# Needs Assessment 2024/25-2026/27

*Update Submitted November 2024*

## Needs Assessment - Main Draft

***Population Health Planning & Insights***

# 1. Narrative

## Our process

The South Eastern NSW PHN (SENSWPHN) has taken a pragmatic approach to undertake this substantial Needs Assessment. This body of work continues the ongoing and comprehensive population health needs analysis and service gaps assessment that the PHN has been undertaking and continuously building on since the inception of the PHN program. This needs assessment has continued our long-standing approach to review and incorporate the latest quantitative data from several topics and sources, alongside a more holistic thematic analysis of qualitative data collated and sourced in recent years from ongoing stakeholder consultation, community and consumer inputs, specific expert opinions and insights from the regular monitoring, review and evaluation of commissioned services and other SENSWPHN facilitated or managed programs and initiatives.

Through a dedicated team of professionals within the Planning and Insights team; supported by the executive tier as well as the relevant governance layers of the organisation, SENSWPHN manages the ongoing and regular assessment of needs and analysis and interrogation of latest data-driven evidence as part of the continuous and ongoing assessment of needs as a routine process. The organisation has several robust mechanisms of collating and analysing a very wide range of quantitative and qualitative data, undertaken by a dedicated team comprised of very diverse and complementary skillsets including but not limited to epidemiological expertise, health planning and reporting specialists along with strategic critical thinkers that support a robust, fit-for-purpose and actionable assessment of regional needs in a structured and methodical way.

The key analytical pillar of SENSWPHN's needs assessment is the **Population Health Profile**, which is a detailed report that accurately and comprehensively quantifies several key variables that are estimated to be pivotal in understanding the relative health needs of the resident population of SENSWPHN. The detailed critical summarisation of this document remains the initial step in undertaking data-driven and evidence-based health service planning for the catchment. This **Population Health Profile** is an ongoing and continuous body of evidence which is updated with more recent information and figures, as and when sourced and adapted from various reliable sources of data and is made publicly available by SENSWPHN here.

Additionally bespoke Information Snapshots were also prepared as supplements for this needs assessment for key strategic topics including mental health including suicide prevention; alcohol and other drugs; and ageing/older persons. These supplements include analytical information summaries such as service location and availability mapping; insights from service utilisation and outputs from PHN commissioned services and summary inferences from other national/state level data where local data was not available; among others. The summary inferences from these supplements were discussed with relevant staff and teams within the organisation in 2 dedicated workshops to ensure no business-critical information gaps were left unexamined. After further refinement of the supplement snapshots based on workshop inputs, the summarised conclusions from these supplements were appended to the holistic summary insights from the Population Health Profile and other information assets to form the evidence backbone of the needs assessment (as outlined in the Health Needs and Service Needs Summary Tables in this report). An additional bespoke analysis was also conducted to incorporate some special topics such as primary care bulk billing distribution; correlation of socio-economic disadvantage with key chronic conditions; geographic hot spotting of a combined and composite assessment of needs; morbidity profile for children; and chronic condition estimates for Aboriginal and Torres Strait Islander persons[1].

All the aforementioned quantitative information was complemented with our novel mechanism of collating and exploring qualitative analysis of a wide range of consultation and/or feedback and/or expert opinion data obtained from multiple sources. This method (of collating a **Planning Journal** report) has enabled the examination of all qualitative input into one thematically analysed and coded master list that now forms the baseline for ongoing updates making SENSWPHN's population health and activity planning evidence base more robust and as comprehensive as feasible without losing any historic knowledge.

A list of priorities was developed by the Planning and Insights team by systematically working through all the identified needs, key issues and themes identified through the above-mentioned process. This then led to the final step in conceptual triangulation process, to undertake a topic expert / senior executive knowledge and skill-based prioritization of the list of priorities. After a strategic planning meeting with the executive level of SENSWPHN a priority ranking and scoring template was devised to obtain structured inputs on the priorities from the executives under the following key domains of:

- Size and distribution of the need
- Cost efficiency and timeframes (of existing and hypothesised solutions/interventions)
- Effectiveness/suitability of the solution/s we can create
- Alignment, Risks and Scope (to our organisational as well as overall PHN vision and remit)

The Planning and Insights team then aggregated the prioritization scores from 5 executives from the above processes into the draft needs assessment report which was then reviewed by SENSWPHN Chief Executive Officer. The Needs Assessment was then finalized for submission to the Department of Health and Aged Care (DoHAC).

After the submission has been concluded the Planning and Insights team at SENSWPHN will continue the ongoing cycle of assessing latest data and information and coordinating and/or undertaking stakeholder and community consultations to ongoingly make the information and evidence base for PHN planning richer and more comprehensive. It is estimated that alongside regular updates of key information assets such as the Population Health Profile; the team will keep collating and synthesising new evidence into planning insights and continually make annual updates to the needs assessment to stay as data/evidence informed in guiding all activity planning and service commissioning decisions of the PHN.

## Our key data needs and gaps

We have attempted to incorporate a large volume of health service and epidemiological quantitative data as well as qualitative evidence to determine the priorities for our catchment; however, a few key data gaps need to be mentioned and acknowledged: -

- While most of the data used in this needs assessment has been sourced from several reliable sources; for many key indicators, the data at granular geographic levels was either unavailable or not published. This is partly due to privacy and confidentiality aspects of the relevant data but the lack of data for some very useful yet hard to capture issues is a major systemic issue and a significant contributor to this data gap. Examples of these include data on mental health consumer perceptions and experiences, outcomes data from non-PHN activity such as Medicare funded mental health and chronic condition treatment activity
- Data for Aboriginal health service outputs and outcomes at useful geographic level for critical needs and service gaps assessment is still lacking. An example of this is the nKPI and

[1]OSR data for Aboriginal Community Controlled Health Organizations (ACCHOs) where no data provision to PHNs is established and hence PHNs are unable to do a comprehensive service gaps analysis for the Aboriginal population's health needs

- Poor access to national or state minimum data sets such as Drug and Alcohol needs and service utilisation data – in the absence of a PHN accessible / mandated minimum data set PHNs find it hard and inconvenient to undertake detailed analysis of service gaps within the alcohol and other drugs sector. National minimum data sets maintained by AIHW are not made available to PHNs at granular geographic levels
- The next level of service mapping including workforce-based capacity mapping, skill/service offering-based capacity mapping and accessibility mapping remains a gap. While national evidence bases such as *healthdirect* managed service directory and DoHAC managed *Heads Upp* are available they still do not address the critical next steps of service gaps analysis. This needs wider national and collaborative PHN level investigation and solution finding
- The timeliness of release for key data assets such as Medicare service utilisation data and national health workforce data amongst a few others, remains a key issue. The time lag results in PHNs using historic / a little outdated data and using that as a guiding assumption rather than work on more time relevant local data to investigate health needs and make service commissioning and program monitoring decisions.

## Our comments or feedback

Through undertaking this needs assessment process, SENSWPHN has refreshed most of its evidence base for all activity planning and decision making with latest evidence but more critically has managed to get executive and organisational governance layer attention to the vastly detailed task of data collation, analysis, information synthesis and insight summarisation.

The continued novel approach to qualitative data collation and thematic analysis has helped the SENSWPHN staff (beyond the Planning and Insights team) to reflect on the already existing wide body of evidence that tells a consistent story to complement the quantitative data insights and establish consistent triangulation of health needs. It has therefore negated the need to undertake any repetitive community and/or stakeholder consultation work that would have proven analytically redundant. SENSWPHN have found this to have significantly helped in working towards realistic expectations and manage needs assessments in relatively well-managed time and human resourcing.

A few key new approaches were also identified which have now been established as business-as-usual process for the planning and insights generation functions of the SENSWPHN. These approaches will continue to be made more robust and are expected to assist in making the needs assessment a regular, ongoing process to deliver a growing and continuously improving evidence base for planning and decision making at SENSWPHN.

[1] In this report the Aboriginal refers to persons identified as Aboriginal and/or Torres Strait Islander.

# 2. Overview

The South Eastern New South Wales Primary Health Network (SENSWPHN) catchment is a large geographic area (as outlined in SENSWPHN's Population Health Profile[i]) which can be explored as following **breakdowns;**

- The **catchment** – entire SENSWPHN geographic landmass
- 12 **regions** – 11 Local Government Areas (LGAs) and 1 Commonwealth Territory / Unincorporated Other Territory (OT)
- 10 substantial **areas** – 10 Statistical Area Level 3 (SA3) areas
- 2 health administrative **boundaries** – 2 Local Health Districts (LHDs)
- 62 substantial **smaller areas** – 62 Statistical Local Area Level 2 (SA2) areas
- 38 substantial health reporting smaller areas – 38 Population Health Areas (**PHAs**)

# 3. Health Needs Summary

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **Aboriginal Health** | Housing circumstances for Aboriginal persons | There is higher level of over-crowding within Aboriginal households within all regions of the catchment compared to non-Indigenous households. | Population Health Profile[i] |
| **Aboriginal Health** | High levels of socio-economic disadvantage for Aboriginal persons compared to non-Indigenous persons | The socio-economic disparity between Aboriginal and non-Indigenous people and/or households is quite wide within the catchment. Across all indicators such as unemployment, low levels of education, low income, lack of internet in households, no motor vehicles within dwellings; and living in multiple family households; the rates for Aboriginal people persons and/or households is higher than the rates for non-Indigenous in the catchment. | Population Health Profile[i] |
| **Aboriginal Health** | Relatively poor figures for (some) maternal health indicators | Maternal and child health metrics show some gross disparities between the Aboriginal people population and the non-Indigenous populations:<br>• Lower proportion of Aboriginal mothers are reported to attend antenatal visits at the best recommended timeliness during pregnancy<br>• Higher proportion of low birth weight babies are born to Aboriginal mothers<br>• Higher proportion of preterm births occur within Aboriginal mothers<br>• A very significantly high proportion of Aboriginal mothers are reported to be smoking during pregnancy | Population Health Profile[i] |
| **Aboriginal Health** | High rates of alcohol and other drug use among Aboriginal persons | Nationally in Australia the latest figures report that:<br>• The prevalence of smoking for Aboriginal people declined from 55% in 1994 to 43% in 2018–19<br>• The proportion of Aboriginal people who consumed alcohol in ways that put their health at risk, declined from 48% in 2010 to 33% in 2022–2023<br>• In 2022-23, 28% of Aboriginal people had used an illicit drug in the last 12 months which is an increase from 23% in 2019. | Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • In 2022-23, 17% of Aboriginal people reported recent use of cannabis and 5.5% reported recent use of cocaine<br>• In 2018, tobacco use accounted for 12% of the burden of disease for Aboriginal people. Tobacco use being the number 1 risk factor for Aboriginal people, followed by alcohol use second and illicit drug use fourth | |
| **Aboriginal Health** | High rates of alcohol and other drug use among Aboriginal persons | • Grief, loss, and trauma are contributing factors to problematic drug and alcohol use<br>• The impact of past government policies and practices has resulted in loss of land, language, culture, family and identity compounding grief, loss, and intergenerational trauma for many Aboriginal people<br>• Community members report increasing concerns with methamphetamine use amongst youth and adults and concerns about the far-reaching impacts on families and communities.<br>• Community members report that methamphetamine is becoming easier to acquire<br>• As a result of problematic drug use Aboriginal people are also experiencing a range of complex issues and health needs such as homelessness, family break down, unemployment, social and emotional well-being issues, interaction with the judicial system and chronic disease<br>• Social exposure to triggers (i.e. family member drug use): lack of positive role-models.<br>• High rates of dual diagnosis. | Planning Journal Summary[iii] |
| **Aboriginal Health** | Significantly high rates of suicide among Aboriginal persons | Nationally in Australia the latest figures from 2022 suggest that suicide is the fifth leading cause of death for Aboriginal people across the 5 jurisdictions that had acceptable data quality for analysis; but is the second leading cause of death for Aboriginal males. The suicide death rates among Aboriginal persons are more than twice the rates in the non-Indigenous population and has increased by 50% in the last 10 years. While local | Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | catchment specific figures are not available by Aboriginality, given the relatively large Aboriginal population of the catchment the national figures are used as suggestive of similar needs in the catchment. | |
| **Aboriginal Health** | High prevalence of chronic conditions and lifestyle risk factors | While SENSWPHN catchment specific data is not publicly available, using NSW state data it is noted that:<br>• Aboriginal persons were 1.2 times more likely to be overweight or obese than non-Indigenous adults in NSW<br>• Aboriginal persons were 1.7 times more likely to have high or very high levels of psychological distress than non-Indigenous adults in NSW<br>• Aboriginal persons were 2.7 times more likely to be current smokers than non-Indigenous adults in NSW<br><br>Almost all major chronic conditions have a relatively higher prevalence for Aboriginal and / or Torres Strait Islander adults compared to non-Indigenous adults in Australia. Of note are the following conditions where Aboriginal prevalence figures were double or more than the non-Indigenous figures:<br>- Otitis media<br>- Kidney disease<br>- Diabetes mellitus<br>- Blindness (complete and partial)<br>- Chronic obstructive pulmonary disease<br>- Heart, stroke and vascular disease<br>- Epilepsy | Population Health Profile[i], Additional Insights for Needs Assessment[iv] |
| **Aboriginal Health** | High proportion of Aboriginal population, with a relatively smaller proportion of older persons. | 5.2% of the catchment population identifies as Aboriginal and/or Torres Strait Islander (hereafter termed as Aboriginal) persons. For the regions of Eurobodalla and Shoalhaven this figure is over 7.5%. These are higher than the NSW and Australian national figures of 4.2% and 3.8% respectively. | Population Health Profile[i], Needs Assessment Snapshot: Ageing[vii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | 6.8% of the Aboriginal people in the catchment are aged 65 years and older, with 1.4% of all persons aged 65 and above identified as Aboriginal, highlighting the disparity in life expectancy between Aboriginal people and the non-Indigenous population. | |
| **Alcohol and Other Drugs** | High portion of alcohol and other drug related offences | Crime rates for some selected crime types are higher than NSW state figures within some regions. From a health needs perspective, higher than state rates for the crime types of liquor offences; possession and/or use of cannabis; malicious damage to property and prohibited weapons offences are concerning for several regions of the catchment. | Population Health Profile[i] |
| **Alcohol and Other Drugs** | High prevalence of lifestyle risk factors related to alcohol and other drugs | The catchment has worse than NSW state figures for the prevalence of several key behavioural self and bio-medical health risk factors<br>• Alcohol consumption posing short-term risk to health<br>• Alcohol consumption posing long-term risk to health<br>• Current smoking<br>Risky alcohol consumption rates are very high for the regions of Bega Valley, the Eurobodalla, and Snowy Monaro Regional. | Population Health Profile[i] |
| **Alcohol and Other Drugs** | Key needs of certain vulnerable cohorts such as persons experiencing homelessness | While data specific to the catchment and its regions is not comprehensively available; but national data suggests that for people experiencing homelessness<br>• There is a strong association between problematic drug and/or alcohol use and experiences of homelessness<br>• In 2022-23, 8.6% of clients of homeless (SHS) reported having problematic drug and/or alcohol use<br>• 4 out of 5 (79%) of SHS clients with problematic drug and/or alcohol use were returning clients in 2022/23<br>• In 2022-23, 3 in 4 (75%) SHS clients who reported problematic drug and/or alcohol use were aged under 45<br>• In 2022-23, 75% of SHS clients with problematic drug and/or alcohol use in 2022-2023 also reported a current mental health issue, this is a large increase from 44% reported in 2019–20. | Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **Alcohol and Other Drugs** | Key needs of certain vulnerable cohorts such as younger persons | While data specific to the catchment and its regions is not comprehensively available; national data suggests that for younger persons;<br>• The daily smoking rate more than halved between 2001 and 2022-23 for both males (24.5% to 6.9%) and females (23.5% to 5%) aged 18 to 24<br>• The age of initiation increased between 2001 to 2022-2023 for tobacco smoking (from 14.3 to 16.3) and alcohol consumption (from 14.7 to 16.1) among those aged 14 to 24<br>• From 2016 to 2022-23, there has been a concerningly large increase in the proportion of people aged 18–24 who have used e-cigarettes in their lifetime (from 19% to 49%)<br>• There has been an increase in the proportion of young adults aged 18–24 who have recently used any illicit drug (from 27% in 2007 to 35% in 2022-2023)<br>• Where treatment was for their own drug use, 66% of clients aged 10–19 sought treatment for cannabis as their principal drug of concern in 2022-23. | Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii] |
| **Alcohol and Other Drugs** | Key needs of certain vulnerable cohorts such as culturally and linguistically diverse (CALD) persons | While data specific to the catchment and its regions is not comprehensively available; national data suggests that for culturally and linguistically diverse (CALD) persons;<br>• People from CALD backgrounds (82%) are more likely to report never smoking compared with those whose primary language spoken at home is English (63%)<br>• Compared with primary English speakers, people from CALD backgrounds were more likely to abstain from alcohol (51% compared with 19.1%) and less likely to have recently used illicit drugs (8.5% compared with 18.8%)<br>• Cannabis is the most commonly used drug among people from CALD backgrounds. | Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **Alcohol and Other Drugs** | Key needs of certain vulnerable cohorts such as persons in the criminal justice system | While data specific to the catchment and its regions is not comprehensively available; national data suggests that for persons within the criminal justice system;<br>• The consumption of alcohol and other drugs remains more prevalent among people in contact with the criminal justice system than the general population<br>• Prison entrants in 2022 were as likely as the general population to be non-drinkers, however those who did drink were more likely to drink at high risk levels than people in the general community<br>• In 2022, nearly two-thirds (64%) of prison entrants smoked tobacco daily<br>• Nearly three-quarters (73%) of prison entrants in 2022 reported using illicit drugs in the 12 months before incarceration<br>• In 2020, of the most common detected drugs among police detainees were amphetamine-type stimulants (52%) and cannabis (45%)<br>• Over three-quarters (77%) of police detainees who provided a urine sample in 2021 tested positive for at least one drug type. | Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii] |
| **Alcohol and Other Drugs** | Key needs of certain vulnerable cohorts such as persons identifying as lesbian, gay, bisexual, transgender, intersex or queer | While data specific to the catchment and its regions is not comprehensively available; but national data suggests that for persons identifying as lesbian, gay, bisexual, transgender, intersex or queer;<br>• From 2019 to 2023, the proportion of lesbian, gay or bisexual people who smoke daily or consume alcohol at risky levels has declined.<br>• 47% of people identifying as homosexual or bisexual recently used any illicit drug in 2022-23. This rate has increased since 2010 (36%). | Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii] |
| **Alcohol and Other Drugs** | Key needs of certain vulnerable cohorts such as persons who inject drugs (PWID) | While data specific to the catchment and its regions is not comprehensively available; but national data suggests that for persons who inject drugs; | Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • 1.4% of the population aged 14 and over reported injecting a drug in their lifetime<br>• In 2022-2023, 0.2% of the population aged 14 and over reported injecting a drug in the past year<br>• There has been an alarming increase in the percentage of people who inject drugs (PWID) reporting that methamphetamine was the drug they injected most often in the last month, from 41% in 2020 to 56% in 2023. However there has been a decrease in the percentage of PWID who report heroin was the drug they injected most often in the last month, from 46% in 2020 to 37% in 2023.<br>• People who inject drugs experience considerably poorer health outcomes than others who use drugs<br>• In 2020, 39% of PWID were HCV antibody positive, a decline since 2016 when it was 51%. | |
| **Alcohol and Other Drugs** | High prevalence of lifestyle risk factors in relation to alcohol and other drugs | • Provider feedback indicates multiple drug use is common and challenging to treat<br>• Treating staff indicate that many people in the Connections program (Justice Health) use amphetamines as well as other drugs and/or alcohol, although no data was available.<br>• Providers report alcohol use disorders are the primary presenting problem for many service providers however, many are also using other drugs problematically.<br>• Providers indicate methamphetamine use is on the rise and has more acute consequences in the community<br>• High rates of cannabis use, both as primary drug problem and as a secondary problem to another disorder.<br>• Lack of regional data available<br>• Inter-generational effects of drug and alcohol use and dependence make treatment challenging<br>• Self-medicating with pharmaceuticals (prescription and non-prescription) and illicit drugs to help 'come down' from | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | amphetamine/ecstasy/cocaine high is cause for concern and contributes to poly drug use<br>• High levels of co-occurring mental illness can make treatment difficult due to siloed nature of service delivery. | |
| **Chronic Conditions and Health Risk Factors** | High prevalence of lifestyle risk factors across the catchment | The catchment has worse than NSW state figures for the prevalence of several key behavioural and bio-medical health risk factors<br>• Alcohol consumption posing short-term risk to health<br>• Alcohol consumption posing long-term risk to health<br>• Current smoking<br>• Obese<br>• Overweight<br>• Adults that are either overweight or obese<br>• High or very high psychological distress | Population Health Profile[i] |
| **Chronic Conditions and Health Risk Factors** | Significant variation in prevalence of lifestyle chronic conditions and risk factors within smaller areas | A bespoke analytical exercise to review prevalence of chronic conditions and key risk factors was undertaken. A relative comparison with all smaller areas in the country reveals that the smaller areas of the catchment have significant variability within the areas as well as within respective metrics. It also outlines key hot spots for respective metrics which are diverse and while somewhat consistent, they do have some level of wide variability too. Therefore, interventions and service delivery options must be thoroughly planned to be regionally tailored, and specific geographic areas must be targeted / prioritised for the exact condition or topic of focus. | Needs Assessment Insights Based on the Population Health Profile[v] |
| **Chronic Conditions and Health Risk Factors** | Several regions with high prevalence of chronic disease across the catchment | Granular and recent estimates of primary care data-based prevalence (age-standardised rates have been examined for relative comparisons across areas) impact of chronic conditions and health risk factors for the catchment reveals the areas of highest prevalence within the population accessing primary care services:<br>• Cardiovascular disease – Highest prevalence in the Goulburn Mulwaree area<br>• Diabetes - Highest prevalence in the Dapto-Port Kembla area | SPDS Insight Series[vi] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Mental health conditions – Highest prevalence in the Kiama-Shellharbour area<br>• Musculoskeletal diseases - Highest prevalence in the Goulburn Mulwaree area<br>• Renal conditions - Highest prevalence in the Shoalhaven area<br>• Respiratory conditions - Highest prevalence in the Kiama-Shellharbour area<br>• Current smoking - Highest prevalence in the South Coast area<br>• Hyperlipidaemia - Highest prevalence in the Goulburn Mulwaree area<br>• Obesity - Highest prevalence in the Young-Yass and the Goulburn Mulwaree area<br>• Overweight - Highest prevalence in the Wollongong and Kiama-Shellharbour area | |
| **Chronic Conditions and Health Risk Factors** | High rates of deaths from chronic conditions including premature mortality | Chronic conditions including cancer form the top causes of death in the catchment with coronary heart disease, dementia including Alzheimer's disease, cerebrovascular disease, lung cancer and COPD being the top 5 causes of crude number of deaths for the catchment.<br>The Goulburn Mulwaree region the highest rate of premature deaths and the Shoalhaven region has the highest rates for potentially avoidable deaths within the catchment; both undoubtedly having chronic conditions as a substantial contributor. | Population Health Profile[i] |
| **Chronic Conditions and Health Risk Factors** | High self-reported prevalence of chronic conditions | In community consultation, respondents reported on their health and disease status:<br>• The highest self-reported disease prevalence was identified for mental health disorders in the form of depression and anxiety disorders, followed by asthma, high cholesterol, and hypertension<br>• Many have had experience managing both multiple health conditions and medications, with most reporting that they or someone they care for has two or three ongoing health conditions | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | and they or someone they care for takes five or more prescription medications to manage their health | |
| **Chronic Conditions and Health Risk Factors** | Low levels of confidence for healthy lifestyle habits | • Low levels of confidence for adequate fruit and vegetable consumption were reported in some pockets of the catchment (Shellharbour LGA)<br>• Low levels of confidence for not smoking and regular exercise were reported in some pockets of the catchment (Shoalhaven LGA including Jervis Bay Territory) | Planning Journal Summary[iii] |
| **Cultural and Linguistic Diversity** | Cultural and linguistic barriers to accessing health care | A high proportion of the population in the regions of Queanbeyan-Palerang and Wollongong respectively are estimated to be born in non-English speaking nations. In these 2 regions a high percentage of people speak a language other than English at home. This culturally and linguistically diverse population also includes a substantial number of persons identifying as having poor English language proficiency. | Population Health Profile[i] |
| **Cultural and Linguistic Diversity** | Subgroups within the broader CALD population | Stakeholder consultation feedback revealed there are 3 main subgroups of populations under broad CALD population, each with distinctive physical and mental health patterns, with variance based on ethnicity, age, gender and various other health factors:<br>• Recent migrants (predominantly young people and families who immigrated as skilled workers or on a temporary visa). Preventative health, mental health, child and maternal health and chronic illnesses were critical needs of this population, as well as support to navigate social and health services.<br>• Elderly migrants (older people who have resided in Australia a long time, yet English proficiency is often limited which created barrier to healthcare access). This is pronounced in older cohorts where cognitive impairment can create additional challenges. Chronic illness, psychological problems and aged and palliative care were reported to be the most pressing health concerns for this group.<br>• Refugee migrants. Group with the most complex needs, including PTSD, anxiety, depression, infectious conditions, chronic conditions, and maternal and child health. This is a smaller cohort | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | but has high needs and greater barriers to accessing services due to being ineligible for Medicare rebates. Competing settlement goals of securing employment, housing and other basic needs would frequently take priority over health needs. It was perceived that there was a delay in onset of mental health symptoms in this group, as early signs would be masked by other settlement stressors, suggesting the need for longer support programs. | |
| **Cultural and Linguistic Diversity** | Diverse health needs of CALD populations | In terms of health needs, participants conveyed the following key health priority areas across diverse CALD populations:<br>• Mental health<br>• Preventative health<br>• Maternal and child health<br>• Aged and palliative care<br>• Chronic conditions | Planning Journal Summary[iii] |
| **Demographic Diversity** | Geographical diversity that can pose challenges to service planning and distribution | The catchment has both very densely populated regions and some very sparsely populated regions, which creates a diversity challenge for health and service planning. | Population Health Profile[i] |
| **Disability** | High prevalence of profound or severe disability, particularly among older persons | A substantial proportion of the catchment's population are identified as having severe or profound disability. The Eurobodalla and Shoalhaven regions have very high proportions of the population estimated to have significant disability.<br><br>The figures are very high for the older cohort of the population with regions like Shellharbour and Wollongong having over 19% of the persons aged 65 years and over, identifying as having severe disability.<br><br>55.7% of all persons with a profound or severe disability in the SENSWPHN catchment were aged 65 years and above. This figure was substantially higher for the Upper Lachlan Shire, Eurobodalla and Kiama regions which were above 60%. Across several indicators among older Australians, people with disability are most likely to live in cared accommodation | Population Health Profile[i], Needs Assessment Snapshot: Ageing[vii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | (94.9%); more likely to receive a government pension than older people without disability; and they are more likely to require home support services. Therefore, support services need to be tailored to address the socio-economic needs of this specific aged cohort. | |
| **Disaster Preparedness and Emergency Response** | Unprecedented events leading to new needs and/or exacerbate existing needs | The bushfires of 2019-20 affected the catchment significantly with almost 2000 houses affected (damaged or destroyed) during this natural disaster. As per October 2020 estimates, the southern parts of the catchment were estimated to have low to moderate levels of community resilience. Additionally, it has been reported through numerous reports that the bushfires had substantial and ongoing negative effects on several other aspects of life for the resident community such as individual and family mental health and well-being as well as other social and emotional impacts. It is acknowledged that whilst there has not been a natural disaster in the last 3 years, the long-term and ongoing impacts of these natural disasters need to be acknowledged and well considered in other priorities and planning projects in the future. | Planning Journal Summary[iii] |
| **End of Life care, Ageing and Frailty** | Ageing population | The overall population structure is indicative of an older/ageing population. 21.6% of the population is aged ears and over in the catchment, with the figure being over 28% in Bega Valley, Kiama, and the Shoalhaven. Eurobodalla has the highest proportion of older persons in the catchment with 33%. Regions of Bega Valley and Eurobodalla have an estimated median age of over 52 years. | Population Health Profile[i] |
| **End of Life care, Ageing and Frailty** | Ageing population | The population projections indicate an estimated 31.3% growth in persons aged 65 and over by 2030 for the catchment, with some regions being much higher such as Queanbeyan-Palerang region which is projected to increase by 54.5%. Yass Valley is also projected to have a large growth in the older persons cohort, with an estimated 46% increase. | Population Health Profile[i] |
| **End of Life care, Ageing and Frailty** | Ageing population | Dementia including Alzheimer disease continues to be the 2nd leading cause of death for the catchment, with the Eurobodalla and Bega regions having high rates. The prevalence of persons living with Dementia in the catchment is projected to increase by 78.6% by 2054. | Population Health Profile[i], |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **End of Life care, Ageing and Frailty** | Older persons chronic conditions and hospitalisations | Nationally, older persons were reported to have an average of 3.5 long-term health conditions. Persons aged of 85 years and over were reported to have an average of 5 long-term health conditions.<br>Catchment figures show for people aged 65 years and over that arthritis was the most common issue (33%), heart disease including heart attack and angina (15.8%) and diabetes (14.3%). 27.% of people reported no long-term health condition.<br>While SENSWPHN catchment specific data is not publicly available, using Australian national data it is noted that chronic conditions including lung cancer, coronary heart disease, COPD, dementia including Alzheimer's disease, and cerebrovascular disease form the top causes of death for persons aged 65 years and over in Australia.<br><br>State figures show that the largest proportion of the older persons population for any hospitalisation was for the cardiovascular diseases, with 68.7% of hospitalisations contributed by persons 65 years and older. Malignant neoplasms, nervous and sense disorders and dialysis also had very high proportions of older persons. 43% of all hospitalisations were from the 65 years and older cohort.<br><br>Persons aged 65 years and above accounted for 62.2% of the total bed days spent for potentially preventable hospitalisations in total, with figures being 79.4% for COPD and 88.7% for congestive cardiac failure. | Needs Assessment Snapshot: Ageing[vii] |
| **End of Life care, Ageing and Frailty** | Potential indicators of vulnerability in older persons cohort in the catchment | There are areas in the catchment that have much higher than state and national figures for persons at risk of social isolation in the 65 years and over age bracket such as the Goulburn Mulwaree, Snowy Monaro and Wollongong regions.<br><br>The Kiama region had much higher than catchment and state figures for Seniors Health Card Holders. Shellharbour and Goulburn Mulwaree had higher than catchment, state and national figures for the proportion of older persons receiving the age pension. | Population Health Profile[i] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | 2022 National figures reported that the common barriers to participating in social and community activities in the last 3 months showed that 44% of older persons had experienced issues. The most common barriers were:<br>• COVID-19 related reasons (53.1%)<br>• Their own health condition/old age (34.6%)<br>• Cost (25.2%)<br>• Too busy or had no time (14.2%) | |
| **End of Life care, Ageing and Frailty** | Housing tenure | National figures from 2022 reported the following statistics regarding housing tenure for older persons:<br>• 68.1% of older persons own their home outright, a decrease from 72.3% in 2018<br>• 9.8% still had a mortgage<br>• 12.2% rented<br>• 10% lived rent free or had other housing arrangements, which was an increase from 5.4% in 2018. | Needs Assessment Snapshot: Ageing[vii] |
| **End of Life care, Ageing and Frailty** | Abuse and neglect | National figures reported that for persons aged 65 years and over:<br>• 4.4% said they had experienced at least one form of abuse or neglect in the last 12 months<br>• 1.2% said they experienced physical abuse<br>• 3.5% said they had experienced emotional abuse<br>• 0.5% said they had experienced neglect<br><br>Abuse and neglect were more commonly reported by older persons who:<br>• Had a disability (5.6% compared with 3.1% of those without disability)<br>• Were female (5.2% compared with 3.6% of males)<br>• Were carers (7.2% compared with 3.7% of non-carers) | Needs Assessment Snapshot: Ageing[vii] |
| **End of Life care, Ageing and Frailty** | Complexities that can impact service access and engagement | Factors that can impact access to and engagement with support services in vulnerable older persons cohort:<br>• Legal issues | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Palliative Care needs<br>• Nutrition or food security issues<br>• Economic disadvantages or financial barriers<br>• Literacy<br>• Mental health issues and or/background of trauma<br>• Cultural background<br>• Cognition<br>• Being from the LGBTIQA+ cohort/people who are HIV positive (who may experience fear and distrust of aged care and support services)<br>• Domestic, family, and non-family abuse<br>• Hoarding and Squalor<br>• Animals/pets<br>• Significant communication or language barriers<br>• Guardianship/power of attorney considerations<br>• Rural/remote living situations | |
| **End of Life care, Ageing and Frailty** | Lack of end-of-life planning among consumers | Community surveys identified that many consumers have not discussed an advance care plan with their GP and of those who had, they said they had initiated the conversation themselves.<br>Many consumers have not made any formal (written) arrangements or feel uncomfortable about end-of-life conversations. | Planning Journal Summary[iii] |
| **End of Life care, Ageing and Frailty** | Lack of housing for older cohort | Consultation feedback is reporting an increasingly greater number of older persons are becoming homeless or at risk of homelessness due to housing shortage and cost of living crisis. There is a very low percentage of rentals that are affordable on an aged pension, even in many regional and rural areas due to the rise in rental costs. It was reported that the residential aged care system should not be seen as a solution to housing issues and can result in incorrect placements. | Planning Journal Summary[iii] |
| **Mental Health and Suicide Prevention** | High rates of mental and behavioural problems and psychological distress | The catchment has higher than NSW state and national rates of prevalence of some form of long term mental or behavioural problems. | Population Health Profile[i] and SPDS Insight Series[vi] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | The catchment residents are reported to be experiencing high or very high levels of psychological distress at rates that are higher than NSW state and national prevalence figures.<br><br>Latest figures on prevalence of long-term mental health conditions show very high prevalence in the Goulburn Mulwaree area. | |
| **Mental Health and Suicide Prevention** | High suicide death rates | Most recent year's figures show an increasing trend in suicide death rates for the catchment. The Southern NSW boundary is quite alarming with latest available 2022 rates placing them as the highest region for suicide death rates among all reported boundaries in NSW state.<br><br>In a more granular yet longitudinal analysis, the Bega Valley region is reported to have the highest suicide death rate within the catchment.<br><br>Across the catchment, nearly three-quarters of suicide deaths are among males.<br><br>Nationally, the 45-54 age bracket had the highest rate of suicide deaths per 100,000 at 17.8, followed closely by the 55-64 age bracket with 15.9. The male population had substantially higher rates than the female population across every age bracket, and more than triple the figures for 'all ages' bracket.<br><br>While the data grossly shows that suicide affects every demographic group; many areas with higher levels of socio-economic disadvantage within the catchment are showing a higher level of suicide deaths.<br><br>In Australian national figures, several associated factors were reported to be the predominant psychosocial risk factors reported in suicide deaths in Australia:<br>• Mental and behavioural disorders, with depressive episode being the most common risk factor for those aged 25-84 years | Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Symptoms and/or history of suicidal ideation and self-harm being the most common risk factor in those under 25 years<br>• Drug and alcohol related issues<br>• Problems with legal circumstances<br>• Limitations of activities due to disability was the most common risk factor in those aged 85 years and over<br>• Family and personal (including spousal) relationship issues including separation and divorce<br>• Death of a family member or close relationship | |
| **Mental Health and Suicide Prevention** | High rates of alcohol and other drug use among persons with mental health issues | While data specific to the catchment and its regions is not entirely convincing; national data suggests;<br>• People with mental health conditions or high psychological distress were twice as likely to smoke daily as people without mental health conditions and those with low psychological distress<br>• People with mental health conditions or high psychological distress were more likely to exceed lifetime and single occasion risk guidelines for alcohol than people without mental health conditions or with low psychological distress<br>• Compared to people without mental health conditions, people with mental health conditions were 1.8 times as likely to have recently used any illicit drug | Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii] |
| **Mental Health and Suicide Prevention** | High levels of co-existing chronic conditions | Experts and community-based consultations identify:<br>• High levels of co-existing substance use within the catchment<br>• High levels of chronic and complex physical health needs in people with complex and severe mental health needs e.g. high proportion of people who are smoking or are obese | Planning Journal Summary[iii] |
| **Mental Health and Suicide Prevention** | Rising rates of mental and behavioural problems and psychological distress in young people | • Service providers and committees in the Eurobodalla LGA have reported a rising trend of younger age groups (under 12 years of age) accessing their services<br>• A high proportion of headspace clients at Batemans Bay and Queanbeyan centres are young teens (12-14 years of age) | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **Mental Health and Suicide Prevention** | Low-moderate levels of mental health literacy | • Lack of use and promotion of e-mental health<br>• Some low levels of mental health literacy<br>• Poor education for the community about MH services / MH promotion and prevention<br>• Anecdotal evidence reports that there is some success triaging consumers while on waiting list to utilise web-based resources for anxiety and depression<br>• Some GP's and psychiatrists prescribing and referring to psychological interventions as first line treatment rather than knowing about and referring to services or options that meet their individual needs | Planning Journal Summary[iii] |
| **Mental Health and Suicide Prevention** | High levels of vulnerability for people with severe mental illness | • Consultation with external stakeholders across the region has acknowledged that people with severe mental illness often have comorbidities and needs based on many social indicators:<br>o Lack of wellbeing (co-morbidities)<br>o Poor dental care<br>o Homelessness and housing<br>o Barriers around employment due to nature of mental health issues | Planning Journal Summary[iii] |
| **Population Health** | Women's Health (including Maternal Health) | • Endometriosis and Pelvic Pain: Recently commissioned specialised clinic for pelvic pain and endometriosis has seen over 150 clients access the service within the FY 23-24. Referrals have been received from various general practices in Shoalhaven as a handful from practices down the South Coast; indicative of some level of unmet local need.<br>• Maternal Health:<br>The SNSWLHD had a variety of maternal health and health condition indicators that performed lower than the catchment and state figures such as:<br>o First antenatal visit done before 14 weeks | Population Health Profile[i] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | ○ First antenatal visit done before 20 weeks<br>○ Smoked at all during pregnancy<br>○ Chronic and gestational hypertension<br><br>Other conditions were also high:<br>○ Gestational diabetes mellitus<br>○ Pre-eclampsia<br><br>The ISLHD had poorer than catchment and state figures for:<br>○ Low birth weight in all births<br>○ Preterm births<br>○ Maternal age of 19 years and under (teenage mothers)<br><br>Domestic violence and sexual offences have significant negative impacts affected communities, with women experiencing greater disparity of poor outcomes. Catchment regions with the highest rates of domestic violence assault and sexual offence crime rates per 100,000 population were Goulburn Mulwaree, Eurobodalla and the Shoalhaven. | |
| **Population Health** | Child health | • A substantial proportion of children in the catchment are estimated to have developmental vulnerability on one or more domains of physical health and wellbeing; social competence; emotional maturity; language and cognitive skills; and communication skills. In particular, the Eurobodalla region was identified to have the highest proportion of children with developmental vulnerability on one or more domains.<br>• While childhood immunisation rates for the catchment were slightly higher than state and national figures, the South Coast and Shoalhaven regions were lower than all averages for the 1-year and 2-year age brackets. For the 5-year age bracket, the Wollongong and Shoalhaven regions had the lowest proportion of children fully immunised, that were on par with state and national figures. | Population Health Profile[i] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **Population Health** | Child health | • 9.7 per 100 children were reported to have one or more long term health condition which was higher than NSW (8.2 per 100) and Australian national rates (8.1 per 100). Figures were highest for Goulburn Mulwaree followed by Shellharbour<br>• A major condition reported in children was asthma and that too was highest in Goulburn Mulwaree.<br>• 8.8 per 100 children were estimated to be obese which was higher than NSW (7.4 per 100) and Australian national rates (8.2 per 100). Figures were very high for multiple regions including Bega Valley, Eurobodalla, Goulburn Mulwaree Snowy Monaro, Upper Lachlan and Shoalhaven. | Additional Insights for Needs Assessment[iv] |
| **Population Health** | Child health | Consultation feedback reported respiratory issues such as asthma, COPD and bronchitis to be the largest group of health conditions prevalent within their children/dependent young persons.<br>Feedback also reported there is a lack of available mental health services to support the growing need for children under 12 and young teens 12-14 years, particularly for early intervention services, complex mental health, NDIS access and ADHD/ASD assessments and management. This is exacerbated in rural areas where telehealth is not suitable for this cohort and there is a lack of funding for adequate outreach. | Planning Journal Summary[iii] |
| **Population Health** | Child health | Children are very high consumers of primary care service provision especially urgent care services in SENSWPHN:<br>• The recently commissioned Medicare Urgent Care Clinics data for the July 2023 to August 2024 period shows that 25% of the presentations were from children aged 0-11 years<br>• Children aged 0-14 had the highest age-specific percentage of utilization of Medicare subsidised GP after-hours urgent service provision | After Hours Needs Assessment[viii] ; Medicare Urgent Care Clinic Performance Monitoring Snapshot[ix] |
| **Population Health** | Youth demographics | Of the cohort of young people accessing headspace, the following demographic data was reported:<br>• 29.5% of clients identify as being from the gender and sexuality diverse community (LGBTIQA+) | Headspace Activity Report[x] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • 4.8% identify as CALD<br>• 13.7% identify as Aboriginal | |
| **Population Health** | Socioeconomic determinants of future youth health | Eurobodalla region had the lowest proportion of persons learning or earning at ages 15-24 as well as proportion of persons participating full-time in secondary education at age 21.<br><br>The catchment had significantly lower than state or national figures for school leavers participating in higher education, with the Upper Lachlan Shire region having very low figures.<br><br>Approximately 1.9% of SENSWPHN headspace clients are homeless, or at risk of homelessness. These figures are slightly higher than headspace national averages (1.6%). Bateman's Bay and Bega Valley had the highest proportion of young people who were homeless, or at risk of homelessness (3.2% and 3.3%, respectively). | Population Health Profile[i], Headspace Activity Report[x] |
| **Social Determinants of Health** | High levels of socio-economic disadvantage | The catchment has the 19th highest level of socio-economic disadvantage amongst all 31 national PHN catchments. Some regions of the catchment rank amongst the top 300 regions (out of over 900 in Australia) in terms of socio-economic disadvantage. Smaller areas of Berkeley-Lake-Heights-Cringila; Port Kembla-Warrawong; Windang-Primbee; Warilla; Albion Park Rail; St Georges Basin-Erowal Bay; Jervis Bay; Nowra; Sussex Inlet-Berrara; Batemans Bay and Eden; fall within the top 5 national deciles of being socio-economically disadvantaged. | Population Health Profile[i] |
| **Social Determinants of Health** | Growing migrant and refugee population with complex needs | The Wollongong region receives significant numbers of newly arrived population including refugee and humanitarian entrants. The health and social service needs of this cohort are extremely complex and need significant social-emotion and wider psychological support. | Population Health Profile[i] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **Social Determinants of Health** | Geographic remoteness as a barrier to access to health care | A substantial proportion of the catchment's geography is classified as Outer Regional in terms of remoteness. | Population Health Profile[i] |
| **Social Determinants of Health** | High unemployment rates | Recent unemployment rates for some regions such as Shellharbour, Shoalhaven, Wollongong and Eurobodalla have been very high compared to NSW state rates, with many regions experiencing a significant increase from June 2023 to December 2023. | Population Health Profile[i] |
| **Social Determinants of Health** | High levels of financial vulnerability | Substantially higher than NSW state and national proportions of resident populations of the catchment are Centrelink income support recipients. The proportions are significantly high for the Eurobodalla and Bega Valley regions. In particular, the benefits payment for long-term unemployment and youth unemployment are suggestive of significant needs in the region. | Population Health Profile[i] |
| **Social Determinants of Health** | High levels of vulnerability with living arrangements | A substantial proportion of households in the SENSWPHN catchment are in the bottom 40% of the income distribution and a large proportion of them are spending more than 30% of income on mortgage repayments or rent. The figures are notably high in the Eurobodalla, Wollongong, Shoalhaven and Shellharbour regions with a high proportion of low-income households living with financial stress from rent or mortgage. | Population Health Profile[i] |
| **Social Determinants of Health** | High levels of vulnerability with living arrangements | The Shoalhaven and Eurobodalla regions have a high proportion of households that rely on rent assistance from the Australian government. | Population Health Profile[i] |
| **Social Determinants of Health** | High levels of vulnerability with living arrangements | Community and stakeholder consultation identified a shortage of available housing, including long-term rentals as a major issue across the catchment. Availability of affordable long-term housing options is particularly low in the Southern NSW boundary, with short-term holiday rentals accounting for many of the available housing options. The impact of this shortage extends to:<br>• Workforce recruitment/retention difficulties in attracting clinicians, especially in primary care, to the catchment<br>• High levels of competition to purchase a home or obtain a long-term rental<br>• An increased risk of homelessness | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **Social Determinants of Health** | Housing issues in the catchment | Stakeholder feedback reported:<br>The Illawarra has one of the tightest vacancy rates in regional NSW with a vacancy rate of 1 percent at September 2023 and that the Shoalhaven has the highest number of short-stay rentals in regional NSW which has a significant negative impact on housing stock. | Planning Journal Summary[iii] |
| **Social Determinants of Health** | Pockets of homelessness | At the latest available estimate some regions of the catchment had some concerning numbers of persons identified as homeless with high portions of the resident population in the Snowy Monaro, Bega Valley, Shoalhaven and Wollongong regions recording the highest rates in the SENSWPHN catchment. | Population Health Profile[i] |
| **Social Determinants of Health** | Pockets of homelessness | Anecdotal evidence suggests that the number of persons identified as homeless is increasing in certain pockets of the catchment, with several camping sites in the Southern NSW boundary known to be used by residents as a temporary accommodation option due to housing shortages. | Planning Journal Summary[iii] |
| **Social Determinants of Health** | Health and social needs of homeless cohort | Stakeholders reported that medical illness, mental illness and drug and alcohol issues are the main health needs of the homeless population. All of which are; a cause, outcome and aggravator of homelessness.<br>Mental illness such as depression, PTSD, schizophrenia and anxiety are experienced at a greater rate by people experiencing homelessness. It was reported that poor mental health negatively impacted on the ability to find and sustain housing, but also the ability to navigate complex referral processes and follow care plans from health professionals, resulting in vicious cycle of exacerbation of illness and poor outcomes.<br>Trauma and domestic violence are also key issues that negatively impact on people experiencing or at risk of homelessness, requiring well-trained, flexible, non-judgemental care from service providers to effectively meet needs. | Planning Journal Summary[iii] |
| **Social Determinants of Health** | Barriers to services access for vulnerable cohorts | • Consultation feedback reported that the socioeconomic determinants of homelessness and health issues are frequently linked and long-term homelessness exacerbates ill-health. Poverty, social exclusion, and low levels of social support are key factors in | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | driving ill-health. Socioeconomic determinants need to be seen as basic health needs for homeless populations.<br>• High co-morbidities between mental health and drug and alcohol yet these cohorts experience consistent barriers to accessing mental health treatment unless abstinent from all alcohol and drug use. This is exacerbated in outer regional and rural areas where there is a lack of service availability.<br>• Unstable and transient living situations, lower preparedness and capacity for engagement, stigma, and discrimination as well as lack of access to technology and personal identification can negatively impact on engaging consistently with services.<br>• Greater levels of chronic illness and co-morbidities combined with lack of access to primary and preventative care, often resulted in escalation of health issues until crisis and admission to ED. This was compounded for older cohorts with greater health needs.<br>• Poor system integration between housing services and primary care results in long wait times and interrupts access to support. | |
| **Social Determinants of Health** | Potential impacts on community wellbeing due to housing and cost-of-living crisis in Southern NSW | Survey respondents from community services and organisations across the Southern NSW region perceived the biggest challenges to be facing the community as: (1) housing access and homelessness; (2) increasing cost-of living pressures; (3) access to care and services; (4) workforce and employment; (5) mental health. It can reasonably be assumed that these challenges will have significant implications on the ability for certain (vulnerable) cohorts in the community to maintain wellbeing. | Planning Journal Summary[iii] |
| **Social Determinants of Health** | Social isolation | Many regions of the catchment have a high proportion of persons living alone therefore estimated to be at risk of social isolation. The Eurobodalla and Bega Valley regions have quite high proportions. This figure is even more concerning within the older population with regions of Goulburn Mulwaree and Snowy Monaro Regional having over 28% of the population aged 65 and over at risk of social isolation. | Population Health Profile[i] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **Social Determinants of Health** | High levels of financial vulnerability for families in some regions | The Eurobodalla and Shoalhaven region have very high proportions of families with children that have vulnerable circumstances such as being single parent families and/or being families where no parent is employed. | Population Health Profile[i] |
| **Social Determinants of Health** | Potential impacts on community resilience for selected groups | The employment profile of the catchment is quite diverse. People in paid employment belong to very diverse industries across the catchment. While Upper Lachlan Shire has a very high proportion of persons within primary industry; regions like Snowy Monaro Regional, Bega Valley and Eurobodalla have quite a high proportion of persons within the Accommodation and Food Services industry. A substantial proportion of persons across multiple regions are involved in the Construction industry. Overall, for the catchment the Health and Social assistance industry continues to have the highest proportions. | Population Health Profile[i] |
| **Social Determinants of Health** | Pockets of significant Socio-economic disadvantage | Median weekly income figures for households, families and individuals are lower than NSW state and Australian national figures for several regions of the catchment but most importantly for Eurobodalla, Shoalhaven, and Bega Valley. Of note is the fact that these figures are lower for Aboriginal households and/or Aboriginal persons in many regions, especially Jervis Bay, compared to non-Indigenous households or persons within those regions. | Population Health Profile[i] |
| **Social Determinants of Health** | Demand for alcohol and other drugs services often influenced by socio-economic factors and complex needs of vulnerable cohorts | Providers report challenges and a lack of resources as many drug and alcohol clients have a range of complex needs including:<br>• Homelessness<br>• Trauma<br>• Family breakdown<br>• Anxiety and depression or other mental health issues<br>• Homelessness / or risk of<br>• Recent release from prison<br>• Chronic disease<br>• Interactions with other medications<br>• Increasing impact of aging clients and long-term drug and alcohol use and poor health | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Women experiencing DV are identified as a highly vulnerable and difficult to access group | |

# 4. Service Needs Summary

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **Aboriginal Health** | High rates of intentional self-harm related activity within hospital settings | While intentional self-harm hospitalisation figures by Aboriginality are not available for the catchment or its specific regions, at the NSW state level the latest figures suggest that intentional self-harm hospitalisation rates are over 3 times higher amongst Aboriginal persons compared to non-Indigenous persons with this ethnicity-based disparity being higher within males. However overall rates even within Aboriginal persons continue to be higher in females than males. | Population Health Profile[i] |
| **Aboriginal Health** | High rates of alcohol and other drug related service utilisation among Aboriginal persons | Nationally in Australia the latest figures suggest that in 2022-23, 18% of clients seeking alcohol and other drug treatment services aged 10 and over were Indigenous Australians. While local catchment specific figures are not available by Aboriginality, given the relatively large Aboriginal population of the catchment the national figures are used as suggestive of similar needs in the catchment. | Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii] |
| **Aboriginal Health** | Low utilisation rates of preventive annual health checks | The proportion of the Aboriginal and Torres Strait Islander people receiving an annual health check funded through Medicare aimed at early detection and treatment of common chronic conditions is substantially lower for the catchment compared to NSW state and Australian national proportions. Rates were particularly low in the Snowy Mountains region. | Population Health Profile[i] |
| **Aboriginal Health** | Health services need to be culturally appropriate | Consultation identified inconsistencies across LGAs and health services around community transport, cultural appropriateness of these services and willingness / logistics for these services to fit in with health appointment times and locations:<br>• Some providers indicate that some community members have found the local hospital services to be culturally inappropriate and Aboriginal people describe some services as culturally 'unsafe'<br>• There is a need for more drug and alcohol programs to be delivered by Aboriginal people for Aboriginal people in a culturally appropriate setting, with a focus on healing intergenerational trauma. Treatment | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | and ongoing support should be holistic and target the family and community.<br>• Some providers indicate at home detox supported by GP does not work well particularly for Aboriginal people<br>• Men report not being comfortable or willing to access health service providers | |
| **Aboriginal Health** | Barriers to access for Alcohol and Other Drugs services | • Lack of culturally appropriate drug and alcohol services<br>• Lack of flexibility at residential facilities for Aboriginal people to leave to attend Sorry Business and other family and cultural commitments<br>• Lack of service options for young people, specifically young women, and women with children<br>• Issues with travel and wait times of several weeks to access existing facilities<br>• Service access: lack of transport; no Community based rehab; lack of treatment options | Planning Journal Summary[iii] |
| **Aboriginal Health** | High level of unmet need for mental health support for First Nations peoples | • Stakeholder feedback reported that there are high wait times for psychology, very limited access to bulk-billing psychiatry and no suitable service to send acutely mentally unwell First Nations clients as they are deemed unsuitable for general practice and ED. Patient often deteriorates until a crisis eventuates and then ends up involved in the justice system.<br>• There is a lack of Aboriginal mental health services for Queanbeyan and Goulburn due to having no ACCHO and not being able to access the ACT AMS. Bega Valley and Eurobodalla and Illawarra AMS services are reported to be under capacity to provide adequate mental health support and have higher wait times. | Planning Journal Summary[iii] |
| **Aboriginal Health** | Barriers to access for mental health services | • Existing services are overburdened with large pockets of the community not accessing services<br>• Long wait times and potentially not exiting existing patients<br>• Providers not offering a culturally responsive service and not employing Aboriginal people | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Aboriginal health workers report difficulty in assisting Aboriginal people seeking appropriate mental health services especially with current lack of mainstream providers funded or assisted in servicing Aboriginal populations<br>• A lack of after-hours options especially identified for the Aboriginal population in the Shoalhaven and Eurobodalla regions<br>• Language barriers create difficulties understanding medical terminology in mainstream services | |
| **Aboriginal Health** | Recruitment and retention issues within the Aboriginal workforce and unequal distribution of services across the catchment | • Very high needs for the Aboriginal population of the catchment needing very close working partnerships of all entities of the wider service and support services with local Aboriginal Community Controlled Health Organisations<br>• Difference in programs across LGAs with Eurobodalla seeming to have the most services by population reach<br>• A need to increase the capacity of the Aboriginal community and workforce to identify and respond to mental health issues of their consumers and the community in general<br>• Limited funding and restrictive criteria around mental health credentialing leads to issues with employing Aboriginal people<br>• Shortage of female Aboriginal Health Education Officers (AHEOs)<br>• Reduction in workforce and changes to registration rules around Aboriginal Health Workers have reduced services' capacity to undertake health assessments (MBS item 715) without RN oversight<br>• Capacity / resource / process issues around follow up and general practitioner (GP) sign-off<br>• Programs are only targeting those who already have a chronic disease<br>• Funding changes mean Koori Bootcamp (intensive gender and culturally specific exercise program) will no longer exist and become a service gap | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **Aboriginal Health** | Lack of culturally appropriate services for End-of-Life care | Consultations suggested that many Aboriginal people do not access support from health services during the palliative stage, often presenting to services 'just before death.' Key reasons being;<br>• Lack of trust in health (and other government) services: historic factors contribute to this distrust<br>• Lack of culturally responsive services that can respect needs in regard to: cultural obligations, protocols and healing practices, kinship care, gender considerations and awareness of historical institutional trauma<br>• Lack of acceptance of death and dying (death is a taboo topic not really spoken about in Aboriginal culture)<br>• Perceived lack of need to access health services if quality of life is sufficient<br>• Lack of transport and access to health services<br>• Perceived stigma within health services: prejudice and racism from some health workers towards Aboriginal people | Planning Journal Summary[iii] |
| **Aboriginal Health** | Challenges in delivering Aboriginal specific health services in primary care | Consultation identified the following issues:<br>• Referral mechanisms to various services are not standardised<br>• Providers describe difficulty in understanding eligibility criteria around various packages and options, and identifying access point in a timely manner<br>• Clinical staff unable to spend adequate time on self-management strategies due to high caseloads<br>• PHN priorities are disease-specific whereas Aboriginal health services work in a holistic, person/family-centred model | Planning Journal Summary[iii] |
| **Aboriginal Health** | Specialist access for First Nations communities | Barriers to accessing specialist services for First Nations peoples:<br>• Long wait time to access specialist services through ACCHOs<br>• Written communication and telehealth for scheduling, referrals and appointments is not always suitable for people who are transient and can result in lack of attendance | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Lack of understanding of service landscape and how to navigate options<br>• Cost barriers due to lack of bulk-billing options<br>• Language barriers involving medical jargon and unfamiliar terminology<br>• High staff turnover and lack of consistency with health professionals has a negative impact on engagement<br>• Needing to travel off-country to attend appointments and treatments compounds issues of transport, cost, cultural beliefs surrounding hospitals and access to family | |
| **Alcohol and Other Drugs** | Key needs of specific cohorts around utilisation of alcohol and other drugs related services | Greater access to transport, support for greater client complexity, addressing social and environmental factors such as housing issues and decreasing staff turnover were crucial factors reported from stakeholders that needed addressing to improve client outcomes. | Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii], Planning Journal Summary[iii] |
| **Alcohol and Other Drugs** | Hospital and tertiary care related service needs | While as a catchment, the SENSWPHN has slightly higher than NSW state rates for alcohol attributable hospitalisations, there are some concerning trends for some regions with Kiama having very high rates that were estimated to be statistically significantly higher than NSW state averages and have been increasing at an alarming rate.<br><br>Alcohol related ED presentations (includes acute intoxication and chronic alcohol problems that lead to unplanned ED visits) are showing a rise for the catchment but are increasing at a more drastic rate for the Southern NSW boundary, which is already substantially higher than the NSW rate. | Population Health Profile[i] and Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii] |
| **Alcohol and Other Drugs** | Community based service needs | In 2022-23 service provision was undertaken by 47 agencies. Insights from the service utilisation figures are below which highlight some service needs and demands for specific groups or service attributes;<br>• Alcohol continued to be the predominant primary drug of concern | Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Counselling and case management were the top 2 treatment types delivered<br>• Non-residential treatment facilities continue to be the significantly highest setting type for service delivery<br>• 52.8% of episodes were self-referrals by the clients themselves and/or their families<br>• A substantial proportion of clients (18.8%) were identified as Aboriginal and/or Torres Strait Islander persons<br>• Majority of clients (60.8%) were males | |
| **Alcohol and Other Drugs** | Demand and supply mismatches in health service delivery and uptake of alcohol and other drug services | For PHN commissioned services current reach in 2023-2024 for residents of regions such as Wollongong, Shellharbour, Queanbeyan-Palerang Regional and Kiama remains very low. Additionally, the very high reach in certain pockets of the catchment seem to indicate a bit of over-servicing as well. These need to be reviewed from a holistic all of system view and re-align service volumes to meet actual community need rather than based on available supply. Poor supply may also be an issue, which is mentioned elsewhere as a workforce, recruitment and retention need. | Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii] |
| **Alcohol and Other Drugs** | Service availability gaps and inequitable distribution | A desktop service mapping exercise[2] has identified significant gaps in service availability across the catchment but more importantly a gross lack in the availability of at least one service offering under each service type within each region of the catchment. Therefore, it can be inferred that there is a lack of comprehensive local availability of services that can cater to all aspects of mental health service needs within every region of the catchment. The lack of service availability is grossly significant for inland regions and the more remote parts of the catchment; with a very high level of supply in more metropolitan locations in the northern parts of the catchment. | Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii] |

[2] There are several caveats to the desktop service mapping; so care should be exercised in interpreting this need. Discussions with SENSWPHN's Planning & Insights team is strongly advised.

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **Alcohol and Other Drugs** | Key needs of specific cohorts around utilisation of alcohol and other drugs related services | • Lack of rehabilitation services inside correctional centres and long wait times to access treatment on the outside was identified as a service gap<br>• People leaving custody are often faced with complex issues such as issues relating to social and emotional wellbeing, homeless, unemployment, lack transport, finances and relevant documentation required to access health services<br>• Barriers around women with children seeking treatment for drug and alcohol issues due to concerns about DoCS intervening and perceived stigma<br>• Inadequate and inappropriate facilities for children at residential facilities<br>• Parents may not have adequate support structures to have someone to care for their children while they are in a residential facility<br>• Women experiencing domestic violence are particularly vulnerable and a difficult to access group<br>• Services gaps in AOD providers ability to address complex patient needs including dual diagnosis, physical health needs, trauma counselling, poly drug use, domestic violence | Planning Journal Summary[iii] |
| **Alcohol and Other Drugs** | Lack of provision of withdrawal management and residential rehabilitation services as a barrier to accessing treatment | • Low numbers or low access to rehabilitation beds in Southern NSW as perceived by community / stakeholders. Concentration of services around urban centres such as Wollongong, Shellharbour, Nowra and Queanbeyan and clients on the far south coast are generally referred to the ACT to detox.<br>• There are long wait lists for rehabilitation services out of area<br>• Disadvantage for Aboriginal people having to travel 'off country' for treatment<br>• There are not enough detox beds in public hospitals and a bed will only be made available if someone presents with other acute health concerns and that will often be a medical bed or a mental health bed | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Restrictive intake criteria can be a barrier to access for rehabilitation services: e.g., no entry for certain past criminal behaviour (conducted while under the influence of drugs or alcohol prevents entry), no smoking | |
| **Alcohol and Other Drugs** | Barriers to access for overall Alcohol and Other Drugs services | • Limited services in priority areas<br>• Inconsistencies with community transport options offered across LGAs<br>• Accommodation issues when entering rehabilitation or leaving custody<br>• Long waiting lists for services<br>• Cost<br>• Lower quality of service and/or skill or ability of provider<br>• Lack of access to non-residential treatment services, in particular day programs and community based/home detox<br>• Hurdles for people living in regional areas such as accessing public transport, housing, and other support services | Planning Journal Summary[iii] |
| **Alcohol and Other Drugs** | Service availability gaps not meeting key community needs | • Need for greater availability of specialised drug and alcohol counsellors trained in trauma recovery interventions and AOD specialists/clinical support<br>• Access to General Practitioners with extensive drug and alcohol experience and improve AOD screening in general practice<br>• Need for new AOD medications<br>• Increase resources to existing service providers to expand their capacity<br>• Lack of awareness of services and referral pathways<br>• Integrating mental health support with primary care is needed to make services easier to access for consumers<br>• Prevention programs and harm minimisation services are also required<br>• Lack of service options for young people | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Need for holistic outreach services that address both social and emotional issues<br>• Greater support for carers and a need for education campaigns | |
| **Alcohol and Other Drugs** | Lack of services for dual diagnosis | • High unmanaged risks for mental health consumers who use drugs and/or alcohol<br>• Specialist services often don't co-assess<br>• In-patient, co-morbidity services were identified to be in short supply and community health and hospitals should be utilised for assessment, detox, and treatment in hospital with appropriate access to acute treatment and services.<br>• Lack of adequate resources to work with complex clients who may also have a range of other issues such as homelessness, unemployment, and interaction with the criminal justice system | Planning Journal Summary[iii] |
| **Alcohol and Other Drugs** | Gaps in care coordination by providers and challenges with service navigation | • There are multiple providers with various funding sources undertaking a variety of interventions<br>• A lack of providers resourced to deliver the whole spectrum of services from detox to ongoing follow up and support after rehabilitation making navigating care complex for consumers and service providers<br>• Some providers indicated confusion around the capacity, intake, and function of local hospitals in relation to detox<br>• Perception of lower levels of participation rates amongst GPs in relation to home detox and pharmacotherapy options<br>• Some providers indicate challenges referring patients to some GPs for assisted withdrawal<br>• Private primary care providers such as community pharmacists and general practices can be uncomfortable in treating addiction<br>• Hospitals have been described by some providers as a challenging environment for some drug users | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Time, confidence, lack of support and training, and patient complexity were main barriers identified by GPs in the catchment to providing AOD care in primary care | |
| **Alcohol and Other Drugs** | Lack of experienced AOD workers and a need to increase knowledge and experience in primary care | • Lack of drug and alcohol workers especially for young people and for Aboriginal people<br>• Increased training in trauma-informed care/dual diagnosis<br>• Lack of opioid replacement therapy dosing points for clients who were engaging in this type of treatment<br>• Workforce recruitment and retention issues are significant barriers to addressing waitlists. Campaigns are needed to attract skilled workers to the area<br>• Funding issues impact on capacity building. 12-month funding contracts make it difficult for planning and sustainability of services<br>• Greater nursing support is needed for General Practice to increase prescribing for withdrawal management<br>• Need for upskilling GPs on methadone and buprenorphine as well as opioid de-prescribing<br>• Increase GP capacity to support home detox | Planning Journal Summary[iii] |
| **Alcohol and Other Drugs** | Systems issues and service integration gaps prevents taking a holistic approach to treatment | • Lack of clear diagnosis during acute phase of disorders hampers treatment planning.<br>• Lack of assessment skills differentiating diagnostic options in general practice can lead to frustration in effective referral pathways<br>• Lack of integration of services especially around clients with co-morbidity issues (e.g. relationships between acute services and drug and alcohol services need to be improved so that if someone is in rehab and they are suicidal, they can access the acute unit without the stigma of being a drug and alcohol client)<br>• Flawed referral pathways and policies e.g. the pathway from corrective services is flawed and the confusion around referral pathways in general, limits continuity and transitional care, creating a revolving door and high levels of recidivism | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Little awareness among GPs, non-drug and alcohol services and the broader community around what addiction looks like, the issues it creates, and how to access help and treatment<br>• Other health, community, or social support organisations e.g., housing, employment services, family support etc. not having the information, tools, or training to work with people experiencing drugs and alcohol issues or having a specialist worker in this area | |
| **Chronic Conditions and Health Risk Factors** | Low participation in cancer screening programs | Prevention initiatives such as cancer screening rates are lower than optimal with some areas such as Dapto-Port Kembla having very low rates of screening for bowel cancer and breast cancer. Cervical cancer screening rates also have substantial room for improvement with very low rates for Goulburn Mulwaree. | Population Health Profile[i] |
| **Chronic Conditions and Health Risk Factors** | Several regions with high service burden impact on primary care due to chronic disease across the catchment | Granular and recent estimates of primary care data-based prevalence (crude rates have been used to better understand actual service burden being faced by primary care practitioners within areas) impact of chronic conditions and health risk factors for the catchment reveals the areas of highest health service burden within the population accessing primary care services:<br>• Cardiovascular diseases - Highest service burden in the South Coast area<br>• Respiratory conditions - Highest service burden in the Shoalhaven area<br>• Diabetes - Highest service burden in the Shoalhaven area<br>• Mental health conditions - Highest service burden in the Kiama - Shellharbour area<br>• Musculoskeletal diseases - Highest service burden in the South Coast area<br>• Renal conditions - Highest service burden in the Shoalhaven area<br>• Obesity - Highest service burden in the Young - Yass area<br>• Overweight - Highest service burden in the South Coast area<br>• Current Smoking - Highest service burden in the Dapto - Port Kembla area | SPDS Insight Series[vi] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Hyperlipidaemia - Highest service burden in the Goulburn Mulwaree area | |
| **Chronic Conditions and Health Risk Factors** | Escalating impact of mental and behavioural disorders as main long-term health conditions. | A significant long-term mental health condition that has a substantial burden in the SENSWPHN catchment is dementia (including Alzheimer's disease). Recent estimates suggest that as of the year 2024, an estimated 13,151 persons in the SENSWPHN catchment had dementia. This figure is projected to grow by 78.6% % by the year 2054 to 23,486 persons with dementia within the SENSWPHN catchment. | Population Health Profile[i] |
| **Chronic Conditions and Health Risk Factors** | Concerning projected growth in some long-term and debilitating conditions, including chronic pain. | Recent estimates suggest that as of the year 2020, an estimated 87,993 persons in the SENSWPHN catchment suffered from chronic pain. This figure is projected to grow by 23.6% by the year 2050 to 108,745 persons with chronic pain within the SENSWPHN catchment. It can be assumed that persons aged 65 years and over would account for most of these figures. This is expected to have a very high burden on the health and social service needs for the affected persons. | Population Health Profile[i] |
| **Chronic Conditions and Health Risk Factors** | Perceived gaps in service provision and barriers for management of chronic conditions | Various consultations identified the following in relation to chronic condition management in the catchment:<br>• Poor coordination of care and lack of associated affordable timely services to refer onto<br>• A lack of affordable prevention programs targeting risk factors for chronic conditions<br>• A lack of understanding among GPs<br>• Need for specialists and allied health professionals around the high health literacy needs of people with chronic conditions<br>• Limited cancer management services available in rural locations<br>• Issues with medication management contributing to preventable hospitalisations<br>• Appropriateness of self-managed care plans - they need to be person-centred and collaborative | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Limited funding to provide support for the under 65 age cohort, particularly in relation to essential medical treatment | |
| **Chronic Conditions and Health Risk Factors** | Factors influencing service capacity of Care Coordination services | Stakeholder feedback reported a high increase in referrals for care coordination services compared to previous years but factors such as lack of access to bulk-billing GP's, specialist gap fees and long wait times for care packages had a negative impact on client outcomes.<br><br>Other stakeholders reported high demand equating to high wait times, lack of available services to refer onto, difficulties with workforce recruitment and retention of adequately trained staff, and multiple comorbidities and higher client complexity were factors that made service delivery challenging. | Planning Journal Summary[iii] |
| **Digital Health Adoption** | Barriers to access | • Poor internet service was identified as a barrier in remote and rural areas<br>• There was concern that telehealth was compromised in those situations where individuals did not have the needed technical skills to use the relevant technology/ or equipment/ reliable internet connections were not available<br>• There was an assertion that providing telehealth in the home setting required additional social support (e.g. family members) to ensure patients correctly understood diagnosis, care plans and misinterpretations were corrected<br>• Access to interpreters in the home was especially important to those from CALD backgrounds | Planning Journal Summary[iii] |
| **Digital Health Adoption** | Enablers to improve access | • Consultation identified high levels of satisfaction with telehealth services among some consumers especially its increased convenience and financial savings<br>• For those in rural locations with less access to services, virtual care models of care are appropriate and therefore likely to reduce number of presentations to Emergency Departments | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **Digital Health Adoption** | Enhance continuity of care by use of virtual models of care for patients (with chronic conditions) | Adaptation and acceptance of Virtual Care Clinic (VCC) models was perceived as high in consultation with GPs in the Shoalhaven as a way of providing additional supports to patients with chronic conditions:<br>• Benefits of the model include a level of ongoing monitoring that GPs are not always able to provide; better access (in terms of expanded hours and access to a clinician); keeps a person engaged in managing their own health<br>• Use of such models may help to recognise exacerbation early and keep patients out of hospital or unnecessary calls to an ambulance | Planning Journal Summary[iii] |
| **Disability** | Needs of carers and informal care givers | A substantial proportion of the population cares / provides support / offers unpaid assistance to a person with a disability. Multiple regions have over 13% of the population that can be assessed as being carers to disabled person/s. The service needs of this cohort such as respite care options need investigation and this cohort needs to be ably supported for both their contribution to the caring tasks as well as their own mental well-being and physical health. | Population Health Profile[i] |
| **Disaster Preparedness and Emergency Response** | Improving workforce resilience for impacts from natural disasters | • There has not been a significant natural disaster in the catchment in the last few years, but the bushfire and subsequent flooding disasters highlighted important components of future natural disaster strategy. Consultation with GPs highlighted that strengthening communication was critical for improving resilience for future natural disasters. Including:<br>  ○ Establishing disaster preparedness manuals/plans to assist GPs with understanding critical roles and responsibilities of emergency response organisations<br>  ○ Multidisciplinary approaches – pharmacists were seen as a key service provider during disasters<br>  ○ Communication plans to better coordinate with other General Practices, LHDs and emergency response organisations<br>• Telecommunications support: Investing in satellites phones or two-way radios for practices and pharmacies would facilitate | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | communication (especially between Ambulance and Hospital services)<br>• Infrastructure support: Investment in on-site generators | |
| **End of Life care, Ageing and Frailty** | Demand and supply mismatches in Residential Aged Care facility services | Residential aged care places for the catchment have been declining and current rates are the lowest in recent years. With 66.9 places in residential care per 1,000 persons aged 70 years and over, the catchment rate is substantially lower than the NSW state and Australian national rate. The occupancy rate for residential aged care in SENSWPHN catchment was 84.4%. With a very ageing population this declining trend highlights a concerning mismatch between demand and supply. | Population Health Profile[i] |
| **End of Life care, Ageing and Frailty** | Variability in access to primary care in certain settings and reduced utilisation and availability of care services | There is low primary care/general practitioner service reach to residential aged care facility residents for the catchment. The latest figures place the catchment substantially lower than the Australian national average for rate of service utilisation, and the PHN has the 10th lowest ranking for this indicator among all 31 PHNs.<br><br>SENSWPHN had lower than state and national figures for utilisation of care types for persons aged 70 years and over across home care services, home support services, residential aged care services and respite residential care services.<br><br>Rough estimates that analysed residential aged care places in relation to population showed that Upper Lachlan Shire, Bega Valley and Snowy Monaro Regional had much lower availability of aged care places. | Population Health Profile[i], Needs Assessment Snapshot: Ageing[vii] |
| **End of Life care, Ageing and Frailty** | Service gaps existing in areas of the catchment | A service gaps analysis demonstrated that regions in the catchment had very low availability of home care services that provided services for special needs populations and vulnerable cohorts such as Yass Valley, Upper Lachlan Shire and Kiama. These regions were also the areas with the lowest level of residential aged care services. | Needs Assessment Snapshot: Ageing[vii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **End of Life care, Ageing and Frailty** | Frailty among older people in the community | Latest estimates show people aged 65 years and over accounted for over 66% of all fall-related hospitalisations in the catchment. These primarily include injury related (injury as principal diagnosis) and the rest were cases of fall being an associated/secondary diagnosis. While rates for the catchment's boundaries are lower than other boundaries in NSW; the Wollongong region still has quite high rates and is higher than NSW state levels. | Population Health Profile[i] |
| **End of Life care, Ageing and Frailty** | Greater utilisation of health services | Persons aged 65 years and older were a high proportion of the cohort of persons who had at least one service from the following: 61% of all nursing and Aboriginal Health Workers services, 39% of all specialist attendances. | Needs Assessment Snapshot: Ageing[vii] |
| **End of Life care, Ageing and Frailty** | High proportion of older persons are carers and need additional support | 17.8% of older persons aged 65 years and over in the SENSWPHN catchment are primary carers or non-primary carers. The service needs of this cohort such as respite care options need investigation and this cohort needs to be supported for both their contribution to the caring tasks as well as their own mental well-being and physical health.<br><br>Nationally, 39.8% of older persons living in households required assistance with at least one personal or everyday activity, the most common being property maintenance, with health care and household chores being commonly needed. These needs were not always met with 43.5% of respondents saying that their needs were partly met, with 4.2% saying their need was not met at all. Just over half (52.3%) said their need for assistance was fully met, which is a decrease from 65.9% in 2018. Tasks where assistance needs were not met at all were:<br>• Property maintenance (12.4%) | Needs Assessment Snapshot: Ageing[vii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Household chores (8.4%)<br>• Cognitive or emotional tasks (6.3%) | |
| **End of Life care, Ageing and Frailty** | Factors associated with in-home supports | Special needs populations and vulnerable groups are predominant users of in-home care services. Within the SENSWPHN catchment, among persons who use home support services;<br>• 3% were identified as Aboriginal<br>• 26.8% were born outside of Australia with 12.6% having a non-English preferred language<br>• 86.7% of did not have a carer<br>• 29.2% had some form of disability<br>• 46.3% lived alone. | Needs Assessment Snapshot: Ageing[vii] |
| **End of Life care, Ageing and Frailty** | Lack of availability of services in the after-hours for palliative care and in RACFs | • Perception of a lack of community supports in the after-hours period, e.g., supervision of new medication, respite care<br>• Consultation identified after-hours access to palliative care support is not consistent across Southern NSW including lack of available after-hours nursing support and hospice-type care<br>• Difficulty finding GPs to service residential aged care facilities (RACFs) during normal business hours and during the after-hours period | Planning Journal Summary[iii] |
| **End of Life care, Ageing and Frailty** | Limited access to suitable primary care | • Limitations in public transport options for older people in the catchment:<br>  ○ Particular problem for dementia patients; this issue is exacerbated by geographic isolation and/or poor service availability<br>  ○ RACF residents; some rely heavily on NSW Ambulance for transfers to medical investigations and appointments such as scans, renal and oncology<br>• Lack of allocated primary health resources to further identify and address aged care issues<br>• Poor succession planning for GP access in aged care and there is a heavy reliance on ED to provide medical care | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **End of Life care, Ageing and Frailty** | Important factors for delivering services to older persons cohort | Aged care planning needs more solutions than just aged-care places and beds and timely implementation to meet the rapidly ageing demography and have 'healthy ageing' as a priority in all planning and policies.<br>It was reported that communication on how to access My Aged Care was often complex and confusing, and that face-to-face services were an important component of service delivery as phone and telehealth options were not always suitable.<br>Stakeholders also reported that providing services for higher support needs were often not able to be utilised until more foundational supports such as food and housing were addressed first. | Planning Journal Summary[iii] |
| **End of Life care, Ageing and Frailty** | Older patient cohorts experiencing service gaps | Stakeholder consultation reported the following cohorts are experiencing lack of access to required services;<br>• Clients that have issues with hoarding and squalor<br>• Gaps in access and eligibility to services of My Aged Care<br>• Limited access for older patients who require specialist and allied health services such as Occupational Therapists to provide reports required for other services | Planning Journal Summary[iii] |
| **End of Life care, Ageing and Frailty** | Availability of appropriate, inclusive and flexible Aged Care services that can meet holistic needs of individual | Stakeholder feedback reported that for cohorts within the community, many current Aged Care services were not suitable. The Aboriginal community and LGBTIQA+ community and other culturally diverse communities were reported to have a greater level of distrust of current providers, particularly organisations with religious affiliations. | Planning Journal Summary[iii] |
| **End of Life care, Ageing and Frailty** | Need to build workforce capacity to meet increased community demand for palliative care services | Consultation with local expert advisory groups in the catchment identified;<br>• Variations in care delivery, often dependent on levels of engagement of a patient's GP (including to support home visits)<br>• Growing demand for community palliative care services; will need to integrate with inpatient palliative care and related services<br>• Inconsistent training/interest of palliative care among primary health nurses; no dedicated palliative care primary health nurses | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • GPs need greater support with delivery of care to RACFs and in their role with advanced care planning | |
| **End of Life care, Ageing and Frailty** | Lack of succession planning within the workforce and difficulties with staff retention affecting continuity of care | Consultation suggested that patients with dementia are not being managed well;<br>• Limited adequately qualified staff, with appropriate mental health skills, working in RACFs<br>• Limited access to carer services to provide emotional and navigation support for understanding the disease of their loved one<br>• Lack of specialist clinicians with skills to work with older people living in RACF's<br>• Shortage of registered nurses (RNs) in RACFs<br>• There are opportunities for further skill development including continued geriatric clinics, practice nurse training | Planning Journal Summary[iii] |
| **End of Life care, Ageing and Frailty** | Better access to Palliative Care services and quality of treatment | Low service reach to patients at palliative and end-of-life stages in the catchment was identified by past focus groups as a barrier to access. Specifically;<br>• The need to travel significant distances to access treatment was a common experience<br>• Delays in transfer of patient and treatment information when care was being delivered across different health services<br>• The capacity of RACFs to effectively meet the palliative and end of life care needs of residents was seen as insufficient<br>• Better care coordination and great support for Carers through access to resources for practical and emotional support services | Planning Journal Summary[iii] |
| **End of Life care, Ageing and Frailty** | Lack of mental health services for older persons | • Inequity in older persons mental health service availability with majority of services catering to younger population. Very low mean ages of current service utilisation suggest issues with either accessibility or ability of current services to cater to older persons who have very high needs and are clinically very vulnerable to multi-morbidity. | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Limited access to psychosocial and clinical services and support for older people both living in the community and in RACF's, as PHN-funded services only support a small number of RACF's in the catchment, with Bombala, Cooma and Braidwood offering no services at all. There is no service for persons aged 65 and older who are discharged from LHD's older persons mental health unit to refer into. | |
| **Mental Health and Suicide Prevention** | High rates of intentional self-harm related activity within hospital settings | SENSWPHN had the 4th highest rate of intentional self-harm compared to all 10 PHNs, with females being 1.6 times higher than males. Persons aged 15-24 years accounted for 33.3% and 30.8% of all intentional self-harm hospitalisations for ISLHD and SNSWLHD respectively with SNSWLHD having the 5th highest and ISLHD the 6th highest rates amongst NSW LHDs.<br><br>At a regional level, the Bega Valley, Goulburn Mulwaree and Wollongong regions were reported to have very high rates of intentional self-harm hospitalisation, with Bega Valley and Goulburn Mulwaree being amongst the top few LGAs in all of NSW state. Eurobodalla has reported a significant drop in self-harm hospitalisations from 21-22 to 22-23 figures but is unfortunately still higher than NSW rates. All LGA's, except for Kiama and Yass Valley, experienced a decrease in self-harm hospitalisations.<br><br>Based on latest figures, the trends for suicide/self-harm-related ED presentations show that the Southern NSW boundary had the highest proportion of older persons (aged 65 and over) and youth (aged 12-17) cohorts presenting, which were higher than the ISLHD, state and catchment averages. Crude rates of self-harm and suicide-related ED presentations have risen substantially for the Southern NSW boundary in the last 4 years. | Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii], Population Health Profile[i] and related analysis |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **Mental Health and Suicide Prevention** | High demand for mental health services and supports | It needs to be acknowledged that apart from self-harm related hospitalisations; other mental health disorders also contribute to the overall tertiary care service burden. In the last year, the rates for hospitalisations for mental disorders is showing an increasing trend for the catchment. | Needs Assessment Snapshot: Mental Health and Other Drugs[ii] |
| **Mental Health and Suicide Prevention** | High demand for youth mental health services commissioned by PHN | The catchment has expanded its *headspace* service footprint in recent years to cover new regions which were deemed as critical service gaps in previous needs assessments. However, the high waiting times for clients to access appropriate care in some centres such as Wollongong headspace in a timely manner continues to be high need. It was reported from stakeholders that there is a trend of increasing numbers of younger age groups accessing mental health services (under 14 and under 12 years). | Headspace Activity Report[x] and Planning Journal Summary[iii] |
| **Mental Health and Suicide Prevention** | Scope of improvements for PHN commissioned services | Ongoing performance monitoring and outcomes-based service review of existing PHN commissioned services reveals;<br>• Inequitable distribution and utilisation (by need as well as geography) of several PHN commissioned service activity domains<br>• There is a clear need to promote more holistic outcomes and measurable outputs in clinical service provision to be able to have any attributable impact in the mental health and well-being of health service consumers<br>• Need to improve population coverage of some service activity domains specifically for some pockets of the catchment.<br>• Increase proportion of consumers reached through alternative and lower intensity options under an effective stepped-care model of service delivery<br>• Need to improve the reach and availability of culturally appropriate services to all parts of the catchment | Mental Health Service Monitoring Snapshot[xi] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **Mental Health and Suicide Prevention** | Demand and supply mismatches in mental health service delivery and uptake | The service utilisation figures of Medicare subsidised/ funded mental health services remains somewhat misaligned to the actual prevalence-based estimations of service utilisation. The more regional parts of the catchment such as areas of Goulburn Mulwaree, Snowy Mountains and Young-Yass (along with Queanbeyan to some extent) seem to have low utilisation figures for all service types subsidised/ funded through Medicare.<br>For PHN commissioned services current reach for residents of regions such as Kiama, Upper Lachlan Shire and Yass Valley remains very low. Additionally, the very high reach in certain pockets of the catchment seem to indicate a bit of over-servicing as well. These need to be reviewed from a holistic, systematic view and re-align service volumes to meet actual community need rather than based on available supply. Poor supply may also be an issue, which needs is mentioned elsewhere as a workforce, recruitment and retention need. | Needs Assessment Snapshot: Mental Health and Alcohol and Other Drugs[ii] |
| **Mental Health and Suicide Prevention** | Need for service delivery to be inclusive, representative and reach to all target socio-demographic groups | Certain socio-demographic groups are under-represented in current mental health service delivery especially within PHN commissioned services such as:<br>• Non-English speaking / culturally linguistically diverse populations<br>• Males<br>• Gender diverse groups<br>• Older aged persons<br>• Children below 12 years of age<br><br>Other cohorts with complexity that are reported to be lacking access to services<br>• People with disability such as acquired brain injury, developmental disability, autism spectrum (too complex for Level 4), intellectual disability, NDIS participants<br>• Co-occurring AOD disorders<br>• Eating disorders | Needs Assessment Snapshot: Mental Health and Other Drugs[ii] and Mental Health Service Monitoring Snapshot[xi] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Consumers discharged from child mental health services with nowhere to go due to their specific condition<br>• Complex PTSD<br>• Personality disorders who need long term DBT<br>• History of suicidal crisis and hospital presentations (deemed too risky for Level 4)<br>• Paranoia/mistrust of telehealth, where that is the only available option<br>• Perinatal anxiety and depression - as PIMHS is only for extremely high acuity, and there is one PIMHS worker for the whole of SNSWLHD<br>• People experiencing DV, often no ability for services to provide a female clinician/PW if requested for example | |
| **Mental Health and Suicide Prevention** | Service availability gaps and inequitable distribution | A desktop service mapping exercise[3] has identified significant gaps in service availability across the catchment but more importantly a gross lack in the availability of at least one service offering under each service type within each region of the catchment. Therefore, it can be inferred that there is a lack of comprehensive local availability of services that can cater to all aspects of mental health service needs within every region of the catchment.<br><br>The lack of service availability is grossly significant for inland regions and the more remote parts of the catchment; with a very high level of supply in more metropolitan locations in the northern parts of the catchment. | Needs Assessment Snapshot: Mental Health and Other Drugs[ii] |

[3] There are several caveats to the desktop service mapping; care should be exercised in interpreting this need. Discussions with SENSWPHN's Planning & Insights team is strongly advised.

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
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| **Mental Health and Suicide Prevention** | Funding distribution across priority areas | Child and youth-specific mental health services receive the largest allocation of Commonwealth mental health funding from the SENSWPHN, followed by psychological therapy services and psychosocial support services. | Needs Assessment Snapshot: Mental Health and Other Drugs[ii] |
| **Mental Health and Suicide Prevention** | Barriers to access for youth mental health services | Numerous consultations with the community and stakeholders have identified barriers to access for mental health services for young people in the catchment:<br>• Lack of availability of appropriate services. There is a gap in moderate intensity face-to-face services for young people and lack of level 4 services for children and young people under 16<br>• Lack of level 5 inpatient services for youth under 18, no adolescent units except in Shellharbour<br>• Lack of trained workforce<br>• Reported long waiting lists for existing services<br>• Need for greater access to counsellors and school counsellors and increased capability in suicide prevention and postvention support in schools (Mental Health First Aid, QPR, YAM)<br>• Barriers of cost and travel costs, particularly for cohorts who live in rural areas and need to travel long distances to access services | Planning Journal Summary[iii] |
| **Mental Health and Suicide Prevention** | Barriers to access for overall mental health services | Key barriers include:<br>• Lack of understanding of services available and poor knowledge dissemination of commissioned services<br>• Perceived cost barriers to access supports and services (especially psychiatry)<br>• Transport – higher travel burden due to large regional area with limited access to affordable public transport options), especially in Eden<br>• Issues with severe lack of access for psychiatry – lack of timeliness for first consult and cost often prohibitive for many in the private sector and eligibility for LHD too high. It was reported that there has been a large increase in request for assessment and support with | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | neurodiverse conditions such as ASD and ADHD, which is negatively impacted by the lack of bulk-billing psychiatry<br>• Lack of bulk-billing GP's which affect access to MHTP, management support, medication, referral pathways and ongoing care<br>• There have been reports that access to free psychology services appear to have improved due to the availability of PHN-funded services, yet there is still a large amount of unmet demand for free or low-cost mental health services for many cohorts and regions across the catchment | |
| **Mental Health and Suicide Prevention** | Barriers to access for vulnerable populations | • Limited access to services and supports (for reasons stated above) for special populations such as drought affected farming communities and people from Culturally and Linguistically Diverse populations as well as the LGBTIQA+ community<br>• In rural areas, building capacity of current providers, utilising farmgate counselling services and mapping out clear referral systems are suggestions for improving access to supports<br>• Due to services lack of capacity to adequately do outreach in rural areas, telehealth was reported to be beneficial. However, it is not always suitable due to lack of access to internet, technology, trust issues, capacity to use telehealth. Characteristics such as complexity, older age and language and cultural barriers were also reported to make telehealth access more difficult<br>• It was also noted that there was a lack of home-based supports for clients with physical health needs as well as mental health needs | Planning Journal Summary[iii] |
| **Mental Health and Suicide Prevention** | Gaps in availability of psychosocial services and support for people with severe mental illness | • Lack of capacity in programs for complex mental health needs such as borderline personality disorder and eating disorders, particularly in Southern NSW<br>• Poor service coverage in the Southern region with extensive workforce shortages further reducing capacity of existing services | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Reports that LHD services are turning away clients who have been stepped up from psychosocial supports, or are discharging from hospital without adequate handover<br>• In the Justice System there is no mental health support in the court system or when exiting<br>• Existing psychosocial services are limited to 9-12 months, yet this cohort require ongoing support<br>• Apart from one service in the Shoalhaven region, there are no providers of long-acting antipsychotic depot injections<br>• Eligibility barriers when connecting into different services<br>• Identified need for greater access to social/interest groups to reduce isolation and improve social skills | |
| **Mental Health and Suicide Prevention** | Complex Mental Health support | Stakeholder feedback informed that current funded programs for Complex Mental Health have good feedback regarding the quality of service but there are ongoing issues with inequitable distribution of services, staff recruitment and retention, resulting in reduced capacity and high wait times. Except for the Shoalhaven, many areas of the catchment have had very minimal service offering in recent months, as even when the programs are fully staffed, there is not enough capacity to adequately support complex cohort. | Planning Journal Summary[iii] |
| **Mental Health and Suicide Prevention** | Need for better care coordination functions and continuity of care fostered by greater interagency collaboration | • Referral coordination is needed including navigation function for consumers and carers<br>• Multiple intake systems currently exist but they are fragmented and program specific<br>• Gaps in pathways: a significant need for fostering stronger connections with non-clinical /social services and LHD services<br>• Scope remains to improve the provision of integrated services and communication between services to overcome the existing provision of siloed services<br>• Need for the adoption and implementation of evidence-based and data-driven strategies in the roll-out of existing after-care pathways | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | for suicide and self-harm prevention, especially within the Southern NSW region to enable good population coverage referral numbers<br>• GPs to some extents have limited confidence in headspace with the perception that GPs are contacted by headspace to just obtain a GP care plan that could then enable billing of psychologist services and not really for integrated and collaborative service delivery | |
| **Mental Health and Suicide Prevention** | Lack of availability of early intervention and prevention services for young people | Consultations highlighted:<br>• A perceived view that for a young person to be admitted to hospital for mental health treatment they need to be extremely unwell to gain admission<br>• Intermediary "step up and step down" services are required to better cater for the level of need and to minimise service acuity needs due to lack of earlier intervention services<br>• More psychological, drug and alcohol, paediatric care and early intervention services are needed<br>• Time delays - difficulties in accessing GPs as their books may be closed, or access to psychology may have long wait times<br>• Lack of resourcing to deliver evidence-based group programs in schools and wider community<br>• Lack of trauma-informed care work taking place | Planning Journal Summary[iii] |
| **Mental Health and Suicide Prevention** | Difficulties navigating service options and a lack of low-intensity services to address prevention and early intervention | • Need to build community capacity around early identification and support for mental health consumers especially during early and/or mild stages of distress/ disorders along with having resources to enable initial interventions<br>• Consumers find it difficult to navigate and find out about what service options are available in the current system<br>• Consistent theme of ensuring all services focus on targeted recovery-oriented interventions<br>• Need for interventions and service models to be based on consumer's unique and individual needs and circumstances with the availability of a degree of flexibility to suit the consumer | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • A current low level of availability as well as uptake of online therapies and low intensity service options that enable self-help and self-management<br>• Poor availability of data on coverage and utilisation of nationally funded low intensity online support site Head to Health | |
| **Mental Health and Suicide Prevention** | Need to strengthen mental health services to respond to new needs or exacerbated needs following disaster events | • Lack of early intervention services and support services with a disconnect between schools, families, and primary health providers<br>• Demand for additional counselling services with ease of access and timely, flexible appointments<br>• Bolster existing local services to cope with the increased demand for services including drug and alcohol, family, and relationship counselling<br>• Need for commissioned services to provide outreach to rural and remote communities to assist with practical needs/life issues and link people into counselling<br>• Need to increase proportion of consumers reached through alternative models, such as recovery-based group sessions<br>• Need to improve alignment of session numbers to population as well as individual consumer-based need<br>• Low uptake/utilisation of electronic and low intensity services which could be enhanced in specific regions<br>• There are limited services or poor uptake of existing services across the Southern NSW region raising needs of collaborative system level communication and referral – it should be noted some evidence-based strategies of suicide prevention are currently underway in terms of being implemented | Planning Journal Summary[iii] |
| **Mental Health and Suicide Prevention** | A consistent gap in a lack of availability of psychosocial service and supports outside of business hours | Extensive consultations with consumers and stakeholders across the catchment identified:<br>• Need to provide opening hours that extend beyond 5pm<br>• Provide regular services over weekends and during the evening | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • These services need to be complemented by access to 24 x 7 online information, Apps, and self-help material<br>• Offer after-hours phone counselling/crisis services | |
| **Mental Health and Suicide Prevention** | Inconsistencies in coordination of care between GPs and MH inpatient services | • GP feedback includes - obscure and time-consuming pathways to secondary and tertiary care; under-funded and under-resourced community mental health services; a lack of bulk-billing psychiatrists<br>• Inequitable follow up and options for mental health consumers who are discharged compared to those discharged for other conditions, increased non-clinical support is needed<br>• Clinicians report ineffective triaging with some GPs over prescribing psychotropic medications and over referring to psychology and psychiatry services especially in parts of Southern NSW such as Goulburn-Yass region<br>• There is a lack of system integration when consumers are admitted or discharged from acute care, with GP's, ACCHO's and commissioned services reporting not being provided with discharge summaries, the same was reported the other way in that LHD's are not provided with update on referral outcome<br>• Lack of early intervention services; and services providing case management<br>• Intake processes can be a barrier for consumers and providers such as providers not funded to provide the intensive case management | Planning Journal Summary[iii] |
| **Mental Health and Suicide Prevention** | Gaps in workforce capacity affecting availability of psychosocial services | • Wait lists and majority of mental health services at capacity and a lack of clinicians in the region: impacting Cooma, Braidwood, Narooma, Bombala, and Eden particularly<br>• Lack of appropriately resourced and trained domestic violence and sexual assault counsellors<br>• Limited access for consumers and their families and carers to peer workers and consumer/carer advocacy | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | and support available for people | • Recruitment and retention difficulties in Shoalhaven and Southern NSW regions for psychiatrists and allied health clinicians<br>• Lack of equitable distribution of mental health nurses and allied mental health professionals creating gross gaps in some areas such as pockets of Southern NSW<br>• Limited family counselling services across the region<br>• Limited access to psychosocial supports and services across the lifespan<br>• Lack of appropriate training and support in region for peer workers | |
| **Population Health** | Lack of availability of primary care and specialist services | • Barriers to accessing the right health specialist services with obstetrician and gynaecologists, psychiatrists, and paediatricians particularly in various consultations. These barriers are compounded in rural communities where there is less service provision.<br>• Long waiting times for specialist appointments, waiting times for GP appointments, and waiting periods for elective surgery<br>• Changes to general practice billing models and a decline in the bulk-billing rates has resulted in increased out-of-pocket expenses for patients and is a large access barrier, especially for socioeconomically disadvantaged cohorts<br>• Difficult and complex referral processes<br>• Geographical isolation/distance resulting in large travel times and costs was identified as barrier to access to health care as was complex referral processes/service navigation<br>• Communication from specialists back to a patient's GP was also limited<br>• It was reported that there was a lack of workforce development for the future for both GP's and non-GP specialists | Planning Journal Summary[iii] |
| **Population Health** | Factors impacting service provision for domestic, family and sexual violence needs | Stakeholder feedback from market analysis of domestic, family and sexual violence services reported:<br>• There is very limited market in the southern district for specialist services in domestic, family and sexual violence services, so often | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | support is provided to victims/survivors by housing services, family support services and early intervention.<br>• The housing crisis impacts on services due to not being able to recruit staff to area as there is minimal availability of rentals. Multiple reports in Bega, Eurobodalla and Cooma of staff turning down roles due to not being able to secure housing. This also impacts on homelessness services and housing providers not being able to provide housing for clients escaping DV or in need of housing support.<br>• Smaller population in some rural areas that are requiring services mean that outreach is often provided by services contracted from out-of-town but there are issues with the travel time and resources required. There are access issues to rural areas during natural disasters which often closes the limited road access.<br>• The bushfires and floods in recent natural disasters negatively impacted on communities in Eurobodalla, Bega Valley and Snowy Mountains regions, meaning that services have reported additional support needs for vulnerable families and children. Workers in the sector are also negatively impacted by loss of property and personal and family impacts of trauma.<br>• As a significant portion of Southern District regional tertiary health services are provided in the ACT, there are issues with system integration. There are ongoing challenges with workforce as higher salaries in the ACT which negatively impact surrounding regions such as Queanbeyan, Yass and Bungendore.<br>• Workforce issues of recruitment and retention are ongoing struggle for DFSV sector.<br>• Short-term funding cycles can deter organisations from applying for funding grants and opportunities to due large investment required for accreditation, management restructure and staffing needs, without guarantee of continual funding. | |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **Population Health** | Current priority cohorts experiencing Family, Domestic and Sexual Violence | Consultation with community organisations and services working in the family, domestic and sexual violence (FDSV) sector highlighted the following service gaps and needs:<br><br>*Children*<br>• Paediatric care including immunisations, assessment, and support for developmental needs. The first 2000 days of a child's life are a critical period when access to supports and allied health are needed to address potential developmental delays and mental health issues<br>• Counselling/mental health support and other allied health supports like OT and speech pathology also for older children<br>• Early intervention and referral pathways for child victims who then exhibit violent behaviours or dangerous/problematic sexual behaviour<br>• Case coordination for children that can also provide advocacy with school needs<br><br>*Youth and younger people*<br>• Increasing need for young people and families under 25<br>• Refuge access for youth in Southern region<br>• Therapeutic supports for youth<br><br>*CALD*<br>• Women without permanent visas who have no access to medical services. Safe spaces and visa supports are also a need for this cohort<br>• CALD specific supports for FDSV and mental health are lacking. Need for bilingual staff to support communication<br>• Outpatient paediatric services for refugees are having issues with recruitment and retention of staff, impacting capacity<br>• Access to funded Translator and Interpreter services. Access to English speaking classes that link in with other services<br>• Maternal and child nurse and antenatal care | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Education for victim/survivors around what constitutes DV and coercive control<br>• There is a need for additional FDSV and CALD training for GPs to support multicultural community<br><br>*Women and Maternal health*<br>• Access to a women's trauma recovery centre<br>• Women's/Maternal and child nurse is a primary need for shelter services<br>• Psychology<br>• Free and accessible terminations<br>• Flexible brokerage funds to support antenatal care and other medical/specialist care, prescriptions and costs associated with women returning to work | |
| **Population Health** | Current needs and gaps in cohorts experiencing issues with Family, Domestic and Sexual Violence | Consultation with community organisations and services working in the family, domestic and sexual violence (FDSV) sector highlighted the following service gaps and needs:<br>• Men's behaviour support and DV education programs<br>• AOD supports for both perpetrators and clients<br>• Psychology/Trauma supports<br>• Accommodation and Homelessness services are in high need<br>• In-reach services<br>• Parenting education<br>• Financial management support for debt issues<br>• Legal support<br>• Intensive case management<br>• Health, medical (including screening) and dental services<br>• Navigation, advocacy and peer support to access all the required services<br>• Brokerage supports for health and housing needs | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Refuges are struggling with staffing. Need to provide services direct to refuge cohorts for AOD, MH and debt issues | |
| **Population Health** | Current regions with needs and gaps in Family, Domestic and Sexual Violence supports | Consultation with community organisations and services working in the family, domestic and sexual violence (FDSV) sector highlighted the following areas of greater needs:<br>• High needs in Nowra, Goulburn and Eurobodalla (although it should be noted that based on reported domestic violence related assault crime figures the rates were highest for Goulburn Mulwaree and Eurobodalla)<br>• Crisis accommodation in Bega<br>• Women's refuge in Moruya, Goulburn, Bega, Queanbeyan, Eurobodalla<br>• Women's resource centre in Crookwell/Bega | Planning Journal Summary[iii] |
| **Population Health** | Limited access to bulk-billing primary care | • Amongst the 82.4% practices that participated in the data collection processes in 2023-24, it was found that only 14.9% were bulk-billing practices with several regions have no / zero bulk-billing practices. SENSWPHN figures were lower than NSW state and Australian national estimated figures. | Additional Insights for Needs Assessment[iv] |
| **Population Health** | Consumer experience of finding bulk-billing GP's | Community Surveys found that 73.7% of respondents believed it was becoming harder to find a bulk-billing GP, 21.1% felt there was no change and 5.2% felt it had become easier within the last 6 months.<br><br>Some of the top locations highlighted from stakeholder feedback that were becoming increasingly difficulty to access GP appointments: Eden, Bateman's Bay, Bega and Moruya. | Planning Journal Summary[iii] |
| **Population Health** | Financial constraints and transport issues in accessing health care services | • Cost and affordability of healthcare services was expressed across several consultations as a barrier to accessing the right healthcare<br>• Suggestions include a need to promote awareness of bulk-billing arrangements | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Consultations have continually highlighted transport as an issue. Poor public transport and costly alternatives exacerbated by long distances needing to be travelled due to geographic isolation and/or poor service availability (e.g. for specialist services) | |
| **Population Health** | Lack of availability of services outside business hours and long wait times for GP availability | • General practices need to be encouraged to consider having more availability/flexibility in terms of opening hours<br>• Consultation with residents from the Illawarra Shoalhaven LHD indicated a perception of limited opening hours and difficulty gaining appointments when needed<br>• Books closed - general practices not accepting new patients was reported as a barrier and was most mentioned by Shoalhaven LGA (including Jervis Bay Territory) and Kiama LGA respondents | Planning Journal Summary[iii] |
| **Population Health** | Fragmented communication and linkages in coordinating care across state-border services | • High volume of NSW residents seeking health care in ACT. Lack of NSW services is driving cross border flows<br>• Providers reporting poor linkages back into the NSW primary care system<br>• Large commuter population accessing ACT services for convenience<br>• Fragmented regional planning - LHD, local government/shire councils and PHN are all urged to undertake planning activities on a regular basis covering all or portions of the same population so there is opportunity for collaboration | Planning Journal Summary[iii] |
| **Population Health** | Poor service knowledge dissemination and lack of service awareness. | Past stakeholder forums and community surveys identified limitations in community awareness of services and associated information on availability, location, and eligibility:<br>• Available options in the after-hours period with clarity around access eligibility, and access points<br>• Promotion of services and relevant information to vulnerable or disadvantaged communities was identified as a need by service providers<br>• Consumers report not knowing where to go and complexity in the system | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
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| **Population Health** | Key needs of certain vulnerable cohorts requiring appropriate care and tailored services to meet their needs | • Stakeholders across various forums have identified a need for holistic models of health and social care for Aboriginal and/or Torres Strait Islander populations; Culturally and Linguistically Diverse (CALD) populations; ageing population; disadvantaged youth; socio-economically disadvantaged persons; and those experiencing geographic isolation<br>• Navigation and coordination especially for more socio-economically and/or complex health needs clients is identified as a major concern in all stakeholder and community consultations | Planning Journal Summary[iii] |
| **Population Health** | Lack of culturally appropriate services tailored to Culturally and Linguistically Diverse (CALD) populations | Community consultation regarding CALD health service access highlighted unmet needs and gaps in service delivery, including:<br>• There is no tailored service to assist people from CALD communities to navigate and access health and social services, especially for younger and older persons<br>• Recruitment and retention of CALD workforce was stated as an enabling factor to support access<br>• Volunteer services and community networks currently fill the gaps where service delivery is lacking<br>• Issues with cultural sensitivity and inclusion in community services (health care, education, and employment) exist and education programmes are needed to help service providers to be more culturally sensitive. Stakeholders reported that cultural competency was more about understanding and respecting cultural differences and world views, and utilising empathetic, effective communication beyond just translating and interpreter services. It was stated that the perspective of conventional health care, in relation to mental health, did not always align with CALD populations as the Western concept of mental health and mental health issues were not relatable | Planning Journal Summary[iii] |
| **Population Health** | Translator and Interpreter Services (TIS) | For the year from February 23 – February 24, the predominant usage of TIS services for SENSWPHN funded mental health services was through immediate | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | phone services (80%), and to a lesser extent, pre-booked phone services (20%).<br><br>The most common language accessed was Farsi (alt Persian) (67.4%), Arabic was the next most common (24.7%), Vietnamese was the third most common (7.9%). Thai, Korean and Italian translator services were also utilised but were below 5 services so could not be reported. | |
| **Population Health** | Need for culturally appropriate services for chronic conditions management | • Services need to be adapted to address the complex and multiple needs experienced by people from CALD backgrounds (many who have come to Australia as refugees), issues such as limited English, lack of understanding of the health and social services systems, finances, reduced health literacy, social networks, and experiences of poor mental and physical health need to be considered<br>• There is a lack of, and poor utilisation of, services for culturally and linguistically diverse populations – this theme included the poor access to interpreter services and the unavailability of culturally tailored services such as bilingual doctors, female GPs (or other gender preferences for health professionals), and poor utilisation of language interpreter services by GPs<br>• The small level of multicultural support services that are available are usually centralised in the Wollongong region, yet people from CALD backgrounds were perceived to be increasingly relocating to more regional areas because of jobs, cost of living and migrant regionalisation policies, thus resulting in poorer access to support services<br>• Increased cost of living and employment challenges provide further barriers to CALD communities accessing primary care and required health services | Planning Journal Summary[iii] |
| **Population Health** | Poor self-management of conditions leading to avoidable | • Lack of timely and regular medication reviews and issues with appropriate discharge medication advice<br>• Lack of communication between the tertiary system and primary care around medications prescribed on discharge from hospital, | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | hospitalisations and re-admissions | leading to medication repetitions and adverse clinical or service outcomes | |
| **Potentially Preventable Hospitalisations** | Potentially avoidable hospitalisations place extra demands on existing services | • While overall rates of potentially preventable hospitalisation (PPH) for the catchment have been on the lower side, there are some significant pockets of the catchment that have very high rates for specific conditions within the wider PPH categories. Notably the Goulburn Mulwaree, and Upper Lachlan Shire areas have significantly higher rates for overall PPH than the NSW state average figures<br>• Congestive cardiac failure; COPD; cellulitis; diabetes related complications; and urinary tract infections are the top 5 conditions in terms of total bed days consumed for PPH for the catchment | Population Health Profile[i] |
| **Social Determinants of Health** | Implications on service access | A higher than NSW state and Australian national proportion of persons are estimated to be Health Care Card Holders, Pensioner Card Holders, and Seniors Health Card Holders. Given the very high ageing population figures for the catchment and some of its regions; these figures may not be sufficient. | Population Health Profile[i] |
| **Social Determinants of Health** | Barriers to service access | Regions of Goulburn Mulwaree, Jervis Bay and Wollongong have over 7% and over 9% of the dwellings respectively with no motor vehicles. | Population Health Profile[i] |
| **Social Determinants of Health** | Life expectancy outcomes variation across the catchment | Regions with higher levels of socioeconomic disadvantage such as Eurobodalla, Shoalhaven and Shellharbour also reported the lowest average life expectancy. | Population Health Profile[i] |
| **Social Determinants of Health** | Barriers and enablers to service access for people experiencing homelessness | Stakeholders reported the lack of flexible, non-judgemental and free-of-cost primary health care was a driver for poor outcomes for vulnerable populations such as people experiencing homelessness. Requirements to provide documentation such ID and Medicare were a barrier to access, as was needing access to technology such as phones with credit for scheduling. It was stated that there needed to be financial incentives to encourage general practices to provide these kinds of services.<br>Feedback from stakeholders reported that care coordination services were an important enabler, when paired with suitable primary care, to support people experiencing homelessness. With high levels of co-morbidities and | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | complexity, care coordination provided the required assistance with understanding care plans and maintaining attendance to various medical appointments. System integration and partnerships between primary care, housing services and related health and social services was noted as an important component to ensure patients were not lost between handover to other services. Co-located outreach GP or nurse-led services were reported to be a strong enabler of access to primary care to help address issues with system integration, willingness to engage, fees, access to transport and service navigation. | |
| **Social Determinants of Health** | High seasonal service demands | The catchment attracts a lot of local as well as international tourists, which can add to the population demand for health and social services especially during holiday periods/seasons. | Population Health Profile[i] |
| **Timely access to appropriate care** | Potentially avoidable Emergency Department (ED) presentations | Some regions in the catchment have higher than catchment average rate for low urgency care presentations to the emergency departments (ED) with rates being very high for residents in the Queanbeyan and Snowy Mountains areas. | Population Health Profile[i] |
| **Timely access to appropriate care** | After-hours access to primary care | A substantial share of the low-urgency ED presentations occur during the after-hours period, with the share being highest for the Wollongong area within the catchment. Several areas of the catchment have figures higher than the Australian national estimates. | Population Health Profile[i] |
| **Timely access to appropriate care** | After-hours service demand | Consultation feedback, in conjunction with other data sources have reported that demand for after-hours services in many cases is due to lack of access to primary care in normal business hours. This can be due to a variety of factors such as lack of bulk-billing GPs, geographic location, long wait times to access an appointment and many general practices being closed to new patients. The majority of presentations to after-hours services are for low-acuity conditions with the more rural areas of the catchment that have reduced access to primary care, having even higher rates of low-acuity ED presentations. | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | Other demands on after-hours services were reported by stakeholders to be due to:<br>• Older cohort were reported to be the largest cohort accessing after-hours services, requiring greater support due to higher rates of chronic and acute illness<br>• Younger cohort of children due to concerned parents or acute illness<br>• Regional towns having increased demand due to tourist seasons that place greater demand on services<br>• Socioeconomically disadvantaged groups who could not afford gap fee for general practice | |
| **Timely access to appropriate care** | After-hours primary care | Consultation feedback reported that while there are a small number of general practices providing after-hours services, it is often not advertised very clearly to the public or to other services.<br>• Factors such as low financial viability and GP workforce issues are reported to be reasons why many general practices are not currently offering after-hours services. Workforce issues were reported to stem from an overworked cohort of GP's who are reluctant to work after-hours and an overall reduction in the number of GP's who are wanting to work in the more southern and rural areas of the catchment. It was also mentioned that younger GP's have less interest in working after-hours and RACF's due to family commitments or are also splitting time also working in local hospitals | Planning Journal Summary[iii] |
| **Timely access to appropriate care** | Important factors for After-hours/ED access | • Stakeholders reported that to promote continuity of care, after-hours services should provide notification to the patient's normal GP for follow-up<br>• It was also reported that telehealth utilisation to provide after-hours services should be used for advice and triage rather than replacing face-to-face care | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • LHD representatives stated that a large portion of ED referrals from GP's were inappropriate and instead should have been referred and managed to the correct hospital outpatient department.<br>• Virtual Care Clinics in general practices and other state-funded after-hours programs needed to be advertised and promoted better to ensure better referrals | |
| **Timely access to appropriate care** | Demand and supply mismatches in after-hours availability of primary care | The utilisation of Medicare funded/subsidised GP After-Hours services is very high for the Dapto-Port Kembla area. Somewhat high rates are also seen for Goulburn Mulwaree area in the non-urgent category. On the contrary very low figures are observed for Shoalhaven and Snowy Mountains areas. | Population Health Profile[i] |
| **Timely access to appropriate care** | Substantial variations in service utilisation across service types | Comparing service utilisation figures for the catchment with other PHN catchments in the country reveals<br>• Relatively high utilisation of some services<br>○ adults who saw a GP in the preceding 12 months<br>○ adults who saw a GP 12 or more times in the preceding 12 months<br>○ adults who saw a medical specialist in the preceding 12 months<br>○ adults who saw three or more health professionals for the same condition in the preceding 12 months<br>○ adults who went to any hospital emergency department for their own health in the preceding 12 months<br>○ adults who were admitted to any hospital in the preceding 12 months<br>• Relatively low utilisation of some services<br>○ adults who saw a GP after-hours in the preceding 12 months<br>○ adults who saw a GP for urgent medical care in the preceding 12 months | Brief Patient Experiences Snapshot[xii] |
| **Timely access to appropriate care** | Relatively poor patient experience on some key indicators | Comparing service experience figures for the catchment with other PHN catchments in the country reveals there are relatively poorer patient | Brief Patient Experiences Snapshot[xii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | experiences with the scores for the catchment being worse than Australian national averages for some service provision metrics such as;<br>• High percentage of adults who could not access their preferred GP in the preceding 12 months<br>• High percentage of adults who did not see or delayed seeing a GP due to cost in the preceding 12 months<br>• High percentage of adults who felt they waited longer than acceptable to get an appointment with a GP<br>• High percentage of adults who needed to see a GP but did not in the preceding 12 months<br>• High percentage of adults referred to a medical specialist who waited longer than they felt acceptable to get an appointment in the preceding 12 months<br>• High percentage of adults who delayed or avoided filling a prescription due to cost in the preceding 12 months<br>• High percentage of adults who did not see or delayed seeing a dentist, hygienist, or dental specialist due to cost in the preceding 12 months | |
| **Timely access to appropriate care** | Scope of improvements in key primary care service quality and patient care metrics | • Through the Sentinel Practices Data Sourcing project (incorporating Quality Improvement Practice Incentive Program), it is evident that a substantial scope of improvement exists on several key measures and quality improvement domains. While primary care service provision and patient care metrics have improved significantly in the past few years for the overall catchment, some measures still warrant continuous effort and holistic support, training and advocacy to general practitioners and other primary care staff to get to ideal levels of data-driven clinical service quality. | Sentinel Practices' Quarterly Data Quality Snapshot[xiii] |
| **Workforce** | Service delivery capacity and sustainability issues for primary care services | The latest available figures for key primary and community care workforce shows high levels of regional inequity in workforce distribution in the catchment with some very concerning shortages within some regions. An | Population Health Profile[i], Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | assessment of FTE as a rate of the residential population in relative region-based comparisons shows: -<br>• Very low general practitioner (GP) workforce figures for the Shellharbour, Queanbeyan-Palerang Regional, Upper Lachlan Shire regions and Goulburn Mulwaree region.<br>Very low primary care nurse workforce figures for the Yass Valley, Shellharbour and Goulburn Mulwaree, Queanbeyan-Palerang regions<br><br>Data suggests that workforce shortages across all health disciplines are a particular problem for towns of MMM5/4 rating, rather than MMM6/7, due to additional supports like Flying Doctors etc available in more remote areas. | |
| **Workforce** | General practice workforce issues in areas of the catchment | Data sources and stakeholder feedback reported the following workforce issues for general practices:<br>• Practices in lower socioeconomic areas are struggling to recruit GP and PN staff as there is a preference to work in more affluent areas with less complex patient cohort and higher fees (as registrars are paid a % of total billings)<br>• A large portion of the GP workforce is ageing and preparing for retirement, with a lack of succession planning, which is reducing primary care service capacity in the catchment. In 2021, 37% of GPs in MMM2-7 areas of NSW were over the age of 55 years<br>• Difficulty from general practices to recruit and retain registrars in regional towns, particularly in the rural and southern regions, as there was a much greater preference to live in more metropolitan areas. Lack of housing and childcare/after school care options were said to negatively impact this issue<br>• Remuneration and leave entitlements were said to be more competitive in the hospital system so young doctors are choosing to work either full or part-time in the LHD system<br>• Greater patient complexity due to increased morbidity, so often patients are wanting to address multiple issues in a short appointment. This is also due to appointments becoming harder to | Planning Journal Summary[iii] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | attain/have gap fee and also due to lack of specialist access in regional areas, so patients expect GPs to manage their care. These components place greater strain on GPs to provide care that does not provide additional remuneration<br>• General practice is not seen an attractive career prospect; high work and time commitments, Medicare rebates are low, rising costs of providing services, GP workforce is often overworked and burnt out/fatigued and patient's expect free health care<br>• As length of GP training often results in registrar's being older, there are often family and spousal commitments and whilst regions are seen as attractive options, family obligations were highlighted as most common reason for not staying in the region<br>• Lack of GP registrar positions due to the heavy supervisory workload<br>• Lack of financial incentives for GPs to become GP supervisors and undertake the training which often requires travelling to a larger city | |
| **Workforce** | Workforce and business sustainability of General Practice | • There are reported issues with maintaining viable businesses within the current general practice model. Workforce issues are also concerning given the decreasing trend in availability of GP's and practice nurses, particularly in regional areas. Both factors are projected to negatively impact the availability of primary care in the future, for many parts of the catchment. | Planning Journal Summary[iii] |
| **Workforce** | Service delivery capacity and sustainability issues for mental health and other allied health services | The latest available figures for key primary and community care workforce shows a relative gap in the catchment with some very concerning shortages within some regions. An assessment of FTE as a rate of the residential population in relative region-based comparisons shows:<br>• Low psychologist workforce figures for several regions of the catchment but very low for the Queanbeyan-Palerang, Yass Valley and Snowy Monaro regions and somewhat low for the Eurobodalla region<br><br>Other key workforce gaps that were assessed at a catchment level and it was found that the catchment had lower than state and national figures for: | Population Health Profile[i] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| | | • Aboriginal Health Practitioners<br>• Chiropractors<br>• Medical Radiation Practitioners<br>• Occupational Therapists<br>• Optometrists<br>• Podiatrists<br><br>Pharmacist workforce figures were significantly lower for the catchment than state and National figures, with Queanbeyan-Palerang having substantially lower figures of 39.1 FTE per 100,000.<br><br>Physiotherapist workforce was also significantly lower for the catchment than state and National figures, with 87.8 FTE per 100,000 for SENSWPHN whereas NSW and National figures showed 106.3 FTE and 110.6 FTE, respectively. Yass Valley region had very low figures with 35.1 FTE, with Queanbeyan-Palerang region also quite low.<br><br>Paramedic workforce figures were in contrast in that the catchment had higher than state and National figures at 100.1 FTE per 100,000 for SENSWPHN, whereas state and National figures were 72.6 and 85.3 FTE, respectively. Wollongong had concerningly low workforce FTE at 77.3. Kiama and Goulburn Mulwaree were also low. | |
| **Workforce** | Service delivery capacity and sustainability issues for selected specialist services | The predominant areas of the catchment are considered as areas of workforce shortage (termed as Distribution Priority Area (DPA)) for several specialist professions such as cardiology; anaesthetics; diagnostic radiology; and obstetrics and gynaecology. In addition, almost all regions of the Southern NSW LHD boundary are also considered as areas of workforce shortage for specialist professions such as ophthalmology, medical oncology, and psychiatry. The psychiatry FTE figures for the catchment are very low compared to NSW and National average figures. Parts of the Shoalhaven region and predominant areas within the Southern NSW boundary are also classified as Distribution Priority Areas indicating shortages of GP workforce. | Health Workforce Locator[xiv] |

| Identified Need | Key Issue | Description of Evidence | Evidence Source |
|---|---|---|---|
| **Workforce** | Service delivery capacity and sustainability issues for PHN commissioned services | Ongoing performance monitoring and review of PHN commissioned services indicates significant issues with recruitment and retention of good health service practitioners within mental health services and Aboriginal health. | Planning Journal Summary[iii] |
| **Workforce** | Service delivery capacity and sustainability issues in Primary care | Consultation identified the importance of strengthening the capacity of the primary health care sector. Specifically:<br>• General Practitioners (GPs) and specialist recruitment and retention to the local regional workforce is essential<br>• Utilisation of Primary Health Care Nurses is low and the rate of nurses intending to leave primary health care in the next 2-5 years is increasing. Development of funding models to increase nurse utilisation and development of workforce strategies to increase recruitment and retention is needed.<br>• There are longer waiting lists and lack of affordable services (declining bulk-billing rates) especially in the Southern NSW LGAs Mental health concerns need holistic approaches with inputs from GPs. Solutions need to avoid 'medicalisation' and foster supportive environments while eliminating service duplication<br>• All healthcare services need to be culturally appropriate. | Planning Journal Summary[iii] |
| **Workforce** | Service delivery capacity and sustainability issues for service providers | Perception of issues with retention and recruitment of clinicians, allied health professionals, support workers and administrative staff in the primary health sector and NGO services especially in mental health and alcohol and other drugs programs. It was reported that the short 12-month funding contracts contribute to issues with recruitment in regional/rural parts of the catchment as it meant that employment contracts were not long term. | Planning Journal Summary[iii] |

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