including confidentiality agreement and a standardized 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
- Lack of certainty due to short term funding affects resourcing including recruitment and retention of skilled staff. This also 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 for in-home carer respite to address carer burnout and the financial and practical burdens faced (PC)
- 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 facilitates 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 have involvement 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

Outcomes of the service needs analysis

- 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

For example, awareness raising by the PHN on community health referral pathways which can be accessed by private service providers was noted.

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 emergency department presentations. For example, admissions can be avoided when early intervention is provided for palliative patients requiring pain management, and 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”*.

Section 4 – Opportunities, priorities and options

This section summarises the priorities arising from the Needs Assessment and options for how they will be addressed. This could include options and priorities that:

- may be considered in the development of the Activity Work Plan, and supported by PHN flexible funding;*
- may be undertaken using programme-specific funding; and*
- may be led or undertaken by another agency.*

Additional rows may be added as required.

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
Chronic disease	<ol style="list-style-type: none"> 1. Commission services to deliver a coordinated model of care, with a focus on highest users of acute health services and people with chronic and complex care needs. 2. Build capacity of general practices within areas of high need to implement coordinated approaches to care 3. Improve collaboration between GPs and other providers through implementation of shared transfers of care guidelines into general practice. 4. Undertake activities that connect priority groups, including older people, Aboriginal and Torres Strait Islanders, culturally and linguistically diverse (CALD) communities, people experiencing homelessness and vulnerable youth, to coordinated primary health care services that will facilitate continuity of care 	<ul style="list-style-type: none"> • Reduction in frequent presentations and admissions to hospital for people with chronic and complex care needs. • Improve quality of life for people with multi-morbidity. 	<ul style="list-style-type: none"> • Hospital re-admission within 28 days • ED re-presentation within 28 days • Management of people with chronic disease. • The number of patients with GP Care Plan 	SEMPHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
		<ul style="list-style-type: none"> Improved capacity of services to deliver coordinated and integrated care 	<ul style="list-style-type: none"> Referrals on discharge to primary care. 	
After hours	<p>Commission services to support the effective delivery of primary care services in the after-hours, focusing particularly on priority populations and areas with high needs</p> <p>This will build on the existing After-Hours Grant Program, and will include the following:</p> <ol style="list-style-type: none"> Funding integrated care arrangements among and between different general practices and health services in the region Reducing clinical variation amongst providers offering after-hours services Increasing the communication between in and after-hours medical services via (among other things) secure messaging 	<ul style="list-style-type: none"> Increase access to and availability of primary care services in the After-Hours period Reduce number of primary care-type presentations to Emergency Departments Increase in continuity and coordination of 	<ul style="list-style-type: none"> Coverage of GP services by time of day, including by type of service Number of patients visits to Emergency Departments due to lack of access to after-hours services Primary care type Emergency 	SEMPHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
		care for patients in the after-hours.	Department attendances by time of day <ul style="list-style-type: none"> • Referrals between in hours and after hours practices • Proportion of GP and nurse time allocated to coordination • Patient experience measures, including: <ul style="list-style-type: none"> - Felt involved in decision making process 	

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
			- Understood their care	
Potentially Preventable Hospitalisations	<ol style="list-style-type: none"> 1. Investigate models of care to improve management of potentially preventable hospitalisations in general practice. 2. Education opportunities to support disease self-management. 3. Investigate the nature of high COPD PPH rates in the catchment. 4. Investigate the nature of high anaemia PPH rates in the catchment 5. Assess access to timely specialist ambulatory care 6. Routine peri-discharge to include referral back to GP at discharge 	<ul style="list-style-type: none"> • Reduced waiting times for specialist ambulatory / public hospital outpatient care. • Rates of discharge referrals and summaries. • Increased consumer and carer engagement and self-management. • Reduced hospital admissions target PPH. 	<ul style="list-style-type: none"> • LGA admission rates • Rates of re-admission • Reduction in primary care type emergency department attendances. • Trends in PPH hospital presentations and GP attendances • Increased Community Nurse consultations 	<ul style="list-style-type: none"> - SEMPHN - LHNs

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
		<ul style="list-style-type: none"> Reduced length of stay for target PPH 	<ul style="list-style-type: none"> Outcomes measured in the Ophelia project. 	
Cancer screening	<ol style="list-style-type: none"> Increase awareness of cancer screening within underscreened communities, such as Indigenous and culturally and linguistically diverse populations Undertake activities to educate health professionals and consumers about upcoming changes to the National Cervical Cancer Screening Program in December 2017 Implement coordinated and targeted approaches in general practice, to improve participation rates in the national bowel, breast and cervical cancer screening programs, particularly in areas with low participation and underscreened communities Investigate the rates of referral for colonoscopy by SEMPHN general practitioners and profile the demographics and outcomes where data can be obtained. Work with general practitioners to ensure colonoscopy referral practices align with applicable NHMRC guidelines and the Royal Australian College of General Practitioners' guidelines for preventive activities in general practice. (Australian Commission on Safety and Quality in Health Care 2015) 	<ul style="list-style-type: none"> Increased participation in the national bowel, breast and cervical cancer screening programs Improved knowledge among health professionals about changes Quantify the outcomes of the high rates of colonoscopy for the detection of bowel cancer in 	<ul style="list-style-type: none"> Participation rates in the national bowel, breast and cervical cancer screening programs Screening rates among underscreened communities Colonoscopy rates within the region reflect best practice. 	<ul style="list-style-type: none"> SEMPHN Cancer Council Victoria Breastscreen Victoria DHHS

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
		the SEMPHN region.		
Immunisation	<ol style="list-style-type: none"> 1. Target local immunization providers with the highest number of children who are not fully immunised, to identify patients who are not fully immunized organise recalls 2. Implement responsive immunisation initiatives which reflect local needs in specific hotspots and build on the strengths of the community through education and patient support. Particular focus should be on identified 'at risk' and hard to reach groups within the hotspot areas. 3. Practical and prompt support for immunization provide within identified hotspot areas with quality data issues, to assist with the implementation of efficient data collection processes 4. Education (such as webinars and/or practice coaching) for GP Practice staff, nurse immunisers and other relevant stakeholders addressing current immunisation topics of concern such as 'catch ups', data cleansing and changes to the Immunisation Schedule. 5. Quantify the impact of influenza within the region and the vaccination rate by at risk population groups. 	<ul style="list-style-type: none"> • Increased immunisation coverage across the SEMPHN region • Improved knowledge among immunisation providers with up to date and accurate information on topics of concern • Implementation of efficient systems and data collection processes 	<ul style="list-style-type: none"> • Australian Immunisation Register – Immunisation coverage rates • Infectious diseases surveillance reports 	<ul style="list-style-type: none"> - SEMPHN - Local councils

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
		among local providers		
Health literacy	<ol style="list-style-type: none"> 1. SEMPLHN has undertaken a project with Deakin University called the Ophelia project with the aim to measure the health literacy across the region and in key hotspots using a validated survey instrument known as the Health Literacy Questionnaire (HLQ). The project is intended to highlight issues relating to health literacy in after-hours primary care. 2. In 2016-2018 SEMPLHN will work with Deakin University to apply the implementation plan and promote, distribute and market those resources developed in 2015-16. SEMPLHN will apply an evaluation framework to determine their efficacy and where necessary make variations to the materials. 3. Implementation of community awareness campaign and strategic marketing to improve health literacy 4. Development of resources in collaboration with GPs and the community 	<ul style="list-style-type: none"> • Improved health literacy among priority groups • More appropriate use of available health resources, particularly in relation to after-hours primary care • Improved understanding of health information by at risk population. • Increased ability to navigate the health system. 	<ul style="list-style-type: none"> • Health literacy questionnaire • Evaluation surveys 	<ul style="list-style-type: none"> • SEMPLHN • Deakin University

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
Humanitarian and refugee	<ol style="list-style-type: none"> 1. Address the complex care needs of humanitarian arrivals and collaborate on the OPTIMISE project with the Refugee Health Research Consortium. 2. Assess models of TB screening for Humanitarian arrivals and barriers to timely testing and management. 3. Improve rates of TB screening for TB amongst refugee, humanitarian and permanent resident population groups with high TB rates. The Victorian Tuberculosis Program is The World Health Organisation (WHO) End TB strategy and is working towards an 18% reduction annually with Greater Dandenong and Casey one of the local government areas targeted. 	<ul style="list-style-type: none"> • Increased access for refugees to appropriate health services. • Identification of health providers who are bilingual. • Improved access to interpreter services. • Reduction in TB notification rates in Greater Dandenong and Casey. • Increased identification and support of GP's who are interested in refugee health. 	<ul style="list-style-type: none"> • Directory of bilingual health providers • Participation rates in TB screening • Infectious diseases surveillance reports 	<ul style="list-style-type: none"> • Refugee Health Research Consortium • SEMPHN • The Victorian Tuberculosis Program PHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
System Priorities				
Health System Alignment Fragmentation of health support services within and between the health (e.g. primary and tertiary health) and non-health sectors (e.g. homelessness, education, social welfare).	1. Map and design pathways across service sectors to provide integrated models of care. 2. Build the capacity of General Practice to provide integrated seamless care for patients 3. Build the capacity of General Practice to improve access for humanitarian arrivals	1. System design understood to achieve improved access for consumers 2. Improved continuum of care for consumers	1. Improved care coordination 2. Improved care co-ordination for humanitarian population groups. 3. Reduction in re-admission rates	- SEMPHN - Monash Health
Intelligent Commissioning	1. Identify potential opportunities for preventative and self-care activities 2. Develop effective transition of patients across the care continuum	1. Understand appropriate service models for preventative and self-care	Improved consumer outcomes within	SEMPHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
Increasing demand for primary health services		activities in SEMPHN 2. Implement appropriate models of care that reflect the level of consumer need, incorporating existing State-funded programs	commissioned services	
Co-Design & Patient Centricity Services not designed to focus on consumer need (e.g. outcomes), but rather on	1. Develop an outcomes-driven commissioning model, informed by consumer need 2. Build capacity of service providers to engage with outcomes-driven commissioning model addressing consumer needs	1. Effective approach to commissioning, driven by consumer need	Improved consumer outcomes within commissioned services	SEMPHN

Opportunities, priorities and options				
Priority	Possible Options	Expected Outcome	Possible Performance Measurement	Potential Lead
service throughput.				

Section 5 - Checklist

This checklist confirms that the key elements of the needs assessment process have been undertaken. PHNs must be prepared, if required by the Department, to provide further details regarding any of the requirements listed below.

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