"Building one world class health system for the Gold Coast."

2018
Gold Coast Primary Health Network
Needs Assessment

phn GOLD COAST

An Australian Government Initiative

2018 Needs Assessment

TABLE OF CONTENTS

Narrative

Gold Coast Primary Health Network (GCPHN) submitted the 2017 health needs assessment to the Department of Health (DOH) in November 2017. Following the submission, the health needs and service issues along with the key priority areas identified by the health needs assessment directly fed into the GCPHN Activity Work Plans for 2018.

Following development of the 2017 needs assessment we conducted and internal review of the process to identify areas for improvement. Findings included:

- As part of the 2017 Needs assessment process, a series of themed topic summary documents were developed that included data, service mapping and details of consultation undertaken to date. These summaries were used to inform engagement with key stakeholders and are now published on Healthygc website as resources and information to support our ongoing implementation work. On review the resulting engagement from presenting the information in this manner was much more meaningful and detailed than in the past when we appeared to receive more general top of mind responses from our previous generic surveys and discussions.
- The need for a simple internal systems to effectively document feedback from stakeholders and emerging trends throughout the year was identified. This led to an enhancement in our monthly reporting system as a particular area to capture this information.
- Exploration of use of online engagement tools for broader community consultation. The engagement to include an online engagement campaign with the broader community and service sector, which will enable a lighter level of resourcing than a more intensive events based consultation.
- Inclusion of a general demographics overview.

Early in 2018, GCPHN commenced scoping for the 2018 Needs Assessment. The Clinical Council, Community Advisory Council, and Primary Care Partnership Council were all consulted in relation to existing and potential additional areas to focus. Recommendations included:

- General support for intended approach of building from the existing summaries in a “modular” approach
- Significant review and more in-depth detail and analysis of the Older Adults summary splitting the information into the following:
    - Older Adults with a focus on Residental Aged Care Facility (RACF) residents
    - Palliative care / End of Life
- While some additional areas including social disadvantage and early childhood were flagged as areas to consider for in depth review, due to limited capacity and relatively good outcomes, it was determined not to progress these areas this year.

In addition as part of the new deed from the Commonwealth, PHNs are required to develop a specific “general practice” needs assessment was required and subsequently a National Psychosocial needs assessment was also required.

PROCESS FOR AGED CARE (WITH A FOCUS ON RACFS) AND PALLIATIVE CARE

This work has actively built on existing work and in particular the Greater Choices for At Home Palliative Care program of work and the Integrated Care Alliance program of work between GCPHN and Gold Coast Health. While there are separate Needs Assessments, given the overlap the work has been progressed in alignment.

Data – A comprehensive review of relevant data has been undertaken with support from external consultants. Data considered includes:

- Demographics
- Gold Coast Health data including projections
- PCOC data
- Gen Aged Care data
- ED presentations

Service mapping - was undertaken in a systematic way, commencing with the existing knowledge base that Gold Coast PHN has previously collected relating to aged care services and providers then assessed against deeper level analysis via desktop research. The service mapping focused on a breakdown of service type, provider, geographic location, target population (e.g. mainstream or specific priority populations) and provider type (e.g. for-profit, not-for-profit, government).

Consultation - Recognising the importance of the project and need for a collaborative approach a multifaceted consultation methodology was taken to inform this needs assessment.

Patient journey mapping was utilised as an engagement tool to understand service issues and enablers from the perspective of health consumers. Patient journey mapping was developed in partnership with Palliative Care Queensland (PCQ) and COTA Queensland for their knowledge and expertise to effectively undertake consumer engagement Patient journey mapping. Several distinct patient journeys reflecting common care pathways for both palliative care and aged care in the Gold Coast PHN region were developed to identify components of the local service system that are working well and highlight potential areas for improvement.

Key advisory mechanisms were consulted to provide direct feedback on initial drafts of the needs assessments including:

- Gold Coast PHN Community Advisory Council
- Gold Coast PHN Clinical Advisory Council
- Gold Coast PHN Primary Care Partnership Council

In July 2018, Gold Coast PHN established the Palliative Care Leadership Group and the Aged Care Leadership Group to provide detailed advice and guidance for the development of a needs assessment and will subsequently on a regional plan and guiding implementation of subsequent activities.

Consultation with the wider sector and community occurred through sector specific co-design workshops attended by sector representatives including Gold Coast Health, a wide range of NGO and private providers and consumers and carers.

As a result of the meaningful engagement undertaken there are real and sustainable connections with health and community providers, recognising and valuing their skills and experience in service delivery, as well as their connections with each other. These relationships between GCPHN, Gold Coast Health and the broader sector will assist in supporting implementation of activities in due course.

PROCESS FOR NATIONAL PSYCHOSOCIAL SERVICES

Data – National frameworks as well as data from local Partners In Recovery Data was explored to identify potential service user cohort.

Service Mapping – Analysis of Gold Coast service providers was undertaken and was in particularly informed by those working with PIR clients.

Consultation – A particular consultation was undertaken with key stakeholders, focussing on prioritisation of a range of rehabilitation and support services.

Triangulation of the above led to identification of needs for consideration and also identified local provider market was likely to be capable of delivery of needed services.
Process for General Practice

PROCESS FOR GENERAL PRACTICE

Data – Drawing heavily on the data from the Gold Coast General Practice Profile including My Healthy Communities data and GCPHN Client Relationship Management tool (CRM), key information particularly in relation to "practice support" activities funded under the GCPHN deed were explored.

Service Mapping – Again drawing on the Gold Coast General Practice Profile, key aspects of General practice distribution, access and quality were considered.

Consultation – In previous years a survey of primary care providers including general practice was conducted, however the lower than desirable response rate and limited detailed information available led GCPHN to use external consultants to conduct focus groups with staff from 13 randomly selected general practices, with a focus on GCPHNs practice support work. The results of this were considered internally and by the primary health Care Improvement Committee with further advice being provided.

Triangulation of the above led to identification of needs for consideration.

PROCESS FOR REMAINING TOPIC AREAS

Apart from these specific areas noted above, 2017 summaries were to be refreshed by:

- Identification and inclusion of updated data and any new emerging data
- Review of service system by GCPHN staff and key stakeholders
- Inclusion of feedback from stakeholders during the year and online consultation, using the 2017 summaries as the basis for engagement.

Data - GCPHN reviewed existing Needs assessment summaries and looked at original data source to identify is any updates had been made. Staff also scanned to identify previously untapped new and emerging data sources at a state, national and regional level and where available SA3 level. Having access to these levels of data allows for simple and powerful comparisons on key statistics affecting the Gold Coast population. This level of analysis allows GCPHN to identify not only national and state health trends, but also to view the different SA3s within the Gold Coast as distinct regions, each with their own unique issues and challenges. Scoping the revision activity took account of time frames, knowledge of new data releases and resource availability. Quantitative sources to be reviewed were determined based on the ability to add value and complement existing knowledge of health on the Gold Coast. In addition to checking for information updated since previous analyses, focus was placed on epidemiological data and new material made available through the national PHN portal.

Supplementary information included in the revision was sourced from a range of sourced including:

- National Health Performance Agency
- Gold Coast Hospital and Health Service
- Australian Childhood Immunisation Register
- National PHN Secure Data Site which included Medicare Benefits Schedule Data, Pharmaceutical Benefits Scheme Data and Digital Health Data
- Australian Institute of Health and Welfare
- Australian Bureau of Statistics
- PHIDU Social Health Atlas of Australia: Primary Health Networks

Service Mapping Revision - As each existing summary already had detailed industry profiling, a lighter re-scan approach was taken to service mapping. Searches were conducted using GCPHN's CRM and public database HealthyGC to determine changes in providers and number of providers. Similar activity was also used to update workforce information. A broad scan of the market was conducted to complement other commissioning activity and ascertain key service gaps and issues.

Consultation - After exploring a range of commercial online engagement software products, it was determined that these were too expensive and as an alternative "EngageGC" was developed by GCPHN staff with similar, if a little more limited, functionality using the 2017 summaries as the basis for engagement. Links to the site were distributed to internal stakeholders, key external stakeholders such Gold Coast Health Strategic Planning team and Mental Health staff. In addition the site was promoted through usual publications such as GCPHN's "Your Local News" (emailed to around 4,000 stakeholders) and through a social media campaign. In addition, direct consultation was undertaken with the Community Advisory Council to identify any significant changes and/or to validate existing identified needs.

Triangulation of the above, specifically considering impact of any changes in data, service system and issues emerging through consultation, led to review and finalisation of needs for consideration.

PRIORITISATION AND OPPORTUNITIES FOR PLANNING

The identified needs across all areas were reviewed and where there was existing activity that is relatively new or demonstrating appropriate outcomes, no significant changes were proposed and instead as part of ongoing monitoring, review and evaluation, opportunities will be identified for continuous quality improvement and alignment with state government and other emerging initiatives.

GCPHN has agreed criteria which is used to guide consideration resource allocation decisions:

- Population health approach
- Equitable
- Evidence based
- Engaged population and engaged clinical leadership
- Stakeholder acceptability
- Cost effective

After reviewing the findings of the Needs Assessments, potential priorities for emerging needs were proposed and considered in light of the above organisational criteria.

NEXT STEPS

GCPHN will continue to undertake comprehensive analysis in relation to priority areas, building on the improved skills and processes developed during the production of updating the 2018 needs assessment.

ADDITIONAL DATA NEEDS AND GAPS

GCPHN acknowledge the significant and welcome improvement in the release of Commonwealth data to assist PHNs. Feedback below is for consideration in relation to the PHN data portal.

Improve data structure and comprehensiveness

- Inclusion of National and state averages for all data on the Commonwealth portal
- Provision of information regarding funding agreements and deliverables would be beneficial to support knowledge of what type of data may be attainable through collaboration with funding receipts.
- Increased granularity of workforce data to assist with determining service access and broader mapping.
- Inclusion of data from ambulance and police services as they relate to health.
- Support to encourage key NGOs (cancer council, heart foundation) and PHNs to collaborate data collection and reporting using SA4, SA3 or SA2 to enable comparison of regions.
- Social Health Atlas to include SA3 regions with the data sets to enable comparison of regions and be in conjunction with PHN data suing SA3.
- Where available on Australian Institute of Health and Welfare, to include PHN and SA3 region figures breakdowns in conjunction with state and national figures. This would enable comparison of regions.

Gold Coast Primary Health Network

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Gold Coast Primary Health Network gratefully acknowledges the financial and other support from the Australian Government Department of Health.

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Demographic Overview

November 2018

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Population

Estimated resident population, 30th June, 2017: 606,291 persons

Table 1: Estimated resident population by SA3, Gold Coast SA4 and Queensland

	2007	2012	2017	Average annual growth from 2012-2017
Broadbeach-Burleigh	58,461	61,961	64,998	1.0%
Coolangatta	50,842	53,042	55,866	1.0%
Gold Coast-North	58,443	63,505	69,299	1.8%
Gold Coast Hinterland	16,929	17,864	19,303	1.6%
Mudgeeraba-Tallebudgera	29,088	32,680	35,179	1.5%
Nerang	58,659	66,113	70,181	1.2%
Ormeau-Oxenford	74,755	102,338	132,732	5.3%
Robina	42,277	48,099	52,399	1.7%
Southport	52,550	57,908	62,199	1.4%
Surfers Paradise	35,814	38,562	44,135	2.7%
Gold Coast	479,818	542,072	606,291	2.3%
Queensland	4,111,018	4,568,687	4,929,152	1.5%

Source: ABS 3218.0, Regional Population Growth, Australia, various editions

Table 1 shows that the Gold Coast population has grown 2.3% from 2012 to 2017 which is slightly above the Queensland rate of 1.5%. The estimated resident population for Gold Coast in 2017 was 606,291 persons. The two SA3 regions with the highest growth in population were Ormeau-Oxenford (5.3%) and Surfers Paradise (2.7%).

Age Breakdown

Table 2: Estimated resident population by age and SA3, Gold Coast and Queensland, 30th June

	0-14		15-24		25-44		45-64		65+	
	No.	%	No.	%	No.	%	No.	%	No.	%
Broadbeach - Burleigh	9,793	15.1%	7,340	11.3%	19,764	30.4%	15,918	24.5%	12,183	18.7%
Coolangatta	9,371	16.8%	6,159	11.0%	14,566	26.1%	14,975	26.8%	10,795	19.3%
Gold Coast - North	10,023	14.5%	8,137	11.7%	16,997	24.5%	18,203	26.3%	15,939	23.0%
Gold Coast Hinterland	3,513	18.2%	1,962	10.2%	4,100	21.2%	6,168	32%	3,560	18.4%
Mudgeeraba - Tallebudgera	8,165	23.2%	4,372	12.4%	8,647	24.6%	9,419	26.8%	4,576	13.0%
Nerang	14,376	20.5%	8,877	12.6%	18,853	26.9%	17,826	25.4%	10,249	14.6%
Ormeau - Oxenford	32,401	24.4%	17,849	13.4%	39,067	29.4%	29,595	22.3%	13,820	10.4%
Robina	9,232	17.6%	7,826	14.9%	14,370	27.4%	12,405	23.7%	8,566	16.3%
Southport	9,188	14.8%	10,589	17.0%	17,454	28.1%	14,672	23.6%	10,296	16.6%
Surfers Paradise	5,087	11.5%	6,173	14.0%	13,521	30.6%	11,161	25.3%	8,193	18.6%
Gold Coast	111,149	18.3%	79,284	13.1%	167,339	27.6%	150,342	24.8%	98,177	16.2%
Queensland	967,026	19.6%	654,532	13.3%	1,349,993	27.4%	1,216,179	24.7%	741,422	15.0%

Source: ABS 3235.0, Population by Age and Sex, Regions of Australia

Table two shows the Gold Coast has the highest percentage of people in the age category of 25-44 years of age (27.6%) which is in line with the Queensland figure (27.4%). As of the 30th June 2017, the estimated resident population aged 65 years and over for the Gold Coast was 16.2%. Within the Gold Coast, Ormeau-Oxenford had the largest percentage of people aged 0-14 years with 24.4%. Surfers Paradise had the largest percentage of people aged 15-64 with 69.9%. Furthermore, Gold Coast-North had the largest percentage of people aged 65+ with 23.0%.

Median age

Table 3: Median age by SA3, Gold Coast and Queensland

	As at 30th June 2017, figures in years			Change
	2007	2012	2017	2007-2017
Broadbeach - Burleigh	40.1	39.4	40.0	-0.1
Coolangatta	40.8	40.9	42.2	1.3
Gold Coast - North	41.7	42.3	44.5	2.8
Gold Coast Hinterland	41.5	43.3	45.2	3.8
Mudgeeraba - Tallebudgera	36.0	37.2	38.3	2.3
Nerang	35.5	36.6	37.8	2.3
Ormeau - Oxenford	34.2	33.7	33.3	-0.9
Robina	35.9	36.7	37.5	1.5
Southport	36.3	36.2	37.0	0.7
Surfers Paradise	40.0	38.8	39.8	-0.3
Gold Coast	37.5	37.8	38.3	0.8
Queensland	36.2	36.6	37.1	0.9

Source: ABS 3235.0, Population by Age and Sex, Regions of Australia unpublished data Queensland Treasury estimates.

Table three shows that as of the 30th June 2017, the median age for the Gold Coast community was 38.3 years. This was an increase of 0.8% from the median age of 37.5 years at the 30th June 2007. Within the region, Gold Coast Hinterland had the highest median age of 45.2 years and Gold Coast Hinterland had the largest increase in median age from 30th June 2007 to 30th June 2017 with 3.8 years.

Indigenous

Table 4: Indigenous status by SA3, Gold Coast SA4 and Queensland, 2016

	Aboriginal	Torres Strait Islander	Both	Total	Percentage of Gold Coast population
Broadbeach - Burleigh	651	35	24	708	1.1%
Coolangatta	1,067	64	72	1,200	2.3%
Gold Coast - North	961	57	36	1,060	1.6%
Gold Coast Hinterland	285	10	19	315	1.7%
Mudgeeraba - Tallebudgera	459	35	32	526	1.6%
Nerang	1,188	41	44	1,274	1.9%
Ormeau - Oxenford	2,177	102	73	2,353	1.9%
Robina	588	30	17	638	1.3%
Southport	1003	52	29	1,081	1.8%
Surfers Paradise	315	22	13	348	0.9%
Gold Coast	8,687	460	357	9501	1.7%
Queensland	148,943	21,053	16,493	186,482	4.0%

Source: *ABS, Census of population and Housing, 2016, Aboriginal and Torres Strait Islander Peoples Profile-102*

Table four shows the percentage of Aboriginal and/or Torres Strait Islander peoples in Gold Coast was 1.7% or 9,501 people in 2016. Within the Gold Coast, Coolangatta had the largest percentage of Aboriginal and/or Torres Strait Islander peoples with 2.3%.

Country of birth

Table 5: Country of birth by SA3, Gold Coast and Queensland, 2016

	Born in Australia Born Overseas		Born Overseas					
	Number	%	Born in ESB countries		Born in NESB countries		Total	
			Number	%	Number	%	Number	%
Broadbeach - Burleigh	40,890	64.0%	8,774	14.2%	6,835	11.1%	15,596	25.3%
Coolangatta	39,668	74.6%	6,222	11.7%	3,131	5.9%	9,341	17.6%
Gold Coast - North	39,658	60.2%	11,551	17.5%	9,237	14.0%	20,782	31.5%
Gold Coast Hinterland	12,755	68.9%	2,837	15.3%	1,155	6.2%	3,992	21.6%
Mudgeeraba - Tallebudgera	23,473	70.3%	5,567	16.7%	2,545	7.6%	8,108	24.3%
Nerang	45,140	67.1%	11,315	16.8%	6,498	9.7%	17,800	26.5%
Ormeau - Oxenford	79,035	65.4%	23,906	19.8%	9,401	7.8%	33,310	27.6%
Robina	29,418	59.5%	8,419	17.0%	8,232	16.6%	16,651	33.7%
Southport	33,800	57.4%	8,249	14.0%	11,882	20.2%	20,133	34.2%
Surfers Paradise	20,917	51.2%	5,611	13.7%	8,995	22.0%	14,594	35.7%
Gold Coast	364,761	64.0%	92,480	16.2%	67,858	11.9%	160,312	28.1%
Queensland	3,343,819	71.1%	493,066	10.5%	522,810	11.1%	1,015,875	21.6%

Source: ABS, Census of Population and Housing, 2016, General Community Profile- G01 and G09

Origin

The top 5 English speaking backgrounds and non-English speaking backgrounds for Gold Coast	
English Speaking	**Non-English Speaking**
New Zealand (7.9%)	China excludes SARs and Taiwan (1.2%)
England (5.2%)	Japan (0.7%)
South Africa (1.2%)	India (0.7%)
Scotland (0.6%)	Philippines (0.7%)
United States of America (0.5%)	Korea Republic of South (0.6%)

Table five shows that In the Gold Coast in 2016, 160,312 (or 28.1%) of people were born overseas. Within this region, Ormeau-Oxenford had the largest number of persons born overseas with 33,310 persons. Furthermore, Surfers Paradise had the largest percentage of people born overseas with 35.7%.

Migration one year ago

Table six: Place of usual residence one year ago by SA3, Gold Coast and Queensland, 2016

	Same Address	Different Address				Proportion with different address	Total persons
		Within Queensland	Rest of Australia	Overseas	Total		
Broadbeach - Burleigh	43,574	8,170	1,768	1,193	11,302	18.5%	60,998
Coolangatta	38,759	6,234	1,836	658	8,903	16.9%	52,637
Gold Coast North	46,102	9,562	1,670	1,071	12,496	19.1%	65,356
Gold Coast Hinterland	14,032	2,035	300	126	2,504	13.6%	18,360
Mudgeeraba - Tallebudgera	25,633	3,806	791	278	4,960	15.0%	33,029
Nerang	50,347	8,444	1,246	670	10,536	15.8%	66,509
Ormeau - Oxenford	83,516	20,215	3,271	1,551	25,376	21.3%	119,123
Robina	34,929	7,068	1,385	1,100	9,697	19.8%	48,943
Southport	40,359	8,602	1,489	1,729	12,020	20.6%	58,363
Surfers Paradise	25,218	5,906	1,301	1,974	9,297	22.9%	40,526
Gold Coast	402,470	80,033	15,054	10,349	107,089	19.0%	563,834
Queensland	3,423,989	655,524	77,129	66,975	813,045	17.5%	4,648,722

Source: ABS, Census of Population and Housing, 2016, General Community Profile

Table six shows the percentage of people in Gold Coast with a different address one year ago was 19%. 402,470 persons resided in the same address as one year ago and 107,089 persons (or 19%) resided in a different address one year ago. Furthermore, within the Gold Coast Surfers Paradise had the largest percentage of people with a different address one year ago with 22.9%.

Migration five years ago

Table seven: Place of usual residence five years ago by SA3, Gold Coast and Queensland, 2016

	Same Address	Different Address				Proportion with different address	Total persons
		Within Queensland	Rest of Australia	Overseas	Total		
Broadbeach - Burleigh	26,112	17,982	4,914	3,850	27,318	46.7%	58,488
Coolangatta	24,285	14,476	5,101	1,853	21,954	43.6%	50,326
Gold Coast North	26,140	21,321	4,889	3,994	30,818	49.2%	62,640
Gold Coast Hinterland	9,493	5,053	847	411	6,438	36.5%	17,630
Mudgeeraba - Tallebudgera	16,099	9,444	2,507	1,137	13,323	42.7%	31,230
Nerang	31,071	20,458	3,842	2,579	27,514	43.8%	62,870
Ormeau - Oxenford	42,881	43,111	9,393	6,325	60,044	54.1%	111,038
Robina	19,570	15,274	4,243	3,716	23,713	50.7%	46,730
Southport	23,311	17,201	4,152	5,573	27,561	49.1%	56,097
Surfers Paradise	13,340	11,552	3,454	5,319	20,667	52.6%	39.312
Gold Coast	232,300	175,864	43,354	34,745	259,347	48.4%	536,368
Queensland	2,118,153	1,456,714	220,316	228,095	1,942,926	44.1%	4,406,728

Source: ABS, Census of Population and Housing, 2016, General Community Profile

Table seven shows the percentage of people in Gold Coast with a different address five years ago was 48.4%. 232,300 persons resided in the same address as five years ago and 259,347 (or 48.4%) resided in a different address as five years ago. Within the Gold Coast, Ormeau-Oxenford had the largest percentage of people with a different address five years ago with 54.1%. The Gold Coast figure of 48.4% is higher than the Queensland state figure of 44.1%.

The index of Relative Socio-economic Disadvantage

Table 8: Population by index of Relative Socio-Economic Disadvantage quintiles by SA3 and Gold Coast 2016.

	Quintile 1 (most disadvantaged)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (least disadvantaged)
Broadbeach - Burleigh	3.4%	14.3%	25.9%	36.3%	20.1%
Coolangatta	5.5%	30.8%	28.6%	24.0%	11.1%
Gold Coast - North	22.6%	28.1%	22.7%	14.2%	12.5%
Gold Coast - Hinterland	0.0%	5.0%	42.3%	38.7%	14.0%
Mudgeeraba - Tallebudgera	0.0	13.7%	9.7%	40.8%	35.8%
Nerang	7.0%	17.5%	26.8%	37.3%	11.4%
Ormeau - Oxenford	4.1%	18.6%	23.8%	28.0%	25.6%
Robina	4.1%	12.6%	32.8%	32.9%	17.6%
Southport	25.9%	21.6%	24.8%	22.9%	4.8%
Surfers Paradise	10.9%	29.9%	14.4%	22.2%	22.6%
Gold Coast	9.0%	20.1%	24.7%	28.6%	17.6%

Source: ABS 2033.0.55.001 Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2016, (Queensland Treasury derived).

Table eight shows the percentage of people in Gold Coast in the least disadvantaged quintile was 17.6% and 9.0% in the most disadvantaged quintile was 9.0%. Within the region, Mudgeeraba-Tallebudgera had the largest percentage of people in the least disadvantaged quintile with 35.8%.

Total family income

Table 9: Total family income by SA3, Gold Coast and Queensland, 2016

	Less than $33,800 per year		$33,800 to $77,999 per year		$78,000 to $155,999 per year		$156,000 or more per year		Median $/year
	number	%	number	%	number	%	number	%	$
Broadbeach - Burleigh	1,300	8.2%	4,916	31.2%	5,242	33.2%	2,676	17.0%	89,440
Coolangatta	1,180	8.6%	4,546	33.0%	4,764	34.8%	1,738	12.6%	83,408
Gold Coast - North	1,887	10.7%	6,508	37.0%	5,380	30.6%	2,111	12.0%	74,360
Gold Coast Hinterland	452	8.9%	1,645	32.4%	1,695	33.4%	703	13.9%	84,292
Mudgeeraba - Tallebudgera	691	7.5%	2,536	27.6%	3,332	36.3%	1,594	17.4%	95,992
Nerang	1,593	8.7%	5,770	31.5%	6,861	37.4%	2,270	12.4%	86,476
Ormeau - Oxenford	2,504	7.7%	8,954	27.4%	12,820	39.3%	5,077	15.6%	94,744
Robina	1,228	9.3%	4,319	32.5%	4,694	35.4%	1,706	12.9%	84,084
Southport	1,669	11.7%	4,987	35.0%	4,553	31.9%	1,612	11.3%	75,556
Surfers Paradise	1,001	10.6%	2,982	31.5%	2,827	29.9%	1,681	17.8%	84,240
Gold Coast	13,525	9.1%	47,157	31.6%	52,191	34.9%	21,183	14.2%	86,060
Queensland	115,233	9.4%	377,889	30.9%	408,072	33.4%	186,810	15.3%	86,372

Source: ABS, Census of Population and Housing, 2016, General Community Profile- G02 and G28

Table nine shows the median total family income in Gold in 2016 was $86,060 per year. With this, 13,525 or 9.1% were low income families. Additionally, Mudgeeraba-Tallebudgera had the highest family income with $95,992 per year and Gold Coast North had the lowest median total family income with $74,360 per year.

General Population Health

November 2018

"Building one world class health system for the Gold Coast."

phn GOLD COAST

An Australian Government Initiative

"Building one world class health system for the Gold Coast."

GENERAL PRACTICE AND PRIMARY CARE

Needs Assessment Summary

2018

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General Practice and Primary Care

Identified local health needs and service issues

- Significant growth in the numbers of general practices and general practitioners
- Clinical handover, particularly to general practice on discharge from hospitals remains a significant issue
- While categories 4 and 5 ED presentations have remained stable, there has been strong growth in higher acuity categories, increasing demand on ED services
- Comparatively high rates of potentially preventable hospitalisations, with particular growth in vaccine preventable conditions (particularly pneumonia and influenza)
- Access to Information about services and resources to support general practice in key areas required
- My Health Record not yet embedded in usual practice for all providers and practices unable to provide detailed support to consumers
- While accreditation rates are currently high, there may be additional support required due changes in RACGP Standards and Quality Practice Incentive Payment
- Potential to increase use of data in general practice software to proactively plan care
- Frequently current systems (including MBS payments and data) do not support population health approach and care-coordination

Key findings

Primary Health Networks (PHNs) were established to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improve the coordination of care to ensure patients receive the right care in the right place at the right time. Achieving this objective involves working directly with various providers within the health care system, particularly general practice. Since its establishment, Gold Coast Primary Health Network (GCPHN) has built on its past iterations (e.g. Medicare Locals, Divisions of General Practice) by continuing to implement various initiatives to support general practice and strengthen its communication and collaboration with the acute sector.

The data explored in this report suggests that Gold Coast have high rates of emergency department presentations and potentially preventable hospitalisation rates. However, residents also appear to have access and positive interactions with primary care services, particularly during the after-hours period, at higher rates than the national average.

Evidence

There are currently 197 general practices and 810 general practitioners (GPs) in the GCPHN region.[1] This reflects an increase of 9% and 7% respectively from the previous year.

Between 2014-15 and 2016-17, Gold Coast residents utilised various types of health services, including primary health, emergency and acute health services. Of all 31 PHNs in Australia, Gold Coast recorded the second lowest proportion of adults who saw a GP in 2016-17 (behind Northern Territory). In contrast, the proportion of adults in the Gold Coast who went to the ED is higher than the national average and appears to be increasing each consecutive year (see Table 1).

Table 1: Proportion of adults utilising health services by type

% of adults	Region	2016-17	2015-16	2014-15	Change (%) between 2014-15 & 2016-17
Who saw a GP in the preceding 12 months	Gold Coast	77.6	77.0	76.1	1.5
	National	82.5	81.9	82.9	-0.4
Who were admitted to any hospital in the preceding 12 months	Gold Coast	14.4	14.6	14.0	0.4
	National	12.6	12.7	13.5	-0.9
Who went to any hospital ED for their own health in the preceding 12 months	Gold Coast	16.0	14.1	10.6	5.4
	National	13.8	13.5	14.6	-0.8
Who saw a GP after hours in the preceding 12 months	Gold Coast	8.4	10.3	10.0	-1.6
	National	8.4	8.0	8.7	-0.3

Source: My Healthy Communities (2018), *Patient experiences in Australia in 2016-17*

Although the overall proportion of people seeing a GP is lower than the national average, those who did see a GP in 2016-17 tend to do so at a higher rate compared to the national average (6.5 vs 5.9 attendences per person per year) (see Table 2). This was consistent for all sub-regions on the Gold Coast and, overall, the rates appear to be increasing each consecutive year. The sub-regions with the highest rates of GP attendances per person in 2016-17 were: Ormeau – Oxenford (6.9), Nerang (6.7) and Southport (6.7).

Table 2: Age-standardised rate of GP attendances per person, by SA3 region

Region	2016-17	2015-16	2014-15	Change between 14-15 & 16-17
Broadbeach – Burleigh	6.6	6.6	6.5	+0.1
Coolangatta	6.1	6.3	6.1	-
Gold Coast – North	6.6	6.7	6.5	+0.1
Gold Coast Hinterland	6.4	6.3	6.1	+0.3
Mudgeeraba – Tallebudgera	6.5	6.4	6.2	+0.3
Nerang	6.7	6.5	6.3	+0.4
Ormeau – Oxenford	6.9	6.8	6.5	+0.4
Robina	6.2	6.2	6.0	+0.2
Southport	6.7	6.8	6.6	+0.1
Surfers Paradise	5.9	6.4	6.2	-0.3
Gold Coast	6.5	6.5	6.3	+0.2
National	5.9	5.9	5.7	+0.2

Source: My Healthy Communities (2018), *Medicare Benefits Schedule GP and specialist attendances and expenditure in 2016-17*

Similarly, the rate of after-hour (AH) GP attendances per person across the Gold Coast in 2016-17 was also higher than the national average (0.66 vs. 0.49 per year). However, while the rate of AH attendances has increased nationally over the last three years, the rate has decreased, overall, across the Gold Coast (see Table 3). The sub-regions with the highest rates of AH GP attendances in 2016-17 were: Southport (0.85), Nerang (0.77) and Gold Coast - North (0.75).

Table 3: Age-standardised rate of after-hour GP attendances per person, by SA3 region

Region	2016-17	2015-16	2014-15	Change between 14-15 & 16-17
Broadbeach – Burleigh	0.56	0.63	0.60	-0.04
Coolangatta	0.55	0.59	0.60	-0.05
Gold Coast – North	0.75	0.80	0.78	-0.03
Gold Coast Hinterland	0.44	0.46	0.42	+0.02
Mudgeeraba – Tallebudgera	0.53	0.59	0.59	-0.06
Nerang	0.77	0.81	0.76	+0.01
Ormeau – Oxenford	0.66	0.69	0.63	+0.03
Robina	0.58	0.60	0.60	-0.02
Southport	0.85	0.89	0.87	-0.02
Surfers Paradise	0.64	0.74	0.72	-0.08
Gold Coast	0.66	0.70	0.67	-0.01
National	0.49	0.48	0.43	+0.06

Source: My Healthy Communities (2018), *Medicare Benefits Schedule GP and specialist attendances and expenditure in 2016-17*

Aside from general practice, Gold Coast residents can also access AH support via 13 HEALTH, a confidential phone service providing health advice from a registered nurse 24 hours a day, 7 days a week for the cost of a local call. In 2016-17, more than 27,500 calls were made by Gold Coast residents, with 54% occurring during the AH period (i.e. between 6pm – 8am). The three suburbs with the greatest number of calls were Upper Coomera, Southport and Surfers Paradise. The top three age groups requiring phone advice were 0-5 years (33% of calls), 20-29 years (17%) and 30-39 years (14%), and reasons for calling were abdominal pain, unwell/irritable newborn and chest pain.

Emergency care can be accessed at two public hospitals located on Gold Coast: Gold Coast University Hospital and Robina Hospital. Table 4 highlights the number of patients presenting to ED in these hospitals from 2013-14 to 2016-17 according to each triage category. As Table 4 suggests, there has been an increase in the number of ED presentations with an annual growth rate of 4.8%. However, this growth is largely attributed to the increase in Category 1 and 2 presentations, which have increased at an annual rate of 29% and 10% respectively.

Table 4: Number of patients presenting to public hospital EDs in Gold Coast according to triage category

Triage Category	2016-17	2015-16	2014-15	2013-14	Average yearly change (%)
All categories	164,035	161,380	150,423	142,446	+4.8%
Category 1: Resuscitation	2,835	2,460	1,861	1,334	+29.0%
Category 2: Emergency	28,211	26,820	24,189	21,202	+10.1%
Category 3: Urgent	86,473	87,402	80,471	73,997	+5.4%
Category 4: Semi-urgent	43,102	41,665	40,997	42,414	+0.6%
Category 5: Non-urgent	3,414	3,033	2,905	3,499	0.0%

Source: My Hospitals (2017), Time spent in emergency departments in 2016-17

Category 4 and 5 presentations, which comprised 27% of all ED patients in 2016-17, are often used as an indicator of presentations that can be managed by general practice or primary health (i.e. non-urgent care). These presentations therefore provide an indication of the effectiveness of the region's primary health care system in preventing unnecessary hospital presentations.[2] The number of ED presentations for these two triage categories have remained stable between 2013-14 and 2016-17, which suggests that Gold Coast residents are utilising their GP for non-urgent care and attending ED for emergency situations.

Potentially preventable hospitalisations (PPH) represent another indicator of the effectiveness of the region's primary health care system in keeping people out of hospital. As described by AIHW, a PPH is an *'admission to hospital for a condition where the hospitalisation could have been prevented through the provision of appropriate individualised preventative health intervention and early disease management usually delivered in primary care and community-based care settings'.*

In 2015-16, there were 678,374 PPHs recorded in the GCPHN region, which equated to a total approximate of 2.7 million hospital bed days. The rate of PPHs have been increasing significantly over the past three years at rates higher than the national average across all categories (see Table 5).

2 AIHW. (2014). *Australian hospital statistics 2013-14: Emergency department care.*

Table 5: Age-standardised rate of PPHs per 100,000 people, by PPH category

	Gold Coast			National		
	2015-16	2014-15	2013-14	2015-16	2014-15	2013-14
Chronic PPHs	1,411	1,258	1,195	1,205	1,148	1,123
Acute PPHs	1,593	1,540	1,441	1,263	1,223	1,202
Vaccine-preventable PPHs	236	195	103	199	175	128
Total PPHs	3,210	2,969	2,731	2,643	2,522	2,437

Source: My Healthy Communities (2017), *Potentially preventable hospitalisations in 2015-16*

The Australian Commission on Safety and Quality in Health Care (ACSQHC) identified five PPH conditions as a priority for action: chronic pulmonary obstructive disease (COPD), congestive heart failure, cellulitis, kidney and urinary tract infections, and diabetes complications. As Table 6 highlights, there are a number of 'hot spot' areas within the GCPHN region that report rates of PPHs well above the overall national and Gold Coast average. In particular, Gold Coast – North and Southport not only had the highest rates of PPHs overall, but also higher rates of PPHs across all five priority conditions.

Table 6: Age-standardised rate of PPHs per 100,000 people for selected conditions by SA3 region, 2015-16

Region	Total PPHs (rate)	COPD	Heart Failure	Cellulitis	Kidney and UTIs	Diabetes complications
Broadbeach – Burleigh	2,754	198	157	231	392	174
Coolangatta	3,207	293	217	340	432	169
Gold Coast – North	3,510	303	215	350	431	221
Gold Coast Hinterland	2,611	143	143	272	343	104
Mudgeeraba – Tallebudgera	3,346	383	205	315	538	151
Nerang	3,159	251	152	283	387	280
Ormeau – Oxenford	3,417	357	250	284	431	168
Robina	3,285	293	192	252	472	222
Southport	3,732	345	260	296	445	278
Surfers Paradise	2,710	192	99	232	314	136
Gold Coast	3,210	280	195	288	416	199
National	2,643	260	211	253	288	183

Below National average

Above Gold Coast and National average

Source: My Healthy Communities (2017), *Potentially preventable hospitalisations in 2015-16*

Patient experiences

The Patient Experience Survey is conducted annually by the Australian Bureau of Statistics provides an indication of people's experiences of the health system at a local level. Good experiences can be associated with quality healthcare, clinical effectiveness and patient safety. Health experiences have also been measured using the 2016 Coordination of Health Care Study, which had a specific focus on understanding the experiences with coordination and continuity of care by people aged 45 years and over who had at least one GP visit in the 12 months prior. Table 7 and Table 8 highlight the results for GCPHN in comparison to the national average for these two surveys.

Table 7: Findings from selected items of Patient Experience Survey, various years

Year of survey	Percentage of adults who reported:	Gold Coast (%)	National (%)
2016-17	Report their health as excellent, very good or good	88.0	85.3
2016-17	Felt their GP always or often listened carefully	91.6	91.6
2016-17	Felt their GP always or often showed respect for what they had to say	93.7	94.1
2016-17	Felt their GP always or often spent enough time	91.9	90.6
2016-17	Delayed or did not see a medical specialist, GP, get an imaging test and/or get a pathology test when needed due to cost	5.2*	7.6
2016-17	Needed to see a GP but did not	9.3	14.1
2016-17	Saw three or more health professionals for the same condition	13.7	16.7

*Interpret with caution. Estimate has a relative standard error of 25% to 50%, which indicates a high level of sampling error relative to its value and must be considered when comparing this estimate with other values.

Source: My Healthy Communities (2018), Patient experiences in Australia in 2016-17

Table 8: Findings from the Coordination of Health Care Study, 2016

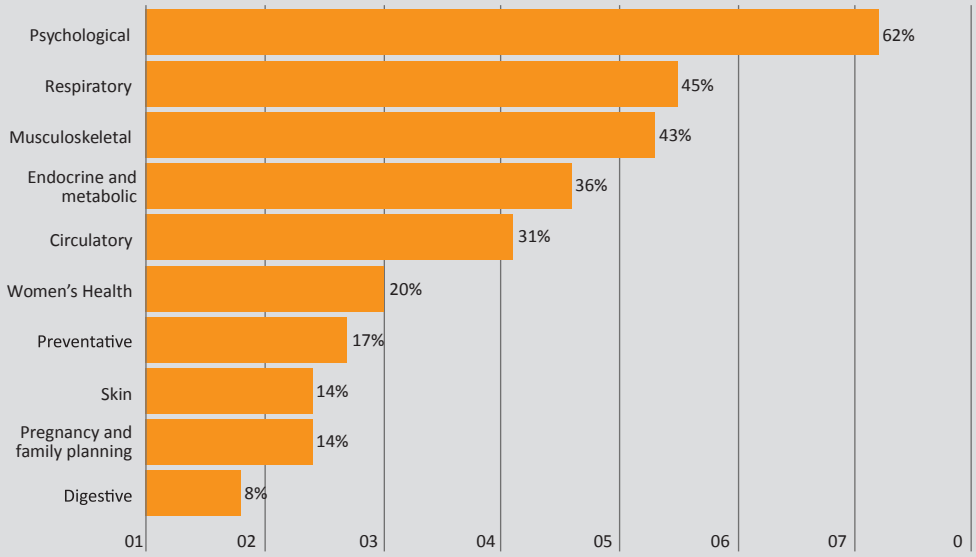
Year of survey	Percentage of adults who reported:	Gold Coast (%)	National (%)
2016	Care rated by patient as excellent or very good	87.2	84.1
2016	Patient involved in decisions about their care	89.6	89.1
2016	Test results were explained in a way that patient could understand	95.0	92.9

Source: My Healthy Communities (2018), Coordination of health care – experiences with GP care among patients aged 45 years and over, 2016

For most indicators, the findings suggest that Gold Coast residents have a similar, if not slightly better, experience with the local primary health care system when compared nationally. Specifically, Gold Coast residents are more likely to rate their own health and the care provided to them as good, very good or excellent. Of all indicators, the 'saw three or more health professionals for the same condition' measure in Table 7 is most noteworthy given that Gold Coast has the fourth lowest proportion of all 31 PHNs. However, it is unclear whether this is due to the increased capability of Gold Coast GPs to accurately diagnose and manage a condition, or issues related to referral and care coordination arrangements and, as such, may warrant further consultation.

General Practitioner Experience

Percentage of GP's who identified these conditions when asked 'What are the three most common ailments you are dealing with?"



General Practice Health of the Nation 2018 report

More than half of GPs surveyed said mental health issues caused them the most concern for the future followed by obesity, diabetes, aged care and the ageing population, drug addiction and chronic pain and palliative care.

Source: General Practice Health of the Nation 2018 report

My Health Record (MyHR)

As at September 2018 the following local providers had registered for MyHR Gold Coast

- 175 general practice (approx. 90% of general practice now registered to participate in MyHR)
- 97 community pharmacies (approx. 72% of pharmacies)
- 27 allied health providers
- 12 private specialists
- While both uploads to and views of My Health Record are increasing, use is still quite limited across the sector.

Service Mapping

Service type	No. in GCPHN region	Distribution	Capacity

General practice	197	Clinics are generally distributed across the Gold Coast, with the majority located in coastal and central areas.
		
		Three general practices are available in the after-hours period (after 6pm and before 8am) at Surfers Paradise, Southport and Palm Beach. There are a number of practices open in extended hours for example Saturday and late night to 9pm. This varies from practice to practice and covers areas including Upper Coomera and Tamborine.
			• 810 GPs on the Gold Coast
			• 23 practices deliver speciality services such as skin checks
			• Average number of GPs per practice: 4.1
			• Non-GP staff working in general practice include:
			  • 378 nurses
			  • 180 allied health staff
			  • 122 practice managers
			• % of GPs aged under 35 years is the lowest represented age group, and has decreased in recent years
			• 83% of practices are accredited or currently working towards accreditation

Medical Deputising Services	4	In-home and after-hour visits from a doctor. Available across most of Gold Coast region with hinterland areas less well serviced	• All consultations are bulk-billed for Medicare and DVA card holders • Depending on the provider, appointments requested by phone or online.

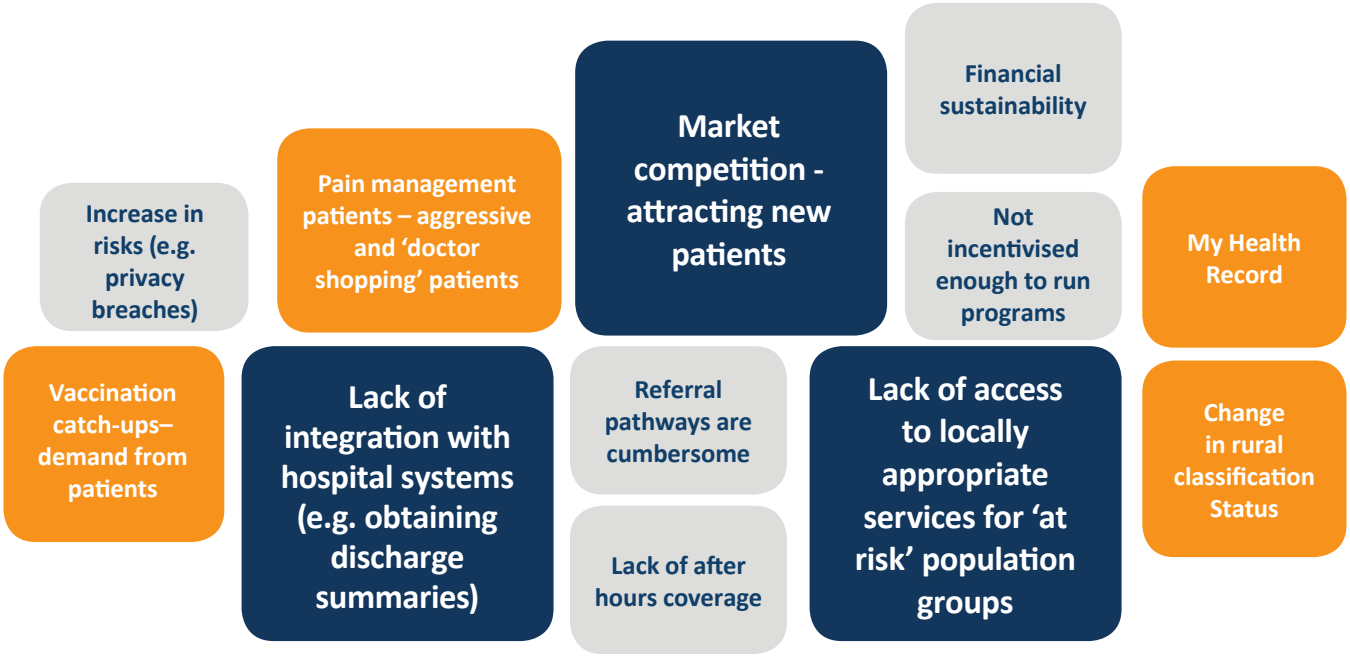
Service type	No. in GCPHN region	Distribution	Capacity
Pharmacy	91	Well distributed across the region: • 64% are open after 6pm on weekdays, 30% after 8pm • 97% are open on Saturday • 76% are open on Sunday • 55% are open on a public holiday	• Medication dispensing • Medication reviews • Medication management • Some screening and health checks • Currently limited integration with other health data sets although increased uptake of My Health Record may affect this.
Emergency departments (ED)	5	Southport and Robina (public) Southport, Benowa and Tugun (private)	• Private health insurance is required to access private EDs. A gap payment may also be incurred. • Limited integration with general practice data • Residents near borders may also frequent nearby hospitals such as Tweed District, Logan and Beaudesert Hopsitals • The drivers for increase in Cat 1,2 and 3 presentations are unclear and could be explored further with Gold Coast Health
Online and phone support	4	Phone or online	• Health Direct After Hours GP Helpline – after hours GP and pharmacy finder, health information and advice • 13 HEALTH – health information and advice • Lifeline Crisis Support Service • PalAssist – 24-hour palliative care support and advice line

Source: *GCPHN Client Relationship Management System*

Consulation

In 2018 focus groups were conducted by an external consultant Impact Co. with 13 Gold Coast general practices. As part of the process practice staff were asked about challenges for general practice. The following themes emerged:

Previous consultation with service providers and consumers has identified the following issues:



Primary care co-ordination

- Access to information about services available in the region, including a "navigation component" is needed because it is difficult for practices to know what is available there and it changes frequently (PHIC November 2018)
- High quality, evidenced based care planning processes support delivery of comprehensive quality health care. Access for GPs to the best evidence based GP Care Plan template and process should be supported. (GCPHN Clinical Council, October 2017)
- Being able to identify and access the appropriate doctors and services is important (GCPHN CAC October 2017)
- A good rapport with a general practitioner fosters an open dialogue and trust (GCPHN CAC October 2017)
- Patients value the personalised care at usual general practice and would like more treatment / services available there rather than having to attend other places. It is easier to access more, trusted, more likely to follow through (GCPHN CAC October 2017)
- Gold Coast general practitioners were generally satisfied with the quality of Gold Coast Health discharge summaries and letters from outpatient department, however they were less satisfied with timeliness (GCPHN Primary Care Opinion Survey 2017)
- Case conferencing is underutilised. While case conferencing meetings occur in tertiary settings, general practitioners are rarely involved. (PHCIC September 2017)

- Fee for service and current MBS structures do not incentivise best practice for chronic disease management, screening or prevention activity and is a particular impediment for practice nurses (PHCIC September 2017)
- There are different views on what the term "holistic" means with general practitioners seeing it as birth to death and family centred (PHCIC September 2017)
- Training and staffing needs as accepted as part of doing business in the rapidly changing health environment and consistent access to quality training for practice staff is important (PHCIC September 2017). It should be noted that education and training for some high potentially preventable hospitalisation conditions such as chronic wound management are well attended.
- Refresher courses as well as more detailed information is requested (industry feedback 2017)
- General practitioners are increasingly working part time or in specific portfolios which needs to be considered in all engagement and coordination work (PHCIC September 2017).
- Currently limited ability to use general practice data to implement proactive care and data is of variable quality. This will become increasingly important as Quality Practice Incentive Payment implemented (practice feedback)

After hours

- Feedback from the GCPHN Clinical Council was that there is a perception among service providers that quality of after hours service providers is variable and they may frequently refer people to EDs where not necessary to do so (2017).
- The Clinical Council also noted the foreshadowed national level changes such as after hours MBS items and abolition of the Aged Care Practice Incentive Payment, there are concerns that there will be a significant reduction in accessibility in the after hours and at RACFs (2017 and 2018).
- It is believed that people will continue to use medical deputising services because it is flexible and there is limited cost to patient, however proposed changes to Commonwealth funding for these arrangements likely to impact provision of services (PHCIC September 2017).
- Urgency of situation and general practitioners were the predominant factors identified by CAC members as influencing choice of after-hours service (2017)
- A patient survey conducted in 2015 at EDs in Gold Coast public hospitals indicated that the seriousness of a person's condition was what drove their decision to attend the ED. The vast majority of respondents stated they would continue to present to ED even if they could have seen their GP within 24 hours—this was due to perceptions of quality, GP skills and services available within the ED (e.g. scans).
- Support for integrated care delivered to RACFs in after hours acknowledged as very important with some services (e.g. palliative care services) having difficulty in servicing demand. (PHCIC September 2017).
- Use of medical deputising services in RACFs "dilutes relationships" making consistency of quality more difficult (PHCIC September 2017).
- It can be challenging for doctors and general practitioners to visit RACF residents as accessibility to RACF staff to accompany them on visits is often difficult and patient information is not always easily accessible. (2018 consultation with Medical Deputising Services)

- GCPHN Community Advisory Council provided the following feedback (October 2017):
    - There were some very good experiences with the home visiting medical deputising services, being seen as convenient and effective.
    - Some concerns were raised about the variability of the quality of clinicians, wait times and areas such as Surfers Paradise not well serviced.
    - CAC members want to see a balance between convenience and appropriate use of government resources.
    - There is a limited understanding by public of costs associated with different after-hours options as most are experienced by patients as “free”, limited health literacy of access to service options
    - People feel more confident about going to ER, knowing that “the problem” will be sorted out.

Opportunities

One of the roles PHNs is to support general practice to:

- Adopt best practices methods to support general practice to improve quality of care
- Promote and improve the uptake of practice accreditation
- Assist general practice in the understanding and meaningful use of digital health systems
- Develop health information management systems to inform quality improvement, specifically use of clinical data in general practice
- Promote the Practice Incentives Program including the Quality Improvement PIP

This provides context to consider building capacity in the primary health sector. To date, GCPHN has facilitated a number of activities as guided by the Commonwealth. Specifically, GCPHN provides support to general practice in a tiered approach, reflected by four levels. Demonstrated in Figure 1 below, these levels of practice support range from low level assistance (Tier 1) to high level practice activity (Tier 4).

Figure 1: Tiered approach to practice support

In July 2018, GCPHN engaged with 46 individuals from 12 general practices across the region to better understand the experience amongst general practices, including GPs, practice managers and practice nurses, have in interacting with the PHN. Amongst other things, this engagement asked participants to consider what the PHN does well and what it can improve on. Consultations also occurred with the General Practice Liaison Unit (GPLU) and Primary Health Care Improvement Committee (PHCIC).

The following sections provide the key themes that emerged from the consultation process and potential next steps according to the key activities delivered by GCPHN.

Access to Clinical Audit Tools

According to the Commonwealth, PHNs are to develop health information systems to inform quality improvement in health care, specifically in the collection and use of clinical data within general practice.

The Pen Clinical Audit Tool (also known as PEN CAT), allows practices to analyse their patient and billing data so that they can devise strategies to improve patient care and report on quality improvement activities. GCPHN currently engages with 141 general practices that use PEN CAT.

The level of support provided by GCPHN to use the tool is related to the tiered level of practice support. For example, Tier 2 practices are provided quarterly reports while Tiers 3 and 4 practices are provided additional resources to improve data quality improvement and population health management.

Consultation Feedback:

Of the participating practices that had experience with GCPHN's clinical audit activities, specifically PEN CAT, the majority (73%) were satisfied or very satisfied. Having access to the tool, rather than the quarterly reports, was considered to be of greater benefit. However, the level of knowledge with using the tool differed across practices.

Tier 3 general practices could all recall some form of interaction or support provided by the GCPHN on how to access the clinical audit tool. By contrast, for Tier 2 general practices, several practice managers and practice nurses reported 'self-teaching' themselves how to navigate and use the tool. The value and usefulness of the quarterly reports provided by GCPHN also varied across practices.

Next Steps:

1. Provide additional support to demonstrate to general practices how to best use PEN CAT

As most practices rated the clinical audit tool highly, alternative ways to support practices will be explored by GCPHN so that practices are able to best use the tool to their advantage. This includes online webinars or easily accessible manuals to enable practices to better integrate their learnings.

This was a point that was reinforced by the PHCIC, whose members noted that any work that GCPHN could do in this domain to build the capacity of general practices to use PEN CAT will be highly beneficial.

Refine the format of the quarterly reports to better suit the needs of general practice

This includes adopting a more simplified format with clear 'take home' messages for general practices. Where possible, comparative data across other like practices will also be explored. Further support will also be provided to guide general practices on how to best to review and interpret the quarterly reports.

Practice Visits for Quality Improvement

Practice visits are a critical aspect of building engagement between GCPHN and general practices across the catchment, enabling practices to implement and participate in quality improvement activities.

Consultation Feedback:

The perceived value of practices visits for quality improvement purposes varied across participating general practices. As per the tiered approach to practice support, Tier 3 general practices had more interactions with or visits from with the GCPHN than Tier 2 general practices. Of all practice staff, practice managers had the most interactions with GCPHN compared to GPs who appeared to have the least.

Next steps:

1. Refine existing, and explore new, communication mechanisms to more effectively engage practices and practice staff

As the level of satisfaction with practice visits was consistent with the practice support tiering of a general practice, GCPHN will seek to refine its communication strategy so that it can more effectively articulate the purpose and nature of practice visits. Establishing expectations may assist in achieving more positive experiences amongst different practice staff with practice visits. A refined strategy will also identify ways to communicate in a voice that will resonate with GPs. As highlighted by the PHCIC, this should include an exploration of other communication mechanisms beyond face-to-face interactions.

Initiate capacity building activities, focusing on new practices

There is a growing recognition that an effective primary care system is dependent on an engaging and productive workforce. This involves an improvement in, or maintenance of, the work/life balance of health care providers (reflecting the Quadruple Aim). The Commonwealth has also demonstrated its commitment to this objective through various literature.

In light of this, the GCPHN will seek to identify and initiate measures to support the resilience and wellbeing of the sector. Initially, this will focus on new clinicians and new practices who are seeking an introduction to the local primary care system.

Digital Health Support

PHNs have a responsibility to assist general practice in the understanding and meaningful use of digital health systems to streamline the flow of relevant patient information.

To date, GCPHN has placed a priority focus on digital health in recognition that safe, better quality healthcare can be delivered with the shared and secured transfer of health information. As such, GCPHN works with general practices to assist them in uploading their patient's shared health summary and support the sharing of vital information with other healthcare professionals.

Consultation Feedback:

By far, the most pressing issue faced by general practices was the integration or communication with hospitals, particularly with respect to the timeliness or lack of discharge summaries of patients. Many practices also commented on the time and cost associated with downloading referral templates to the hospitals, indicating that the templates could not be populated with the data from their practice software.

The My Health Record (MyHR) was also considered to be a key challenge faced by general practices in the catchment. All practices engaged in the consultation process reported some form of support or interaction

with the GCPHN related to digital health, which, as identified by the PHCIC, was due to the strong PHN branding used in a communication campaign. Interactions ranged from reading information through the newsletter, attendance at an information session or a practice visit from a GCPHN representative. Of the participants that had experienced some form of digital health support, 85% were either satisfied or very satisfied with the support received. However feedback received by GCPHN when educating practices and supporting to embed in usual systems, highlights concerns that general practice don't have the capacity to support consumers to maximise personal benefit of MyHR.

Next Steps:

1. Continue to proactively support the digital health needs of general practice

As digital health, specifically My Health Record, is a current and pertinent challenge for general practices, GCPHN will continue to be proactive in supporting practices through its different mechanisms.

2. Explore, trial and implement new models to deliver seamless patient care between general practice and Gold Coast Health

GCPHN recognises the role it can play as a facilitator in improving the integration and communication between general practices and hospitals. Together with the GPLU, GCPHN will seek to commence a pilot project focused on improving the timeliness of discharge summaries (i.e. issued within 24 hours of discharge) within the year. This will leverage the strong reputation of the GPLU, who is well known and respected within the catchment.

Accreditation Information

Meeting the Standards for General Practice set by the Royal Australian College of General Practitioners (RACGP) through accreditation demonstrates the commitment of the practice to delivering high quality, safe and effective care to its patients. Achieving accreditation also provides access to Commonwealth's Practice Incentives Program (PIP) and the PIP Quality Improvement (QI) Incentive.

Improving the uptake of practice accreditation and promoting participation in these Commonwealth programs is a responsibility of PHNs.

Consultation Feedback:

Practices were aware of the release of RACGP's 5th Edition of the Standards of General Practice. However, there was uncertainty on how the changes would implicate their practice. That said, most general practices were not aware that GCPHN provided any support or information on accreditation. This was reflected by the fact that 70% of participants indicated that they were either dissatisfied with the role played by GCPHN or not aware that this activity was carried out by the GCPHN. Tier 3 general practices were more likely to report they were satisfied with accreditation information than Tier 2 general practices.

Subsequent consultation over 2 meetings with the Primary Healthcare Improvement Committee indicated the following:

- GCPHN role with respect to accreditation, not currently clear with mixed views amongst general practices of the work that GCPHN does (and the capability that it has) to support general practices with accreditation.
- Concern from practices regarding compliance with new RACGP standards

Next steps:

1. Better define GCPHN's role in supporting general practices with accreditation

As most practices considered that the GCPHN had some form of responsibility in supporting general practices with accreditation and achieving consistency across practices, GCPHN will reconsider its role in this area. Having done so, it will communicate clearly to set expectations of and raise awareness amongst general practices.

Education and Training Sessions

As part of its remit to support the adoption of best practice to improve the quality of care, GCPHN assists healthcare professionals through facilitating professional education events and training sessions. These education events are predominately at GPs, nurses and allied health professionals.

Consultation Feedback:

Overall, general practices were satisfied with the quality of the events and training sessions facilitated by GCPHN. Participants in the consultation process found the events to be well organised and easy to register. However, they also highlighted the following:

- The location and timing of the events were often to the detriment of some practices. For example, some events were held one hour away from some practices.
- GPs were less likely to attend an event or training session held by the PHN because of the lack of availability and relevance or interest in the presenting topic.
- Some events (e.g. immunisation) were in high demand and tended to book out in advance. Some practices reported missing out.
- More events catered to practice management and administration would be of benefit.

Next steps:

1. Explore alternative avenues to deliver education and training, particularly for GPs

Explore the feasability of providing an online or webinar option for training to enable practice staff to access training provided by GCPHN in their own time (and at their own location). This includes events that are more clinically focussed to obtain greater traction with GPs.

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CANCER

Needs Assessment Summary

2018

phn GOLD COAST

An Australian Government Initiative

Cancer

Identified local health needs and service issues

- High rates of melanoma across the region.
- Higher rates of colorectal cancer and breast cancer but lower rates of screening compared to national rates.
- Low community awareness of eligibility for screening in Gold Coast region, men in particular.
- High overall incidence of cancer in Gold Coast-North.
- Low participation of BreastScreen in Surfers Paradise and Southport.
- Low participation in cervical screening in Surfers Paradise, Southport and Gold Coast-North.
- General practice has had limited view of data to support proactive steps with patients.

Key findings

The incidence of new cancer diagnoses on the Gold Coast for common cancers such as breast, colorectal and lung, is generally in line with national averages, with the exception of melanoma (Gold Coast has a substantially higher rate) and prostate cancer (Gold Coast has a lower rate). In particular, Gold Coast North and Broadbeach-Burleigh experience a high total volume and relatively high rate of cancer incidence across various indicators.

Screening rates for breast, bowel and cervical cancer are national performance indicators for all 31 PHNs. Australian Institute of Health and Welfare (AIHW) data from 2014-15 on participation in cancer screening programs shows that the Gold Coast PHN region has a:

- Lower rate of participation in the National Bowel Cancer Screening Program than state and national averages
- Higher rate of breast cancer screening through BreastScreen Australia than the Australian average but lower than the Queensland average
- Lower rate of participation in the National Cervical Screening Program than the Australia average but higher than the Queensland average.

Utilisation of cancer screening services varies across the Gold Coast PHN region. The data identifies opportunities to further improve overall cancer screening participation rates. Some areas with low participation rates across all screening types (e.g. Southport and Ormeau – Oxenford) require an overall effort to increase screening consistency. Others require targeted strategies corresponding to screening type, age and specific locations.

Consultation suggests that low awareness of screening target groups in addition to limited knowledge about client eligibility causes confusion with community and health professionals, resulting in fewer people being screened.

Evidence

Cancer incidence

Table 1 shows the Gold Coast has a comparable rate of new cancers diagnosed for all types of cancer per 100,000 people compared to the national average (516 vs. 479 respectively).

Areas within the Gold Coast with the highest rate of new cancers being diagnosed include Southport (533 per 100,000) and Nerang (532 per 100,000). Gold Coast North has both a high rate of new cancers diagnosed (512 per 100,000) and a total volume of cases (2,244). Broadbeach-Burleigh also has a high total volume of cases (2,086), followed by Ormeau-Oxenford (2072) and Coolangatta (1,779)

Gold Coast ● 516 □ 15,297
National ● 479 □ 609,888

Table 1: Incidence of all cancers combined by number of cases and age-standardised rate (ASR), by SA3 region, 2009-13

Source: Australian Institute of Health and Welfare (AIHW), 2018 Australian Cancer Database (ACD)

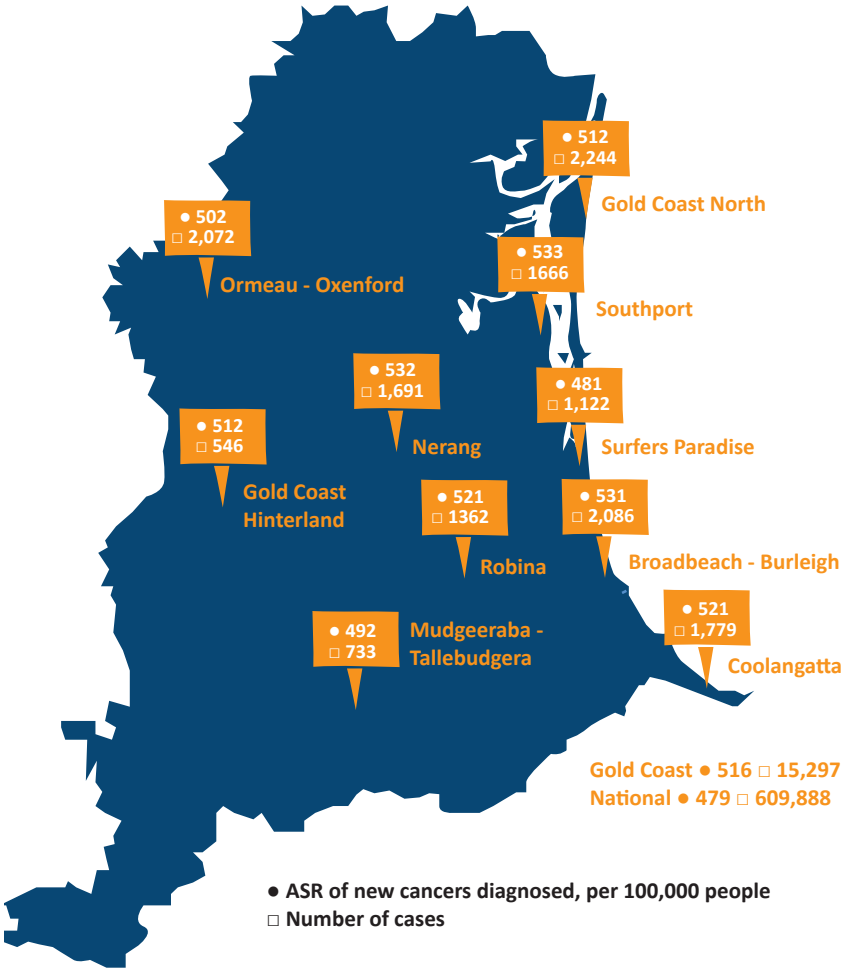


Table 2 below provides the incidence of a sample of cancer types across each sub-region of the Gold Coast. The data shows that the Gold Coast region has a comparable rate of new cancers diagnosed compared to the Australian averages for breast, colorectal, lung and prostate cancer. However, the region has a higher rate of new skin melanomas diagnosed (76 per 100,000) when compared to the national figure (49 per 100,000)—a level of almost 1.4 times the national rate.

Data analysis at a more granular level provides further insight into smaller geographic regions where increased effort may be required to prevent and treat particular types of cancer. Within the Gold Coast, noticeable trends include:

- Higher number of diagnoses for multiple cancer types in Broadbeach-Burleigh.
- Higher rates of melanoma and prostate cancer cases in Coolangatta.
- Gold Coast North is an area of concern across all cancer types based on incidence rates and total numbers of cases.
- Higher rates of lung cancer and melanoma in Nerang.
- Higher rates and absolute numbers of cases of breast cancer, colorectal cancer and melanoma in Ormeau-Oxenford.
- Higher rates of all cancer types in Surfers Paradise—particularly for breast, colorectal and melanoma, which were the highest rates observed across the PHN region.

Table 2: Incidence of various cancer types by number of cases and age-standardised rate (ASR), by SA3 region, 2009-13

Region	Breast cancer		Colorectal cancer		Lung cancer		Melanoma		Prostate cancer	
	ASR	No. of cases	ASR	No. of cases	ASR	No. of cases	ASR	No. of cases	ASR	No. of cases
Broadbeach- Burleigh	124	239	68	276	44	187	88	328	170	314
Coolangatta	108	184	54	193	42	147	90	296	188	314
Gold Coast Hinterland	118	66	59	52	40	39	76	83	163	102
Gold Coast-North	128	281	60	266	49	288	57	230	173	367
Mudgeeraba-Tallebudgera	124	101	61	86	31	45	81	123	172	130
Nerang	126	214	188	60	51	159	80	259	163	257
Ormeau- Oxenford	120	271	64	251	38	147	67	288	153	323
Robina	124	169	58	153	38	99	81	205	235	186
Southport	68	103	64	202	47	152	80	244	170	251
Surfers Paradise	128	202	55	128	36	86	69	155	164	205
Gold Coast	123	1,866	68	1,795	43	1,239	76	2,211	170	2,497
National	120	74,599	60	73,993	44	53,992	49	59,588	173	103,189

Source: AIHW, 2018 Australian Cancer Database (ACD)

The Gold Coast had a higher incidence of cervical cancer (8.3 per 100,000 females) compared to the national average of 7.0 in 2000-2013. This data is not available at the local level. Interestingly, Robina and Southport have relatively lower rates and total numbers of new cancer cases across cancer types.

Incidence of cancer has obvious impacts on individual health and the health system more broadly, which makes monitoring the incidence of new cancers important. AIHW mortality data[1] indicates that within the Gold Coast region between 2012 and 2016:

- There was a total of 5,404 deaths from all cancers in the Gold Coast region.
- Cancer accounted for 8 of the top 20 leading causes of death on the Gold Coast, with these cancer types making up over 20% of all causes of mortality.
- Lung cancer caused 1,016 deaths at a rate of 31.7 deaths per 100,000 persons compared to the national rate of 31.5. It was the 3rd leading cause of death for Gold Coast people.
- Colorectal cancer caused 564 deaths at a rate of 17.1 deaths per 100,000 persons compared to the national rate of 15.7. It was the 6th leading cause of death for Gold Coast people.
- Breast cancer caused 353 deaths at a rate of 19.9 deaths per 100,000 females compared to the national rate of 20.1. It was the 6th leading cause of death for Gold Coast women.
- Prostate cancer caused 458 deaths at a rate of 30.8 deaths per 100,000 males compared to the national rate of 26.2. It was the 4th leading cause of death for Gold Coast men.
- Melanoma caused 214 deaths at a rate of 6.5 deaths per 100,000 persons compared to the national rate of 6.0. It was the 16th leading cause of death for Gold Coast people.

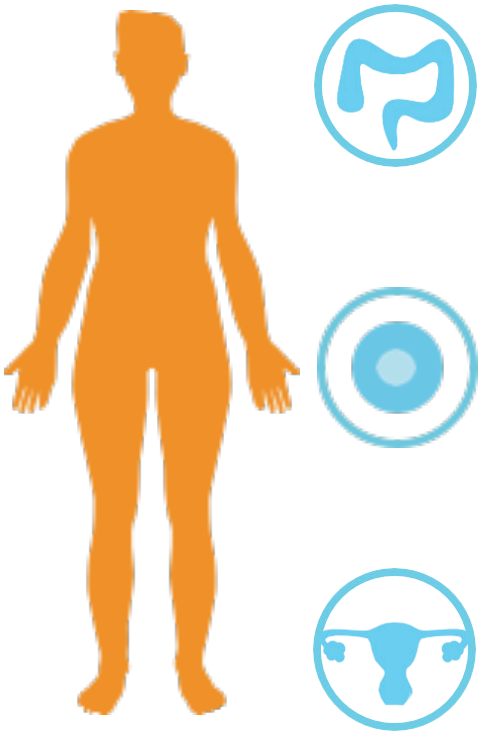
[1] AIHW, 2018. MORT (Mortality Over Regions and Time) books: Primary Health Network (PHN), 2012-2016

Service utilisation data

Table 3 below shows the rates of participation in national cancer screening initiatives for bowel, breast and cervical cancers in the Gold Coast region in 2015-16. Colour-graded columns provide a visual comparison to the national average for each screening program.

Table 3: Participation rates in national cancer screening programs, by SA3 region, 2015-16

Source: AIHW analysis of National Bowel Cancer Screening Program Register, BreastScreen Australia data and state and territory cervical screening register data. Extracted from www.myhealthycommunities.gov.au on 26/09/2018.



Bowel Cancer Persons aged 50–74 (%)

Broadbeach - Burleigh	40.1	Nerang	38.1
Coolangatta	38.9	Ormeau - Oxenford	37.2
Gold Coast - North	39.3	Robina	38.8
Gold Coast Hinterland	40.8	Southport	37.4
Mudgeeraba - Tallebudgera	39.3	Surfers Paradise	37.3

Gold Coast 38.5 Queensland 39.4 Australia 40.9

Breast Screen Women aged 50-74 (%)

Broadbeach - Burleigh	58.7	Nerang	54.5
Coolangatta	56.4	Ormeau - Oxenford	53.9
Gold Coast - North	53.9	Robina	56.0
Gold Coast Hinterland	54.3	Southport	52.4
Mudgeeraba - Tallebudgera	55.0	Surfers Paradise	50.5

Gold Coast 54.5 Queensland 56.6 Australia 55.1

Cervical Screening **Women aged 20-69 (%)**

Broadbeach - Burleigh	59.7	Nerang	55.3
Coolangatta	60.1	Ormeau - Oxenford	52.5
Gold Coast - North	51.6	Robina	54.5
Gold Coast Hinterland	54.9	Southport	50.0
Mudgeeraba - Tallebudgera	58.9	Surfers Paradise	49.4

Gold Coast 54.2 Queensland 54.1 Australia 55.4

There was a lower rate of participation in the National Bowel Cancer Screening Program for Gold Coast residents aged 50-74 years (38.5%) when compared to both Queensland (39.4%) and Australian (40.9%) averages. Bowel cancer screening rates sat below national averages in all regions of the Gold Coast, with particularly low rates in Surfers Paradise, Southport and Ormeau-Oxenford. There was also a significant difference in participation rates across the Gold Coast by gender—male screening rates (33.2%) remain lower than females (36.8%).

The rate of women aged 50-74 years participating in BreastScreen Australia screening services in 2015-16 on the Gold Coast (54.5%) was lower than rates in Queensland (56.6%) and Australian (55.1%) averages. The only SA3 regions of the Gold Coast that recorded BreastScreen rates higher than the national average was in Broadbeach Burleigh (58.7%), Coolangatta (56.4%) and Robina (56.0%). More recent data provided by BreastScreen shows that the number of Gold Coast women accessing screening services is increasing, with a total of 32,425 women screened during 2016-17, up from 31,459 women two years prior. This included 4,379 first-time clients.

Screening rates vary by age across the target age range of 50-74 years—rates are lowest in women aged 50-54 years (49.4%) and highest in 65-69 years (59.7%).

There were several SA3 regions with lower rates of participation in the National Cervical Screening Program, particularly Surfers Paradise (49.4%), Southport (50.0%) and Gold Coast North (51.6%). Screening rates vary by age across the wide target age group for screening of 20-69 years which has now changed to 18-74 on the 1/12/17. Based on 5-year age categories, rates were lowest amongst women aged 20-24 years (44.9%) and increased up to a peak in women aged 45-49 years (61.1%), then decreased again in older age groups.

Service Mapping

Services	Number in GCPHN Region	Distribution	Capacity Discussion
General practice	197	Broad distribution and availability across region	• Screening for cervical cancer • Skin checks for melanoma • Limited integration of utilisation and results data with general practice impacts follow up, availability and accessibility • National cervical screening program will have electronic results going to GP by end-2017 • Screening relation information events very well attended
BreastScreen	4	3 permanent sites (Southport, West Burleigh and Helensvale) 1 mobile service visiting 6 locations (e.g. Tamborine Mountain, Nerang, Elanora, Robina)	• Public breast screening • Fewer permanent sites than comparative HHS regions (e.g. Sunshine Coast area) • Previously long wait times but now under 2 weeks due to growing private screening market • Follow up occurs at Southport site • Follow up of abnormal results usually incurs a 2 week wait as service is often at capacity • BreastScreen and GPs • BreastScreen has set a screening target of 34,000 for Gold Coast region in 2017-18
Private breast screening clinics	11	Majority of providers along Eastern strip of Gold Coast	• Growing market—some private imaging clinics, some women's health-focused • Eligible for Medicare rebate—out-of-pocket costs still generally apply

National Bowel Cancer Screening Program (NBCSP)	1	Eligible people aged 50 – 74, identified by Medicare and Department of Veterans' Affairs, are posted a faecal occult blood test (FOBT) kit and invited to complete the test.	• People of all ages can also source a FOBT privately through some pharmacies, pathology companies and organisations such as Bowel Cancer Australia and Rotary. • These are not integrated with the national system or factored into local bowel cancer screening participation rates. • Current roll-out of NBCSP results sent electronically to GP • Follow up of abnormal results from the program incurs a variable wait time, with service within the public health system often at capacity. • People with a positive result may also choose to follow up with a private referral. • Screening will be biennial by 2019 • Some people who are eligible for the NBCSP screen via private colonoscopy which provides added cost and health risk.
Skin clinics	32	Spread across region Mostly located at medical centres	• An identified shortage of culturally appropriate and culturally safe services inhibits access for CALD and Aboriginal and Torres Strait Islander consumers

Consultation

Community and stakeholders identified:

- Many people in the community are not aware of cancer screening target groups.
- There is negative stigma with the screening process itself.
- There are low levels of health literacy in specific pockets of the population which adversely influences screening awareness and uptake.

Barriers to general practice playing a more prominent role in screening include:

- Invitations to participate in the National Bowel Cancer Screening Program are sent out to eligible Australians separate to general practice, with GPs initially left out of the loop.
- While FOBT kits are easily available, those not being integrated with NBCSP makes it difficult for GPs to receive information and provide follow-up.
- While results from BreastScreen and BowelScreen are now coming directly into general practice software, GPs are not made aware of Bowelscreen service decliners, so they can't be proactively followed up.
- The way the national bowel screening program operates leads to duplications e.g. if a person has a private colonoscopy, they may still receive a kit for screening.
- People attending private breast screening services are not entered into the state reminder system
- Cultural complexities may inhibit screening for some groups.
- Regularly changing eligibility criteria and national priorities
- Funding model for screening in practices influences uptake and cost effectiveness of a consultation
- The change for cervical cancer screening to a 5-year timeframe is causing some anxiety for women so education is needed to support the change.

The Gold Cost PHN's Community Advisory Council (CAC) 2017, noted a limited awareness in Gold Coast community regarding screening and eligibility requirements:

- 66% knew about cervical cancer screening.
- 75% knew about breast cancer screening.
- 50% knew about bowel cancer screening.
- Only 50% indicated they were aware of target groups for the different screening services.

The CAC also noted:

- The community expects health professionals to notify/remind them to get screened, carry out the screening test if relevant and make referral if required – this ranked as more important than providing them with information on what screening services are available.
- The community has differing attitudes towards public and private screening services.
- The community identified difficulty accessing services and report high complexity navigating the system.
- There is a "yuck" or "embarrassment" factor in breast, bowel and cervical screening that inhibits uptake (Oct 2017).

What we understand works

Australian Government National Bowel Cancer Screening Program (NBCSP)

From the commencement of the NBCSP in mid-2006 up to mid-2014, over 2.5 million Australians were screened, with 3,989 people found to have suspected or confirmed cancers and 12,294 diagnosed with advanced adenomas (i.e. a benign tumor that may become cancerous). A 2014 study found that people who were invited to screen through the NBCSP had 15% less risk of dying from bowel cancer and were more likely to have less-advanced bowel cancers when diagnosed, than people who were not invited[2]. It is expected that from 2016 to 2020 approximately 9,000 suspected or confirmed cancers and over 26,000 advanced adenomas will be detected and removed. This will significantly reduce the burden of bowel cancer on Australians and their families.

A study published in MJA found that participation in the National Bowel Cancer Screening Program led to colorectal cancer down-staging. Participants were more likely to have stage A lesions compared with all other patients, and half as likely to have stage D colorectal cancer. A further shift towards earlier stage was seen in those who participated in screening and those with positive test results compared with all other patients. (Cole, S et al. Shift to earlier stage at diagnosis as a consequence of the National Bowel Cancer Screening Program. MJA 2013: 198(6))

[2] AIHW 2014. Analysis of bowel cancer outcomes for the National Bowel Cancer Screening Program. Cat. no. CAN 87. Canberra: AIHW

National Cervical Screening Program

Since its introduction in 1991, the National Cervical Screening Program has been very successful. Incidence and mortality from cervical cancer in Australia fell by around 50% in the first decade. However, in the second decade of the screening program, rates of cervical cancer incidence and mortality appear to have levelled out.

An independent review of the National Cervical Screening Program was undertaken in 2014, which led to changes to improve the effectiveness of the program that commenced on 1 December 2017. These changes include:

- Women will be invited when they are due to participate via the National Cancer Screening Register.
- The Pap smear will be replaced with the more accurate Cervical Screening Test to detect human papillomavirus (HPV) infection, which is the first step in developing cervical cancer.
- The time between tests will change from two to five years.
- The age at which screening starts will increase from 18 years to 25 years.
- Women aged 70 to 74 years will be invited to have an exit test..

Evidence shows that changes will reduce cervical cancer incidence and mortality by at least 20% and require fewer tests over a woman's lifetime.

BreastScreen Australia

When free BreastScreen Australia services started in 1991, the rate of mortality due to breast cancer was 68 deaths per 100,000 women, which decreased to 43 deaths per 100,000 women by 2010. This decrease is due to the early detection of breast cancer through mammogram and the effective treatment for breast cancer. Detecting any abnormalities early ensures that women have all treatment options available to them. The earlier breast cancer is found, the better the chance of surviving it. It is recommended that women aged 50-74 years without breast cancer symptoms should have a screening mammogram every two years, as more than 75% of breast cancers occur in women aged over 50. BreastScreen Australia has a program participation target of 70% of women in the target age group, which has not been met previously at a national level. Women aged 40-49 and 75 and over are eligible to receive free mammograms but do not receive an invitation to attend. It is estimated that around 8 deaths from breast cancer will be prevented for every 1000 women screened every two years from age 50 to age 74, based on evaluation of mammographic screening in Australia[3].

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IMMUNISATION SUMMARY

Needs Assessment Summary

2018

phn GOLD COAST

An Australian Government Initiative

Immunisation

Identified local health needs and service issues

- Lower rates of children fully immunised in Gold Coast Hinterland, Surfers Paradise and Mudgeeraba-Tallebudgera.
- Lower rates of HPV vaccination in Gold Coast compared to the national figure.
- Higher rates of hospitalisation for pneumonia and influenza in Gold Coast compared to the national figure.
- Southport and Surfers Paradise had the highest rates in the Gold Coast for hospitalisation for pneumonia and influenza.
- Access to ongoing quality education / training.

Key findings

Achievement of the National Immunisation Program is measured by vaccination coverage, and is reported at 12, 24 and 60-month milestones (1, 2 and 5 years of age). Health authorities at the national, state and local level aim for vaccination coverage of at least 95%. Generally speaking, childhood immunisation rates on the Gold Coast have increased in recent years but remain slightly below (but comparable to) national immunisation rates apart from 2-year old's which is now above the national average. Vaccination rates for Aboriginal and Torres Strait Islander children are generally higher than the national rates on the Gold Coast.

HPV (Human Papillomavirus) causes genital warts and a number of cancers in males and females. Under a national program, vaccinations are provided free in schools to all males and females aged 12-13 years. In the Gold Coast region, rates are increasing but remain lower than national rates.

Gold Coast has higher rates of people admitted to hospital for potentially preventable hospitalisations due to vaccine-preventable conditions compared to national figures, with influenza and pneumonia being more common for very young children and older people.

Evidence

Immunisation coverage

Table 1 below shows the percentage of children immunised against a range of infectious diseases and fully immunised at age 1 year, 2 years and 5 years as at March 2018. These immunisations are based on the National Immunisation Program Schedule, which include:

- Diphtheria, tetanus and pertussis (DTP)
- Polio, haemophilus influenzae type b (HIB)
- Hepatitis B
- Measles, mumps and rubella
- Pneumococcal
- Meningococcal
- Varicella

Immunisation for DTP and polio at 5 years shows a large discrepancy (i.e. over 2%) between rates for the Gold Coast PHN region and nationally. Immunisation for hepatitis B, pneumococcal and DTP at 1 year also show modest discrepancies between rates on the Gold Coast and nationally.

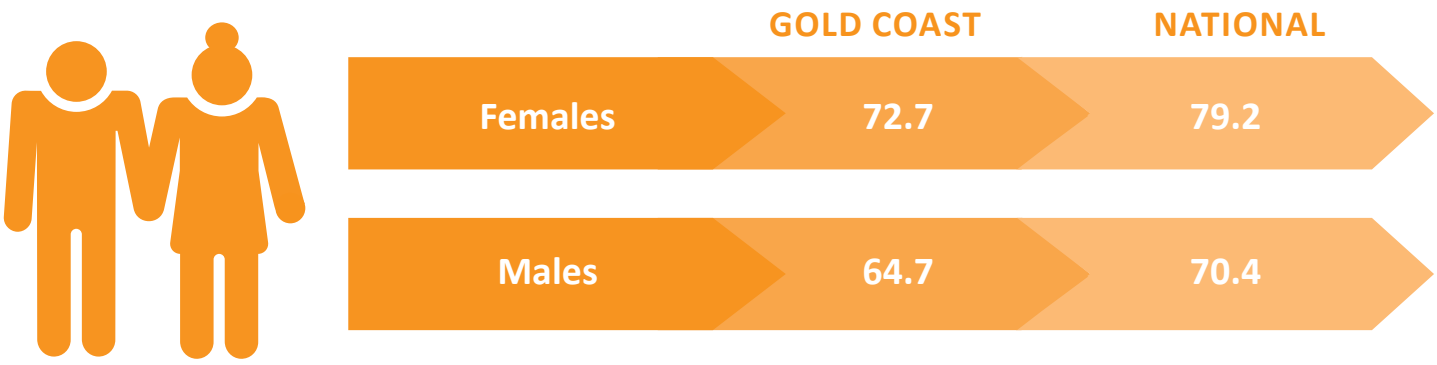
Table 1: Percentage of children immunised based on National Immunisation Program Schedule, March 2018

	At 1 year		At 2 years		At 5 years	
	Gold Coast	National	Gold Coast	National	Gold Coast	National
Fully immunised	93.1	94.1	91.2	90.5	92.2	94.2
DTP	92.7	94.8	91.8	93.0	91.3	94.5
Polio	93.3	94.7	94.8	96.5	91.5	94.5
HIB	92.6	94.5	93.4	95.5	n/a	n/a
Hep B	92.6	94.7	94.6	96.3	n/a	n/a
MMR	n/a	n/a	93.3	93.3	94.1	94.8
Pneumococcal	92.4	94.4	n/a	n/a	n/a	n/a
Meningococcal	n/a	n/a	93.5	95.4	n/a	n/a
Varicella	n/a	n/a	91.6	92.6	n/a	n/a

Source: Australian Govenment, Department of Health, Resources, https://beta.health.gov.au/resources/publications/qld-childhood-immunisation-coverage-data-by-sa3. n/a indicates not measured in the aged cohort.

The human papillomavirus (HPV) vaccine is provided free to girls and boys aged 12–13 years as part of the National HPV Vaccination Program. Table 2 shows the percentage of females and males aged 12-13 years in mid-2013, who had received the third dose by 2016. It shows significantly lower levels of vaccination in both males and females on the Gold Coast compared to national levels.

Table 2: Percentage of children aged 12-13 years in mid-2013 who had received Dose 3 of HPV vaccine by 2016



Source: Compiled by Public Health Information Development Unit (PHIDU), Torrens University using data from the National HPV Vaccination Program Register

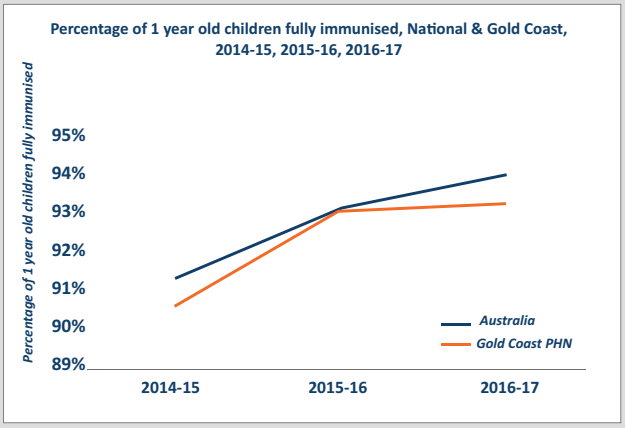
Table 3 below illustrates that childhood immunisation rates for all children and those who identified as Aboriginal and Torres Strait Islander within the Gold Coast have fluctuated between 2014-15 and 2016-17.

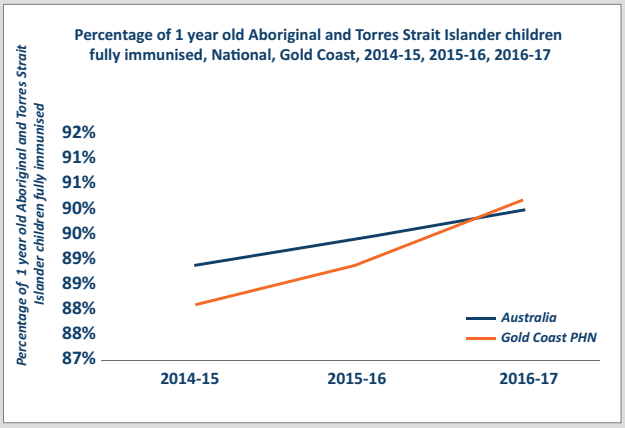
For all children, the Gold Coast has consistently returned lower immunisation rates for children aged 1, 2 and 5 years each year for the five-year period when compared to the national average. However, in 2016-17 the Gold Coast average for 2 year old's fully immunised children was higher compared to the national average. For Aboriginal and Torres Strait Islander children, the Gold Coast mostly returned higher immunisation rates for children aged 1, 2 and 5 years old each year over the period than the national average. In 2016-17, 5-year-old Aboriginal and Torres Strait Islander children on the Gold Coast had a lower immunisation rate compared to the national figure.

Noticeably, local trends in immunisation rates largely mirror national trends which may indicate the significance of Australia-wide immunisation policy and universal immunisation initiatives.

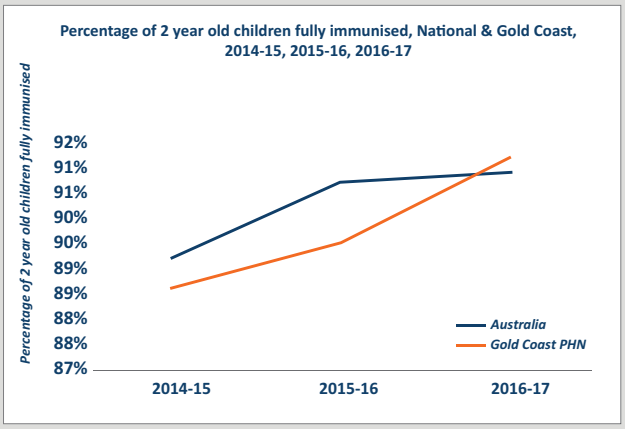
Table 3: Immunisation trends over time, all children and Aboriginal and Torres Strait Islander children, 2014-15 to 2016-17

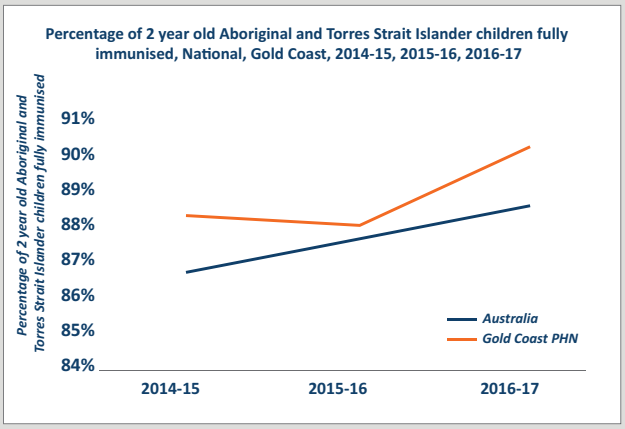
Percentage of 1 year old children fully immunised



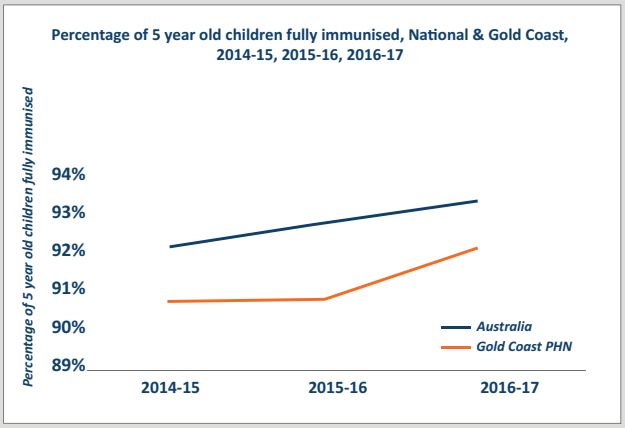


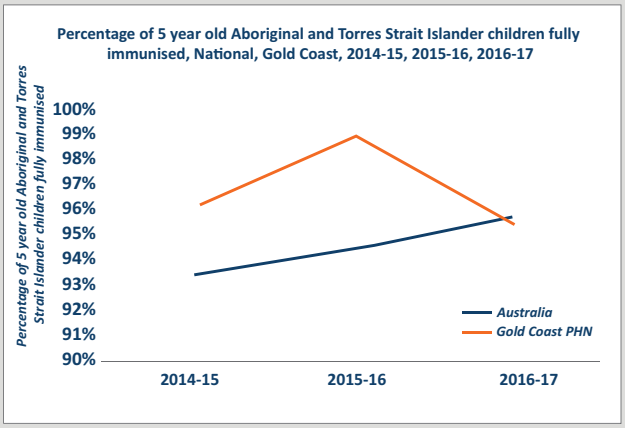
Percentage of 2 year old children fully immunised





Percentage of 5 year old children fully immunised





Source: AIHW analysis of Department of Human Services, Australian Immunisation Register statistics 201516. Extracted from my-healthycommunities.gov.au on 26/07/2017

Data analysis at a more granular level provides further insight into geographic regions where increased effort may be required to improve immunisation coverage. The data displayed in Table 4 highlights Statistical Area Level 3 (SA3) regions with either a low immunisation rate or a high number of children not immunised at ages 1, 2 and 5 years old.

Table 4: Percentage of 1, 2 and 5-year old's fully immunised, and number of children not fully immunised, by SA3 region, 2016-17

	At 1 year old		At 2 years old		At 5 years old	
Region	% fully immunised	Number not fully immunised	% fully immunised	Number not fully immunised	% fully immunised	Number not fully immunised
Broadbeach-Burleigh	92.2	61	90.1	75	92.6	56
Coolangatta	90.2	63	91.7	51	91.2	51
Gold Coast-North	93.7	42	91.1	63	91.6	58
Gold Coast Hinterland	90.2	17	89.7	21	87.8	27
Mudgeeraba-Tallebudgera	90.8	37	90.1	39	90.5	41
Nerang	93.9	57	91.9	81	92.9	72
Ormeau-Oxenford	94.0	118	91.8	169	93.4	145
Robina	94.5	32	91.7	45	91.7	52
Southport	94.1	37	92.6	50	91.7	58
Surfers Paradise	91.7	31	86.8	48	90.6	33
Gold Coast	93.1	492	91.2	642	92.2	594
Australia	93.8	19,171	90.9	28,484	93.5	20,524

Source: AIHW analysis of Department of Human Services, Australian Immunisation Register statistics 2016–17. Extracted from myhealthycommunities.gov.au on 25/09/2018.

Areas that have low immunisation rates include Surfers Paradise, Gold Coast Hinterland and Mudgeeraba-Tallebudgera. However, these regions have some of the lowest absolute numbers of children who are not fully immunised. Those regions with a high absolute number of children not immunised include Ormeau-Oxenford and Nerang. Analysis of the Australian Immunisation Register statistics at a more granular SA2 level for the 1 July 2016 to 30 June 2017 highlights even smaller geographic pockets that have lower rates of immunisation including Coolangatta, Guanaba-Springbrook, Currumbin Valley – Tallebudgera.

Health service utilisation

Potentially preventable hospitalisations (PPHs) are an indicator of both adverse health outcomes but also financial costs to the health system. Table 5 shows the rate of PPH per 100,000 people for vaccine-preventable conditions between 2013-14 and 2015-16. 'Other vaccine-preventable conditions' include chicken pox, diphtheria, haemophilus meningitis, hepatitis, measles, mumps, pertussis (whooping cough), polio, rubella and tetanus.

Table 5: Age-standardised rate of potentially preventable hospitalisations per 100,000 people for vaccine-preventable conditions, 2013-14 to 2015-16

Category	Region	2015-16	2014-15	2013-14
Total vaccine-preventable	Gold Coast	236	195	103
	National	199	175	128
Pneumonia and influenza (vaccine-preventable)	Gold Coast	159	123	42
	National	92	81	49
Other vaccine-preventable conditions	Gold Coast	78	73	62
	National	107	95	80

Source: AIHW analysis of the National Hospital Morbidity Database 2015-16. Extracted from myhealthycommunities.gov.au on 26/07/2017.

Table 5 shows the Gold Coast has a higher rate of PPHs for vaccine-preventable conditions compared to the national figure. These conditions accounted for approximately 1,427 hospitalisations in the Gold Coast region in 2015-16 and accrued a total of 6,890 hospital bed days. The rates of PPHs have been steadily increasing in the Gold Coast region, mirroring the trend at a national level. Most of the increase in PPHs observed for the Gold Coast region was driven by pneumonia and influenza.

Table 6 shows the rate and absolute number of PPHs for vaccine-preventable conditions in 2015-16 at the SA3 level.

Table 6: Regional breakdown of age-standardised rate (ASR) of potentially preventable hospitalisations (PPHs) per 100,000 people and number of PPHs for vaccine-preventable conditions, 2015-16

Region	Pneumonia and influenza		Other vaccine-preventable conditions	
	ASR	Number of PPH	ASR	Number of PPH
Broadbeach - Burleigh	133	94	59	42
Coolangatta	123	79	50	29
Gold Coast - North	164	136	98	78
Gold Coast Hinterland	NP	19	NP	7
Mudgeeraba - Tallebudgera	178	56	NP	13
Nerang	148	103	76	56
Ormeau - Oxenford	158	176	60	68
Robina	165	89	76	40
Southport	219	137	176	105
Surfers Paradise	178	66	95	40
Gold Coast	159	955	78	478
National	92	23,774	107	27,022

Source: AIHW analysis of the National Hospital Morbidity Database 2015-16. Extracted from myhealthycommunities.gov.au on 26/07/2017. NP=not available for publication.

This data shows that the rate of possible preventable hospitalisations for pneumonia and influenza is higher across all local areas of the Gold Coast than the national rate. Southport has a very high rate and absolute number of PPHs for both pneumonia/influenza and other vaccine-preventable conditions. Ormeau-Oxenford has a very high absolute number of PPHs for pneumonia and influenza. Avoidable admissions data provided from Gold Coast Health indicates that young children aged 0-5 and older people aged 65-75 have the highest percentage of people being admitted to hospital for influenza and pneumonia.

Service Mapping

Services	Number in the GCPHN region	Distribution	Capacity discussion
General practices	197	• Practices are well spread across the region. • High number of practices in the northern growth corridor where many children live, 87% of which have a practice nurse.	• Childhood immunisations are free, funded by the Government but the consultation fee may differ between practices. • Many new practice nurses require training in immunisation—40% increase in number of practice nurses between 2015-2016. • Immunisation education events always well attended, often have a wait list. • Practices require support from PHN regarding data recording on Australian Immunisation Register.
Dedicated GP immunisation clinics	4	• Labrador, Canungra, West Burleigh and Mermaid Beach	• These clinics provide a separate waiting area, no appointment is required and does not need to be a patient of the clinic.
Community immunisation clinics, Gold Coast Health	6	• Helensvale, Carrara, Upper Coomera, Burleigh and Southport	• Drop-in—no appointments required. • Free for people with a Medicare card to attend the clinic. • Vaccines on the National Immunisation Program Schedule Qld are provided free. • Other vaccines incur a cost.
Schools	20	• Public and private schools across the region.	• Free vaccinations including HPV through the school immunisation program. • Queensland has legislated to require schools to provide student details to immunisation providers to assist with communication and consent processes.
Gold Coast Hospital Maternity and Antenatal Clinic	1	• Southport	• Pregnant women can access immunisations including whooping cough and influenza.
Private obstetricians and midwives	12	• 9 obs, 3 midwives • Spread across region	• As above

Pharmacy	At least 27	• Various locations	• Pharmacist must undertake additional training to administrate vaccines and pharmacy must implement additional processes (e.g. cold chain). • The Pharmacy guild has had two sessions at GCPHN to Pharmacist about vaccination procedures in 2018. • In these two sessions a total of 19 Pharmacist attended. • The Gold Coast Public Health Unit (GCPHU) conducts backs to basics training around immunisation to nurses monthly. • GCPHU offers catch up schedule immunisation to nurses monthly. • Pharmacists can't vaccinate children or pregnant women.
Homeless immunisation clinics	2	• Surfers Paradise and Coolangatta	• 140 people experiencing homelessness on the Gold Coast have been vaccinated between 1/5/18 and 31/8/18. This occurred across the Homeless Connect event and the regular church free meals. • PHN/PHU continue with annual homeless connect day in August to provide influenzas and pneumovax vaccines. • Interest reported from some homeless support services to work with PHU and PHN to improve vaccination access to homeless or at-risk people.
Information	Multiple	• Web, brochures etc	• While there are credible sources, there is a lot of incorrect information on the internet.

Consultation

Feedback from general practices and the GCPHN Primary Health Care Improvement Committee identified a number of issues:

- Consistent and reliable supply of some vaccines to general practice remains an issue. Most but not all general practice clinics have a reminder system in place to follow up overdue immunisations and the inconsistent supply impacts on ability to efficiently manage use of recall and reminder systems, resulting in many immunisations being done opportunistically.
- Travel vaccinations also noted as challenging with a desire for improved access to up to date information to support GPs.
- Larger uptake of flu vax for children observed over recent season, noted this is likely due to media coverage.
- Some general practices advertise to the general population that flu vax is free 'for everyone' creating confusion for some patients if they are not in an eligible group and the practice they visit does not bulk bill.
- Ongoing education for staff in a highly mobile workforce is very important. In addition, there are some concerns there may be health professionals on the Gold Coast who do not actively support or recommend vaccination, further reinforcing the need for ongoing education.
- Complicated changes to schedules and variation between states cause issues, particularly for cross border patients.

GCPHN Community Advisory Council (October 2017) identified:

- As flu vaccines only covers some strains there is scepticism about effectiveness of flu vaccine and having / hearing about reactions to vaccines make many reluctant to have one
- Growing awareness in community of potential harm of vaccine preventable diseases but still some who are adamant against childhood vaccines in particular. Some concerns that forcing people to vaccinate their children through monetary and other mechanisms is not ethical.
- Where there is a cost for a vaccine it is a significant barrier for many.

What we understand works

Research, evaluation, service reviews

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PERSISTENT PAIN

Needs Assessment Summary

2018

phn GOLD COAST

An Australian Government Initiative

Persistent Pain

Identified local health needs and service issues

- High rates of musculoskeletal conditions in Gold Coast North and Coolangatta
- Ageing population means more musculoskeletal conditions projected
- Pain management frequently focusses on medication
- High levels of opioid dispensing across region, particularly Southport
- Need for more awareness and support for prevention and self-management
- Focus on multidisciplinary and coordinated care

Key findings

Persistent pain refers to pain that persists beyond the normal healing time, typically considered to be around three months. It can be the result of a surgery, trauma or health condition, or pain that exists without a clear reason. It is categorised differently to acute pain or pain related to the effects or treatments of cancer.

While prevalence data on persistent pain at a regional level is limited, it is estimated that one in five of the Australian adult population suffers from persistent pain. Persistent pain is often linked to chronic musculoskeletal conditions, which have a slightly lower prevalence in the Gold Coast PHN region compared to state or national rates. However, an ageing Gold Coast population combined with predictions that the prevalence of musculoskeletal conditions will rise in Australia over the next few decades means that there is likely to be increasing cases of persistent pain in the Gold Coast region.

Health system costs associated with the treatment of persistent pain are significant, estimated to be around $7 billion each year. Concerns exist that sufferers are missing out on potentially beneficial treatment whilst also being directed to treatments that are potentially unnecessary and costly with limited benefit. There are increasing concerns about the trend in prescribing opioid medications, dependency and addiction issues and possible long- term adverse effects. Rates of opioid medication prescriptions in the Gold Coast region are slightly higher than the national average, with rates particularly high in the Southport region.

Recommended treatment for persistent pain promotes self-management and involves an integrated multidisciplinary approach. There are several specialist pain clinics on the Gold Coast and a range of primary care providers, but consultation indicates issues exist with service access and coordination.

An initiative delivered by the Gold Coast PHN found that an integrated self-management model of care can lead to improved perceptions on pain, health service access, safe and effective medication use, ability to perform everyday activities and coping, as well as a reduction in hospitalisations.

Evidence

Prevalence

In 2001, it was estimated that around one in five adult Australians live with persistent pain[1]. This prevalence rises to one in three for people aged over 65 years. If this rate were to remain stable today, a crude estimate would be that 114,000 Gold Coast residents are living with persistent pain based on 2016 census population.

More recent estimates of the prevalence of persistent pain at a national or regional level have been difficult to come by. Persistent pain is often not categorised as a health condition in its own right. Persistent pain is not a National Health Priority Area (NHPA) but is directly linked to at least three of the nine NHPAs. It is also not an item covered in the National Health Survey conducted every few years.

The Bettering the Evaluation and Care of Health (BEACH) study[2] provides an indication of the prevalence of persistent pain in a sample of patients treated by general practitioners (GPs) in Australia. In 2014-15, it found that 25.4% of patients presented with either chronic musculoskeletal or neural pain. The most commonly reported causes of persistent pain were osteoarthritis and lower back problems. This same study found that demand for treatment for persistent pain had increased significantly between 2006-07 and 2015-16. It was estimated that MBS-claimed GP treatment occasions increased by 400,000 for chronic back pain and a further 400,000 for unspecific chronic pain over the decade.[3]

There are many conditions that cause persistent pain, with most being chronic musculoskeletal conditions such as osteoarthritis, back and neck pain, osteoporosis and fibromyalgia. In Australia, the burden of disease attributed to musculoskeletal conditions is ranked second amongst all chronic health conditions in terms of years of healthy life lost due to disability[4]. Modelling conducted by Arthritis and Osteoporosis Victoria[4] in 2013 on the prevalence of arthritis and other musculoskeletal conditions in Australia predicted that:

- As Australia's population ages over the next two decades, the prevalence of musculoskeletal conditions will rise substantially.
- By 2032, it is projected that the number of cases of arthritis and other musculoskeletal conditions will increase by 43% to 8.7 million, affecting 30.2% of the population. The number of people with osteoarthritis and osteoporosis is projected to increase the fastest
- (58% and 50% growth respectively), however back problems will remain the most prevalent condition.
- The age group with the most cases of arthritis and other musculoskeletal conditions is currently 55-64 years, however this will change to the 75+ age group by 2032.

[1] Blyth FM, et al. (2001) Chronic pain in Australia: a prevalence study, Pain, 89:127-134

[2] Family Medicine Research Centre, University of Sydney (2015) SAND abstract No. 234 from the BEACH program: Chronic musculoskeletal/nerve pain in general practice patients

[3] Britt H, et al. (2016) A decade of Australian general practice activity 2006–07 to 2015–16. General practice series no. 41

[4] Arthritis and Osteoporosis Victoria (2013). A problem worth solving

In 2011-12, there were almost 150,000 Gold Coast adult residents living with a musculoskeletal condition at a rate of 26.8 per 100 people, slightly lower than the rates across Queensland and Australia. A regional breakdown of the number and rate of people living with musculoskeletal condition can be seen in Table 1.

Table 1: Estimated number of people with musculoskeletal system diseases, 2011-12

Region	Number	Age-standardised rate per 100 persons
Broadbeach - Burleigh	18,087	26.9
Coolangatta	16,000	27.5
Gold Coast - North	19,798	27.6
Gold Coast Hinterland	5,255	26.6
Mudgeeraba - Tallebudgera	8,288	26.7
Nerang	17,294	27.3
Ormeau - Oxenford	23,658	27.0
Robina	11,863	25.0
Southport	15,038	26.1
Surfers Paradise	10,782	26.7
Gold Coast	145,793	26.8
Queensland	-	27.2
Australia	-	27.7

Source: Public Health Information Development Unit (PHIDU), Torrens University. Social Health Atlas of Australia: Primary Health Networks (online). Extracted 10/10/1

Of the 145,793 Gold Coast residents living with a musculoskeletal condition, 73,586 or about 50% of cases have a form of arthritis.

There are a number of risk factors associated with the onset and management of chronic musculoskeletal conditions that cause persistent pain. These include age, obesity, physical inactivity and co-morbidities such as cardiovascular disease and mental health conditions. Persistent pain is also more likely to be experienced by people in low socioeconomic groups. Due to the complex nature of persistent pain, it is often unclear whether persistent pain is the cause or the result of socioeconomic disadvantage.[5] In the Gold Coast PHN region, there is a relatively older age profile compared to the national average[6], which could indicate that levels of persistent pain could increase in the region in the coming years.

Persistent pain has a significant negative effect on quality of life and contributes to wide economic costs. Financial modelling conducted in 2007[5] estimated that the total cost of persistent pain was $10,846 per person with chronic pain. It is reasonable to assume these costs have increased over the last decade due to the increase in the average age of the population. Around 20% of costs impact the health system, including inpatient or outpatient hospital services, primary care, pharmaceuticals and residential aged care.

Over half of the cost of chronic pain is borne by individuals and their families and friends, with loss of productivity being a significant contributory factor. Over 90% of people with severe or very severe pain report some level of interference with the ability to work in both paid employment and housework[7].

Rates of paid employment for people with arthritis and other musculoskeletal conditions are 3.5% lower than the general population[4]. Back pain and arthritis are the most common causes for people aged 45-64 years to leave the workforce, accounting for around 40% of forced retirements[8].

[5] MBF Foundation (2007) The high price of pain: the economic impact of persistent pain in Australia. Report conducted by Access Economics in collaboration with the Pain Management Research Institute - The University of Sydney/Royal North Shore Hospital

[6] Public Health Information Development Unit (PHIDU) Social Health Atlas of Australia: Primary Health Networks (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data (accessed 23 August 2017).

[7] ABS (2011), 4841.0 Facts at your fingertips: Health: Characteristics of bodily pain in Australia

[8] Schofield et al. (2012) Quantifying the productivity impacts of poor health and health interventions, Health Economics, University of Sydney

Persistent pain has been shown to lead to depression, anxiety spectrum disorders and suicide. The nature of persistent pain means that it can restrict self-management, particularly a person's capacity to manage their weight through physical activity. This can lead to co-morbidities such as type 2 diabetes and cardiovascular problems. Older people experiencing persistent pain with co-morbidities are likely to be taking multiple medications, which places them at a greater risk of an adverse drug event.

Service utilisation

Pain Australia, the peak advocacy body for pain-related conditions in Australia, estimates that less than 10% of people with persistent non-cancer pain gain access to effective care, despite the fact that current knowledge would allow 80% to be treated effectively if there was adequate access to pain services[9].

On the Gold Coast during 2009–2013, 5% of GP consultations were specifically for the management of arthritis or chronic back pain, compared to 6% for a cardiovascular condition and 7% for anxiety or depression. The most common treatments resulting from consultations for arthritis or chronic back pain were:

- medication prescribed (69%)
- imaging ordered (18%)
- referred to a health professional (13%)

Data from the BEACH study of general practice in Australia found that persistent pain affects around 1 in 5 patients attending GP consultations and increases with age, which is consistent with broader population estimates. Around 86% of patients managed persistent pain with at least one medication, with that rate increasing to 93.4% of patients in the 65 years and over age group. In this age group, about a third of those prescribed medications for management of persistent pain included opioids (including low dose combination products).

Opioids such as codeine and oxycodone are often prescribed to relieve and treat pain symptoms. According to a report published by Australian Commission on Safety and Quality in Health Care[10] into the prescribing and dispensing of opioid medicines:

- current evidence does not support using opioid therapy for chronic pain
- the prescribing of opioids for chronic pain is increasing
- evidence is growing of the adverse effects of long-term use of opioids

This report found considerable variation in the levels of prescribing opioids across regions of Australia with no apparent explanation for the cause. A 2016 report by the Alcohol and Drug Foundation[11] stated that the number of fatalities from drug overdoses by pharmaceutical opioids in Australia has risen significantly over the past decade. The report suggests that opioids are overused and overprescribed, and is causing increases in the rates of drug dependency, injury and death.

Statistics from the Pharmaceutical Benefits Scheme (PBS) indicate that 263,714 prescriptions for opioids were filled across the Gold Coast PHN region in 2014-15, up from 250,745 prescriptions in the preceding year, an increase of over 5%. The rate was higher in the Gold Coast region than the national average, but slightly lower than the state average. Table 2 below provides a breakdown of opioid prescriptions dispensed across sub-regions of the Gold Coast. The three regions with the highest rates of opioid use were Southport, Gold Coast North and Ormeau-Oxenford.

[9] Pain Australia (2016). Prevalence and the Human and Social Cost of Pain, Pain Australia Fact Sheet 2
[10] Australian Commission on Safety and Quality in Healthcare, The First Australian Atlas of Healthcare Variation.
[11] Alcohol and Drug Foundation (2016) Is there a pill for that? The increasing harms from opioid and benzodiazepine medication, Prevention Research

Table 2: Age-standardised rate of PBS prescriptions dispensed for opioid medicines per 100,000 people, by SA3 region, 2013–14

Region	ASR per 100,000 people
Broadbeach - Burleigh	55,050
Coolangatta	59,592
Gold Coast - North	64,000
Gold Coast Hinterland	60,279
Mudgeeraba - Tallebudgera	60,082
Nerang	59,844
Ormeau - Oxenford	62,761
Robina	51,875
Southport	73,571
Surfers Paradise	52,337
Gold Coast	59,939
Queensland	61,115
Australia	55,126

Source: ACSQHC, Australian Atlas of Healthcare Variation

Concerns have also been raised about potentially ineffective and unnecessary treatments, such as medical imaging for chronic back pain and surgical interventions for osteoarthritis[11]. Table 3 shows the rate of CT scans performed for low back pain was higher in all Gold Coast regions than Queensland and Australian averages.

Table 3: Age-standardised rate of MBS-funded services for CT imaging of the lumbar spine per 100,000 people, by SA3 region, 2013–14

Region	ASR per 100,000 people
Broadbeach - Burleigh	1,597
Coolangatta	1,786
Gold Coast - North	1,879
Gold Coast Hinterland	1,798
Mudgeeraba - Tallebudgera	1,641
Nerang	1,683
Ormeau - Oxenford	1,841
Robina	1,598
Southport	1,935
Surfers Paradise	1,584
Queensland	1,381
Australia	1,282

Source: ACSQHC, Australian Atlas of Healthcare Variation

The Australian Commission on Safety and Quality in Health Care (ACSQHC) suggests that the rate at which GPs refer patients with low back pain for diagnostic imaging, particularly CT scans, may be excessive based on current guidelines and potentially exposing patients to radiation unnecessarily. Modelling done by PriceWaterhouseCoopers[12] predicted annual savings to the MBS as a result of disincentivising unnecessary imaging for chronic low back pain to be over $100 million.

[12] MOVE and PwC (2017). Everybody MOVE: Improving outcomes in musculoskeletal health

Similarly, ACSQHC has identified that the rates at which some surgical interventions are being used to treat conditions associated with persistent pain vary widely across locations, indicating possible over-reliance in lieu of conservative treatments. Such interventions include lumbar spinal fusion and spinal decompression for low back pain, and knee arthroscopy or replacement for osteoarthritis. Table 4 below shows that rates of hospitalisations for these procedures are generally higher than national averages across the Gold Coast.

Table 4: Age and sex-standardised rate of hospitalisations for selected surgical interventions per 100,000 people aged 18 years and over, by SA3 region, all data 2014-15 except knee arthroscopy (2012-13)

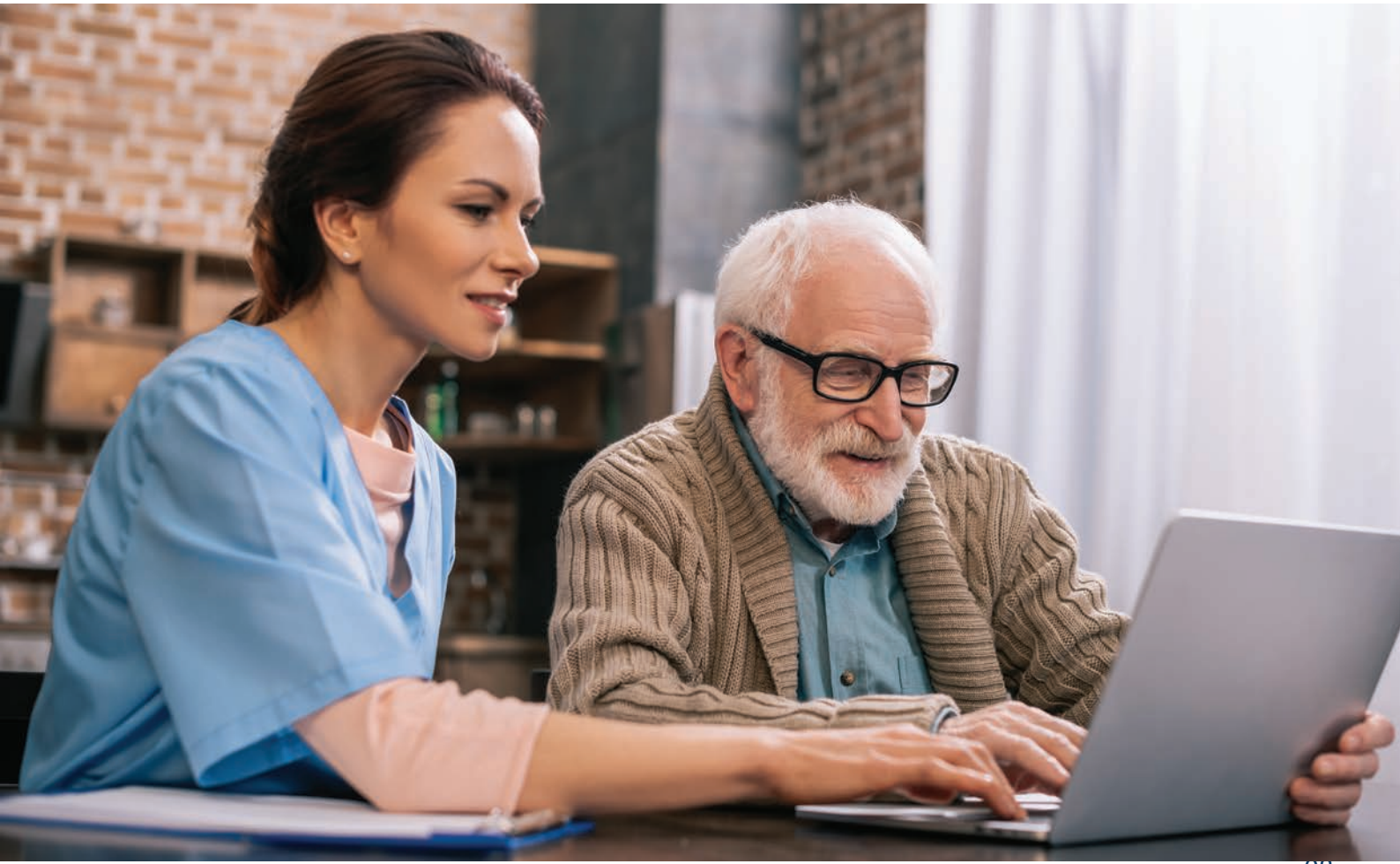
Region	Knee arthroscopy (55 years and over)	Knee replacement	Lumbar spinal decompression	Lumbar spinal fusion
Broadbeach - Burleigh	562	217	67	37
Coolangatta	663	268	67	37
Gold Coast - North	578	293	70	43
Gold Coast Hinterland	501	238	104	38
Mudgeeraba - Tallebudgera	685	267	70	37
Nerang	460	293	74	48
Ormeau - Oxenford	573	298	73	43
Robina	511	285	70	35
Southport	604	252	62	37
Surfers Paradise	589	257	71	43
Queensland	496	266	75	30
Australia	560	257	81	26

Source: ACSQHC, Australian Atlas of Healthcare Variation

Service Mapping

Services	Number in the GCPHN region	Distribution	Capacity discussion
Turning Pain Into Gain program, Gold Coast PHN	1	Physical service at Varsity Lakes Education sessions mobile across various locations including Southport, Robina and Kirra.	• No cost but limited places in each program • Must be referred by a GP • Previous increases in funding led to an increase in patients able to access program and decreased cost per person • 252 participants enrolled in 2015-16 increasing to 340 participants enrolled in 2016-2017 • There is currently a wait time of around 3 weeks • Increasing demand—more GPs referring into the program each year • 2015-2016 evaluation shows positive outcomes in ability to perform everyday activities and self-management, and 78% reduction in hospitalisations. The 2016-2017 data showed a statistically significant reduction in morphine equivalent use.
Interdisciplinary Persistent Pain Centre, Gold Coast Health	1	Physically located at Robina	• No cost to access • Eligibility criteria include impairment, no ongoing investigations or claims, no acute psychiatric condition and residing within catchment area • GCH specialist wait list is long and approximately 8 – 12 months • GCH no longer have an in-house pain specialist — currently contracting.
Persistent Pain and Rehabilitation Clinic, Griffith University	1	Physically located at Southport	• Fee-for-service, rebate available through private health or chronic disease management plan • Multi-disciplinary team care approach involving physiotherapy, exercise physiology, dietetics and psychology
The Pain Centre of Excellence, based at Spendelove Private Hospital	1	Physically located at Southport	• Multi-disciplinary approach including pain and rehab specialists, OTs, pharmacists and physios • Treatment available as either a day patient or inpatient • Program completed over 2 weeks with outpatient follow up for up to 3 months • Cost fully covered by private insurance • Anyone experiencing pain for more than 3 months can apply
Chronic Pain Rehabilitation Unit, Pindara Private Hospital	1	Located at Benowa Also services John Flynn Private Hospital (Tugun) and Gold Coast Private Hospital (Southport)	• 11-bed chronic pain inpatient service • Pain specialists and rehabilitation consultants work with allied health services including physio, OT and exercise physiology

Arthritis Queensland Infoline	State-wide	Phone service	• Free call—Mon-Fri, 8.30am-4pm • Can arrange free, individualised information pack for self or family
Anglicare Better Health with Self-Management	1	Delivered at Southport and Robina	• Self-referral or a GP referral • Free to any HACC eligible individuals/or their partner or carer • Course teaches participants skills in day to day management of chronic conditions • Two and half hour workshops run once a week, over a period of six weeks • Not specific to persistent pain
Pain Management Network, NSW Agency for Clinical Innovation	National	Online resource	• Focus on self-management for chronic pain • Tailored content for youth and spinal cord injury pain • Information available for health professionals
Supporting Kids in Pain (SKIP) program	1	Not-for-profit organisation Based in Brisbane with outreach held on Gold Coast	• Free program for children under 14 • Requires GP or paediatrician referral • Self-management program involving assessment, education and follow-up • Multidisciplinary approach including paediatricians, psychologists, physios, OTs



Consultation

Attendees at the Collaborating for Better Pain Management event for general practitioners and allied health professional held by Gold Coast PHN in June 2017 expressed a desire for more training related to pain, specifically:

- developing integrated care systems in primary care
- referral pathways
- back pain
- role-specific evidence-based treatment practices.

The GCPHN Clinical Council (Oct 2017) provided the following feedback:

- Wait time for the Gold Coast Health multidisciplinary service and private service is very long.
- Pain specialists are an important component of any multidisciplinary team and there are limited specialists.
- People who feel they have run out of options to manage chronic pain often present to the emergency department and, if admitted, as chronic pain does not ever fully resolve, patients are reluctant to be discharged.
- Changes to make codeine prescription only is likely to increase demand for primary care which could lead to better overall management for people.
- Inadvertent overdose for pain relief medication including codeine and paracetamol are quite regular presentations at emergency department.
- Limited system infrastructure to feed back to general practice of people who are potentially doctor shopping and being prescribed high doses of pain relief medication

The GCPHN Community Advisory Council (Oct 2017) provided the following feedback:

- Confirmed persistent pain is seen as a significant issue
- There is a perception general practitioners focus a lot on medication to manage persistent pain, rather than a more holistic approach. This was seen to pose significant risks of addiction to medications for people with persistent pain
- Persistent pain required a multidisciplinary approach, focussed on holistic care of the patient including mental health as there is a strong link between depression and pain
- Complex and perhaps inconsistent language across different service providers leads to confusion for consumers (what is chronic, acute, persistent, episodic)
- Importance of existing programs like Active and Healthy and other exercise options
- Long wait times for some services and limited benefit once seen

Feedback from stakeholders in 2018

- A barrier to services is transport for patients, socio economic factors and the ability to manage pain while accessing public transport.
- Concern on waitlist for people with persistent pain to access services with patients reporting that they remain on the list having waited at least six months.
- Changes to medication availability has created concern and inconvenience for some people with persistent pain

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CHRONIC DISEASE

Needs Assessment Summary

2018

phn GOLD COAST

An Australian Government Initiative

Chronic disease

Identified local health needs and service issues

- Better systems to support care coordination required.
- Referral pathways and care coordination including self-management systems to identify suspected at-risk patients.
- Need for greater focus on prevention, early identification and self-management.
- High numbers of people with chronic disease in Ormeau-Oxenford and Gold Coast North.
- High rates of smoking and harmful alcohol intake across the region.

Key Findings

While certain non-modifiable factors such as age, genetics, gender and ethnicity can contribute to chronic disease, many of the conditions can be prevented or managed by addressing common modifiable risk factors. These include smoking, obesity, excessive alcohol intake, physical inactivity, poor nutrition and high blood pressure.

Addressing modifiable risk factors and improving the coordination of care for people with a chronic condition may prevent them from being hospitalised. Reducing potentially preventable hospital admissions is a national PHN priority. Effective clinical management of the condition combined with health service coordination, patient health literacy, self-management and variations in healthcare can contribute to better chronic disease outcomes.

Generally speaking, the Gold Coast PHN population has a higher relative standard of health when compared to Australian averages. However, rates of cardiovascular disease across the region are higher than national levels. Coronary heart disease and cerebrovascular disease were the leading causes of death for the Gold Coast population, both of which are related to modifiable risk factors and effective chronic disease management. The Gold Coast PHN region recorded a higher rate of potentially preventable hospitalisations due to chronic disease compared to Australian averages. The number of MBS-funded items claimed by GPs for chronic disease management has been increasing steadily in recent years, but the number of health assessments has been decreasing.

The community and stakeholders from the service system recognise that there are issues pertaining to community capacity and development, service access, health professional capacity and capability development, coordination and integration and system barriers that are required to be addressed through a variety of measures.

Evidence

Health status

Overall, when compared to national averages, the Gold Coast population has a high relative standard of health. The proportion of adults who self-reported excellent, very good or good health in the Gold Coast PHN region in 2016-17 was 88%, compared to the national average of 85.3%. This trend has decreased from last year for both the Gold Coast average and national average.

The proportion of adults who reported having a long-term health condition in the Gold Coast PHN region in 2016-17 is less than the national average at 40.9% and 49.9% respectively. This Gold Coast average has decreased from 45.6% in 2015-16. There was no marked difference in life expectancy at birth for either males or females in the Gold Coast PHN region compared to the national average for all people (82.6% vs 82.1%), with life expectancy slightly higher for females mirroring national trends.

The most recent data available at a region level on the number of people living with certain types of chronic disease comes from the 2011-12 Australian Health Survey. Table 1 below provides a breakdown of the prevalence of chronic disease types across the local areas of the Gold Coast in 2011-12.

Table 1: Number and age-standardised rate (ASR) per 100 of people with reported chronic diseases, by type and SA3 region, 2011-12

Region	DIABETES MELLITUS		CIRCULATORY DISEASES		RESPIRATORY DISEASES		MUSCULOSKELE-TAL DISEASES	
	Number	ASR	Number	ASR	Number	ASR	Number	ASR
Broadbeach - Burleigh	2,381	4.4	12,837	18.9	17,814	28.4	18,087	26.8
Coolangatta	2,008	4.3	10,944	18.6	16,044	30.0	16,000	27.6
Gold Coast - North	2,885	4.9	14,317	19.3	16,419	25.9	19,797	27.7
Gold Coast Hinterland	678	4.1	3,378	17.0	5,424	29.9	5,255	26.6
Mudgeeraba - Tallebudgera	1,043	4.4	5,277	18.2	8,674	26.3	8,287	26.7
Nerang	2,521	5.3	10,699	17.9	17,418	26.2	17,294	27.4
Ormeau - Oxenford	3,238	5.1	14,642	18.5	25,729	26.1	23,659	27.0
Robina	1,576	4.3	8,776	19.1	11,964	25.3	11,862	25.2
Southport	2,465	5.8	10,427	19.0	16,471	28.8	14,768	26.1
Surfers Paradise	1,428	4.5	7,397	18.4	9,246	24.2	10,783	26.4
Gold Coast	20,224	4.8	98,694	18.6	145,203	27.0	145,793	26.8
Queensland	169,497	5.1	747,828	17.8	1,209,239	27.2	1,186,542	27.2
Australia	917,838	5.4	3,721,333	17.3	6,336,155	28.7	6,118,605	27.7

Source: Please note National Health Survey results for 2014-2015 have not been released at a local level

There are several interesting findings from this data:

- There were higher numbers of people living with chronic diseases in the areas of Ormeau-Oxenford, and Gold Coast North.
- The rate of diabetes mellitus was lower than the national average in all areas except in Southport, which is markedly different to other areas.
- The rate of circulatory diseases was higher on the Gold Coast than the state and national averages in all sub-regions except one.
- The rate of respiratory diseases was higher in Coolangatta and Gold Coast Hinterland.
- The rate of musculoskeletal disorders was lower than the national average in most areas.

- Coronary Heart Disease (CHD) was the leading cause of death for the Gold Coast population, between 2012 and 2016 with 2,320 deaths. However, The Heart Foundation analysis of the data indicates
- CHD mortality rate for City of Gold Coast as 74 per 100,000, lower than the Queensland rate of 83.6 per 100,000 (using Mortality Over Regions and Time (MORT) books to compare CHD Mortality (2010-2014)
- All heart admissions rate for City of Gold Coast was 47.6 per 10,000, lower than the Queensland rate of 61.9 per 10,000 (using AIHW National Hospital Morbidity Database)
- The second most common cause of death was cerebrovascular disease (i.e. stroke) which accounted for 1,220 deaths.

It is well established that a number of lifestyle-related risk factors increase the likelihood of developing chronic diseases. Understanding the levels of these risk factors within the population can provide an indication of future chronic disease burden and the level of need for health interventions focused on prevention, early identification and management. Chronic disease risk factors include:

- tobacco smoking
- obesity
- excessive alcohol consumption
- physical inactivity
- poor nutrition
- high blood pressure.

In 2014-15 there were 324,529 adult Gold Coast residents who had at least one risk factor of smoking, high alcohol intake, obesity or physical inactivity in 2014-15. This equates to around 4 in every 5 adults. The rate at which several modifiable risk factors for chronic disease are present across each sub-region of the Gold Coast is shown in Table 2.

Table 2: Age-standardised rates of chronic disease risk factors per 100 people, by SA3 region, 2014-15

Region	High blood pressure	Obesity	Current smoker	Harmful alcohol intake	Physically inactive	Inadequate fruit intake
Broadbeach-Burleigh	22.1	25.9	17.4	19.0	56.4	47.2
Coolangatta	20.7	27.7	19.4	20.7	60.2	48.0
Gold Coast - North	22.0	28.3	19.1	15.7	60.5	48.5
Gold Coast Hinterland	16.3	34.0	14.8	22.2	65.8	47.9
Mudgeeraba-Tallebudgera	17.1	29.9	15.7	19.6	61.0	46.7
Nerang	21.1	29.9	18.1	16.5	63.0	49.0
Ormeau-Oxenford	19.1	30.9	18.2	18.1	62.0	47.8
Robina	20.1	26.9	15.7	17.1	59.5	47.3
Southport	24.8	27.3	19.2	18.4	60.3	49.1
Surfers Paradise	26.2	24.6	16.1	19.2	53.3	47.1
Gold Coast	21.2	28.4	17.8	18.2	60.1	48.0
Queensland	23.4	30.4	17.0	17.2	67.9	48.3
Australia	23.1	27.9	16.1	16.7	66.3	50.1

Source: PHIDU based on National Health Survey 2014-2015

This data shows that rates of obesity, smoking and harmful alcohol intake are comparable or higher for the Gold Coast PHN region than national levels. Rates of high blood pressure are particularly high in Surfers Paradise, and rates of obesity are particularly high in Gold Coast Hinterland. The Gold Cost PHN region fares significantly better than the national average on physical inactivity and nutrition measures.

It should be noted that most data on chronic disease risk factors comes from self-report surveys, which have inherent limitations. There is some inconsistency across different population measures. For example, the Queensland Chief Health Officer (CHO) prepares a 'Health of Queenslanders' report every two years based on survey data. The estimate of the smoking rate for the Gold Coast region in the 2016 CHO report was 11.1%, which is quite different to the levels in Table 2, which come from the National Health Survey by the Australian Bureau of Statistics. These discrepancies are likely due to several factors such as different data items (i.e. 'daily' smoker versus 'current' smoker), different samples and possible changes over different survey periods. In addition, it should be noted that the obesity rate on the Australian Institute of Health and Welfare's My Healthy Communities website is also based on the National Health Survey is 22.8%, lower than the national average of 27.9%. The 2016 Health of Queenslanders Report estimated the obesity rate for the Gold Coast as 16.4%, lower than the state average of 30.2% and the lowest in the state.

More objective data is available through the Clinical Audit Tools, which capture de-identified patient data submitted by registered general practices throughout the region. As at June 2017, 118 (62%) Gold Coast practices submitted data, there was a Body Mass Index (BMI) measurement recorded in PATCAT for 138,100 patients, approximately 41% of all patients in PATCAT[1]. This data shows that the rate of obesity (i.e. BMI over 30) amongst a sample of general practice patients in the Gold Coast region aged 18 years and over is approximately 28%, with almost 5% of these being morbidly obese (i.e. BMI over 40). A further 34% are overweight but not obese (i.e. BMI 25 to 30).

[1] Disclaimer: While there are limitations to general practice data in PATCAT (PenCS – data aggregation tool), the data is still able to provide valuable insights into population cohorts that access primary care in the Gold Coast PHN region. Adjusted figures are used for total patient population to reduce the duplication of patient data as patients can visit multiple practices.

Service utilisation

There are a number of chronic disease management items listed on the Medicare Benefits Schedule (MBS) that enable GPs to plan and coordinate the health care of patients with chronic or terminal medical conditions, including patients with these conditions who require multidisciplinary, team-based care from a GP and at least two other health or care providers. Table 3 below provides statistics from Medicare Australia on the number of chronic disease management items claimed by GPs in the Gold Coast region between 2013-14 and 2016-17.

Table 3 Number of MBS-funded services claimed for chronic disease management in general practice, Gold Coast PHN region, 2014-15 to 2016-17

MBS ITEM	2016-17	2015-16	2014-15
721 - Preparing a management plan for a patient with a chronic condition	72,157	60,932	55,647
723 - Coordinating the preparation of Team Care arrangements	63,630	54,097	48,721
729 - Contribute to a multidisciplinary care plan prepared by another health care provider	29	28	36
731 - Contribute to a multidisciplinary are plan prepared for resident of an RACF	4,221	4,474	3,448
732 - Reviewing a GP management plan	92,975	84,176	81,841

Source: Department of Human Services, Medicare Australia Statistics. Extracted 26/09/18.

This data shows that the number of services claimed by GPs for chronic disease management has increased significantly over the last three years. The number of GPs claiming these services has also increased significantly—approximately 765 GPs claimed the preparation of a chronic disease management plan in 2016-17, which represents about 94% of the roughly 810 GPs working in the Gold Coast region.

While the data above represents services to people who have a diagnosed chronic condition, there are also items listed on the MBS with a more preventative focus such as routine health assessments. However, the utilisation of these items appears to be decreasing—there are fewer GPs providing fewer health brief and standard assessments occasions of service. However prolonged health assessments and long health assessments are increasing. Trends relating to services delivered in general practices in the Gold Coast region for health assessments between 2015-16 and 2016-17 include:

- total number of Brief Health Assessments (MBS Item Number 701) remained the same at 1,056 and a decrease in number of providers claiming this item from 178 to 156
- decrease in the total number of Standard Health Assessments (MBS Item Number 703) from 4,945 to 4,636 and a decrease in number of providers claiming this item from 432 to 403
- slight increase in the total number of Long Health Assessments (MBS Item Number 705) from 7,576 to 8,272 with an increase in number of providers claiming this item from 481 to 513
- slight increase in the total number of Prolonged Health Assessments (MBS Item Number 707) from 11,367 to 12,445 and an increase in number of providers claiming this item from 441 to 461.

Table 4 below shows that the Gold Coast had a higher rate of potentially preventable hospitalisations (PPHs) for chronic conditions when compared to Australia (1,411 vs. 1,205 per 100,000).

Table 4 Rate of potentially preventable hospitalisations for selected chronic conditions per 100,000 people, age-standardised, 2015-16

CONDITION	GOLD COAST	AUSTRALIA
All chronic conditions	1,411	1,205
Iron deficiency anaemia	294	206
Chronic obstructive pulmonary disease (COPD)	280	260
Diabetes complications	199	183
Congestive heart failure	195	211
Asthma	153	133
Angina	152	130
Hypertension	76	37

Source: AIHW analysis of the National Hospital Morbidity Database. Extracted from myhealthycommunities.gov.au on 14/08/17.

Many presentations to Gold Coast Health emergency departments for iron deficiency are referred by general practice. There is cause for further investigation to determine if iron deficiency is the reason for referral, or if people are being referred to determine the underlying cause of iron deficiency (i.e. gut bleeding).

Data on PPHs at the sub-region level identifies that Southport has the highest overall rate of PPHs for chronic conditions. For particular types of chronic diseases, Mudgeeraba-Tallebudgera has high rates of PPHs for COPD and Nerang has high rates for diabetes complications.

Service Mapping

Services	Number in the GCPHN region	Distribution	Capacity discussion
General practices	197	Clinics are generally well spread across Gold Coast; majority in coastal and central areas	• GP services include preparation of chronic disease management plans, team care arrangements, medication prescribing and management, health checks and plan review
Special interest general practices	23	Peppered throughout Gold Coast	• These practices offer only a limited range of services such as skin cancer checks, cosmetic clinics and other specific health areas
COACH and Get Healthy services, Queensland Health	State-wide programs	Free phone services	• Both programs focus on reducing avoidable admissions through prevention and self management • Get Healthy service provides advice and coaching on leading a healthy lifestyle by qualified health coaches • COACH Program involves qualified health coaches discussing treatment with patients with a diagnosed chronic condition (e.g. medication compliance, risk factor management, follow-up appointments with physicians) • Reported referrals into COACH are very low on the Gold Coast. However, limited capacity to accept new referrals
Quitline	Region-wide	Phone service	• Quitline (13 78 48) is a confidential, free service for people who want to quit smoking • Quitline counselors provide advice on setting goals to quit, and quitting methods such as nicotine replacement therapies
Diabetes and resource centre, Gold Coast Health	4	Palm Beach, Southport, Robina and Helensvale	• Focus on promoting self-management skills • Provides care, education and support for people with diabetes and their carers as well as community education (e.g. schools, community groups) • Multidisciplinary service for inpatients and outpatients • No information online regarding eligibility or access
Haemodialysis unit, Gold Coast Health	2	Robina and Southport	• Southport has 12 chronic chairs and 4 acute, focus is on end stage renal disease. • Robina has 20 chairs plus 2 self care chairs. • In addition there are 2 self care chairs in which patients are cared for by Home Therapies Unit.
Rehabilitation services, Gold Coast Health	5	Robina (2), Palm Beach, Helensvale, Southport	• Rehabilitation from stroke and other conditions • Service is comprised of 40 beds at Robina, 32 beds at Southport, specialist mobile rehab assessment team, community rehabilitation program and outpatient services

Chronic disease wellness program, Gold Coast Health	2	Robina, Helensvale or in-home or at community centres	• Program for people with complex needs related to a diagnosis of heart failure, COPD, kidney disease or type 2 diabetes. • Program usually runs for up to 12 weeks • Goals is to work with GP and acute services to reduce hospital admissions and focus on self-management
Community programs, City of Gold Coast	Region-wide	Varied locations (parks, sports centres, community centres)	• Range of free and low cost physical activity and healthy eating programs • There is low referral to these programs from health care providers.
National Prescribing Service	National	Phone or online	• Free Clinical e-Audits to help GPs review prescribing for patients with certain conditions compared with best practice guidelines • NPS Medicinewise have produced a free application to assist consumers with managing their medications (MedicineList+) • NPS also operate a help line to answer consumer questions about medicines
VIP Diabetes	1	Runaway Bay	• Targeted allied health and coordination for people with diabetes • Referral required from GP, self-referrals will be directed to involve GP • Home medicine review is free for people with a Medicare card and who are referred by their GP for a review • GP case conference Medicare funded • nsulin support programs are fully funded
Diabetes Queensland	2	Helensvale, Robina	• Self referral • Targets newly diagnosed—new registration on national diabetes patient register will trigger an invite • Free to those with a Medicare card
Other private and NGO services	Various	21	• There are a number of services offering support for people with chronic disease. • Service types include medication management and review, care coordination, care planning, self-management, allied health, nursing, respite, peer support, social and community activities. • Access is varied with many fee-for-service, some claimable through Medicare or other government avenues (e.g. DVA, aged care, disability services) • Limited information available on the demand for and outcomes of these services
My Heath for Life	State-wide programs	Currently 6 providers (may expand) and telephone option	• evidence-based lifestyle modification program provided by trained facilitators including dietitians and exercise physiologists, who have a keen interest in preventive health.

There is no public bariatric surgery available in the Gold Coast PHN region although there is a trial in Brisbane and patients from Gold Coast can access, although there is limited capacity.

Consultation

This information has been collated from various sources including: 2017 GCPHN Primary Care Opinion Survey, GCPHN Primary Health Care Improvement Committee, direct liaison with practice staff, GCPHN Community Advisory Council.

Community capacity and development

Many factors complicate one's capacity to self-manage their chronic condition including cultural barriers, homelessness, alcohol and drug use, obesity, socio-economic status, health literacy and knowledge of available support.

Stakeholders suggest that improvements in community capacity could enhance chronic disease early identification, self-management and medication management, specifically:

- More support from health professionals is required for people to manage their own health, navigate the current system and empower them to share ownership of personal health outcomes.
- Patients want support from GPs and health teams to make management decisions and goals that are realistic for their individual circumstances, moving from a medical model of care planning to a patient focussed model.
- Gold Coast Health held a community jury in June 2017 specifically focussed on the topic of obesity. The jury determined that obesity should be a priority for all key agencies, citing stigma as a key issue. In addition, collaboration was across agencies was recommended.
- Early education is required to ensure that patients fully understand the long-term nature of chronic disease and are not waiting to access services until their condition is acute.
- Clearly communicating the benefit of prevention and engaging in your health care. Many GPs use health assessments (particularly 75plus) as opportunity to raise issues such as advanced care planning, some patients may be reluctant to have health assessments because they don't see the immediate value. For people who work, they may be unwilling to prioritise a health assessment, when they don't feel unwell or have concerns, over work and other family commitments.

Service access

Stakeholders suggest that improved service access is required to ensure effective management of chronic disease, including:

- Enhanced access to chronic disease screening and early identification via age-appropriate health checks, particularly health checks for those at risk of developing cardiovascular disease and type 2 diabetes for those aged 40-49 years old. A barrier to this has been participation because individuals may not prioritise proactive health checks.
- Simplified criteria and referral pathways to enable access to chronic disease self-management courses and programs.
- Engagement with pharmacies to enhance the role they play in supporting chronic disease management.
- Eliminating cost barriers to enable patients to access care in general practice or the community, for example:
    - Some wound care clients are not able to afford treatment in the community setting and are returning back to the hospital for further follow up.
    - Limited fully subsidised chronic pain programs exist to manage pain in the community setting and

prevent hospitalisations.
    - The cost of the wound management products (consumables such as particular bandages and dressings) that are used to treat the patient is a barrier to delivery of these services by general practice.

Health professional capacity and capability development

Stakeholders consistently report the need for capacity and capability development amongst health professionals in the Gold Coast region relating to multidisciplinary team care approaches, collaborative planning and case conferencing.

- Chronic disease management including holistic and lifestyle approaches (as opposed to prescribing medication)
- Awareness-raising about the kinds of services already available to support people with chronic conditions
- Chronic pain and pain management (e.g. integrated care systems in primary care, referral pathways, back pain and role specific evidence-based treatment practices).
- Each professional needs to own their own gaps in service delivery, by identifying where there are gaps in their service delivery based on evidence and guidelines available and addressing the issues.
- There have been many improvements in recent years in pharmacological treatments for iron deficiency administered through general practice, education and upskilling for general practice could be required.
- The cost for the consumables for iron deficiency is a problem for general practice which can limit delivery of these services
- In the 2017 GCPHN Primary Care Opinion Survey the following were identified most frequently for future education:
    - General practitioners – Wound management, emergency medicine women's health
    - Practice nurses - Wound management, diabetes, chronic disease and COPD

Coordination and integration

Stakeholders report that:

- Poor mental health means people are more likely to be smoking and abusing drug and alcohol so include as part of screening
- Link into existing programs like Active and Healthy
- Care coordination does not always effectively engage the person and their family. A full briefing will help to ensure information understood and actions required known.
- Service access and coordination is being hindered by suboptimal information sharing between hospital and primary care including lack of timeliness of discharge summaries and outpatients.
- Fragmentation between services at primary and tertiary levels of the health system creates difficulties for communication and information sharing between providers and also with patients. This is particularly evident in discharge planning and procedures.

- Further developments and enhancements for digital health, including data integration may improve care coordination.
- Wound care services lack clearly defined pathways, formalised linkages and information sharing between different providers.
- Chronic disease risk stratification processes could be better implemented to:
    - target and identify patients with increasing risk of hospitalisation, particularly for diabetes complications, pyelonephritis and COPD
    - ensure engagement and effective treatment with patients at a stage before their condition becomes acute.
    - Pulmonary rehabilitation is an effective evidence based treatment for COPD and it is currently quite readily accessible.

System barriers

Common barriers reported by stakeholders at a system level include:

- GPs are currently not remunerated adequately for non-contact time spent planning and supporting care for patients with chronic conditions.
- Difficult to identify at risk patients through current software systems making practice care difficult.
- Case conferencing MBS items are not well utilised
- Similarly, the current Practice Nurse Incentive Payment does not sufficiently support Practice Nurses to invest time in care-coordination for patients with chronic disease.
- GP management plans have limitations, such as:
    - plans requested for access to team care arrangement, there is limited emphasis on review to ensure goals and actions are addressed by patients
    - plans not always individualised or patient-centred meaning that goals and actions set are not achievable or meaningful to patients.
- GPs are less engaged to lead or participate in quality improvement activities than practice nurses or practice managers. For example, feedback from general practice is that preparing for health care homes is challenging as non-clinical contact is not funded (for staff doing the work).

"Building one world class health system for the Gold Coast."

OLDER PEOPLE

Needs Assessment Summary

2018

phn GOLD COAST

An Australian Government Initiative

Older People

Identified local health needs and service issues

- High numbers of preventable hospital admissions for older adults are recorded for Chronic Obstructive Pulmonary Disease, urinary tract infections, angina and heart failure.
- Lack of established clinical coordination tools and processes that result in fragmentation of the local health system in patient centred care – management and problematic after-hours management.
- Low use of advance care directives - plans and deficits in confidence and capacity of staff to provide adequate and/or quality palliative care.
- Residents in residential aged care presenting with increasing complexity of care, including dementia behaviour management, mental health, palliative and end of life care.
- Limited uptake of existing education, training and resources to RACF's, GPs and health care professionals in early identification and management of palliative care – end of life.
- Limited capacity to provide a coordinated and sustained coverage for palliative and end of life care – within RACF's out of hours.

Key findings

The Gold Coast has a higher proportion of older adults aged 65 years and over compared to the rest of the country, with several areas with higher numbers of older people (Gold Coast North, Ormeau - Oxenford and Broadbeach-Burleigh).

The age profile of the Gold Coast population is increasingly becoming older and this is projected to continue. The Gold Coast sub-regions of Southport and Robina report high rates of older people with profound or severe disability, which is likely attributable to consumers with complex needs residing in close proximity to major public hospitals.

Gold Coast older residents report higher levels of health and wellbeing and lower levels of disability than other regions of Australia. Fewer older people in the Gold Coast receive an age pension than the national average, which could indicate less socio-economic disadvantage. More older adults in the Gold Coast live alone than other South East Queensland regions. This, combined with high levels of older people moving to the Gold Coast in their later years who may lack informal care and support networks, raises concerns of social isolation and limited ability to access services without support.

Mortality and morbidity for older people in the region arises from cardiovascular disease and stroke, dementia, fall-related injuries, chronic obstructive pulmonary disease (COPD) and urinary tract infections (UTIs).

There are high utilisation rates of primary health care, particularly GP attendances (standard and after-hours) which were higher for older people on the Gold Coast when compared to the national population.

Utilisation rates of publicly-funded aged care services, both residential and home care, is high with a significant number of providers spread across the region. However, there appears to be relatively low accessibility and utilisation of palliative care services and advance care planning.

Consultation highlighted the impact of aged care reforms and system changes on delivering timely and appropriate care to older Australians, including NDIS reforms and challenges with home care package wait times. Significant concerns were raised around limited service awareness and community health literacy and continued low update of advance care planning.

What is commissioning?

In Primary Health Network (PHN) context, commissioning is the continual practice of purchasing services aligned to:

- local needs
- outcomes from strategic planning
- Gold Coast PHN's unique objectives and
- identified national priorities.

Scope

This health needs assessment provides evidence-based information to inform commissioning processes, including:

- Establishing local health needs through qualitative and quantitative data analysis
- Informing annual planning, reporting and evaluation processes for Gold Coast PHN
- Informing service planning and co-design mechanisms for effective aged care after-hours service commissioning.

Focus areas aligned to Gold Coast Primary Health Network's (GCPHN) organisational objectives relating to older people (with a focus on RACF and After-Hours Services) include:

- Access to after-hours services to the individual's home (including RACFs) inclusive of community organisations, general practice and medical deputising services
- Primary and community-based programs delivering services to older people within RACFs
- Services and/or programs focused on reducing preventable emergency presentations and admissions from the individual's home (including RACFs).

Methodology

A mixed methodology was used to ensure a complete needs assessment evaluation including quantitative data analysis, service mapping, patient journey mapping, consultation and co-design workshops.

Quantitative data analysis

Quantitative data indicators used for this report provide a detailed analysis of the drivers of service demand and levels of existing service utilisation to strategically guide future program investment for GCPHN. Data sources included but not limited to:

- Australian Bureau of Statistics Census data
- Social Health Atlases of Australia, Public Health Information Development Unit (PHIDU)
- Australian Institute of Health and Welfare (AIHW) Gen Aged Care Data Portal
- AIHW My Healthy Communities Data Portal
- Medicare Item Reports
- Data supplied by Gold Coast Health

Other sources of data explored, ensured a rounded and holistic view of data-informed need. Analysis was primarily limited to that data which was publicly available with breakdown at a regional level. Where possible, indicators were examined at a subregional level.

Service mapping

Service mapping was undertaken in a systematic way, commencing with the existing GCPHN knowledge base relating to aged care services and providers.

Service mapping focused on a breakdown of service type, provider, geographic location, target population (e.g. mainstream or specific priority populations) and provider type (e.g. for-profit, not-for-profit, government).

Patient journey mapping

Patient journey mapping was utilised as an engagement tool to understand service issues and enablers from the perspective of health consumers. Patient journey mapping was developed in partnership with Council on the Ageing Queensland (COTA Queensland) to capture knowledge and expertise to effectively undertake consumer engagement.

COTA Queensland presented distinct patient journeys reflecting common pathways into residential aged care services in the Gold Coast PHN region using the following approach.

Key Activity	Process
Determine Common Journey Types	Utilise the expertise of GCPHN and the Aged Care Leadership Group to determine common journey Types for the Gold Coast aged care and after-hours environment.
Identification of Gold Coast Common Journey Pathways (based on Common Journey Types)	Facilitate a two-hour workshop with local stakeholders (based on peak bodies local networks) to identify common journey pathways based on the pre-determined common journey types Explore both positive and negative experiences within each common journey type Identify why individuals (health professionals or patients/ residents/ family members) felt the experience was positive or negative
Develop Common Journey Pathways into a visual format (including a narrative) for co-design workshops	Develop a visual representation of the Patient Journey Pathways to inform the co-design and planning phases of the project.

The aim of the patient journey mapping was to identify components of the local service system that are working well and highlight potential areas for improvement. Consumer interactions and experiences with a range of stakeholders were considered including but not limited to:

- Family, carers and informal support networks
- Aged care service providers
- Primary health care services, particularly after hours
- Hospital services
- Queensland Ambulance Service
- Pharmacies
- Community and psychosocial supports

Targeted consultation

Recognising the importance of the project and need for a collaborative approach a multifaceted consultation methodology was taken to inform this needs assessment.

GCPHN has established high-functioning advisory mechanisms to provide expert input and advice into PHN core business and activities. These groups were key in providing direct feedback on initial drafts of this report and include:

- GCPHN Community Advisory Council
- GCPHN Clinical Advisory Council
- GCPHN Primary Care Partnership Council

In July 2018, GCPHN established the Aged Care Leadership Group to provide advice and guidance for the development of the needs assessment, the subsequent regional plan and guiding implementation of resulting strategies and activities. The Leadership Group included representation from:

- Gold Coast Health
- service providers
- GCPHN
- general practitioners
- consumer/carer representatives.

Further consultation with the sector and community occurred through an Older Persons co-design workshop (with a focus on after hours and RACF services) held in partnership with COTA Queensland on 13 September 2018. The workshop was attended by 27 sector representatives including Gold Coast Health, non-government organisations (NGOs), consumers, carers and several aged care facilities.

Evidence

Demographics

The estimated resident population of the Gold Coast Primary Health Network (GCPHN) region aged 65 years and over, referred hereafter as 'older adults' was 94,531 people.

Table 1 provides a breakdown of the older adult population in the Gold Coast region by sex and age group based on 2016 Census data.

Table 1: Number and proportion of estimated resident population by broad age group, Gold Coast PHN region, 2016

Age group	Number of people			% of total population		
	Male	Female	Total	Male	Female	Total
65-74 years	26,866	28,143	55,009	9.3	9.3	9.3
75-84 years	13,034	14,497	27,531	4.5	4.8	4.7
85 years or more	4,525	7,466	11,991	1.6	2.5	2.0
Sub-total of 65+yrs	44,425	50,106	94,531	15.4	16.5	16.0

Source: Australian Bureau of Statistics (ABS), 2016 Census of Population and Housing

53% of the Gold Coast older adult population are female, compared to 51.2% of the all-age population, which is likely due to a higher life expectancy for females.

Overall, the age profile of the Gold Coast population is becoming relatively older. The proportion of the regional population aged over 65 years and over, represented 16.0% of the total population in the Gold Coast PHN region in 2016.

This is slightly higher than the proportion of people in this age group nationally of 15.2%. In 2012, the proportion of people aged 65 years and over represented only 14.6% of the total Gold Coast population. While the Gold Coast local government area (LGA) has slightly different geographical boundaries than the GCPHN region, data from Gold Coast City Council forecasts the number of older people aged 65 years and over residing in the Gold Coast LGA to double by 2030 which will account for over 20.2% of the total Gold Coast LGA population[1].

Table 2 describes the size and proportion of the older person population across the GCPHN region. Within the region, the areas with the highest proportion of residents aged over 65 years are Gold Coast North (e.g. Runaway Bay, Labrador, Paradise Point, Biggera Waters), Coolangatta, Broadbeach-Burleigh and Surfers Paradise.

Table 2: Estimated Resident Population by age group and SA3 region, 2016

Region	65-74 years		75-84 years		85 years or more	
	Number of persons	% of total pop.	Number of persons	% of total pop.	Number of persons	% of total pop.
Broadbeach - Burleigh	6,591	10.2	3,693	5.7	1,620	2.5
Coolangatta	5,713	10.4	3,180	5.8	1,607	2.9
Gold Coast - North	8,623	12.6	4,783	7.0	2,031	3.0
Gold Coast Hinterland	2,273	11.9	888	4.7	237	1.2
Mudgeeraba - Tallebudgera	2,824	8.2	1,164	3.4	371	1.1
Nerang	5,795	8.3	2,829	4.1	1,187	1.7
Ormeau - Oxenford	8,509	6.8	3,304	2.6	1,131	0.9
Robina	4,529	8.8	2,497	4.8	1,355	2.6
Southport	5,405	8.8	3,000	4.9	1,637	2.7
Surfers Paradise	4,747	11.1	2,193	5.1	815	1.9
Gold Coast	55,009	9.3	27,531	4.7	11,991	2.0
Australia	-	8.6	-	4.6	-	2.0

Source: Australian Bureau of Statistics (ABS), 2016 Census of Population and Housing

[1] Gold Coast City Council, Social Planning and Research Reports, http://www.goldcoast.qld.gov.au/thegoldcoast/gold-coast-seniors-statistics-888.html

There are 1,524 people aged 50 years and over identifying as Aboriginal and Torres Strait Islander who reside on the Gold Coast, which is the age of eligibility for Aboriginal and Torres Strait Islander people to enter the public-funded aged care system. This represents a proportion of 0.8% of all people aged 50 years, compared to a national rate of 1.4%. The highest numbers of older people identifying as Aboriginal and Torres Strait Islander reside in Ormeau-Oxenford (282 persons), Gold Coast-North (231 persons) and Coolangatta (221 persons).

Data from the 2016 Census reports a total of 1,798 people aged over 65 years residing in the Gold Coast region whose rated proficiency in speaking English is 'not well' or 'not at all'. This represents 1.9% of the older adult population in the region. The rates of older people with poor self-rated proficiency in spoken English are highest in Southport (3.1%) and Robina (3.0%).

The proportion of people aged 65 years and over in a region receiving a government age pension provides an indication of the socioeconomic status and financial vulnerability of older people. As at June 2016, there were 61,523 Gold Coast residents receiving an age pension, which represents 68.7% of people aged 65 years and over which is lower than the national level of 71.1%. This finding aligns with the lower levels of socio-economic disadvantage observed within the wider Gold Coast population relative to other regions. Table 3 outlines the absolute number and relative proportion of age pensioners within the Gold Coast PHN region.

Table 3: Number and proportion of age pensioners by SA3 region (June 2016)

Region	Number of age pensioners	% of persons aged 65+ who are age pensioners
Broadbeach - Burleigh	7,626	62.6
Coolangatta	7,079	69.9
Gold Coast - North	10,454	72.3
Gold Coast Hinterland	2,163	64.6
Mudgeeraba - Tallebudgera	2,901	68.1
Nerang	6,952	76.2
Ormeau - Oxenford	8,186	68.9
Robina	5,439	68.0
Southport	6,839	76.4
Surfers Paradise	3,898	54.0
Gold Coast	61,537	68.7
Australia	-	71.1

Source: Social Health Atlas of Australia, compiled by Public Health Information Development Unit (PHIDU) based on data from the Department of Social Services

A total of 6,572 older people aged 65 years and over who reside on the Gold Coast migrated to the region from interstate or overseas within the last 5 years, which represents 7.0% of the older adult population. Over 30% of these people migrated within the last 12 months. This may provide an indirect indication of the extent of older people who may not have strong informal caring and support networks such as family and friends.

The number of older adult lone person households in the Gold Coast region is 19,519. This represents around 9.1% of all household types in the region, which is slightly higher when compared to the rate for South-East Queensland more broadly (8.5%).

Table 4 below outlines the number of older person households residing in self-contained retirement villages across the Gold Coast region.

Table 4: Number of dwellings in self-contained retirement villages in Gold Coast region in 2016, by household type and SA3 region

Region	Lone person dwellings	Two or more person dwellings
Broadbeach - Burleigh	110	42
Coolangatta	183	54
Gold Coast - North	712	635
Gold Coast Hinterland	25	15
Mudgeeraba - Tallebudgera	17	4
Nerang	404	175
Ormeau - Oxenford	402	573
Robina	169	56
Southport	557	264
Surfers Paradise	36	6
Gold Coast	2,611	1,833

Source: Census of Population and Housing, 2016, TableBuilder

These figures, particularly for single person dwellings, may provide an indication of the potential future demand for public-funded services.

The proportion of people aged 15 years and over on the Gold Coast who identify as having informal caring responsibilities (9.9%) is lower than the Australian rate (11.3%). This is recorded in the 2016 Census as those reporting the provision of unpaid assistance to a person with a disability, long-term illness or problems related to old age. While only an indirect indicator of the number of carers of older people within the region, the absence of informal carers can be a contributing factor to older people being unable to remain at home and requiring entering the residential aged care system.

Health Status

Between 2012 and 2016, the median age at death for Gold Coast residents was 82 years. 79 years for males and 85 years for females[2]. These figures are comparable to the Australian population. The top five leading causes of mortality for Gold Coast residents are:

1. Coronary heart disease (13.8% of all deaths)
2. Lung cancer (6.8%)
3. Cerebrovascular disease (5.6%)
4. Prostate cancer (5.1%)
5. Dementia and Alzheimer disease (4.9%)

Chronic diseases represent the cause of many deaths in the GCPHN region, similar to the wider Australian population.

Several well-established risk factors for chronic disease including obesity, excessive alcohol intake, poor nutrition, physical inactivity and smoking are provided in Table 5 noting the prevalence of these chronic disease risk factors amongst older people residing in the GCPHN region. For each known risk factor, there has been minor upward and downward variation over the reporting periods available, but no significant improvement or deterioration observed.

[2] AIHW, Mortality Over Regions and Time (MORT) books 2012-2016

Table 5: Prevalence of chronic disease risk factors for Gold Coast PHN residents aged 65 years and over, by survey year

Risk factor	2009-10 (%)	2011-12 (%)	2013-14 (%)	2015-16 (%)
Obesity (BMI > 30)	19.5	21.3	21.7	16.5
Lifetime risky drinking	-	13.9	14.3	15.5
Insufficient daily fruit intake	-	-	34.0	38.5
Insufficient daily vegetable intake	-	-	92.8	91.6
Insufficient physical inactivity	48.4	45.8	46.7	49.4
Daily smoker	8.2	6.2	7.3	6.6
Source: Queensland Survey Analytics System (QSAS) regional detailed data, Nov 2016				

More detailed analysis on the prevalence of chronic conditions amongst the older adult population was analysed via patient data collected and reported by general practices across the Gold Coast seen in Table 6. This includes data for patients aged 65 years and over who are active attending a GP (3 GP attendances in last 2 years) and recent (last recorded result within last year).

Table 6: Prevalence of chronic conditions for active and recent patients of general practices aged 65 years and over in Gold Coast PHN region, as at Aug 2018

Patient condition	Number of patients 65+	Proportion of 65+ patients (%)	Proportion of patients aged 18-64 (%)
Chronic obstructive pulmonary disorder (COPD)	7,466	7.9	1.1
Coronary heart disease	12,406	13.2	1.2
Diabetes	12,743	13.6	3.0
Chronic renal failure	4,627	4.9	0.3
Patient has a GP Mental Health Treatment Plan	1,965	2.1	6.3
Total number of patients recorded in PATCAT	93,983	-	-

Source: PATCAT data extracted by Gold Coast PHN

Note: PATCAT is a web-based platform designed for PHNs to collect and aggregate de-identified general practice data from practices within their region. This data is typically used for program and population health planning purposes.

Dementia

One of the health conditions that causes significant levels of disability amongst older people is dementia. While estimates on the prevalence of people living with dementia at a given time are difficult to obtain, modelling done by Alzheimer's Australia in 2011 projected that the number of people living with dementia in the Gold Coast region in 2018 would be 9,477 people—5,319 females and 4,159 males3.

This is projected to almost double to 16,271 people by 2030. This modelling ranked the Gold Coast region as having the third highest prevalence of dementia in Queensland consistently across the period 2011 to 2050. For older people living in permanent residential aged care in the Gold Coast region, 51.9% had a diagnosis of dementia4.

In 2015-16, there were a total of 436 overnight hospitalisations relating to dementia in the GCPHN region, which represented a total 5,232 hospital bed days, or an average length of hospital stay of 12 days. The age-standardised rate for the region (6 per 10,000 people) ranks 13th highest out of all 31 regions.

[3] Projections of dementia prevalence and incidence in Queensland 2011-2050, Alzheimer's Australia Qld

[4] Data item extracted from GEN Aged Care data portal, www.gen-agedcaredata.gov.au

Table 7 shows that the number of dementia related hospitalisations in the region has increased by over 24% in the last three available reporting years.

Table 7: Overnight hospitalisations for dementia, by SA3 region, 2013-14 to 2015-16

Region	Number of hospitalisations			Rate of hospitalisations per 10,000 people, 2015-16	Rate of bed days per 10,000 people, 2015-16
	2013-14	2014-15	2015–16		
Broadbeach - Burleigh	45	37	49	5	65
Coolangatta	24	47	51	6	64
Gold Coast - North	68	56	84	7	96
Gold Coast Hinterland	9	13	8	NP	NP
Mudgeeraba - Tallebudgera	17	19	12	NP	NP
Nerang	27	26	48	7	64
Ormeau - Oxenford	38	45	50	6	63
Robina	41	58	47	7	74
Southport	55	46	72	10	134
Surfers Paradise	27	26	15	NP	NP
Gold Coast	351	373	436	6	74
Australia	-	-	-	6	93

Source: AIHW MyHealthyCommunities portal, www.myhealthycommunities.gov.au

Falls

Another significant cause of morbidity and impaired quality of life among older people is falls, often related to impaired balance, immobility and frailty, as well as feeling dizzy and poor vision which can be an undetected side effect of dementia. While the availability of data relating to falls among older people is limited, data on hospital admissions for hip fractures in people aged 65 years and over can provide an indication of incidence, as the vast majority of hip fractures are associated with falls.

In the Gold Coast region in 2012-13, there were a total of 530 hospitalisations for people aged 65 years and over for hip fractures at an age-standardised rate of 635 per 100,000 people[5]. This is noticeably higher than the Queensland (628) and Australia (610) rates.

Heart Failure

Heart failure is a chronic health condition associated with impaired physical functioning, poorer quality of life, increased hospitalisation and co-morbidity. While only an estimated 1-2% of the Australian population lives with heart failure at a given time, the prevalence rises steeply with age. Two-thirds of people living with heart failure in Australia are aged over 65 years. This provides a forecast of the number of people with heart failure aged under 65 years who are likely to experience disability and have higher support needs in their older years.

Table 8 outlines the number and rate of hospitalisations for heart failure in the GCPHN region in 2014-15.

[5] Australian Commission on Safety and Quality in Health Care, The First Australian Atlas of Healthcare Variation 2015

Table 8: Number and rate of hospitalisations for heart failure in Gold Coast, by SA3 region, 2014-15

Region	Number of hospitalisations	Sex and age-standardised rate per 100,000 people
Broadbeach - Burleigh	129	129
Coolangatta	148	164
Gold Coast - North	236	210
Gold Coast Hinterland	30	148
Mudgeeraba - Tallebudgera	67	252
Nerang	117	170
Ormeau - Oxenford	165	218
Robina	100	155
Southport	136	183
Surfers Paradise	58	107
Queensland	-	210
Australia	-	196

Source: Australian Commission on Safety and Quality in Health Care (ACSQHC), The Second Australian Atlas of Healthcare Variation, 2017

Disability

The care needs of the older adult population are generally higher than the rest of the population, due to disability, illness and injury.

A person with profound or severe limitation is defined as someone that needs help or supervision always or sometimes to perform core activities of self-care, mobility and/or communication. Table 9 outlines the absolute number and relative proportion of older people aged 65 years and over within the GCPHN region with a profound or severe disability.

The data within Table 9 includes figures for all older people, and older people living in the community and excludes those in residential aged care facilities, non-self-contained residences and psychiatric hospitals. The figures indicate that there are higher proportions of older people living with high care needs in Southport (both in the community and not) and Robina (not in the community), with high absolute numbers of older people living with high care needs in Gold Coast-North (both in the community and not).

Table 9: People with a profound or severe disability aged 65 years and over within Gold Coast PHN region, 2016

Region	Total		Living in the community (i.e. self-contained accommodation)	
	Number of persons with a disability	% persons aged 65 years and over with a disability	Number of persons with a disability	% persons aged 65 years and over with a disability
Broadbeach - Burleigh	1,815	13.8	1,552	11.8
Coolangatta	1,833	16.1	1,467	12.9
Gold Coast - North	2,519	17.3	1,930	13.3
Gold Coast Hinterland	393	11.8	363	10.9
Mudgeeraba - Tallebudgera	647	15.8	550	13.4
Nerang	1,570	17.0	1,384	15.0
Ormeau - Oxenford	2,123	17.5	1,625	13.4
Robina	1,670	20.7	1,001	12.4
Southport	2,191	22.6	1,516	15.6
Surfers Paradise	992	10.9	894	9.9
Gold Coast	15,753	16.6	12,282	13.0
Australia	-	18.4	-	14.3

Source: Public Health Information Development Unit (PHIDU) www.phidu.torrens.edu.au, based on the ABS Census of Population and Housing data, August 2016

Aged Care Assessment Teams (ACATs) conduct comprehensive assessments of the care needs of older adults when entering the government-subsidised aged care system. ACATs assess the needs of older people across three different areas of care:

- Activities of daily living
- Cognition and behaviour and
- Complex health care.

Table 10 shows the care need ratings of people in permanent residential care in the Gold Coast region compared to national levels. Across all domains, the proportion of people needing high levels of care are lower in the Gold Coast region. Notable trends in this dataset indicate:

- The proportion of people requiring high levels of care increases with age for the 'activities of daily living' and 'complex health care' domains, whereas the rate decreases with increasing age for the 'cognition and behaviour' domain
- Females have a higher proportion of people requiring high levels of care for 'activities of daily living' and complex health care' than males. However, this may be driven by the age-related trend above due to a higher life expectancy for females.
- People who have a preferred language other than English are more likely to have high care needs across all domains.

Table 10: Care need ratings of people in permanent residential aged care in Gold Coast region based on Aged Care Funding Instrument assessment, at 30 June 2017

Region	Care domain	Care need rating (%)			
		Nil	Low	Medium	High
Gold Coast	Activities of daily living	1.1	16.5	30.3	51.6
	Cognition and behaviour	5.1	12.5	21.5	60.4
	Complex health care	3.1	16.5	30.4	49.4
National	Activities of daily living	0.6	12.8	30.1	56.6
	Cognition and behaviour	4.3	10.9	22.1	62.7
	Complex health care	1.9	15.0	28.1	55.0

Source: Data supplied by Australian Institute of Health and Welfare from National Aged Care Data Clearinghouse

Service Utilisation

Aged care services

The public aged care service system provides support to people aged 65 years and over (under 65 considered with medical evidence), and for Aboriginal and Torres Strait Islander People aged 50 years and over, who can no longer live without support in their own home.

The services available within the publicly-funded aged care system known as 'My Aged Care' include:

- Home support (Commonwealth Home Support Program), which provides entry-level support at home across services such as personal care, transport, home modification, nursing and allied health, meals, household duties, mobility equipment and social activities
- Home care (Home Care Packages Program), which provides coordinated packages of aged care services for people with more complex needs to remain living at home, ranging from basic care needs (Level 1) through to high-level care needs (Level 4)
- Residential care, which offers both permanent and short-term respite in an aged care facility
- Transition care, which provides short-term care to restore independent living after a hospital stay
- Short-term restorative care to help improve wellbeing and independence, and delay or avoid the need to enter long-term care; can be provided in a home setting or residential care setting, or a combination of both
- Multi-purpose services, which offer aged care alongside health services in regional and remote areas
- Innovative Pool, which pilots new approaches to providing aged care
- The National Aboriginal and Torres Strait Islander Aged Care Program (NATSIACP), which provides culturally-appropriate aged care at home and in the community
- The Australian Department of Health provides a range of services to support older people, their families and carers. These include access to information through My Aged Care and support services relating to dementia, diverse backgrounds, carers, community visitors' scheme, advocacy and complaints

Table 11 shows the number of users and allocated places for aged care services in the Aged Care Planning Region (ACPR) of 'South Coast', which mostly aligns to the GCPHN boundaries.

Table 11: Number of users and allocated places for South Coast ACPR by care type and provider type, as at 30 June 2017

Care type	Number of users	Number of allocated places
Residential	4,606	5,117
Home care	1,575	NA
Transition care	85	96
Short-term restorative care	0*	0*
Multi-purpose service	0^	0^
NATSIACP	0	0
Innovative pool	0	0

Source: AIHW, GEN Aged Care data portal, extracted from www.gen-agedcaredata.gov.au

Note: does not include home care places, or home support users or places

* Short-term restorative care places only allocated since 2016-17 Aged Care Approvals Round (ACAR)

^ Multi-purpose places are only allocated in regional and remote locations

There were a total of 52 different residential care services, 45 home care services, and 47 home support services available to care recipients.

The number of people using the home support program is not available at a regional level, but nationally it represents the vast majority of all aged care services utilised (73.6%), which reflects its role as a high-volume, low-intensity entry point to the aged care system.

Current waiting lists to access home care packages are extensive both within the Gold Coast region and nationally, which is likely to impact the utilisation of other aged, community and health services.

The number of people on the National Prioritisation Queue for a home care package residing in the South Coast Aged Care Planning Region (ACPR) who are not accessing or not been assigned a package was 1,347 people as at 31 March 2018.

The majority of these people are approved for Level 3 packages (571 people), followed by Level 2 packages (384) and Level 4 packages (372). Estimated wait times for people entering the National Prioritisation Queue are outlined in Table 12:

Table 12: Estimated waiting time for home care package on National Prioritisation Queue, as at March 2018

Package level	First package assignment	Time to first package	Time to approved package
Level 1	Level 1	3-6 months	3-6 months
Level 2	Level 1	3-6 months	6-9 months
Level 3	Level 1	3-6 months	12+ months
Level 4	Level 2	6-9 months	12+ months

Source: Department of Health, Home Care Packages Data Report 1 January to 31 March 2018.

The Commonwealth Government's GEN Aged Care data portal shows the Gold Coast region had a higher rate of places allocated for residential aged care facilities (RACFs) for people aged over 70 years (85.4 per 1,000 people) when compared to Queensland (73.4) and Australia (76.5).

The majority (63%) of residential aged care places are allocated to private providers. A sub-regional breakdown of the allocation of permanent residential aged care places across the Gold Coast PHN region is outlined in Table 13.

Table 13: Number of allocated places for permanent residential care across Gold Coast by SA3 region, as at June 2017

Broadbeach - Burleigh	363
Coolangatta	503
Gold Coast - North	1,140
Gold Coast Hinterland	38
Mudgeeraba - Tallebudgera	299
Nerang	251
Ormeau - Oxenford	707
Robina	803
Southport	944
Surfers Paradise	107
Gold Coast	5,155

Source: Australian Institute of Health and Welfare, GEN Aged Care data portal, extracted from, www.gen-agedcaredata.gov.au

It shows areas within the Gold Coast region with high numbers of RACF places, particularly Gold Coast North and Southport. The areas with higher rates of placements are reflective of the SA3 areas with a higher proportion of 65+ population (with the exception of Broadbeach – Burleigh) demonstrating an adequate representation of facilities across the GCPHN. Other areas of higher density include Southport and Robina, which is unsurprising given they are clustered around the location of public hospitals.

Utilisation trends for permanent residential aged care services in the GCPHN region, including number of admissions, people using aged care services, average length of stay and exits during the year 2016-17 is outlined in Table 14. It includes a breakdown for various demographic characteristics such as age, sex, Indigenous status and preferred language. Several points observed from the data include:

Table 14: Admissions, utilisation, length of stay and exits from permanent residential aged care, Gold Coast PHN region, 2016-17

Breakdown		Number of admissions	No. of people using aged care Due to death	Average length of stay (mths)		No. of exits from aged care	
				Due to other reasons	Due to death	Due to other reasons	Due to other reasons
Total		1891	4631	31	17	1431	394
Age group	0-49	9	21	NA	44	0	7
	50–54	9	13	49	14	2	5
	55–59	27	42	5	23	6	10
	60–64	31	97	20	23	10	7
	65–69	81	169	18	17	37	23
	70–74	136	291	23	16	64	27
	75–79	271	514	28	11	142	70
	80–84	372	785	27	14	228	71
	85–89	477	1198	30	18	310	90
	90–94	360	1036	34	18	410	68
	95–99	111	424	39	35	182	12
	100+	7	41	46	41	40	4
Sex	Male	778	1561	25	20	584	223
	Female	1113	3070	36	14	847	171
Indigenous status	Yes	9	16	14	14	5	2
	No	1882	4606	31	17	1421	392
Preferred language	English	1830	4489	31	17	1393	377
	Other	59	136	44	10	37	16

Source: Australian Institute of Health and Welfare, GEN Aged Care data portal, extracted from www.gen-agedcaredata.gov.au

This data is limited to people residing in aged care facilities through the public system as the availability of data on older people who utilise aged care services privately is limited. However, it is acknowledged that understanding the role of the privately funded system is important in understanding and predicting potential future demand for public-funded services that might be driven by socioeconomic changes, such as financial crises affecting retiree incomes.

Hospitalisations

Reducing the number of avoidable hospital admissions is a performance priority for PHNs across the country. Data supplied by Gold Coast Health for potentially preventable hospitalisations (PPHs) for people aged 75 years and over shows that there were 4,302 PPHs recorded in Gold Coast public hospitals between July 2016 and June 2017. See Table 15.

The five leading causes of PPH bed days in this age group are:

1. diabetes complications
2. congestive cardiac failure
3. chronic obstructive pulmonary disorder (COPD)
4. urinary tract infections (UTI) and
5. pneumonia and influenza.

Table 15: Potentially preventable hospitalisations (PPHs) for Gold Coast public hospitals by age and condition, Jun 2016 to Jul 2017

Age group	PPH condition	Number of bed days	All PPH separations	PPH as primary diagnosis - separations	% primary diagnosis of all PPH separations	Avg. length of stay, primary diagnosis (days)
75+ years	Diabetes complications	5,323	968	199	5.9%	5.78
	Congestive cardiac failure	2,469	515	515	15.2%	4.79
	COPD	2,379	626	626	18.5%	3.80
	UTIs including pyelonephritis	2,265	659	659	19.4%	3.44
	Pneumonia and influenza	1,119	182	106	3.1%	4.83
	All PPH conditions	17,721	4,302		100%	3.60
All ages	All PPH conditions	42,632	13,851	-	-	3.10

Source: Supplied by Gold Coast Health, Queensland Hospital Admitted Patient Data Collection (QHAPDC).

Note: One admitted patient may have more than one condition that is classified as a potentially preventable hospitalisation and therefore the total numbers of PPH may not equal the number of patients admitted.

When compared to include all causes of overnight hospitalisations for older people (i.e. not just those categorised as preventable), the leading five causes are:

1. Encountering health services in other circumstances (e.g. review of medications or assessment results, assisted living or transition to assisted living facility)
2. COPD
3. Person awaiting admission to residential aged care service
4. UTI
5. Pneumonia

Additional data supplied by Gold Coast Health relating to emergency department presentations and inpatient admissions for residents of Gold Coast RACFs shows that:

- 5,551 or 3.14% of patients presenting to a public emergency department (ED) in 2017-18 were transferred from an RACF. Of these, 26 patients (0.46%) died in hospital.

- The number of patients presenting to Emergency Departments (EDs) from RACFs has been increasing steadily over the last 5 years, up 62% from 3,441 presentations in 2013-14. However, the proportion of these patients who died in ED has generally decreased (except for 2017-18).
- 7,430 or 4.5% patients admitted to a public hospital as an inpatient in 2017 were transferred from an RACF. Of these, 205 patients (2.8%) died in hospital. Over 15% of all inpatient deaths in public hospitals were residents of RACFs.

Primary care providers

The capacity of the primary health care system to manage the ongoing health needs of older people, particularly those living in RACFs, is critical in preventing unnecessary transfers to hospital facilities. The number of GP and specialist attendances per person for the GCPHN region based on Medical Benefits Schedule (MBS) claims data is outlined in Table 16. Unsurprisingly, older people on the Gold Coast had higher claim rates than the all-age population in the region. GP attendances (standard and after hours) were higher for older people on the Gold Coast when compared to the older adult population nationally, but specialist attendances were lower.

Table 16: Number of GP and specialist attendances per person, Gold Coast PHN region, 2016-17

	GP attendances		After-hours GP attendances		Specialist attendances	
Population	65+ years	All ages	65+ years	All ages	65+ years	All ages
Gold Coast	13.3	6.8	0.77	0.66	2.2	0.86
Australia	11.8	6.1	0.6	0.49	2.5	0.95

Source: Australian Institute of Health and Welfare, MyHealthyCommunities portal, www.myhealthycommunities.gov.au

Note: Results are based on the patient's Medicare enrolment postcode

There are several items on the Medicare Benefits Schedule (MBS) specifically for professional attendances at an RACF. Claim rates for these items can provide an indication of the level of coordination and integration between RACFs and general practitioners. Table 12 outlines the number of services claimed for these MBS items across the GCPHN region and shows they have typically increased significantly over the last five years, except for medication management.

Table 17: Number of MBS items relating to residential aged care facilities (RACFs) claimed in Gold Coast PHN region, 2012-13 to 2016-17

Items	2012-13	2013-14	2014-15	2015-16	2016-17
GP attendances at RACFs (20, 35, 43, 51)	81,967	87,615	88,981	96,737	105,091
Other medical practitioner (non-GP) attendances at RACFs (92, 93, 95, 96)	0	756	526	0	1,663
After hours GP attendances at RACFs (5010,5028, 5049, 5067)	12,255	13,740	17,834	18,566	19,599
After hours non-GP attendances at RACFs (5260, 5263, 5265, 5267)	0	0	29	219	0
GP contribution to multi-disciplinary care plan for resident of RACF (731)	3,416	3,916	3,447	4,473	4,211
Medication management review for resident of RACF (903)	2,579	2,419	1,772	2,224	1,653

Source: Department of Human Services, Medicare Australia Statistics

Note: Claims data is based on the street address of the provider rather than the patient's place of residence

Prescribed medications

Dispensing rates under the Pharmaceutical Benefits Scheme (PBS) provide an indication of the utilisation of medications compared to other regions as well as an insight into the health needs of older people within the region. Table 18 provides dispensing rates for medications listed on the PBS under several relevant categories for older people including antidepressants, anxiolytics (for treating anxiety), anti-psychotic and anticholinesterase (for treating conditions including Alzheimer's) medications. The rates of dispensing for anxiolytic and anticholinesterase medicines is higher than the state and national rates in almost all regions of the Gold Coast. Southport has particularly high rates of dispensing across all four selected medicine types.

Table 18: Rate of prescriptions dispensed for selected medications for people aged 65 years and over in Gold Coast PHN region, by SA3 region, 2013-14

Region	Age-standardised rate of prescriptions dispensed per 100,000 people aged 65 years and over			
	Anti-depressants	Anti-psychotics	Anxiolytics	Anti-cholinesterases
Broadbeach - Burleigh	182,793	18,533	45,666	14,121
Coolangatta	196,998	19,341	54,714	14,782
Gold Coast - North	201,933	22,025	53,587	14,830
Gold Coast Hinterland	183,492	18,967	39,013	17,052
Mudgeeraba - Tallebudgera	220,915	21,381	52,490	16,263
Nerang	192,221	17,161	43,510	11,993
Ormeau - Oxenford	216,858	18,259	43,619	14,672
Robina	176,026	13,888	40,708	10,202
Southport	230,803	34,386	62,901	14,126
Surfers Paradise	176,153	17,442	49,921	14,426
Queensland	221,409	31,763	42,664	11,655
Australia	196,574	27,043	37,695	12,650

Source: Australian Commission on Safety and Quality in Health Care (ACSQHC), The First Australian Atlas of Healthcare Variation, 2015

Advance Care Planning

Advance Care Planning (ACP) involves planning for future health and personal care should a person lose their decision-making capacity. ACP can lead to completion of Advance Health Directive (AHD), a legal document intended to apply to future periods of impaired decision-making.

There are no dedicated MBS item numbers for Advance Care Planning, instead it is undertaken as part of standard GP consultations, health assessments, chronic disease management plans or case conferencing items.

As such, there is no regional data to indicate the number of ACP services being undertaken by GPs. A survey to measure the prevalence of AHDs undertaken in 2014 found that around 14% of the Australian population has an AHD, with that level as high as 19% in Queensland[6]. Those people who had made a Will or had an Enduring Power of Attorney were more likely to have an AHD. However, these findings are limited by the small sample size.

A Statement of Choices document enables a patient to record their wishes and choices for health care into the future. In 2017-18, there were a total of 451 Gold Coast PHN residents who had a completed Statement of Choices uploaded to Queensland Health's 'The Viewer' system, which is an increase of 270 on the previous year. Almost 90% of completed Statement of Choices recorded were for residents of an RACF[7].

[6] White B et al (2014). Prevalence and predictors of advance directives in Australia, Intern Med J, 44(10):975-80

[7] Data supplied by Office of Advance Care Planning, Metro South Hospital and Health Service (HHS)

Service Mapping

There are a range of stakeholders to consider when mapping services for older people. For the purpose of this report, the focus will include;

- After-hours service providers inclusive of not-for-profit organisations
- GPs and medical deputising services and
- RACFs.

Aged care services

An overview of the number of publicly-subsidised aged care services available in the GCPHN region by the type of aged care program and the type of provider is in Table 19.

Table 19: Number of aged care services in Gold Coast PHN region by program and provider type, as at June 2018

Provider type	Residential care			Home care	Home support
	Permanent	Respite Low Care	Respite High Care		
Private	32	24	24	17	3
Not-for-profit	20	19	24	24	43
Government	0	0	0	0	2
Total	52	43	48	41	48

Source: GEN Aged Care data portal, AIHW

There are 52 RACFs in the Gold Coast region stretching from Ormeau to Coolangatta. The RACFs range from capacity of 12 beds to much larger 167 bed facilities providing differing levels of care and services across general aged care, palliative, respite and dementia care.

Variation of the different levels of care and support have been widely reported throughout the consultation phase of this project. Information is limited around the type of supports available in some of the smaller, private and non-government funded facilities.

The register of providers of aged care services in the publicly-subsidised 'My Aged Care' system includes information about whether services focus on the needs of diverse groups. Table 20 shows the number of RACFs that identify as focusing on particular need groups by sub-region.

A full list of aged care service providers within each sub-region of the Gold Coast by program type can be referred to in *Appendix 1, Service Mapping*.

Table 20: Number of residential aged care services in Gold Coast PHN region identifying services specifically for diverse groups, as at June 2018

Region	Financial disadvantage	Aboriginal and Torres Strait Islander	LGBTI	CALD	Dementia	All services
Broadbeach - Burleigh	1	1	1	1	1	3
Coolangatta	4	2	2	2	4	5
Gold Coast - North	8	3	3	3	9	11
Gold Coast Hinterland	1	1	1	1	1	1
Mudgeeraba - Tallebudgera	2	2	1	1	2	4
Nerang	2	0	0	0	2	4
Ormeau - Oxenford	5	0	0	1	3	7
Robina	4	3	1	2	6	8
Southport	8	2	1	1	8	10
Surfers Paradise	1	0	0	0	1	1
Total	36	14	10	12	37	54

Note: Includes residential, home care and home support services

Source: GEN Aged Care data portal, AIHW

An identified issue on the Gold Coast is the level of skilled nursing staff available in RACFs, particularly availability of Registered Nurses (RNs) during the after-hours period. Table 21 shows that while the number and rate of RNs working in aged care (residential and home care) in the Gold Coast PHN region has been increasing over recent years, the rate is still lower than the national level.

Table 21: Number and rate of aged care nursing staff per 1,000 users of aged care services in Gold Coast PHN region, 2014 to 2017

Region	Nurse type	Number of aged care nursing staff			Rate of aged care nursing staff per 1,000 aged care users		
		2014	2015	2016	2014	2015	2016
Gold Coast	Registered Nurse	543	577	615	87.5	93.0	99.1
	Enrolled Nurse	389	387	408	62.7	62.4	65.7
National	Registered Nurse	-	-	-	113.7	116.8	120.9
	Enrolled Nurse	-	-	-	74.8	73.9	74.2

Source: AIHW, Health Workforce Data Planning Tool and GEN Aged Care Data Portal

Primary care

General Practitioners

In the context of older people's health needs in the primary care sector, General Practitioners (GPs) play a pivotal role in managing and coordinating an individual's health care needs. GPs deliver continuity of care for older people as they age and use their clinical judgements to make decisions about the most appropriate care for the individual. Roles carried out by GPs generally include:

- recognition and management of health conditions
- assessment of functional capacity of the individual
- recognition of their accommodation and care needs
- identification of the impacts on family and carers and associated needs for respite care.

A GP's role in the requirement for and facilitation of ACP is critical due to their ongoing and trusted relationships with patients. In the Gold Coast region, GPs provide services for older people in practices, at an individual's private residence and into RACFs.

As at March 2017, there were a total of 759 GPs on the Gold Coast across 180 practices. They are supported by a total of 1,225 non-GP staff working in general practice (e.g. nurses, allied health professionals, practice managers and administration). GP clinics are generally well distributed across the GCPHN region, with majority in populated coastal and central areas. Three practices are available for after-hours care (after 6pm and before 8am) at Surfers Paradise, Southport and Palm Beach.

Medical deputising services

The National Association for Medical Deputising includes a number of services that offer after-hours care in in the Gold Coast region. Services such as The House Call Doctor, National Home Doctor Service and Dial A Home Doctor provide after-hours doctors to attend appointments at a person's residence, whether that be an RACF or own home. These services account for approximately 65% of the after-hours home and RACF visits in Australia[8]. These services bulk bill eligible patients with a Medicare or DVA card and the consultation notes are electronically transferred, faxed or posted to the individuals' preferred local doctor.

Research has found that the most utilisation of after-hours GP services are children under the age of 4 years and elderly people, both in their homes or in aged care facilities. However, it should be taken into consideration that deputising services operate on a triage system that prioritise children, followed by the elderly. After hours services operate between 6pm – 6am Monday – Friday, 12pm Saturday - 6am Monday and all hours on public holidays.

As at March 2017, there were four medical deputising services operating on the Gold Coast providing in-home and after hours visits from a doctor.

Allied health services

Many different allied health groups contribute to the care of older people on the Gold Coast both individually or as part of multidisciplinary care teams. Allied health can be provided in a community or hospital setting and range from dieticians, physiotherapists, occupational therapists, pharmacists, podiatrists, psychologists and social workers.

Allied health plays a key role in care for older people by providing:

- Interventions to promote healthy ageing and reduce the impact of chronic conditions and disabilities
- Rehabilitative care to support people to regain function and strength after serious injury or an illness such as a stroke
- Strategies to support people to live independently in their own home
- Care co-ordination to assist people navigate the aged care system and make choices that are best for them[9]

In addition to allied health counsellors and pastoral care workers can provide a range of support to RACF residents.

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8 http://www.namds.com/wp-content/uploads/2017/01/Deloitte-Report-Analysis-of-after-hours-primary-care-pathways-1.pdf

9 https://ahpa.com.au/key-areas/aged-care/

Hospital and Health Service (Gold Coast Health)

Gold Coast Health provides a range of specific services for older people in the region, including:

- Aged Care Assessment Teams at Gold Coast University Hospital (GCUH) at Southport, Robina Hospital, Helensvale Community Health Centre and Palm Beach Community Health Centre
- Specialist palliative care in an inpatient and community setting
- Older Persons Mental Health Unit at Robina Hospital: 16 inpatient beds and community outreach
- Complex Needs Assessment Panel (CNAP) 65+ providing coordination of care and services to support older people with complex mental health needs
- Geriatric Evaluation and Management in the Home located at GCUH
- Bereavement services at Robina Hospital and GCUH

Non-Government Organisations

There are a range of not-for-profit providers who deliver after hours and in-home care. Services can include:

- Home modification and maintenance
- Cleaning
- Personal care
- Shopping
- Social outings
- Transportation to respite care
- Palliative care and dementia care.

The cost of the individual's community care can often be supported through Commonwealth Home Support Program (CHSP) and Home Care Package (HCP) depending on the eligibility. Co-contributions are an expectation for individuals accessing CHSP and HCP except in cases of hardship.

Consultation

Patient Journey Mapping

One of the key items taken to consultation was Patient Journey Mapping. These visual representations of common patient journeys developed in partnership with COTA Queensland support the consumer engagement component of the consultation.

Four common pathways were documented for further consultation including:

- Dementia/CALD/family pathway, Keng
- Complex co-morbid ED presentation/social isolation pathway, Betty
- Self-funded retiree/Advance Care Plan/loss and grief pathway, Peter
- RACF palliative care pathway (prepared by Palliative Care Queensland), Mary

These were validated by Gold Coast PHN and the Aged Care Leadership Group.

Overarching issues identified across all common pathways worth noting included:

-
- Aged care reforms and system changes
- Lack of consumer and carer system literacy
- NDIS Reforms (links with dementia)
- Untimely re-assessment and scarcity of HCP 3 and 4 packages
- Unique challenges regarding CALD groups
- Cognitive impairment and decision making
- Advance Care Planning

Workforce issues:

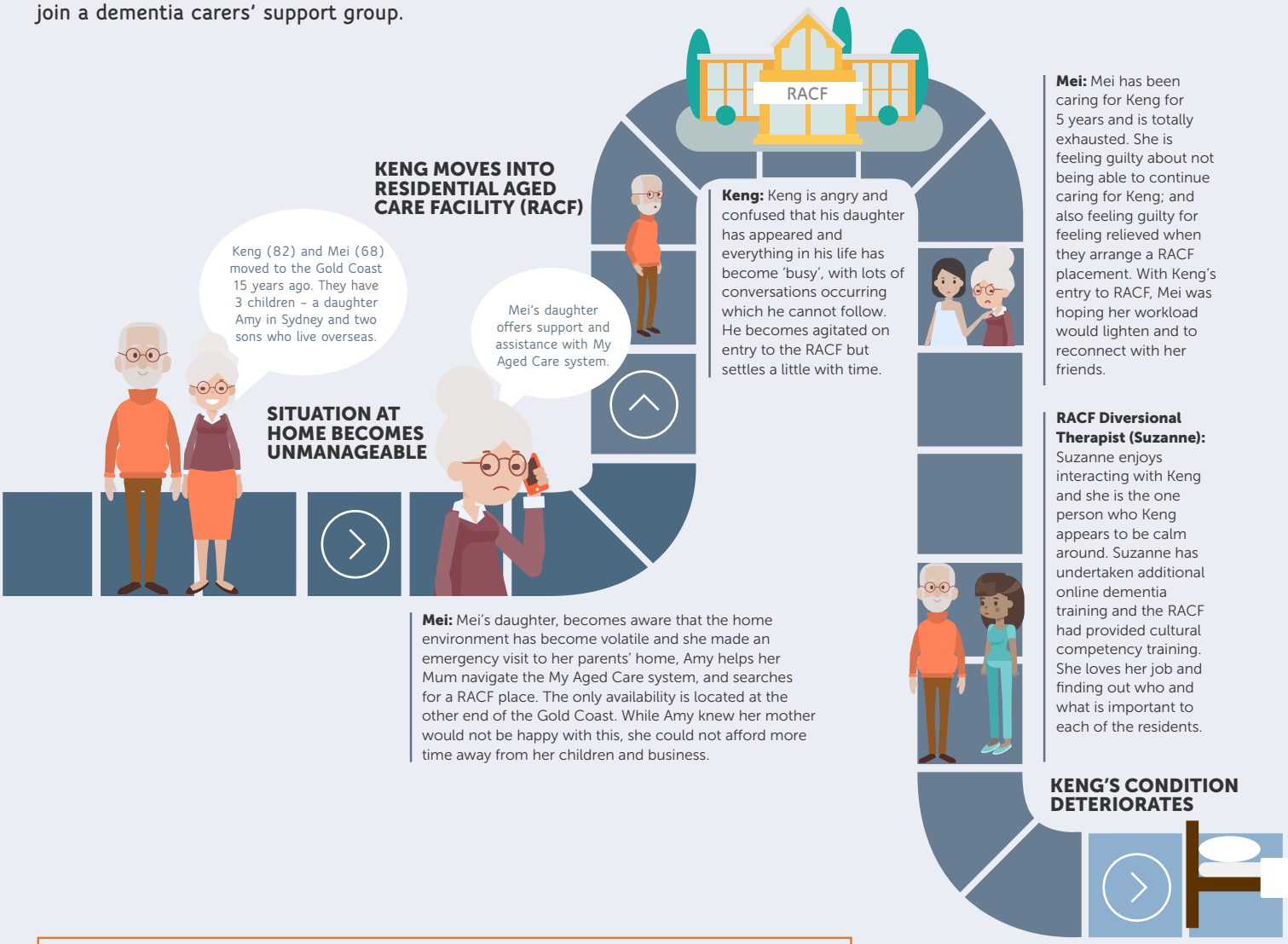
- Decrease in nursing in the community setting
- Under-resourcing of nursing in RACF
- Capacity and capability issues regarding assessors and assessment teams
- GPs not compensated for going in to RACFs / time required
- Lack of allied health in RACFs.

The common pathways with extracted key themes and issues specific to each journey can be found below:

Figure1 : Dementia and CALD Journey

Keng's journey

Keng's hobbies include reading, gardening and meeting weekly with a group of other Chinese men. A few years ago, Keng was diagnosed with dementia. His diagnosis came as a shock and Keng and his wife Mei were in denial for some time. Keng would not allow Mei to tell others. Mei tried to calm Keng's growing frustration and distress; and over time, withdrew from her own regular social activities. Mei's daughter began to realise the severity of Keng's condition and the impact on her mother's health. Through her volunteer work with a community organisation, Mei's daughter Amy knew how to assist Mei to get some support in the home and encouraged Mei to join a dementia carers' support group.



Mei: Mei's daughter, becomes aware that the home environment has become volatile and she made an emergency visit to her parents' home, Amy helps her Mum navigate the My Aged Care system, and searches for a RACF place. The only availability is located at the other end of the Gold Coast. While Amy knew her mother would not be happy with this, she could not afford more time away from her children and business.

Keng: Keng is angry and confused that his daughter has appeared and everything in his life has become 'busy', with lots of conversations occurring which he cannot follow. He becomes agitated on entry to the RACF but settles a little with time.

Mei: Mei has been caring for Keng for 5 years and is totally exhausted. She is feeling guilty about not being able to continue caring for Keng; and also feeling guilty for feeling relieved when they arrange a RACF placement. With Keng's entry to RACF, Mei was hoping her workload would lighten and to reconnect with her friends.

RACF Diversional Therapist (Suzanne): Suzanne enjoys interacting with Keng and she is the one person who Keng appears to be calm around. Suzanne has undertaken additional online dementia training and the RACF had provided cultural competency training. She loves her job and finding out who and what is important to each of the residents.

Key themes:

- Community knowledge about aged care and support available in the home improves service identification and navigation
- Important life decisions often made in made in times of emergency and distress
- Limited family supports can impact timely identification of issues and responses
- High emotional and physical stress for carer
- Appropriate recruitment of RACF staff e.g. Staff that are able to provide support across a range of health and social conditions including dementia and people from diverse backgrounds
- Timely comprehensive medical assessment in the RACF in response to escalating conditions
- Recognition of a person's social, cultural, spiritual and emotional needs

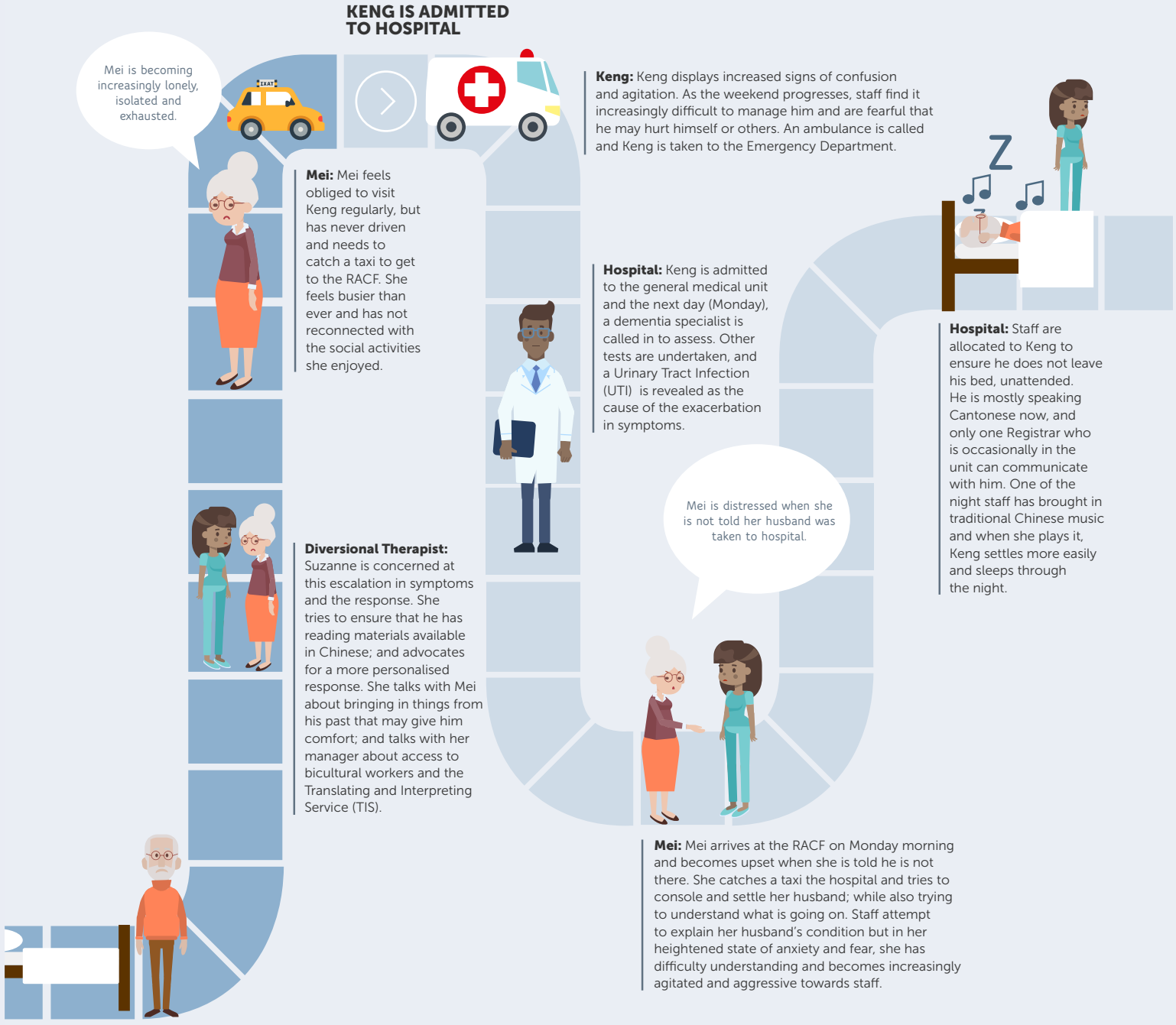
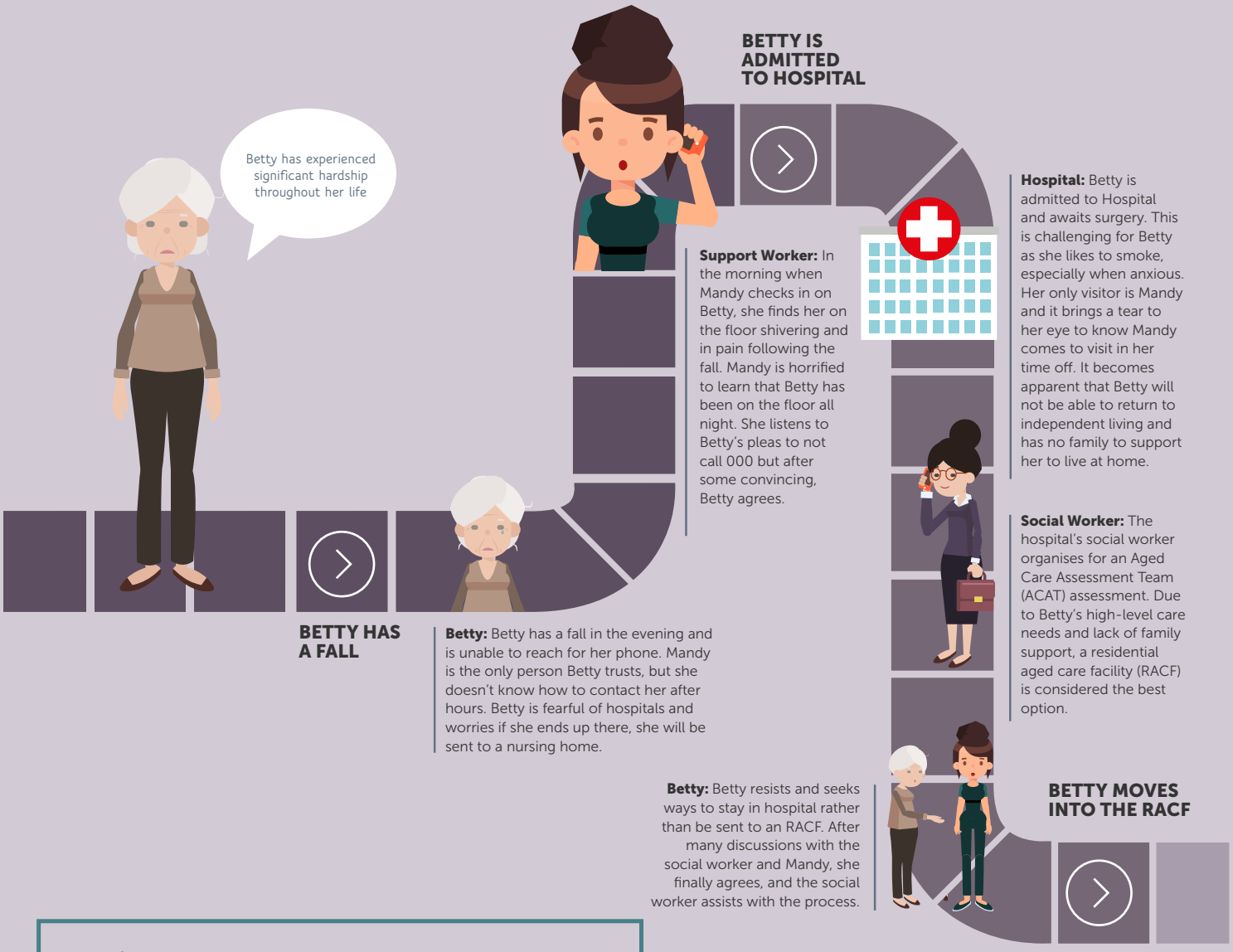

KENG IS ADMITTED TO HOSPITAL
Mei is becoming increasingly lonely, isolated and exhausted.
TAXI
Mei: Mei feels obliged to visit Keng regularly, but has never driven and needs to catch a taxi to get to the RACF. She feels busier than ever and has not reconnected with the social activities she enjoyed.
Diversional Therapist: Suzanne is concerned at this escalation in symptoms and the response. She tries to ensure that he has reading materials available in Chinese; and advocates for a more personalised response. She talks with Mei about bringing in things from his past that may give him comfort; and talks with her manager about access to bicultural workers and the Translating and Interpreting Service (TIS).
Keng: Keng moves to a more 'secure' wing of the RACF but feels trapped and becomes increasingly agitated as he cannot find his way 'home'. He frequently reverts to his first language of Cantonese.
Keng: Keng displays increased signs of confusion and agitation. As the weekend progresses, staff find it increasingly difficult to manage him and are fearful that he may hurt himself or others. An ambulance is called and Keng is taken to the Emergency Department.
Hospital: Keng is admitted to the general medical unit and the next day (Monday), a dementia specialist is called in to assess. Other tests are undertaken, and a Urinary Tract Infection (UTI) is revealed as the cause of the exacerbation in symptoms.
Mei is distressed when she is not told her husband was taken to hospital.
Mei: Mei arrives at the RACF on Monday morning and becomes upset when she is told he is not there. She catches a taxi the hospital and tries to console and settle her husband; while also trying to understand what is going on. Staff attempt to explain her husband's condition but in her heightened state of anxiety and fear, she has difficulty understanding and becomes increasingly agitated and aggressive towards staff.
Hospital: Staff are allocated to Keng to ensure he does not leave his bed, unattended. He is mostly speaking Cantonese now, and only one Registrar who is occasionally in the unit can communicate with him. One of the night staff has brought in traditional Chinese music and when she plays it, Keng settles more easily and sleeps through the night.

Figure 2: Co-morbid mental health and emergency presentation journey

Betty's journey

Betty is 78 years old and is prematurely aged due to her life circumstances. She has been homeless at times in her last 30 years and is grateful to now be living in a self-contained unit. Betty has the support of a Housing Support Worker, Mandy, who supports Betty to maintain regular check-ups at the local bulk-billing General Practitioner (GP) clinic and to stay on her medications for her mental health condition.



Key Themes:

- Limited capacity of RACF to support complex, high needs residents
- RACF staff require adequate training and support to recognise, understand and work with the needs of people with mental health conditions
- Limited access to mental health specialist services for RACF residents and staff
- Lack of shared medical records between systems can result in lack of good continuity of care

Figure 2: Co-morbid mental health and emergency presentation journey cont.

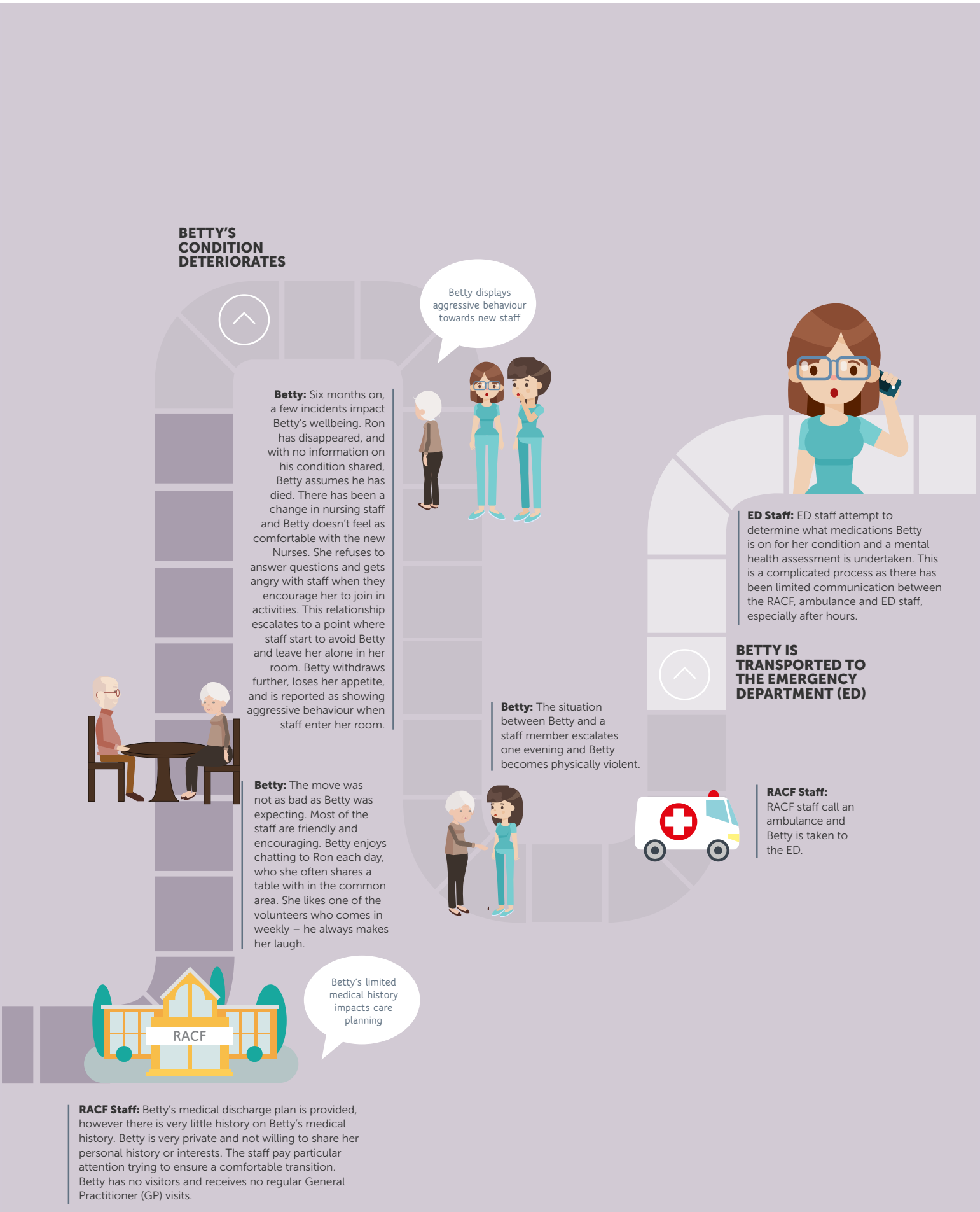
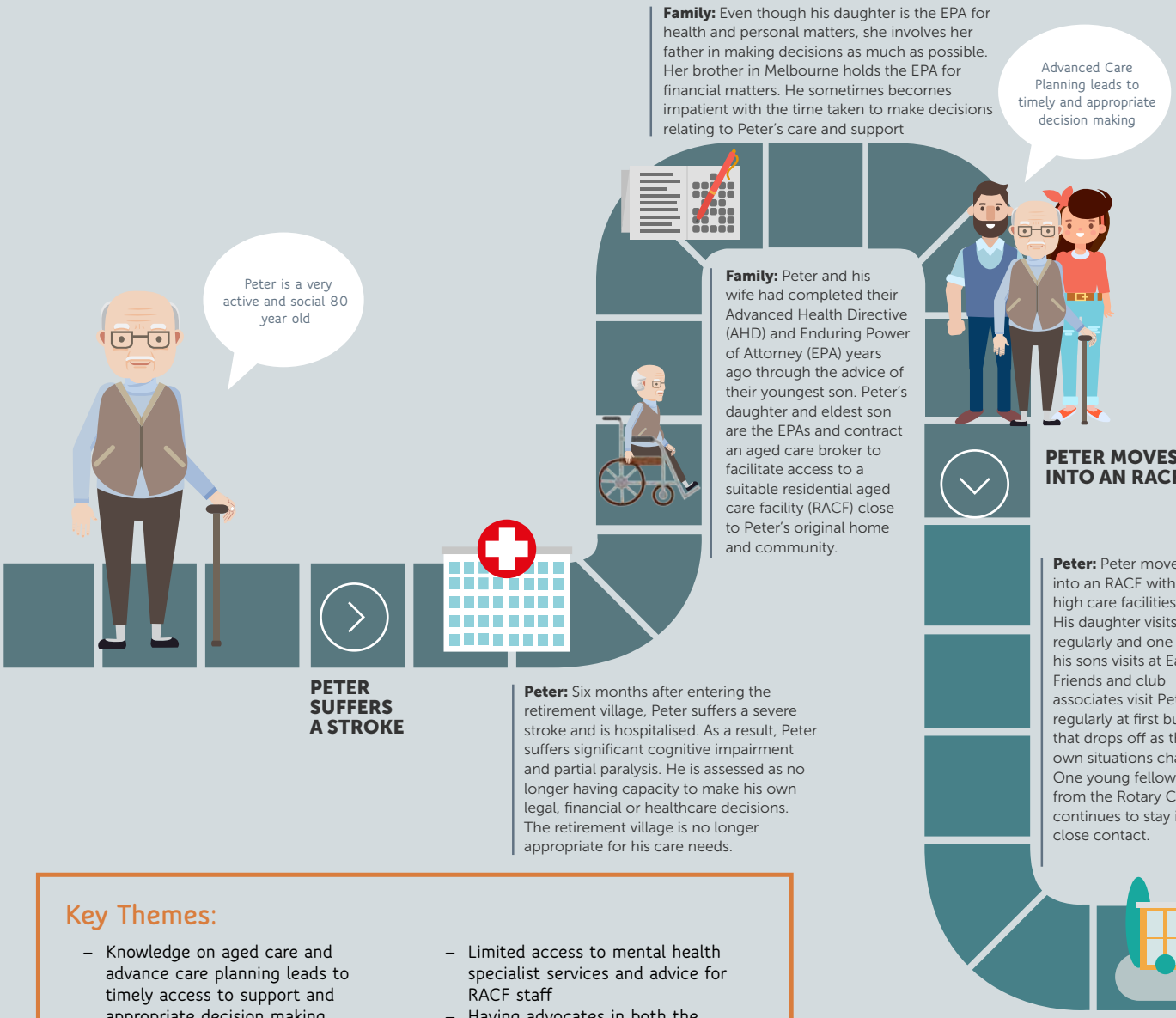


Figure 3: Self-funded RACF and Advance Care Planning journey

Peter's journey

Peter is 80 years old and has moved to a retirement village unit after the death of his wife. It was a difficult transition to move from their home of 50 years. Peter is supported by his family, especially his daughter who lives on the Gold Coast. He is a long-standing member of the local Lions Club and the golf club and continues to enjoy an active life. Peter's daughter supports him to arrange for some paid weekly cleaning. He visits and dines with friends and family and loves looking after his youngest grandchild every Thursday. He regularly attends the general practitioner (GP) he and his wife have used for the last twenty years.



Key Themes:

- Knowledge on aged care and advance care planning leads to timely access to support and appropriate decision making
- Staffing numbers and skill levels (clinical and social) in RACF can make a significant impact to care on a daily basis as well as during an emergency
- RACF staff require adequate training and support to understand the ageing process and the impact of loss, disability and grief
- Limited access to mental health specialist services and advice for RACF staff
- Having advocates in both the RACF and hospital setting makes a significant difference in effectively assessing a person's condition and developing a comprehensive care plan

Figure 3: Self-funded RACF and Advance Care Planning journey cont.

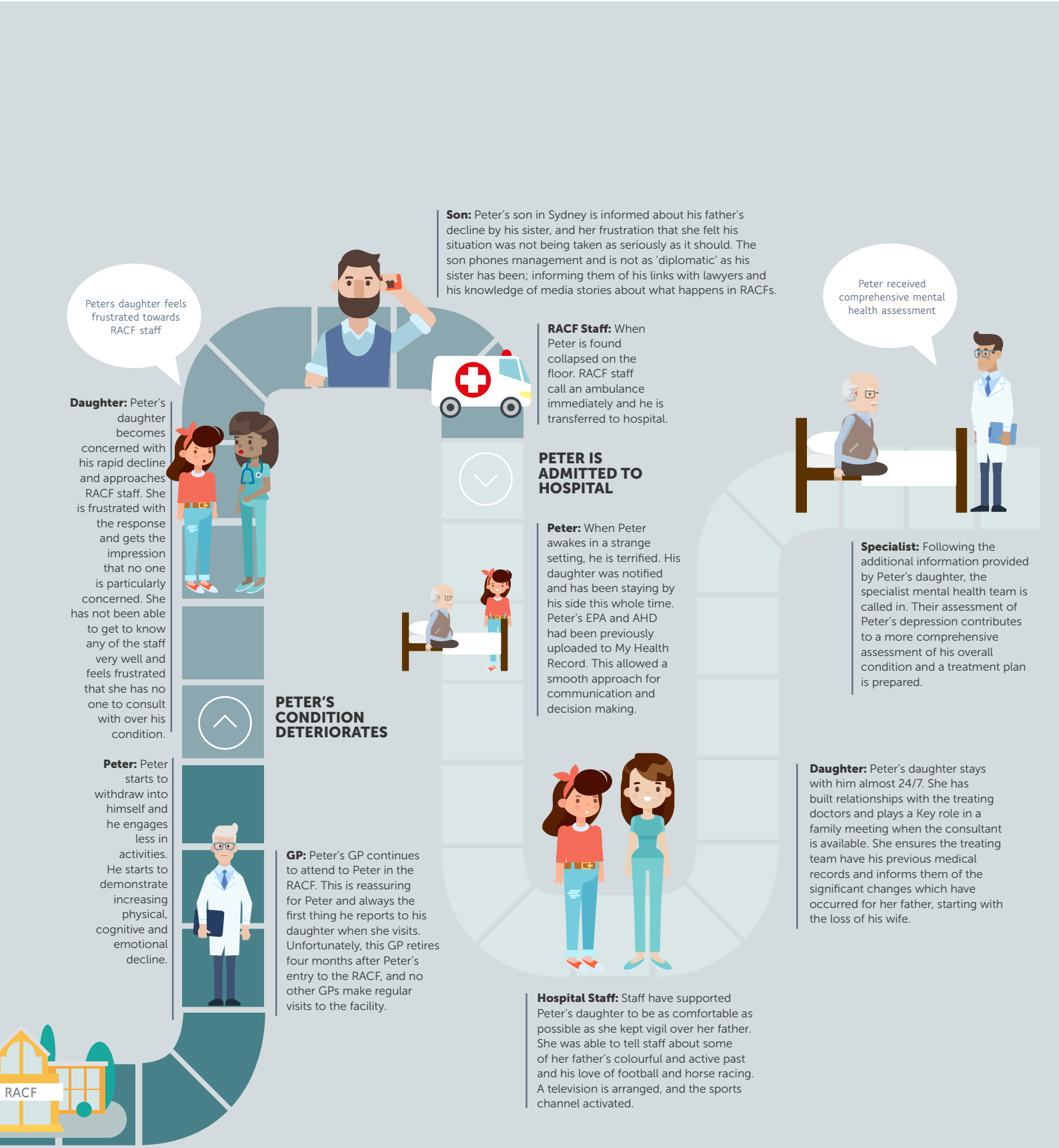
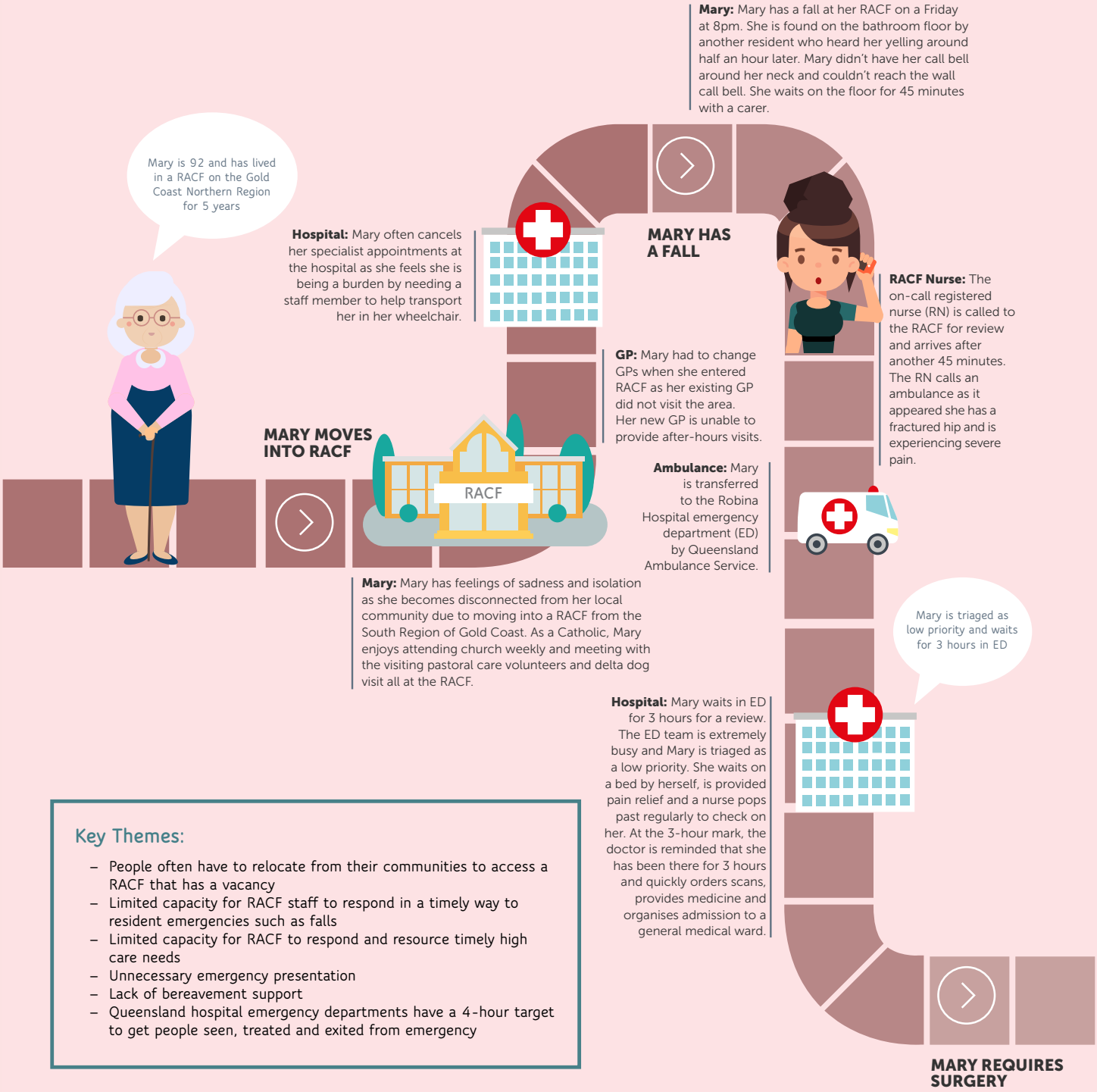


Figure 4: RACF Palliative Care journey

Mary's journey

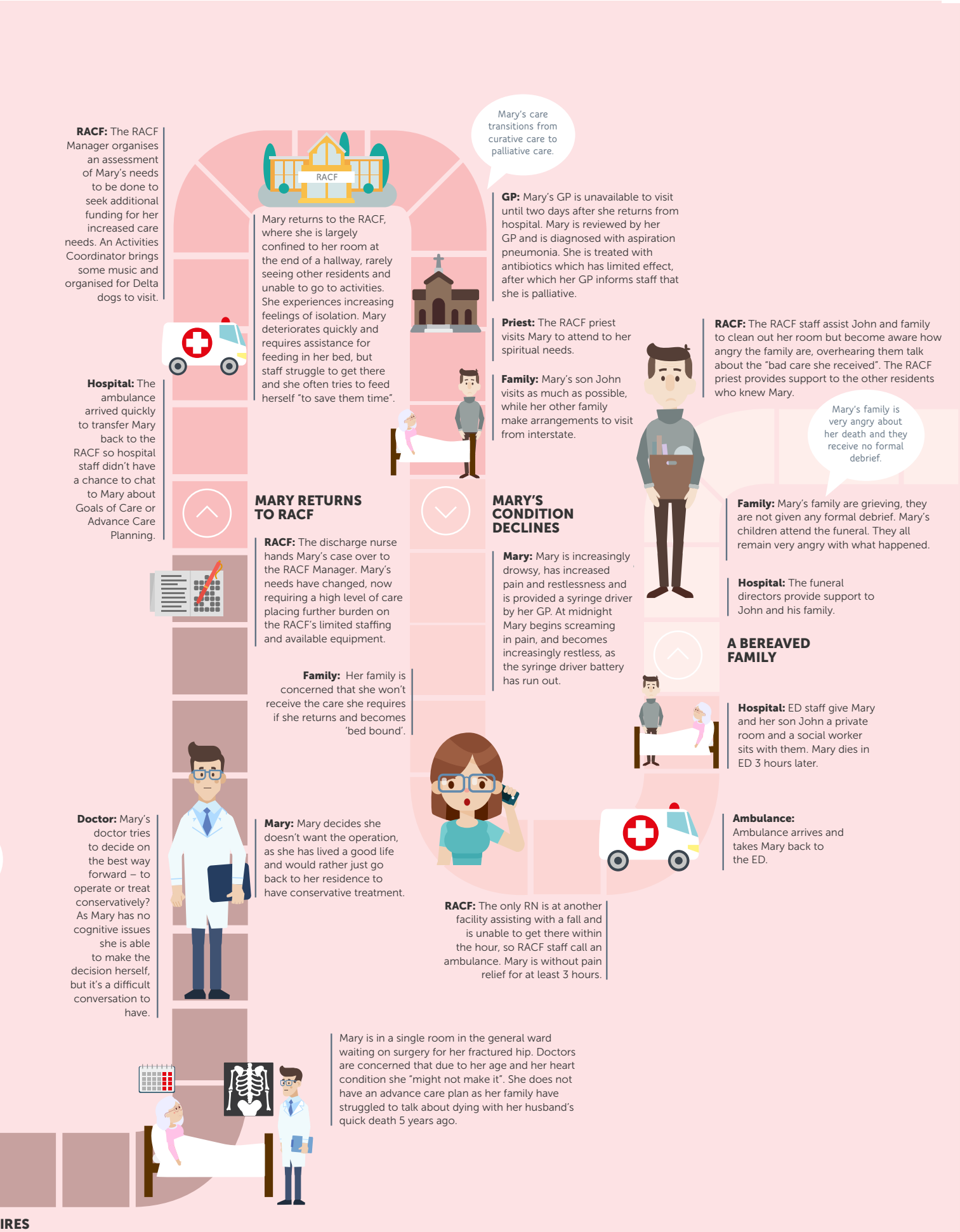
Mary is a Gold Coast local with three children; one (John) who lives in Brisbane, while the others live interstate. Mary's husband died 5 years ago, after which she decided with the help of her family to move into a Residential Aged Care Facility (RACF). Mary suffers from heart failure and several other co-morbid conditions. She requires some support to shower and needs a wheelchair to move long distances. She was previously active with a local craft group but hasn't seen them since moving into the RACF.



Key Themes:

- People often have to relocate from their communities to access a RACF that has a vacancy
- Limited capacity for RACF staff to respond in a timely way to resident emergencies such as falls
- Limited capacity for RACF to respond and resource timely high care needs
- Unnecessary emergency presentation
- Lack of bereavement support
- Queensland hospital emergency departments have a 4-hour target to get people seen, treated and exited from emergency

Figure 4: RACF Palliative Care journey cont.



GCPHN Clinical Council

In June and August 2018, GCPHN undertook engagement with their Clinical Council to explore inefficiencies and opportunities within the aged care sector. The qualitative data is summarised under two main domains:

- Medications
    - Access to some medications can be problematic if stocks are low
    - Medication dispensed days ahead, problematic if GP recently changed medication. This causes issues with wastage of medications.
    - Some corporate pharmacies request backdated scripts, which is illegal for a GP.
    - Medication can often be prescribed on admission, however reviews can be overlooked
- Staffing
    - High staff turnover and limited expertise in palliative care
    - Number and experience of staff – high likelihood of transfer of resident to hospital
    - Some RACFs can be 'unwelcoming' to visiting GPs
    - Residents are often described in quote 'rosy terms' when in fact, their behaviour is worse
    - Limited time to engage or upskill staff. Unsupported by facility when staff are required to deliver front line services.

While these issues are not representative of all RACFs, this information identifies inconsistencies across the sector. The importance of understanding the size and scope of the private fee-for-service aged care environment was noted, acknowledging the challenges in sourcing data.

Anecdotally, it was reported that the Gold Coast has pockets of high socio-economic status with people willing to self-fund care to avoid wait lists and maintain choice. It was noted that the local context can change quickly, for example with financial crises leading to a greater number of older people accessing publicly-funded services who may have previously been self-funded. Alongside issues presented, there was a range of opportunities identified by the Clinical Council, including:

- Case conferencing between GPs and Hospital and Health Service (HHS) staff to work together on more complex cases such as dementia to avoid unnecessary hospital transfers
- Networking across RACFs and GPs to ensure backup outside of the individual facility
- Trialling new models of care in which a GP services RACFs in an area.

GCPHN Community Advisory Council

Recent (June 2018) feedback obtained through the GCPHN Community Advisory Council (CAC) found 93% of CAC members either agreed or strongly agreed on the needs identified in the Older Persons Needs Assessment Summary document released in December 2017.

The CAC highlighted the provision of transport assistance is a fundamental factor contributing to older people's ability to continue to stay at home. It therefore, needs to be considered when planning future service models.

In previous consultation carried out with the CAC in 2016, Advance Care Plan (ACP) was a key topic. It was emphasised that people preferred their GP to raise ACP with them, particularly if there is diagnosis of chronic disease. At the same time, the formal ACP documentation was labelled as not consumer friendly.

Loneliness was identified is a key consideration for older people. Particularly in the Gold Coast region where women often relocate after their husband passes away leaving them with limited social support or social connection. Loneliness, a predominant risk factor for prolonged grief can have catastrophic physical, mental, social, spiritual and financial health implications for the individual.

Considerations need to be given to the opportunities NDIS funding provides for this population group, if a person under 65 is approved for a NDIS package, they will continue to receive their package as they age. It would be advantageous to promote NDIS to those individuals nearing 65 with an impairment or condition that is likely to be

permanent and reduces independence.Further engagement with this group recognised the level of need for PHN Commissioned Services is higher in RACFs and After-Hours Services compared to palliative care.

The CAC reconvened in August 2018 to provide review and feedback on the aged care with a focus on RACF and After Hours Draft One Needs Assessment Summary, their feedback has been incorporated into the report. Additional key themes which emerged and need to be considered include:

- Medical Tourism on the Gold Coast
- COPD need to be targeted as action area
- High variability of the types and quality of services available to people within RACFs

Co-Design Workshop

Co design workshops with 27 sector representatives and in partnership with COTA Queensland were held to inform the design and delivery of a regionalised approach to GCPHN's investment in an after-hours response relating to aged care.

The outcomes from the co-design workshop along with the findings of the needs assessment will directly inform the development of GCPHN's three-year strategic service planning report – *"The Regional Plan for Older People (with a focus on After-Hours and RACF services)".*

The co-design workshops were designed to maximise participation, incorporating a variety of feedback mechanisms including small group sessions, whole-of-room sessions or individual opinion in an anonymous format. Informal breaks were included for networking and further discussion and integration amongst the group.

Key themes emerged from the co design workshop included:

Workforce capacity building – The need for meaningful, appropriate, accessible workforce capacity building across the aged, community and primary care sectors was a prominent theme. It was reported that confident, skilled, and connected staff would lead to a reduction in potentially preventable hospitalisations.

Community awareness and education - While some difficulties were reported in measuring community awareness and education outcomes, it was still a leading theme throughout the workshop. Some recurring areas for education and awareness identified were advance care planning, aged, community and health service awareness, and health and death literacy.

Advance Care Planning – Advance Care Planning continues to carry significant importance across both the aged care and palliative care sectors on the Gold Coast. It has been reported that uptake remains low, which can be attributed to the difficulty and complexity of the paperwork involved. However, it is reported that having an Advance Care Plan in place results in a more informed, seamless, coordinated and appropriate journey for the individual in line with their values, beliefs and wishes at the end of life.

Service navigation and coordination – While activities around service navigation and coordination were strongly supported by participating representatives, measures to improve this can often be challenging in a constantly evolving and time-poor sector. Activities proposed to improve service navigation and coordination on the Gold Coast were dependent on having a key a navigator role to support individuals through their personal journeys.

Service integration –The need for more effective service integration on the Gold Coast was a significant theme. This can be attributed to the reported fragmentation between hospital services, RACFs and primary and community-based services. Challenges in accessing and receiving clinical support within RACFs have consistently been reported during this project, meaning RACFs have limited capacity and capability to respond to complex situations. Activities focusing on service integration with RACFs are an important consideration.

Additional information

The Australian Medical Association (AMA) *Aged Care Survey Report*[10]*,* sought feedback on members' impressions and experiences of providing medical care to older people. The survey presented some insights which need to be taken into consideration for the future planning of primary care services for older people, particularly in RACFs and after-hours periods including:

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[10] https://ama.com.au/system/tdf/documents/2017%20AMA%20Aged%20Care%20Survey%20Report.pdf?file=1&type=node&id=48948

- Over a third of survey respondents reported an intention to decrease or stop attending RACFs in the coming two years, attributed to the considerable amount of paperwork involved, responding to faxes and phone calls, and discussing issues with RACF staff or relatives of residents. This was despite a reported increase in demand for RACF-visiting medical practitioners.
- Respondents reported that in almost half of instances of GPs reducing the frequency of visits to RACFs in the last 5 years it was due to unpaid non-contact time, while a further 40% was due to practitioners being too busy in their practices.

The 2014 *Review of After-Hours Primary Health Care*[11] undertaken to consider the most appropriate and effective delivery mechanisms to support ongoing after-hours primary health care services nationally. Some of the key findings are highly relevant for the purposes of this report, and support some of the concerns raised throughout the consultation process:

- Medical deputising services require better triaging to eliminate visits which can wait until usual business hours
- Consumers often had limited knowledge of the variety of services available
- Consumers expressed the need for better integration and coordination of existing services
- Better health literacy around types of after-hours services and how to access them would increase consumer knowledge, accessibility, appropriateness and efficiency
- Practice infrastructure and hours of operation was seen to impact on extended hours care, if consumers were unable to access same-day appointments with their regular GP
- Supporting continuity of care and effective communication between after-hours service providers and a patient's regular GP
- Established and emerging eHealth solutions have great potential to improve after hours health care.

[11] http://www.health.gov.au/internet/main/publishing.nsf/content/79278C78897D1793CA257E0A0016A804/$File/Review-of-after-hours-primary-health-care.pdf

What we understand works

The *National Consensus Statement: Essential elements for safe and high-quality end-of-life care* identified 10 essential elements for delivering safe and high-quality end-of-life care in Australia. Elements when tailored to the appropriate setting and needs of the population will strengthen opportunities for delivering best practice end-of-life care.

Models of care below have been identified through a process of consultation with GCPHN, the Aged Care Leadership Group and GCPHN advisory mechanisms and desktop evidence review.

Stakeholders were asked to submit models of care which have worked well in other areas, and which would have successful elements which could be adapted to meet the local health needs and service issues of the Gold Coast region. In general, the identified models are focused towards:

- Providing education and clinical supports to RACFs
- Reducing preventable emergency department presentations and hospital admissions
- Supporting GPs to remain at the centre of a person's care

The examples below are indicative of the type of service responses that could respond to the identified local health needs and service issues.

Example models of care are described below:

Model: After-Hours Service Model	
Program Example	Hunter Primary Health's GP Access After Hours (GPAAH)
Description	The After-Hours Service Model utilised telephone patient screening service to effectively triage after hours cases, GP's co-located in public EDs and transport support for people who would otherwise be unable to attend after hours clinic or GP home visits
Evidence	Independent evaluation showed an estimated annual cost saving of $10 million to the health system, mostly attributed to diverting low-acuity patients from the ED to primary care. Hunter Research Foundation, A cost study of GP Access After Hours (GPAAH), 2015 Available at: https://hunterprimarycare.com.au/wp-content/uploads/2015/11/GP-Access-Cost-Study.pdf
Alignment to Health Needs and Service Issues	• Triaging service enabling right care, right time, right place • Reducing preventable emergency department presentations • Consistent and high-quality support provided to RACFs

Model: RACF Service Model	
Program Example	Geriatric Outreach Assessment Service (GOAS), Brisbane North PHN and Metro North HHS
Description	GOAS aims to improve quality of care and reduce emergency department presentations and hospital admissions for RACF residents who are acutely unwell. The GOAS team includes a part-time geriatrician, a full-time registrar, two clinical nurses and an administration officer. It is supported by an external service facilitator, clinical nurse consultant. GOAS services include: • Reviewing residents following hospital discharges • Management of acute conditions (e.g. pneumonia) • Exacerbation of chronic cardiac failure • Acute management of behaviour disorders in residents with Dementia • Falls • End of life care • Clinical support and education for RACF staff
Evidence	Internal evaluation found GOAS had improved access to specialist geriatric outreach care for 744 patients and delivered 960 episodes of care (an average of 4 episodes per day), of which 638 episodes (66 per cent) were considered to have been potentially prevented Emergency Department presentations. Also, inpatient hospital admissions and average length of stay was lower for in-scope RACFs. https://www.brisbanenorthphn.org.au/page/health-professionals/community-care/geriatric-outreach-assessment-service/
Alignment to Health Needs and Service Issues	• GP centre of person's care needs • Increased continuity of care • Supporting uptake of Advance Care Plans • Reduction in emergency department presentations and hospital admissions for RACF residents. • Clinical support and education for RACF staff

Model: RACF Service Model	
Program Example	Implementation of a team model for RACF care by a general practice[12]
Description	A team model is characterised by a general practice or specialist team providing rostered outreach into RACFs. Models typically enable GPs to perform clinical tasks through twice-weekly rounds, with the clinical nurses as the first point of call to triage and assess the case for follow-up by the GP or specialist where necessary. Clinical nurses in these models play and integral role in liaising with RACF staff and families, collecting patient information, drafting advance care plans and supporting patients to maintain a preferred GP.
Evidence	While testing the effectiveness of the model compared to other models is required, benefits might include promoting the use of standard MBS consultation item numbers, reduction in after-hours consultations and increased continuity of care Reed RL (2015). Models of general practitioner services in residential aged care facilities, Aust Fam Physician, 44(4), 176-179
Alignment to Health Needs and Service Issues	• GP centre of person's care needs • Increased continuity of care • Supporting uptake of Advance Care Plans • Reduction in emergency department presentations and hospital admissions for RACF residents. • Clinical support and education for RACF staff

Model: RACF Service Model	
Program Example	*Clustered domestic residential aged care in Australia*[13]
Description	Clustered domestic residential aged care facilities offer small-scale living units designed to look like a home, with staffing models and physical design that afford greater choice and flexibility in living arrangements for residents. These facilities service a smaller number of residents per unit and individualised living spaces compared to standard Australian models of residential care.
Evidence	Clustered domestic models of residential care are associated with better quality of life and fewer hospitalisations for residents, without increasing whole of system costs. Dyer SM et al (2018). Clustered domestic residential aged care in Australia: fewer hospitalisations and better quality of life, Med J Aust, 208(10, 433-438
Alignment to Health Needs and Service Issues	• Improved health and wellbeing, lower levels of social isolation • Consumer choice • Reduction in emergency department presentations and hospital admissions for RACF residents.

12 https://www.racgp.org.au/afp/2016/april/implementation-of-a-team-model-for-racf-care-by-a-general-practice/

13 https://www.mja.com.au/journal/2018/208/10/clustered-domestic-residential-aged-care-australia-fewer-hospitalisations-and

Gold Coast Initiatives

GCPHN is already undertaking significant projects to contribute to the organisation's strategic success in the aged care sector and is continuing to improve integration of and coordination with Gold Coast Hospital and Health Service.

InterACT Program

The InterACT Project, was established in 2017 by Gold Coast Health to provide in-hour services to best meet the needs of people living in RACFs. GCPHN provided additional funding to pilot an after-hours component of the service from March 2018. InterACT utilises a clinical nursing workforce through a mixed-modality service model to support RACF residents from 6am to 10.30 pm Monday – Friday and 2pm to 8.30pm Saturday and 8am – 12pm Sunday, 7 days a week. InterACT has supported just under 400 residents in the Gold Coast region from its inception to March 2018, demonstrating a clear need for a service of its kind.

Navigation Services in RACFs Program

GCPHN's Navigation Services in RACFs program is supporting RACFs to engage an existing nursing staff member to assume the part time role of Service Coordinator. Service Coordinators have responsibility for working with general practitioners and medical deputising services to implement consistent cycle of care aligned with the Royal Australian College of General Practitioners (RACGP) Silver Book guidelines ensuring co-ordinated multidisciplinary care and comprehensive care planning. A key role of the service coordinator will be to develop, champion and embed the process and program into the RACF to ensure sustainability beyond GCPHN funding.

The RACF service coordinator role will support:

- Education of RACF clinical staff in proactive care planning
- More effective communications between all multidisciplinary team members in a resident's care
- Increasing number of residents with Advance Care Plans
- Increase use of My Health Record
- Increased access to specialist services where required to meet patient needs.

Consideration should be given to the outcomes of these programs to support ongoing funding for the program as they are filling identified service gaps in the Gold Coast region.

Opportunities

Commonwealth and State priorities

Aged Care Reform

The Australian Government's Department of Health is progressively implementing aged care reforms and moving towards consumer-directed care, meaning people have greater choice and care will be based on their individual needs. By 2022, the Department of Health envisions Australia's aged care system to:

- Be sustainable and affordable, long into the future
- Offer greater choice and flexibility for consumers
- Support people to stay at home, and part of their communities, for as long as possible
- Encourage aged care businesses to invest and grow
- Provide diverse and rewarding career options[14]

The aged care system in Australia is currently undergoing substantial reform to support change within the system towards the delivery of more person-centred, high quality care to older Australians. The development of *Single Aged Care Quality Framework*[15] by the Department of Health will see a framework focused on a single set of quality standards for all aged care services, improved quality assurance measures, a charter of rights for aged care participants and publication of information about quality to assist consumers to make informed decisions on aged care services.

The *National Aged Care Diversity Framework* [16]offers opportunities for existing aged care services to build an inclusive, respectful, and person-centred aged care system. It promotes organisations to recognise and respond to older people with diverse needs including:

- Aboriginal and Torres Strait Islander people
- People from culturally and linguistically diverse (CALD) backgrounds
- Lesbian, Gay, Bisexual, Transgender, Intersex (LBGTI) communities
- People who live in rural, remote or very remote areas
- People with mental health problems and mental illness
- People living with cognitive impairment including dementia
- People with a disability
- Parents separated from their children by forced adoption or removal
- Care-leavers
- People who are homeless or at risk of becoming homeless
- Veterans
- Socio or economic disadvantage

Mental Health

The Australian Government has announced specific funding for RACF in-reach mental health services to be delivered through PHNs. $82.5m will be distributed nationally over 4 years with services due to commence in early 2019. Services will focus on alignment of local mental health and RACF services with national consultation currently underway to determine eligibility and required resources. Individual PHN budgets are not known at this stage. However, this represents a significant opportunity for Gold Coast PHN, given local health needs and services issues reflecting unmet mental health needs in RACFs and high dispensing rates on the Gold Coast for anxiety, antidepressants and antipsychotic medications.

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14 https://agedcare.health.gov.au/aged-care-reform

15 https://agedcare.health.gov.au/quality/single-quality-framework-focus-on-consumers

16 https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/04_2018/aged_care_diversity_framework.pdf

With residents of RACFs no longer having access to MBS funded Psychological Services a unique opportunity presents in targeting Low Intensity Psychological Services to support RACF residents in need of mental and behavioural health services and to upskill RACF staff to be able to recognise and respond to mental health related episodes of residents.

ACAT Assessments

There are upcoming changes that need to be taken into consideration for planning future models of care in the Gold Coast region. ACAT assessment changes from July 1, 2018 will impact the operating environment. It has also been reported that significant changes are on the horizon with CHSP and HCP models, presenting opportunities for improvement to the current delayed care for older people on the Gold Coast due to substantial waitlists with HCP levels 3 and 4.

Palliative Care in Aged Care

As part of the 2018-19 Budget, the Commonwealth Government has committed over $32 million over four years from 2018-19 for the Comprehensive Palliative Care in Aged Care measure which will improve palliative care for older Australians living in residential aged care. It supports new and innovative approaches to how care is delivered by state and territory governments to improve palliative and end-of-life care coordination. While this opportunity overlaps with the work undertaken in the *Palliative Care Needs Assessment Final Report,* it aligns with several local health needs and service issues identified in this report, including the need for timely and appropriate services, capacity-building for RACF staff and presenting opportunities to enable enhanced service integration and resourcing GP support in RACFs.

Aged Care Quality and Safety

Most recently, in September 2018, a Royal Commission into Aged Care Quality and Safety was announced. The Royal Commission will primarily look at the quality of care provided in residential and home aged care to senior and young Australians. It will also explore challenges associated with caring for people with disabilities and dementia, and future challenges and opportunities in delivering aged care in the changing demographics of older Australian population. This presents an opportunistic time for Gold Coast PHN to engage and support local RACFs in quality improvement, person-centred approaches.

As well as being a national priority, Gold Coast PHN has committed to developing a world class health system for the Gold Coast region by enabling strategic measures to improve the experience, value and outcomes of the services they commission and support. Gold Coast PHN's Strategic Plan 2017 – 2022[17] outlines indicators relevant to this project which include:

- Reduction in potentially preventable hospitalisations
- Enhanced skills and knowledge through evidence-based education and training

It is therefore a key priority of this project to influence the strategic measures of success for the Gold Coast PHN.

Locally Driven Opportunities

Throughout the needs assessment and consultation phases of this project, several key themes have evolved. These key themes represent opportunities for improvement or enhancement of existing services to lead to improved experience, value and outcomes of the services Gold Coast PHN commission, coordinate and support.

The purpose of this section is to explore these opportunities and reflect their alignment to the health needs and service issues which form the basis of this report.

[17] https://www.healthygc.com.au/GCPHN/media/Site-Pages-Content/GCPHN/Strategic-Plan-2017-2022.pdf

Opportunity	Alignment to Health Needs and Service Issues
Opportunity One: Workforce Capacity Building	• Improved understanding of business processes for GPs and other providers could support more frequent and effective delivery of integrated services into RACFs • The increased complexity of care and support needs of RACF residents requires an appropriately skilled workforce. • The unmet needs and complexity of issues for people who are homeless or at risk of homelessness has been identified as a significant service gap in consultations. • Low numbers of people identifying as Aboriginal and Torres Strait Islander or who have a preferred language other than English utilise RACF services, despite many RACFs self-reporting they deliver appropriate services for these priority groups. Data availability for other diverse population groups such as older adults identifying as LGBTI+ is limited. • Over 80% of residents in residential aged care facilities (RACFs) have medium-to-high care needs in the domains of daily living activities, cognition/behaviour and complex health care. • The Gold Coast has high rates of medicine dispensing for anxiety disorders and Alzheimer's compared to national rates, and pockets of high dispensing for antidepressants and antipsychotics such as Southport. • The prevalence of dementia in the Gold Coast region is projected to almost double by 2030, and the rate of hospitalisations for dementia has increased rapidly in recent years. In permanent residential aged care, over half of residents have a diagnosis of dementia. • High numbers of preventable hospital admissions for older adults are recorded for chronic obstructive pulmonary disorder, urinary tract infections, angina and heart failure
Opportunity Two: Service Integration	• Improved understanding of business processes for GPs and other providers could support more frequent and effective delivery of integrated services into RACFs • Low numbers of people identifying as Aboriginal and Torres Strait Islander or who have a preferred language other than English utilise RACF services, despite many RACFs self-reporting they deliver appropriate services for these priority groups. Data availability for other diverse population groups such as older adults identifying as LGBTI+ is limited. • The Gold Coast has high rates of medicine dispensing for anxiety disorders and Alzheimer's compared to national rates, and pockets of high dispensing for antidepressants and antipsychotics such as Southport. • The prevalence of dementia in the Gold Coast region is projected to almost double by 2030, and the rate of hospitalisations for dementia has increased rapidly in recent years. In permanent residential aged care, over half of residents have a diagnosis of dementia. • The Gold Coast population is increasingly becoming older, with future demand for aged care services likely to increase significantly

Opportunity Three: Community Awareness and Education	• National and local consultation highlights the ongoing need for timely, appropriate and accessible community information to support people in accessing, navigating and negotiating the aged care system; and the subsequent impact on all levels of the community and service sector support systems • Interstate migration to the Gold Coast for people in their older adult years potentially impacts the availability and strength of formal and informal support systems • The issue of 'reluctant consumers' of conventional services and support, particularly in relation to entering RACFs, is a hidden need which potentially impacts all levels of the community and service sectors. • Low uptake, awareness and confidence in relation to advance care planning, including documentation, legal requirements and how to approach conversations, for both service providers and community members. • Home Care Package waitlists are substantial (HCP 3 and 4 in particular), delaying the delivery of care to older people to support them to remain at home, which can lead to acute hospitalisations and premature placement in an RACF • Low numbers of people identifying as Aboriginal and Torres Strait Islander or who have a preferred language other than English utilise RACF services, despite many RACFs self-reporting they deliver appropriate services for these priority groups. Data availability for other diverse population groups such as older adults identifying as LGBTI+ is limited.
Opportunity Four: Service Navigation and Coordination	• Home Care Package waitlists are substantial (HCP 3 and 4 in particular), delaying the delivery of care to older people to support them to remain at home, which can lead to acute hospitalisations and premature placement in an RACF • Interstate migration to the Gold Coast for people in their older adult years potentially impacts the availability and strength of formal and informal support systems • The issue of 'reluctant consumers' of conventional services and support, particularly in relation to entering RACFs, is a hidden need which potentially impacts all levels of the community and service sectors. • National and local consultation highlights the ongoing need for timely, appropriate and accessible community information to support people in accessing, navigating and negotiating the aged care system; and the subsequent impact on all levels of the community and service sector support systems • The Gold Coast has high rates of medicine dispensing for anxiety disorders and Alzheimer's compared to national rates, and pockets of high dispensing for antidepressants and antipsychotics such as Southport.
Opportunity Five: Advanced Care Planning	• Low uptake, awareness and confidence in relation to advance care planning, including documentation, legal requirements and how to approach conversations, for both service providers and community members. • The prevalence of dementia in the Gold Coast region is projected to almost double by 2030, and the rate of hospitalisations for dementia has increased rapidly in recent years. In permanent residential aged care, over half of residents have a diagnosis of dementia. • Over 80% of residents in residential aged care facilities (RACFs) have medium-to-high care needs in the domains of daily living activities, cognition/behaviour and complex health care.

Appendices

Service Mapping: Aged care service providers by SA3 region

SA3	Organisation name	Service name	Residential care	Home Care Packages	Home Support Program
Broadbeach - Burleigh	McKenzie Aged Care	SandBrook Aged Care	Yes	No	No
Broadbeach - Burleigh	Meals on Wheels Queensland	Broadbeach Meals on Wheels	No	No	Yes
Broadbeach - Burleigh	Ozcare	Ozcare Day Respite Centre - Burleigh Heads	No	No	Yes
Broadbeach - Burleigh	Ozcare	Ozcare Ozanam Villa Burleigh Heads Aged Care Facility	Yes	No	No
Broadbeach - Burleigh	Tricare	Mermaid Beach Aged Care Residence	Yes	No	No
Broadbeach - Burleigh	Volunteering Services Australia	Volunteering Gold Coast Transport Service	No	No	Yes
Broadbeach - Burleigh	**Sub-total**		**3**	**0**	**3**
Coolangatta	Australian Unity	Australian Unity Home Care Service Tweed Heads	No	Yes	Yes
Coolangatta	Bannister In Home Care	Bannister In Home Care Queensland	No	Yes	No
Coolangatta	Blue Care	Blue Care Kirra Community Care	No	No	Yes
Coolangatta	Blue Care	Blue Care Kirra Aged Care Facility	Yes	No	No
Coolangatta	Blue Care	Blue Care Elanora Community Care and Allied Health	No	Yes	Yes
Coolangatta	Blue Care	Blue Care Elanora Pineshaven Aged Care Facility	Yes	No	No
Coolangatta	Bolton Clarke	RSL Care Gold Coast - Galleon Gardens	Yes	No	No
Coolangatta	Bupa	Bupa Tugun	Yes	No	No
Coolangatta	Carers QLD Australia	Carers Queensland South/Gold Coast Region	No	No	Yes
Coolangatta	Coolangatta Senior Citizens Centre	Coolangatta Senior Citizens Centre	No	No	Yes
Coolangatta	Feros Care	Feros Care (CHSP) and (STRC) - South Coast QLD	No	Yes	Yes
Coolangatta	Gold Coast Home Care	Home Care and Allied Health Gold Coast Services	No	No	Yes
Coolangatta	Meals on Wheels Queensland	Palm Beach Meals on Wheels	No	No	Yes
Coolangatta	Opal Aged Care	Opal Kirra Beach	Yes	No	No
Coolangatta	**Sub-total**		**5**	**4**	**8**
Gold Coast - North	501 Care Centre	501 Respite & Care Services	Yes	No	No
Gold Coast - North	Blue Care	Blue Care Southport Community Care	No	Yes	Yes
Gold Coast - North	Blue Care	Blue Care Labrador Aged Care Facility	Yes	No	No

Gold Coast - North	Blue Care	Blue Care Arundel Woodlands Lodge Aged Care Facility and Blue Care Arundel Community Care	Yes	Yes	Yes
Gold Coast - North	Bupa	Bupa Runaway Bay	Yes	No	No
Gold Coast - North	Dementia Australia	Alzheimer's Australia Gold Coast	No	No	Yes
Gold Coast - North	HomeCare Australia	HomeCare Australia - Gold Coast	No	Yes	No
Gold Coast - North	Islamic Women's Association of Australia	IWAA - Gold Coast	No	Yes	Yes
Gold Coast - North	Labrador Memorial Senior Citizens Association Incorporated	Labrador Memorial Senior Citizens Assn Inc	No	No	Yes
Gold Coast - North	Meals on Wheels Queensland	Paradise Point Meals On Wheels	No	No	Yes
Gold Coast - North	Ozcare	Ozcare Day Respite Centre - Runaway Bay	No	No	Yes
Gold Coast - North	Ozcare	Ozcare Keith Turnbull Place Aged Care Facility	Yes	No	No
Gold Coast - North	Ozcare	Ozcare Parkwood Gardens Aged Care Facility and Respite Centre	Yes	No	Yes
Gold Coast - North	Paradise Lakes Care Centre	Paradise Lakes Care Centre	Yes	No	No
Gold Coast - North	Provectus Care	Harbour Quays Aged Care	Yes	No	No
Gold Coast - North	St Vincent de Paul Society	St Vincent de Paul Gold Coast	No	No	Yes
Gold Coast - North	St Vincent's Care Services	St Vincent's Care Services Arundel	Yes	No	No
Gold Coast - North	Tricare	Labrador Aged Care Residence	Yes	No	No
Gold Coast - North	Tricare	Bayview Place Aged Care Residence	Yes	No	No
Gold Coast – North	**Sub-total**		**11**	**4**	**9**
Gold Coast Hinterland	Beaumont Care	Beaumont Care - Roslyn Lodge	Yes	No	No
Gold Coast Hinterland	Tamborine Mountain Community Care Association	Tamborine Mountain Community Care	No	No	Yes
Gold Coast Hinterland	**Sub-total**		**1**	**0**	**1**
Mudgeeraba - Tallebudgera	Blue Care	Blue Care Tallebudgera Talleyhaven Aged Care Facility	Yes	No	No
Mudgeeraba - Tallebudgera	Carinity	Carinity Cedarbrook	Yes	No	No
Mudgeeraba - Tallebudgera	Estia Health	Estia Health Mudgeeraba	Yes	No	No
Mudgeeraba - Tallebudgera	Kalwun Development Corporation	Kalwun Aged Care Project	No	Yes	Yes
Mudgeeraba - Tallebudgera	Lutheran Services	St Andrews	Yes	Yes	No
Mudgeeraba - Tallebudgera	**Sub-total**		**4**	**2**	**1**
Nerang	Adventist Retirement Plus	Melody Park Adventist Residential Care residence (also called Wisteria Lodge)	Yes	No	No
Nerang	Churches of Christ Care	Churches of Christ Care Homesteads Aged Care Service	Yes	No	No
Nerang	Clanwilliam Aged Care	Nerang Nursing Centre	Yes	No	No
Nerang	Earle Haven Retirement Village	People Care Pty Ltd Hibiscus House / People Care Pty Ltd (Earle Haven Retirement Village)	Yes	Yes	No

Nerang	Liberty Community Connect	Liberty Community Connect	No	Yes	Yes
Nerang	Meals on Wheels Queensland	Nerang And Districts Meals On Wheels	No	No	Yes
Nerang	**Sub-total**		**4**	**2**	**2**
Ormeau - Oxenford	Arcade	Arcare Home Packages QLD Gold Coast	No	Yes	No
Ormeau - Oxenford	Arcade	Arcare Hope Island	Yes	No	No
Ormeau - Oxenford	Arcade	Arcare Helensvale	Yes	No	No
Ormeau - Oxenford	Arcade	Arcare Sanctuary Manors	Yes	No	No
Ormeau - Oxenford	Arcade	Arcare Helensvale St James	Yes	No	No
Ormeau - Oxenford	Baldwin Living	Baldwin Living HomeServe (Sequana)	No	Yes	No
Ormeau - Oxenford	Blue Care	Blue Care Coomera Community Care	No	Yes	Yes
Ormeau - Oxenford	Blue Care	Blue Care Beenleigh Allied Health and Community Care	No	Yes	Yes
Ormeau - Oxenford	CPSM Care	Magnolia Aged Care Coomera	Yes	No	No
Ormeau - Oxenford	Enrich Living Services (formerly St Ives Home Care)	Enrich Living Services QLD (formerly St Ives Home Care) - 1300 20 20 03	No	Yes	No
Ormeau - Oxenford	Lions Haven for the Aged	Lions Haven For The Aged	Yes	No	No
Ormeau - Oxenford	Queensland Government Gold Coast Health	Helensvale Community Health Centre	No	No	No
Ormeau - Oxenford	Tricare	TriCare Pimpama Aged Care Residence	Yes	No	No
Ormeau – Oxenford	**Sub-total**		**7**	**5**	**2**
Robina	Allity	Villa Serena Aged Care	Yes	No	No
Robina	Anglicare	Anglicare Southern Queensland Gold Coast	No	Yes	Yes
Robina	Bupa	Bupa Merrimac	Yes	No	No
Robina	Care Connect	Care Connect Queensland Home Care Package Level 1-4	No	Yes	No
Robina	Hibernian (QLD) Friendly Society	BalliCara HomeCare	No	Yes	Yes
Robina	HillView	HillView - Merrimac	Yes	No	No
Robina	Just Better Care	Just Better Care Gold Coast	No	Yes	Yes
Robina	McKenzie Aged Care	The Terraces Aged Care	Yes	No	No
Robina	Opal Aged Care	Opal Varsity Rise	Yes	No	No
Robina	Opal Aged Care	Opal Varsity Rise	Yes	No	No
Robina	Ozcare	Ozcare - Gold Coast	No	Yes	Yes
Robina	Superior Care Group	Merrimac Park Private Care	Yes	No	No
Robina	Tricare	TriCare Cypress Gardens Aged Care Residence	Yes	No	No
Robina	Vision Australia	Vision Australia Gold Coast	No	No	Yes
Robina	Wesley Mission Australia	Wesley Mission Queensland - Community Care (South Coast)	No	Yes	Yes
Robina	**Sub-total**		**8**	**6**	**6**
Southport	Anglicare	Anglicare SQ Abri Home for the Aged	Yes	No	No
Southport	Australian Red Cross	Australian Red Cross Social Support - Bridges	No	No	Yes
Southport	Bolton Clarke	RSL Care Gold Coast - Bolton Clarke	No	Yes	Yes
Southport	Churches of Christ Care	Churches Of Christ Care Community Care Gold Coast	No	Yes	Yes

Southport	Churches of Christ Care	Churches of Christ Care Marana Gardens Aged Care Service	Yes	No	No
Southport	Churches of Christ Care	Churches of Christ Care Golden Age Aged Care Service	Yes	No	No
Southport	CURA	CURA Community Services	No	Yes	Yes
Southport	De Paul Villa Aged Care	De Paul Villa Aged Care	Yes	No	No
Southport	Diversicare	Diversicare - South Coast	No	Yes	Yes
Southport	Estia Health	Estia Health Gold Coast	Yes	No	No
Southport	FSG	FSG Home Care Gold Coast	No	Yes	No
Southport	Gold Coast Health	Gold Coast Transition Care Program	No	No	Yes
Southport	Hibernian (QLD) Friendly Society	BallyCara HomeCare Gold Coast	No	Yes	No
Southport	HillView	HillView - Ashmore	Yes	No	No
Southport	Home Care Assistance Gold Coast	Alzheimer's Care on the Gold Coast	No	Yes	No
Southport	Home Care Assistance Gold Coast	Home Care Assistance Gold Coast	No	Yes	No
Southport	Home Instead Senior Care QLD	Home Instead Senior Care	No	Yes	No
Southport	Home Support Services	Home Support Services - South Coast	No	Yes	No
Southport	KinCare	KinCare	No	Yes	Yes
Southport	Luminise Care Solutions - The Henley	Luminise Care Solutions - The Henley	No	Yes	No
Southport	Meals on Wheels Queensland	Gold Coast And Districts Home Care Meals On Wheels And Senior Citizens Welfare Organisation	No	No	Yes
Southport	Opal Aged Care	Opal Leamington	Yes	No	No
Southport	Opal Aged Care	Opal Ashmore	Yes	No	No
Southport	Retreat Care	Ashmore Retreat	Yes	No	No
Southport	Southern Cross Care	Southern Cross Care Community Services - Gold Coast Office	No	No	Yes
Southport	Southport Lodge	Southport Lodge	Yes	No	No
Southport	St Vincent's Care Services	St Vincent's Care Services - Gold Coast Home Care	No	Yes	No
Southport	Transcord Community Transport Organisation - Gold Coast Inc.	Transcord Community Transport Organisation - Gold Coast	No	No	Yes
Southport	**Sub-total**		**10**	**13**	**10**
Surfers Paradise	Angels in Aprons	Angels in Aprons Gold Coast	No	Yes	No
Surfers Paradise	Avida Care	Avida Care	No	Yes	Yes
Surfers Paradise	Churches of Christ Care	Churches of Christ Care Lady Small Haven Aged Care Service	Yes	No	No
Surfers Paradise	CO.AS.IT Community Services	CO.AS.IT Community Services Inc. - South Coast	No	Yes	Yes
Surfers Paradise	Greek Orthodox Community of St George	GOC Care Gold Coast	No	Yes	Yes
Surfers Paradise	PresCare	PresCare Community Care Gold Coast	No	Yes	No
Surfers Paradise	STAR Community Services	Star Community	No	No	Yes
Surfers Paradise	**Sub-total**		**1**	**5**	**4**

Gold Coast Primary Health Network

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PALLIATIVE CARE HEALTH

Needs Assessment Summary

2018

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Palliative Care Health

Identified local health needs and service issues

- Carers require support to ensure they don't "burn out".
- Limited uptake of Advanced Care Plans (ACPs).
- Care coordination and support to general practice to be the centre of care where possible
- Residential Aged Care Facilities (RACFs) service high numbers of palliative patients.
- Current systems not always supportive to ensure planning, commissioning and delivery of integrated and coordinated service matrix.
- Access to integrated palliative care system across the health and social sector so people are supported as early as possible.
- Current limitations for ensuring that patient choice and wishes are respected.
- Options for better conversations about death and dying, and involvement.
- Need to ensure people can access good quality end of life care 24/7.
- Access to clear communication, and accessible information for patients, families and healthcare professionals.
- Provisions of care required to allow patients achieving their preferred place of death.
- Current systems not always established for the provision of clinical coordination of end of life care between providers.
- To ensure all providers are skilled and competent in delivering high quality palliative and EOL care.

Key Findings

National research shows that most Australians would prefer to die at home, but many don't, with over half of deaths occurring in a hospital.

While the accessibility and use of palliative care services is increasing, the proportion of people who receive palliative care services is still relatively low, particularly for non-cancer related diagnoses.

At a national level, patient outcomes show that the effectiveness of palliative care services has increased significantly over the last 10 years in relation to symptoms such as pain, fatigue, breathing problems and family or carer problems.

Actual data on patient outcomes for palliative care services in the Gold Coast region is still emerging. Early indicators would show the effectiveness of inpatient treatment exceeds national benchmarks, however treatment delivered in a community setting did not meet benchmarks due to the limited availability of these services to provide treatment on demand at all times of the day.

The demand on palliative care and specialist palliative care services is projected to increase in the Gold Coast region, with its ageing population and higher proportion of older people in the region.

Currently, the majority of the specialist palliative care service demand falls to the specialist public inpatient and community facilities at Robina Hospital and Gold Coast University Hospital.

Consultation highlighted a range of issues that may be impacting the effectiveness of generalist palliative care services to meet the needs of people, which would enable specialist services to more appropriately focus their limited resources on more complex cases.

These issues include clinical handover and discharge planning to support transitions between the hospital and home (including RACFs). Continued integration and coordination of specialist and generalist palliative care services could lead to more positive patient outcomes. A desire for general practitioners (GPs) to play a central role throughout a person's palliative care journey was reported from multiple perspectives. More broadly, community and sector consultation confirmed issues on the Gold Coast with:

- service access and navigation
- limited health and death literacy
- workforce capacity and capability for generalist services
- service availability and resourcing.
- Professionals feeling supported and able to learn and to care
- People want to receive care in their homes and local communities as much as possible.
- People want information that supports them to be partners in decisions about their care.
- People need end of life and palliative care that responds to an ageing population.
- People are sicker and require palliative care that can be provided alongside other treatments that respond to their complex care needs.
- Many people with chronic or life-limiting illnesses (including some cancers) are living for much longer, requiring a different response from end of life and healthcare services.
- Some groups in our community do not access services for end of life care or get the care they need.
- The healthcare, human services and community workforce needs to adapt with new skills to better identify and support the end of life needs of people, their families and carers.
- All services need to operate more efficiently in order to deliver care that is sustainable.
- Community expectations have increased, with growing interest in discussing death and dying and planning for end of life with a method such as advance care planning.

What is commissioning

In Primary Health Network (PHN) context, commissioning is a continual practice of purchasing services aligned to:

- local needs
- outcomes from strategic planning
- Gold Coast Primary Health Network's (GCPHN) unique objectives
- identified national priorities.

Scope

The key objectives for this health needs assessment was to provide evidence-based information to inform commissioning processes including:

- Establish local health needs through qualitative and quantitative data analysis
- Inform annual planning, reporting and evaluation processes for GCPHN
- Inform service planning and co-design mechanisms for effective palliative care commissioning.

Focus areas identified by GCPHN's organisational objectives and relating to palliative care include:

- Activities aligning to and addressing the recommendations from the Integrated Care Alliance's Model of Palliative Care
- Primary and community-based programs delivering palliative care services to people in their home, including residential aged care facilities (RACFs)
- Activities focused on reducing preventable emergency presentations and admissions from the individual's home (including RACFs).

Methodology

A mixed methodology was used to ensure a comprehensive needs assessment incorporating quantitative data analysis, service mapping, patient journey mapping, consultation and co-design workshops.

Quantitative data

Quantitative data indicators selected aimed to provide a detailed analysis of the drivers of service demand and levels of existing service utilisation to strategically guide future program investment for GCPHN. Data sources included but not limited to:

- Australian Bureau of Statistics Census data
- Social Health Atlases of Australia, Public Health Information Development Unit (PHIDU)
- Australian Institute of Health and Welfare (AIHW) Gen Aged Care Data Portal
- AIHW My Healthy Communities Data Portal
- Medicare Item Reports
- Data supplied by Gold Coast Health.

Other sources of data were explored to ensure a rounded and holistic view of data-informed need.
Analysis was primarily limited to that data which was publicly available with a breakdown at a regional level.
Where possible, indicators were examined at a subregional level.

Service mapping

Service mapping was undertaken in a systematic way, commencing with the existing knowledge base that GCPHN has previously collected relating to aged care services and providers then assessed against deeper level analysis via desktop research.

Service mapping focused on a breakdown of service type, provider, geographic location, target population (e.g. mainstream or specific priority populations) and provider type (e.g. for-profit, not-for-profit, government).

Patient journey mapping

Patient journey mapping was utilised as an engagement tool to understand service issues and enablers from the perspective of health consumers. Patient journey mapping was developed in partnership with Palliative Care Queensland (PCQ) for their knowledge and expertise to effectively undertake consumer engagement.

PCQ captured several distinct patient journeys reflecting common palliative care pathways in the Gold Coast PHN region using the following approach:

Key Activities	Process
Determine Common Journey Types	Utilise the expertise of GCPHN and the Palliative Care Leadership Group to determine common journey types for the Gold Coast palliative care environment.
Identification of Gold Coast Common Journey Pathways (based on Common Journey Types)	Facilitate a two-hour workshop with local stakeholders (based on peak bodies' local networks) to identify common journey pathways based on the pre-determined common journey types Explore both positive and negative experiences within each common journey type Identify why individuals (health professionals or patients/residents/ family members) felt the experience was positive or negative
Develop Common Journey Pathways into a visual format (including a narrative) for co-design workshops	Develop a visual representation of the patient journey pathways to inform the co-design and planning phases of the project.

The aim of the patient journey mapping was to identify components of the local service system that are working well and highlight potential areas for improvement. Consumer interactions and experiences with a range of stakeholders were considered including but not limited to:

- Family, carers and informal support networks
- Specialist palliative care services (i.e. hospital and hospice)
- Community-based providers of palliative care
- Aged care service providers
- Primary health care services, particularly GPs
- Queensland Ambulance Service
- Pharmacies
- Community and psychosocial supports

Targeted consultation

Recognising the importance of the project and need for a collaborative approach a multifaceted consultation methodology was taken to inform this needs assessment.

In June 2018, Gold Coast PHN established high-functioning advisory mechanisms to provide expert input and advice into PHN core business and activities. These groups were key in providing direct feedback on initial drafts of this report and include:

- GCPHN Community Advisory Council
- GCPHN Clinical Advisory Council
- GCPHN Primary Care Partnership Council

In July 2018, Gold Coast PHN established the Palliative Care Leadership Group to provide advice and guidance for the development of a needs assessment, regional plan and guiding implementation of subsequent activities that support people to continue to:

- live and die at home
- access appropriate primary health care services
- avoid unnecessary hospital transfers.

Consultation with the wider sector and community occurred through sector specific co-design workshops attended by 41 sector representatives including Gold Coast Health, a wide range of NGO support and palliative care providers, Hopewell Hospice, independent providers, consumers and carers.

Evidence

The Australian Commission on Safety and Quality in Health Care (ACSQHC) defines palliative care as care specifically tailored to assist with the effects of life-limiting illnesses1. It positions palliative care as different from the broader concept of end-of-life care which generally refers to the period of the 12 months prior to death, whereas palliative care may be episodic over an extended period.

Palliative care is an approach to treatment that improves the quality of life for patients and their families facing life-limiting illness, through the prevention and relief of suffering. It involves early identification, impeccable assessment and treatment of pain and other problems (physical, psychosocial and spiritual).

Service demand

There were 3,512 deaths recorded for the GCPHN region during 2016, the most recent year for which data is available. The number of deaths recorded in the region has increased from 2,836 in 2006, an increase of almost 24% in the 10-year period.

The ten leading causes of death for the Gold Coast region over the period 2012-2016 represented 50% of all deaths, is outlined in Table 1.

Table 1: Ten leading causes of death for Gold Coast PHN region by number and proportion of all-cause mortality, 2012-2016

Cause of death (ICD classification)	Number of deaths	Proportion of all causes
Coronary heart disease (I20–I25)	2,320	13.5
Cerebrovascular disease (I60–I69)	1,220	7.1
Dementia and Alzheimer disease (F01, F03, G30)	1,188	6.9
Lung cancer (C33, C34)	1,033	6.0
Chronic obstructive pulmonary disease (COPD) (J40–J44)	675	3.9
Colorectal cancer (C18–C21)	564	3.3
Prostate cancer (C61)	458	2.7
Cancer of unknown or ill-defined primary site (C26, C39, C76–C80)	404	2.3
Diabetes (E10–E14)	396	2.3
Suicide (X60–X84)	381	2.2

Source: AIHW, Mortality Over Regions and Time (MORT) books (PHN)

Given many of the deaths recorded within the region are related to a chronic cause many of these deaths are likely to have a distinguishable phase where there was an opportunity for the provision of appropriate and effective palliative care.

Service utilisation

Accessibility and appropriate utilisation of high-quality palliative care services can enable a person and their family to receive the care and support they need at the end-of-life, supporting them to die at home with dignity and in comfort and prevent unnecessary hospitalisations. Previous estimates indicate that 70% of Australians wish to die at home[2], however around half of all deaths occur in hospital.

1 Australian Commission on Safety and Quality in Health Care (2015). National Consensus Statement: essential elements for safe and high-quality end-of-life care

2 Swerissen, H and Duckett, S., (2014). Dying Well. Grattan Institute: Melbourne

Palliative care services in Australia are provided in a range of settings including:

- public and private hospital facilities,
- residential aged care facilities and
- in patient's homes through primary care providers.

The availability of data relating to palliative care services is limited, particularly comprehensive data relating to palliative care services delivered in the community by general practitioners (GPs), non-palliative medicine specialists and allied health and ancillary practitioners. The Australian Institute of Health and Welfare (AIHW) has reported it is exploring the development of a mechanism to collect national data on palliative care activity in general practice.

Palliative care delivered in hospital setting

AIHW's report *Palliative care services in Australia 2018*[3] identifies several key service issues at a national l evel, including:

- There were 62,800 palliative care-related hospitalisations reported from public hospitals in Australia in 2015-16, with a further 11,100 in private hospitals. This represented a 13.8% increase from the previous year.
- Over half of these (52%) were for people aged 75 years and over.
- 51% of patients who die as an admitted patient at a hospital received palliative care
- Almost half (48.2%) of palliative care hospitalisations involved a type of cancer as the principal diagnosis, with the next most frequent diagnoses stroke (4.2%), heart failure (3.4%) and influenza and pneumonia (3.4%).
- 53% of patients admitted to hospital for palliative care died in hospital, while around 29% of patients were discharged to their own accommodation or usual residence (including usual residents of aged care facilities) and 8% are transferred to another acute hospital facility.
- The average length-of-stay for palliative care-related hospitalisations in public hospitals, including same-day separations, was 10 days.

Table 2 shows the change in Gold Coast Health palliative care-related hospital separations and associated bed days over the period 2011 to 2017, as well as projections over the next five and ten years.

Table 2: Number of palliative care-related separations and occupied bed days in Gold Coast Health facilities, 2011 to 2017 actual, 2022 and 2027 projected

Age group (years)	2011	2012	2013	2014	2015	2016	2017	2022 (proj.)	2027 (proj.)
Separations									
0-14	0	1	1	3	0	1	0	2	2
15-44	44	40	24	46	41	43	57	43	47
45-69	276	266	320	271	333	298	299	414	500
70-84	296	277	267	256	417	341	335	573	742
85+	100	89	100	112	155	160	163	278	430
Bed days									
0-14	0	15	10	33	0	6	0	13	17
15-44	443	396	141	472	315	309	529	351	395
45-69	2,659	2,877	2,967	2,794	2,509	2,442	2,147	3,300	3,829
70-84	3,071	2,531	2,250	2,034	3,203	2,678	2,346	4,417	5,505
85+	788	660	605	934	1,137	1,101	967	2,036	2,998

Source: Gold Coast Hospital and Health Service, Strategy and Health Service Planning Branch

This shows a total of 854 palliative care-related separations occurred in 2017, which represented a total of 5,989 occupied bed days at an average length of stay of around 7 days.

[2] AIHW (2018). Palliative care services in Australia, AIHW: Canberra

The most separations were recorded for the 70 to 84-year age group, while the highest average length of stay was for patients aged 15-44 years. By 2027, it is projected that the number of palliative care-related separations will double to over 1,700 separations.

Palliative care delivered in primary care and community settings

There are a number of items listed on the Medical Benefits Schedule (MBS) for palliative care treatment by palliative medicine specialists, but not specifically for palliative care provided by GPs, other specialists (e.g. geriatricians, oncologists) or allied health.

The most recent publicly available data from 2015-16 shows that in the Gold Coast region only 96 services were claimed by four providers for any palliative medicine specialist items listed on the MBS4. This equates to a crude rate of MBS-subsidised palliative services of around 16.8 per 100,000 people for the Gold Coast region, compared to the national rate of 310.4 per 100,000 population. All of these services were claimed under MBS item 3005, for a palliative specialist initial attendance at consulting rooms or hospital. However, it is acknowledged that this is likely to have since increased due to the creation of specialist palliative outpatient clinics locally that utilise MBS charging as a component of the resourcing.

MBS items used by GPs treating palliative care patients are likely to be recorded across a range of other non-specific MBS items such as standard attendances (including after hours and within RACFs) and chronic disease management. Available data relating to the provision of palliative care by GPs is limited to the nationally representative Bettering the Evaluation and Care of Health (BEACH) survey which was administered using an ongoing data collection process up until 2015-16[5].

National reported by the BEACH survey indicated that about 1 in every 1,000 GP consultations reported were palliative care-related. Interestingly, the rate of palliative-care related GP encounters was lower in Major Cities (0.7 per 1,000 encounters) compared to Inner Regional (2.0 per 1,000) and Outer Regional (1.5 per 1,000) locations. Most of the GCPHN region is categorised as 'Major City'. This may indicate a greater proportion of palliative care services are provided by specialist palliative services in those regions that are more likely to have them (e.g. large public hospitals, hospices). A more recent survey commissioned by the Department of Health into the provision of palliative care within general practice[6] indicates that GPs may be providing more palliative care than previously thought. It suggests the rate of palliative care-related GP attendances is closer to 1 in every 100 consultations rather than the 1 in 1000 figure quoted earlier.

[3] Department of Human Services, Medicare Australia Statistics, http://medicarestatistics.humanservices.gov.au/

[4] Bettering the Evaluation and Care of Health (BEACH) survey 2015-16, Family Medicine Research Centre, University of Sydney http://sydney.edu.au/medicine/fmrc/beach/

[5] Department of Health (2017). Research into awareness, attitudes and provision of best practice advance care planning, palliative care and end of life care within general practice.

Performance of palliative care services

The Australian Palliative Care Outcomes Collaboration (PCOC) is a national program that utilises standardised clinical assessment tools to measure and benchmark patient outcomes in palliative care[7]. Participation in PCOC is voluntary and can assist palliative care service providers to improve patient outcomes. It is administered by the Australian Health Services Research Institute based at the University of Wollongong. PCOC's data collection covers more than 250,000 people who have received palliative care over the last decade. National data for 2017 shows that[8]:

- Just over half of all episodes completed were in an inpatient setting (53.4%), with the remainder completed in the community (46.6%).
- Palliative care episodes were disproportionately accessed by socioeconomic status, with those people in higher socio-economic status categories reporting higher episodes of palliative care in both inpatient and community settings.
- The average age of people undertaking a palliative care episode was 72.8 years
- There was a total of 228 episodes reported for patients under 25 years of age, which represented only 0.4% of all episodes.
- A higher proportion of males (53.2%) underwent palliative care episodes compared to females (46.8%).
- Over three quarters of episodes of palliative care (77.6%) were for patients with a cancer diagnosis, despite patients suffering from other chronic life-limiting conditions such as heart failure, COPD or dementia have symptoms as severe and distressing as those of cancer patients.
- Over three quarters of episodes of palliative care (77.6%) were for patients with a cancer diagnosis.

Analysis of the patterns of national outcome data collected through PCOC from 2009 to 2016 shows:

- More patients are having palliative care commence within two days of when they are ready.
- The time patients spend in the unstable phase has been getting shorter
- The proportion of patients reporting absent or mild distress at the end of a phase has been improving, with slightly better outcomes in the inpatient setting
- The number of family members and carers experiencing moderate or severe problems at the end of a phase of care has been decreasing over time.

At a local level, PCOC data is available for the specialist palliative care services delivered in public facilities at Robina Hospital and Gold Coast University Hospital and the privately-operated Hopewell Hospice. BlueCare, an NGO who provide community palliative care services for Gold Coast Health have previously submitted data to PCOC but data from 2017 was not available for analysis.

Table 3 compares the patient outcomes of the four Gold Coast Health specialist palliative services and Hopewell Hospice against the PCOC benchmarks. The outcomes for all Queensland inpatient and community setting services are also included for comparative purposes.

[6] Palliative Care Outcomes Collaboration (PCOC), Australian Health Services Research Institute, University of Wollongong https://ahsri.uow.edu.au/pcoc/index.html

[7] Palliative Care Outcomes Collaboration (2018) Palliative care services at a glance, 2017 data tables Australian Health Services Research Institute, University of Wollongong

Table 3: PCOC patient outcomes data reported for hospital/hospice palliative care services in GCPHN region, Jul to Dec 2017

Outcome			PCOC benchmarks	Robina Hospital Specialist Palliative Unit - Inpatient	Robina Hospital Consultation Service	GCUH Consultation Service	Hopewell Hospice	Robina Hospital Specialist Palliative Unit - Community	All Qld inpatient services	All Qld community services
Patient volumes	Patients			234	87	250	80	246	3,161	1,303
	Episodes			277	91	297	80	283	3,800	1,561
	Phases			787	133	564	154	464	7,879	2,747
Median age at episode start				71	77	69	76.5	71	72	72
Median episode length in days				7	1	3	5	18	5	26
Patient outcomes	% of episodes starting day of or day after patient is ready for care to start		90	97.0	98.9	99.0	100	59.5	98.4	81.7
	% of patients with three days or less in unstable phase		90	91.1	100	85.7	-*	70.3	86.6	74.4
	% of patients who started episode with absent / mild symptoms ended with absent / mild	Pain PCPSS	90	94.0	91.4	87.5	76.7	70.5	92.6	80.7
		Pain SAS	90	93.3	95.3	NA	87.3	75.5	92.6	84.6
		Fatigue	90	95.6	100	NA	93.8	69.7	91.8	80.7
		Breathing problems	90	98.5	100	NA	98.6	75.6	96.0	87.4
		Family / carer	90	95.8	96.2	93.3	91.9	70.9	92.6	74.4
	% of patients who started episode with moderate / severe symptoms ended with absent / mild	Pain PCPSS	60	61.5	51.7	59.1	75.0	40.0	61.9	40.8
		Pain SAS	60	61.6	52.9	NA	69.2	18.8	58.8	32.2
		Fatigue	60	78.4	-*	NA	100	9.6	52.1	26.8
		Breathing problems	60	65.4	-*	NA	-*	24.1	53.3	26.0
		Family / carer	60	56.8	47.4	53.7	50.0	32.5	51.1	30.3

*This item was suppressed as there were less than 10 observations included in this benchmark
NA – these items are unavailable as SAS is not currently collected in this service
Source: Palliative Care Outcomes Collaborative (PCOC), data supplied by Australian Health Services Research Institute at University of Wollongong

Workforce

Reliable data relating to the size and breakdown of the palliative care workforce is not currently available for the Gold Coast region.

- Nationally, there was a total of 153.1 full-time equivalent (FTE) specialist palliative medicine physicians working in clinical positions in 2016, of which 45.4 FTE work in Queensland[9].
- The majority of specialist palliative medicine physicians work mostly in the hospital setting (74.8%), followed by 'other community health care services (8.9%) and outpatient service (8.1%).

There were an estimated 2,719 FTE palliative care nurses employed in a clinical role nationally in 2016. Of these, 549.4 FTE were working within Queensland. Most of these roles are working in the hospital setting (52.4%), followed by 'community health care services' (24.1%) and hospices (13.7%).

Prescribed medication

Prescribed medication is an important component of palliative care. These medications are defined as clinically relevant for patients with 'active, progressive and far advanced diseases for whom the prognosis is limited and the focus of care is quality of life'[10]. These medications typically involve:

- analgesics for pain relief
- anti-epileptics to treat seizures
- anti-inflammatory and anti-rheumatic products to treat inflammation
- drugs for gastrointestinal disorders
- laxatives to treat constipation)
- psycholeptics to tranquillise/depress the central nervous system
- stomatological preparations to treat diseases of the mouth.

While no regional data is not available, national data on palliative care-related prescribing in 2015-16 indicates that:

- Around 83,000 palliative care medications were prescribed to around 52,000 patients.
- 78.6% of palliative care-related prescriptions were subsidised in full or part by the Pharmaceutical Benefits Scheme (PBS).
- The most commonly prescribed medication type was laxatives (28.3%) followed by analgesics (22.0%), and anti-inflammatory and anti-rheumatic products (18.0%).
- Almost 90% of palliative-care related prescribing was done by GPs, with palliative medicine specialists only prescribing 2.4% of palliative care-related medications.
- There were differences in the medications prescribed by type of clinician, with GPs most frequently prescribing laxatives (28.6%) and palliative medicine specialists mostly prescribing analgesics (46.6%).

[8] Australian Institute of Health and Welfare (2018). Palliative care services in Australia – Summary

[9] ibid

Service Mapping

GCPHN shares an aim with the Gold Coast Hospital and Health Service (HHS) to enhance, integrate and collaborate community and primary palliative care services. This service mapping activity provides an overview of the current service environment, including definitions of both palliative care and specialist and generalist palliative care.

To ensure consistency at a local level, Gold Coast HHS has undertaken a significant body of work through their Integrated Care Alliance [11](The Alliance) in categorising types of palliative care providers:

Generalist Palliative Care (Primary Generalist Provider, Primary Specialist Provider):

Generalist Palliative Care is palliative care provided for those affected by a life-limiting illness as an integral part of standard clinical practice by any healthcare professional that is not part of a specialist palliative care team.

Not all people approaching the end of life need specialist palliative care. Generalist palliative care is provided in the community by a Primary Generalist Provider which can include; general practice teams, allied health teams, community nurses, residential care staff, community support services and community paediatric teams, however, in general, the substantive work of a primary generalist provider is not in the care of people who are dying.

Generalist palliative care can also be provided by Primary Specialist Providers, defined by Palliative Care Australia as a specialist that has first contact with the patient with a life-limiting illness. Primary specialist providers include oncologists, renal, cardiac or respiratory physicians. In general, their substantive work is not in palliative care. The care of a primary specialist provider is generally received in hospital.

Providers of generalist palliative care will have defined links with specialist palliative care team(s) for the purposes of support and advice, or in order to refer persons with complex needs. If palliative care is a performed on a regular basis or they simply have an interest in this type of care, these health providers have access to education and learning to support their practice.

Generalist Palliative Care Providers

General Practitioners

GPs are typically the key navigator of an individual's care and often have long-standing relationships with individuals. GPs support palliative care patients in their practice or through home visits and play a vital role in the delivery of advance care planning due to the often long-term and trusting relationship they have with their patients. GPs play an important role in identifying and assessing palliative care needs, pain management, medication management, bereavement support, and can be pivotal in the promotion of early referral to supportive and palliative care services.

Non-Government Organisations

There are a wide range of Non-Government Organisations (NGOs) on the Gold Coast region that provide different levels of community palliative care services. Care can range from complex nursing care, home care, personal care and bereavement, often with supports available 24/7. Cost of the individual's community care can often be subsidised under the Commonwealth Home Support Programme (CHSP) or a Home Care Package (HCP), depending on individual eligibility. NGOs work closely with both GPs and specialist palliative care services to ensure patients are receiving best practice and high-quality care.

Allied Health

Many different allied health groups contribute palliative care individually and as part of multidisciplinary care teams. Allied health can be provided in the community or hospital setting. Allied health can range from counsellors, dieticians, occupational therapists, pastoral care workers, pharmacists, podiatrists, psychologists and social workers.

[11] Gold Coast Health, Integrated Care Project, Centre for Health Innovation, 2018

- Allied health plays a key role in palliative care by:
- Assisting patients in maintaining function and independence
- Providing education for patients and families receiving support
- Sharing knowledge about the progression of disease

Helping patients and family achieve their goals.[12]

Private Providers

While limited data is available for private providers, they play a key role in palliative care service provision in the Gold Coast. Private providers refer to fee-for-service practitioners, private health funds and private hospitals. The private sector provides generalist and specialist palliative care services to individuals, without government subsidies both in the community and hospital setting. While the private sector is not a key focus of the scope of this needs assessment, private services need to be acknowledged and taken into consideration when planning services.

As an example, Bupa is piloting a Palliative Care Choice Program13 in partnership with the St Vincent's Private Hospital in Brisbane. Following multidisciplinary assessment, the program offers a range of services tailored to the person's needs including physician, nursing, psychological, social, and spiritual support. Patients can access the palliative care unit directly at St. Vincent's Hospital if needed. The patient or their carer is given the flexibility to make choices about end-of-life care to ensure preferences are met.

Hospice

There is one hospice located on the Gold Coast, Hopewell Hospice. Hopewell is an 8 bed, (minimum 1 public bed) hospice and is available to people with advanced, progressive disease where treatment is no longer available, and the individual is unable to continue to stay at home. Hopewell Hospice provides a home-like environment, holistic palliative and respite care, 24-hour on-site nursing, ancillary services and follow-up bereavement services. Hopewell Hospice has a unit for supporting children, parents and families around grief and loss and a day respite care centre.

Specialist Palliative Care

A specialist palliative care provider is a medical, nursing or allied health professional recognised as a palliative care specialist by an accrediting body or who substantively works in a specialist palliative care service if an accrediting body is not available.

A palliative care specialist has the specialist knowledge skills and expertise in care of people living with a life-limiting illness and their families and carers, including in the management of complex symptoms, loss, grief and bereavement.

Specialist Palliative Care Services

The majority of specialist palliative care services on the Gold Coast are situated in the Robina Hospital with the Specialist Palliative Unit Inpatient and Community Care teams.

Palliative Care Consultation and Liaison Service teams available at both Robina Hospital and the Gold Coast University Hospital (GCUH) in Southport.

Robina Hospital has a 16-20 bed inpatient palliative care unit is focused on delivering short term, pain and symptom control with the aim for patient to be discharged back into their home (including residential aged care facilities) or in some cases the local hospice.

Gold Coast HHS Specialist Palliative Care service assists in patient care and is designed ensure GPs remain central to care of patient. The specialist palliative care service follows national best practice guidelines. A patient may be seen as a one-off consult, or for a short period until their needs are no longer specialist, or on an ongoing basis for especially complex patients.

12 https://www.caresearch.com.au/caresearch/tabid/2744/Default.aspx
13 https://www.bupa.com.au/health-and-wellness/programs-and-support/member-support-programs/palliative-care-choices-program

A ‘pop up’ paediatric service is also available at GCUH, with staffing shared across Oncology, Haematology and Palliative Care. This service cares and supports for children with life-limiting illness and their families.

Alternative Therapies

Alternative therapies can often be accessed by people receiving mainstream palliative care services. Therapies may include acupuncture, aromatherapy, herbal medicines, hypnosis and, complementary pain treatments. Data is limited on who and how often these alternative therapies are being utilised in the Gold Coast region, as it’s often not disclosed to the treating health professional.

Consultation with clinicians acknowledged a range of issues with alternative therapies including lack of supporting research into effectiveness, lack of disclosure of therapy types which may lead to complications or impaired effectiveness of prescribed medications and, treatments and misinformation provided by alternate therapists such as terminal individuals being led to believe they are being cured.

A full list of palliative care service mapping data can be referred to in *Appendix 1, Service Mapping.*

Consultation

Patient journey mapping

- One of the key items taken to stakeholder consultation was patient journey mapping. These visual representations of typical patient journeys developed in partnership with PCQ supported the consumer engagement component of the consultation. Four common pathways were documented for further consultation including:
- Culturally and linguistically diverse (CALD) and NDIS at-home palliative care pathway, 'Brian'.
- RACF palliative care pathway, 'Mary'.
- Paediatric palliative care pathway, 'Cooper'.

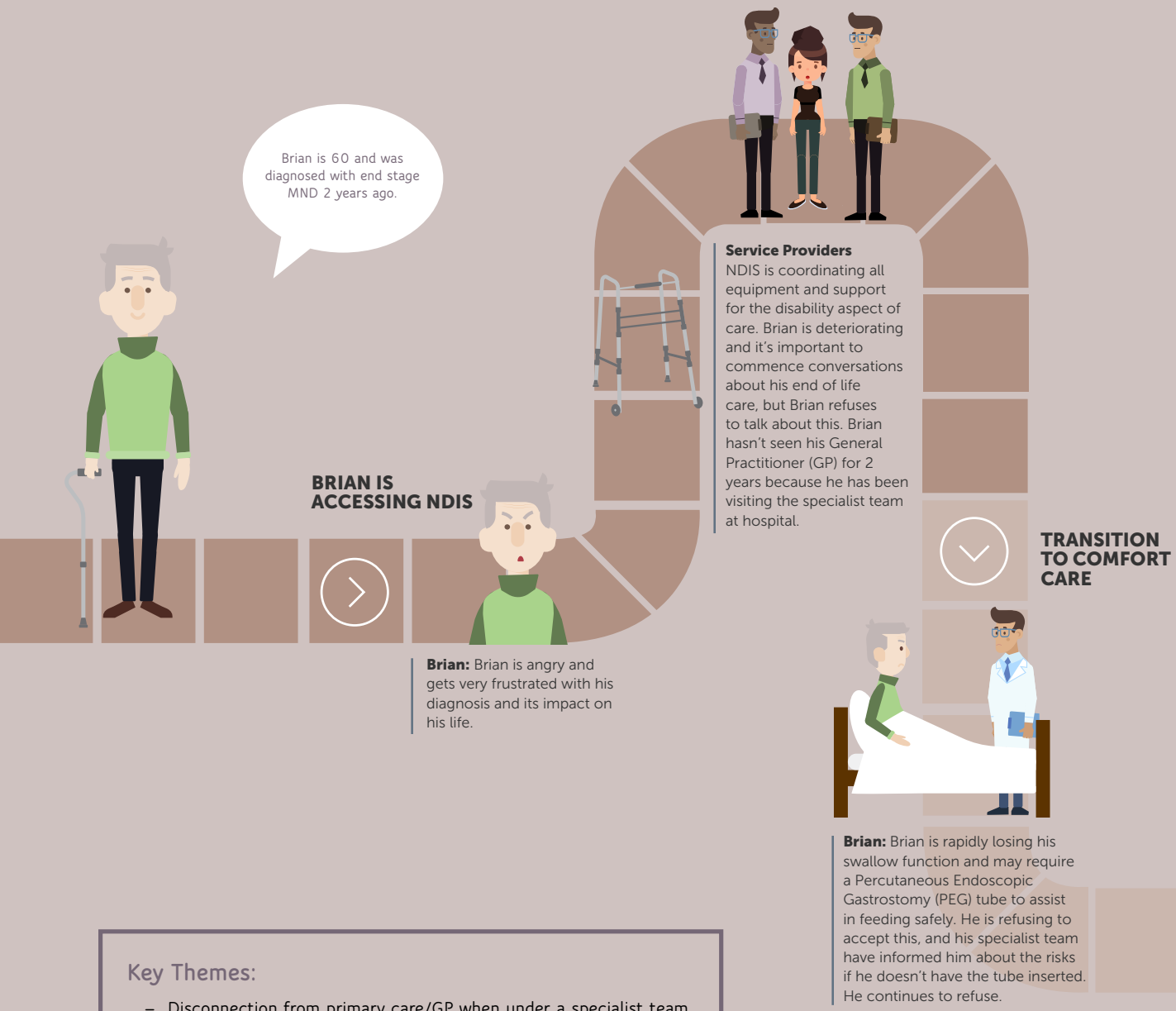
Complex specialist palliative care pathway, 'Wayne'.

The four common pathways were validated by GCPHN and the Palliative Care Leadership Group. *Note: The Leadership Group was established to provide local, strategic input and advice on project and its deliverables.*

Figure 1: CALD and NDIS at-home palliative care journey

Brian's journey

Brian emigrated from Greece when he was 40 and is an Australian citizen, his spoken English is limited but understands it well, his daughter usually assists with interpretation. He and his family are still very angry about Brian's diagnosis at such a young age, particularly after moving to Australia less than 20 years ago. Brian and his family have disconnected from their small circle of friends and there is a financial burden because Brian is unable to work, and he has limited savings. Brian receives support from National Disability Insurance Scheme (NDIS) and is a part of the local Motor Neurone Disease (MND) Association support group.



Key Themes:

- Disconnection from primary care/GP when under a specialist team
- Psychosocial support - no just medical (ie deal with anger)
- CALD population groups
- Case conferencing is a successful way to address all Brian's needs, driven by specialist palliative care team & involve a GP again
- Hopewell Hospice has high demand, limited capacity to deliver (by number of beds available)
- Funding source challenge between NDIS (Functionality focused) and Palliative Care (Health Funding)

Figure 1: CALD and NDIS at-home palliative care journey cont.

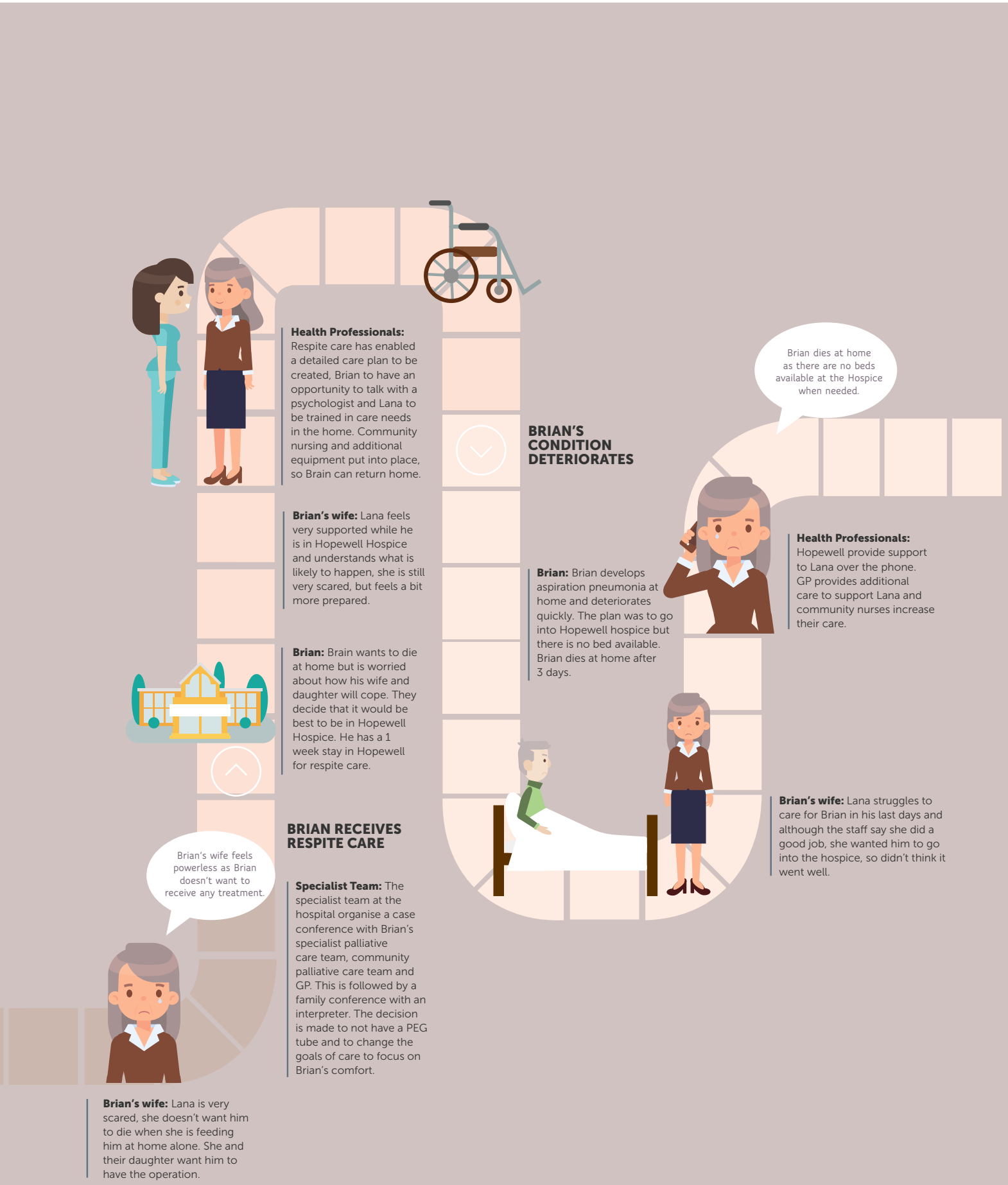
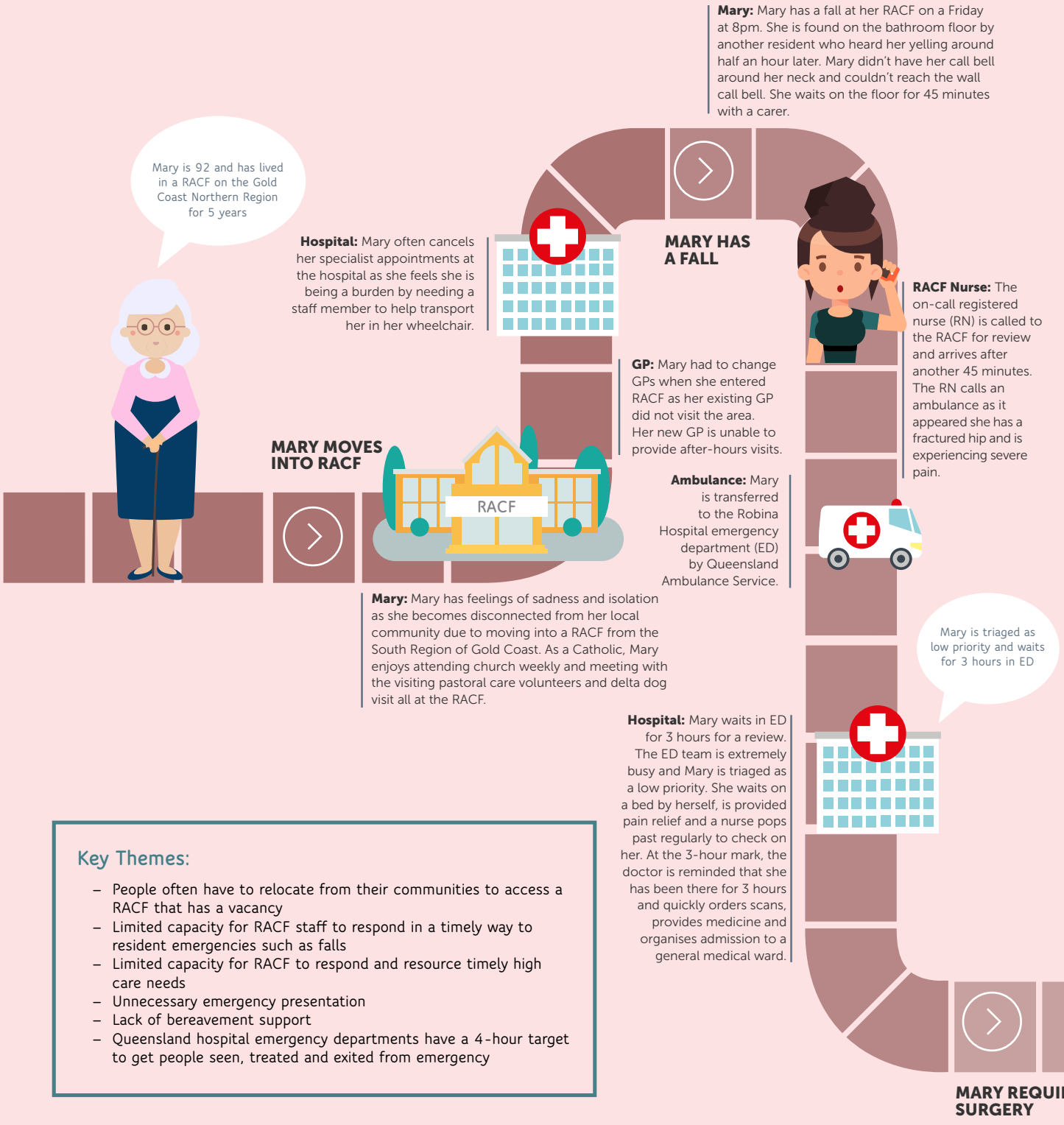


Figure 2: RACF palliative care journey

Mary's journey

Mary is a Gold Coast local with three children; one (John) who lives in Brisbane, while the others live interstate. Mary's husband died 5 years ago, after which she decided with the help of her family to move into a Residential Aged Care Facility (RACF). Mary suffers from heart failure and several other co-morbid conditions. She requires some support to shower and needs a wheelchair to move long distances. She was previously active with a local craft group but hasn't seen them since moving into the RACF.



Key Themes:

- People often have to relocate from their communities to access a RACF that has a vacancy
- Limited capacity for RACF staff to respond in a timely way to resident emergencies such as falls
- Limited capacity for RACF to respond and resource timely high care needs
- Unnecessary emergency presentation
- Lack of bereavement support
- Queensland hospital emergency departments have a 4-hour target to get people seen, treated and exited from emergency

Figure 2: RACF palliative care journey cont.

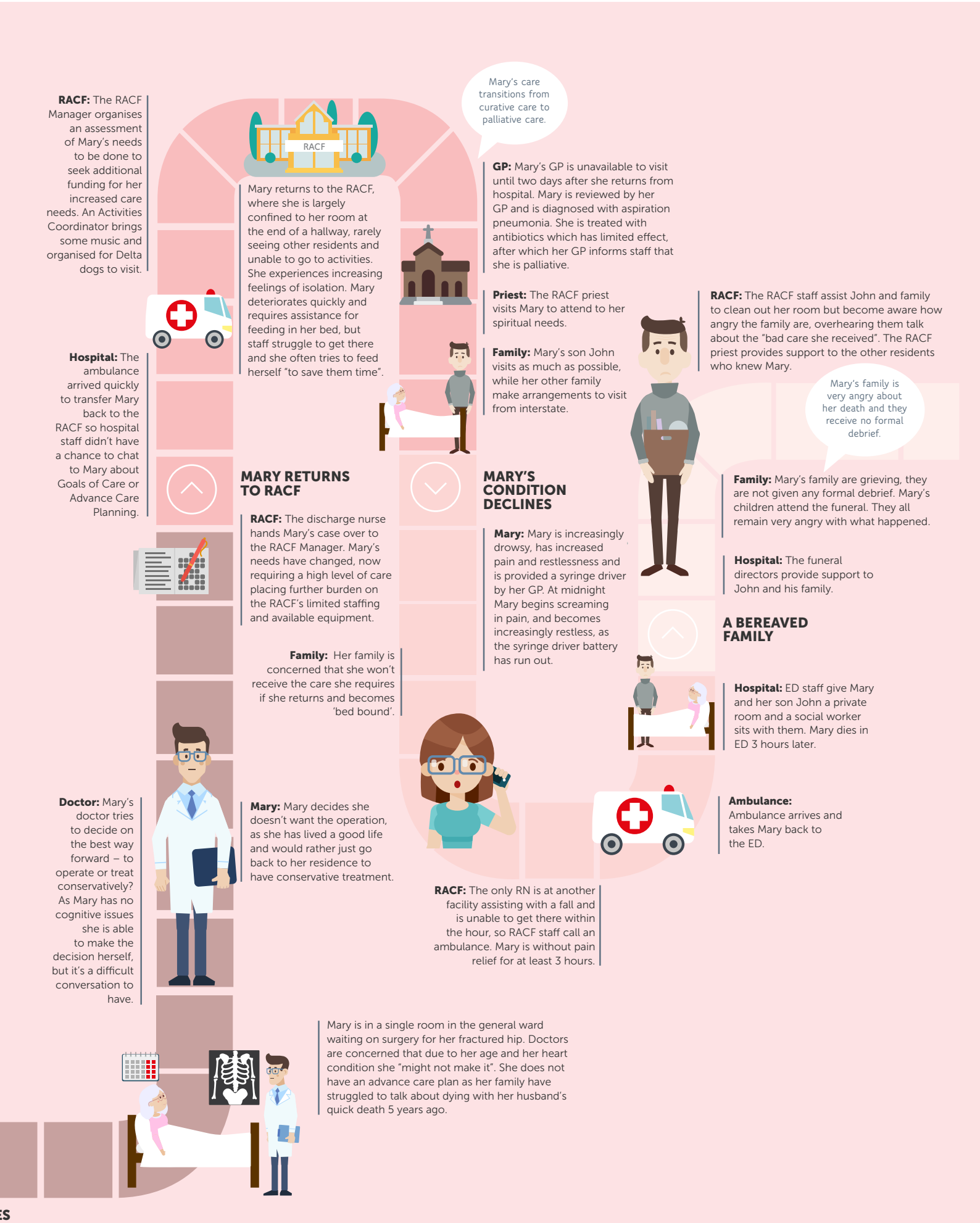
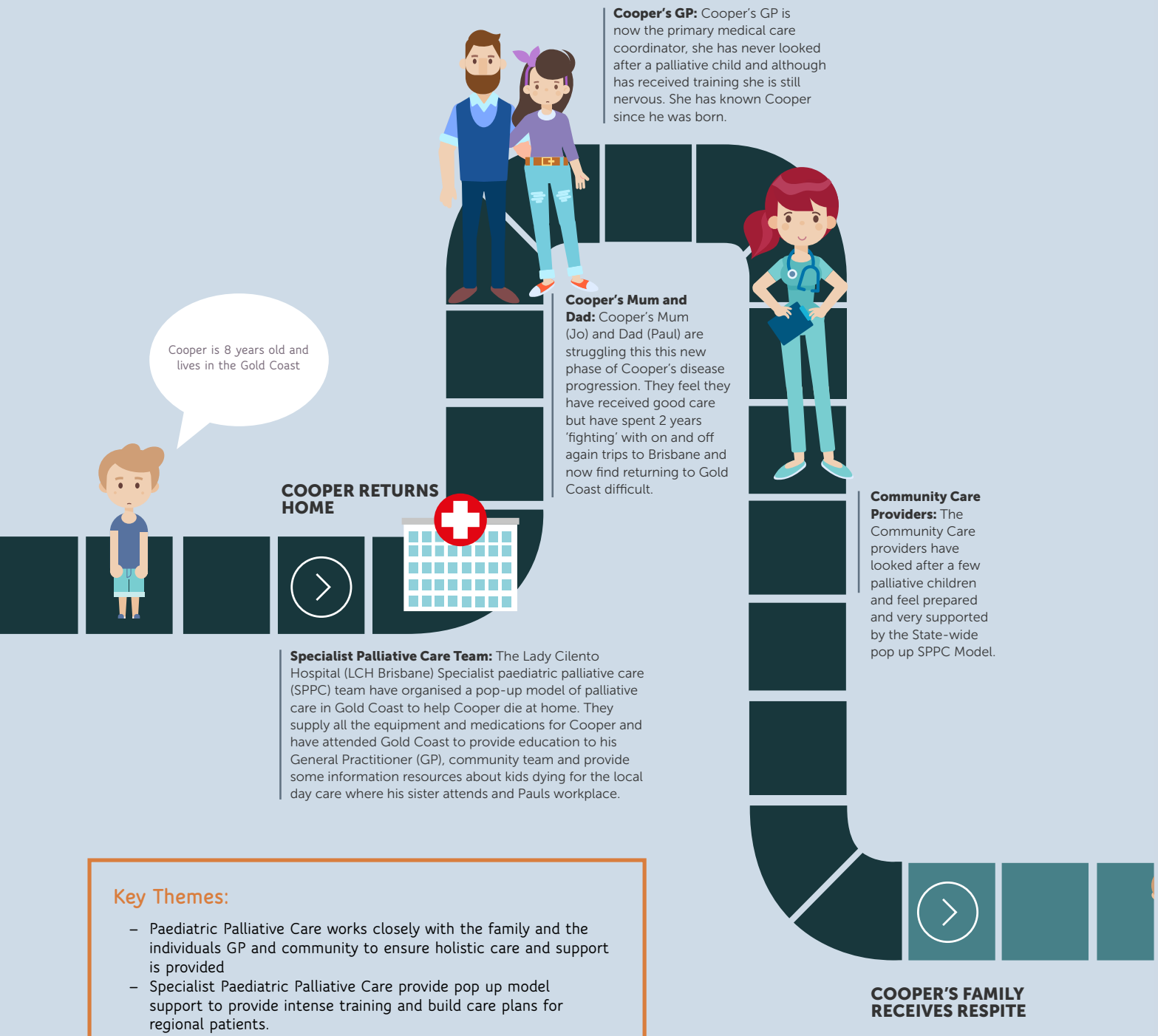


Figure 3: Paediatric palliative care journey

Cooper's journey

Cooper has been living with ALL, a type of cancer, for 2 years – having most of his treatment up in Brisbane. Cooper's cancer has spread, and he now requires palliative care. Cooper has a 3-year-old sister and lives with both of his parents. His father works full time and his mother is a full-time carer for Cooper.



Key Themes:

- Paediatric Palliative Care works closely with the family and the individuals GP and community to ensure holistic care and support is provided
- Specialist Paediatric Palliative Care provide pop up model support to provide intense training and build care plans for regional patients.
- Paediatric Palliative Care is psychosocially challenging for all involved including health professionals.
- Paediatric Palliative Care provides an exceptional bereavement support to families

Figure 3: Paediatric palliative care journey cont.

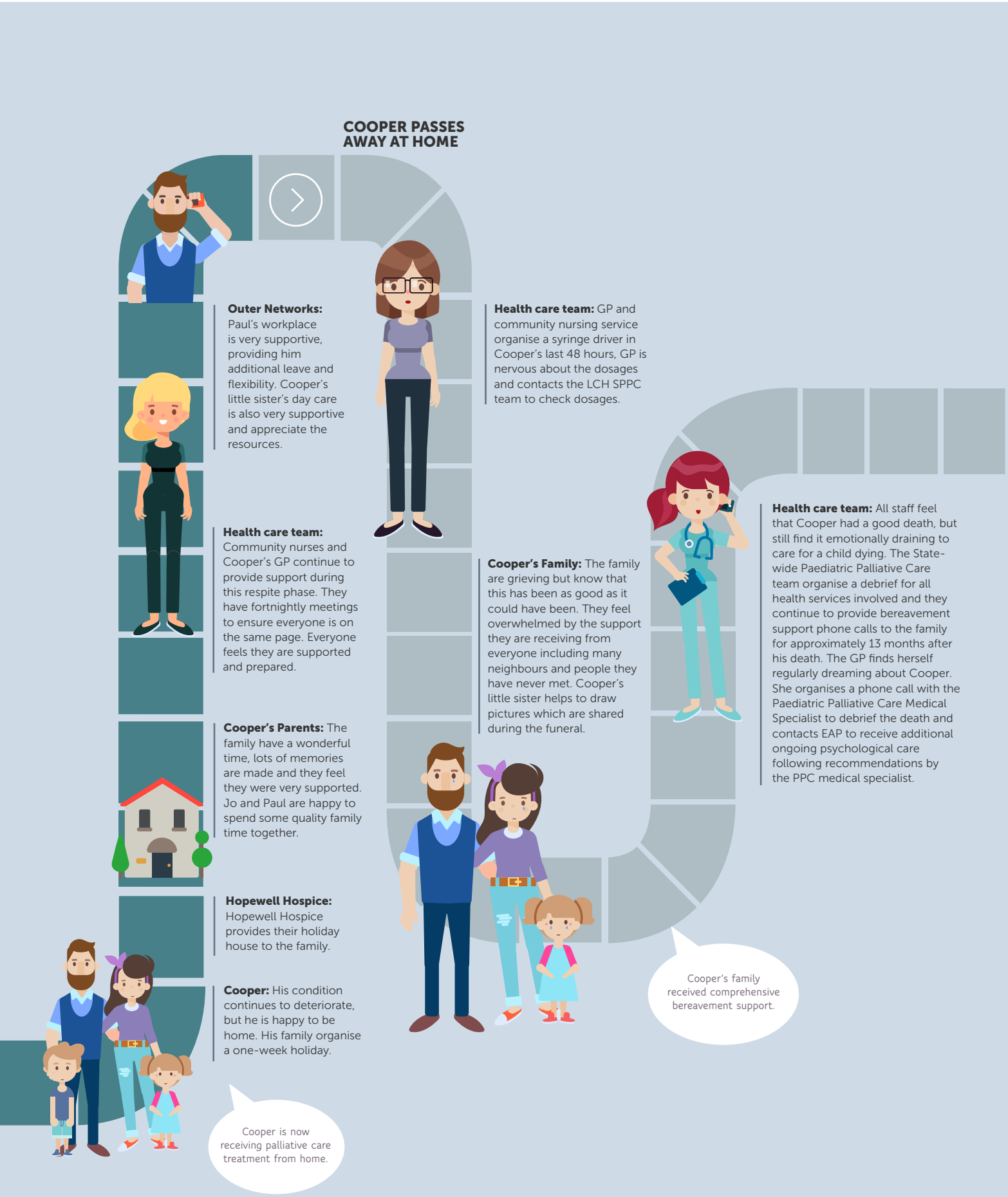
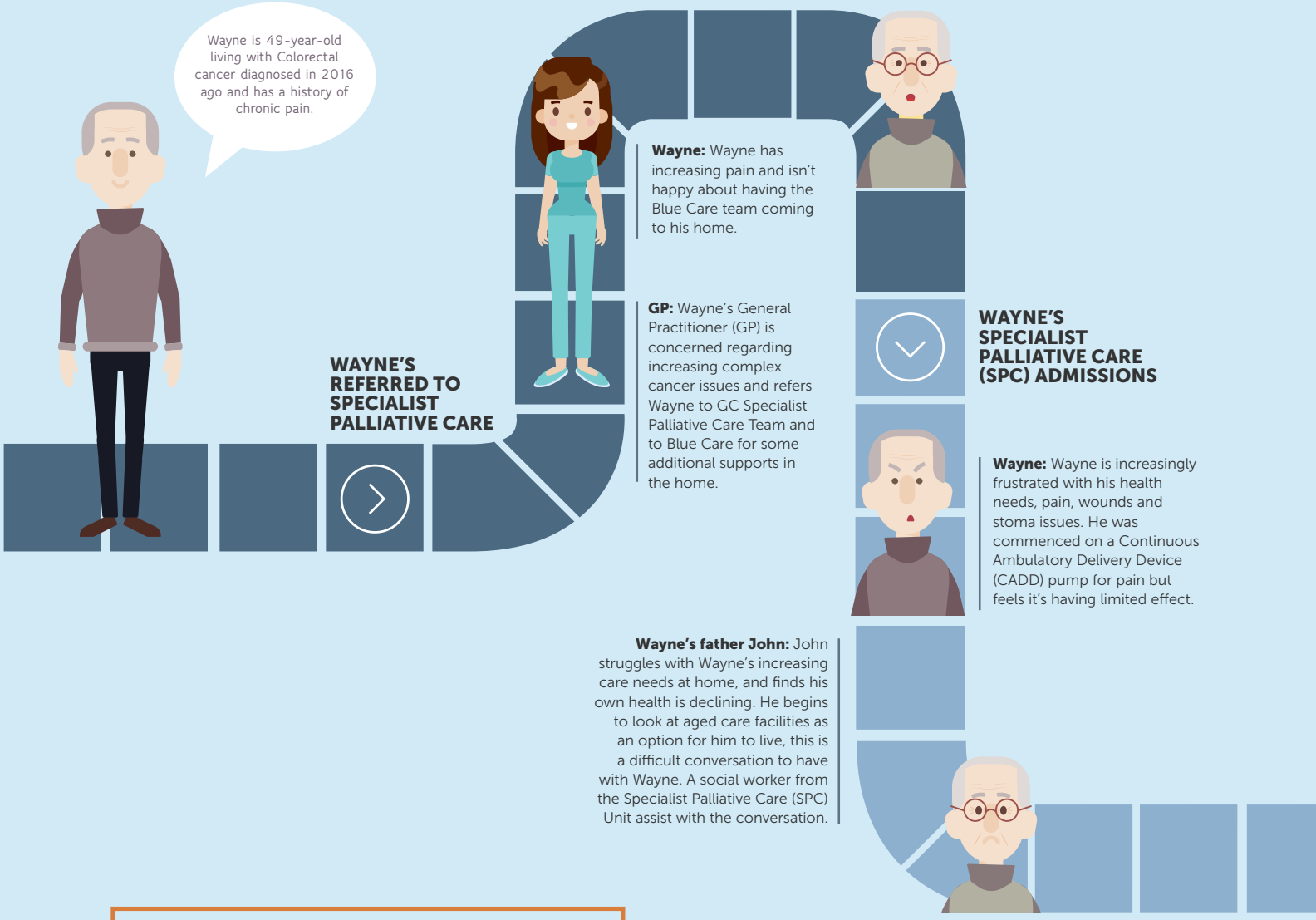


Figure 4: Complex specialist palliative care journey

Wayne's journey

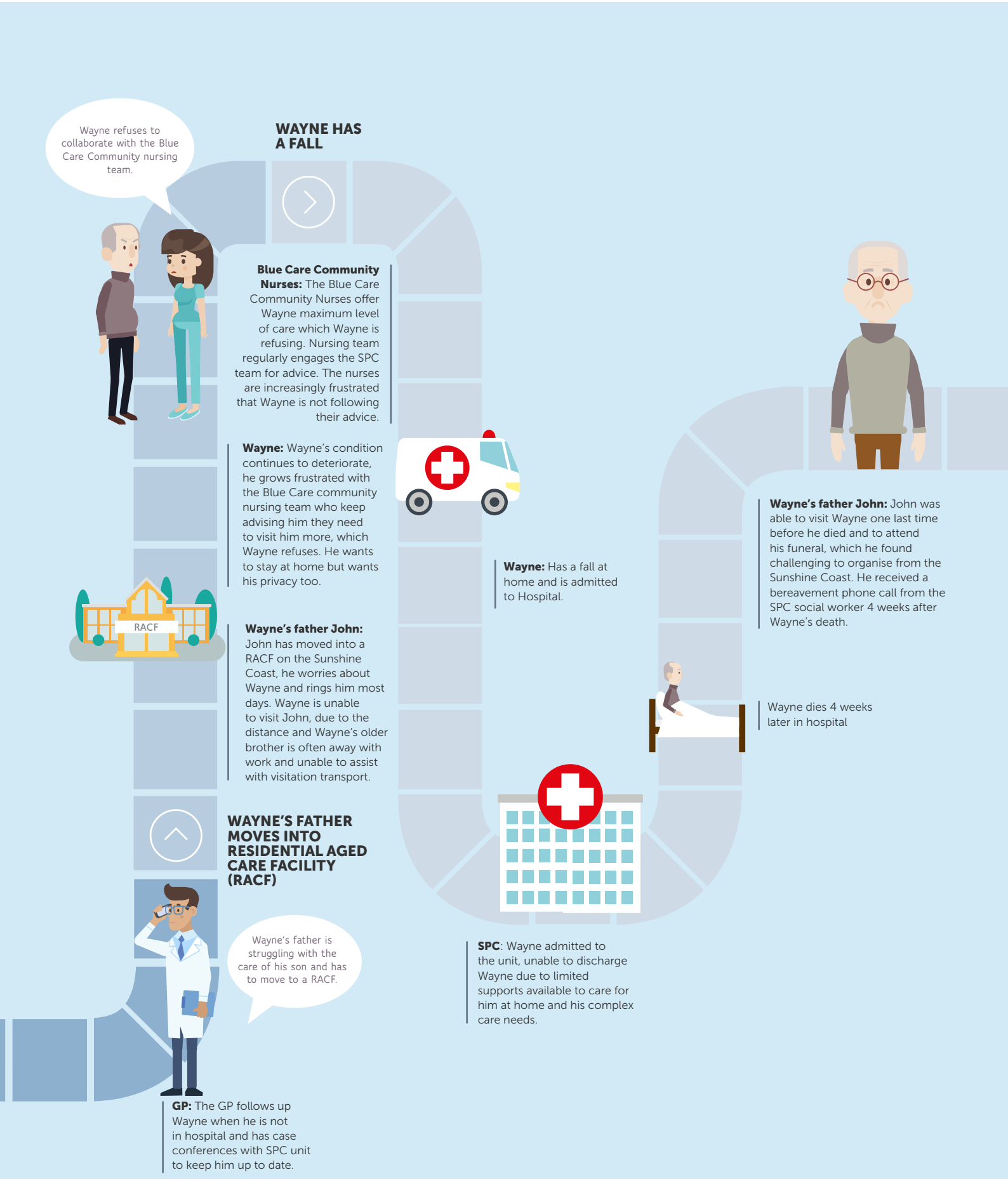
Wayne lives in Surfers Paradise, with his elderly father who also has cancer, but is caring for Wayne. Wayne has an older brother who lives in Sunshine Coast. Wayne has had surgical treatment as well as chemotherapy, however his cancer is progressive, and he now has pelvic masses and fungating tumour.



Key Themes:

- Social issues, carer burden
- Challenge of caring for people living alone at home
- Complex care needs
- Challenge for people in aged care facilities to visit relatives in hospital / disconnected families

Figure 4: Complex specialist palliative care journey cont.



Gold Coast Primary Health Network Clinical Council

In June 2018, Gold Coast PHN utilised their Clinical Council as an engagement mechanism to discuss emerging issues relating to palliative care services in the Gold Coast region. Key issues and themes raised include:

- Cost across several domains, the cost of non-PBS listed palliative medications and their lack of availability at some pharmacies across the region. With RACFs not serviced under state funded palliative care services, their residents have little options but hospital admission to access palliative care services.
- Clinical handover in both public and private settings can be challenging. Case conferencing and discharge planning can help to ensure the GP remains the centre of a person's care, however telehealth services are rarely utilised due to a lack of MBS subsidies in metropolitan locations such as the Gold Coast. Both specialist services and GPs have raised the desire to ensure GPs are position as a central and ongoing part of a patient's care, but some instances reported this was not the experience.
- Resourcing is often an issue with timely access to palliative beds and other potential resources, when the case is often urgent. With the Gold Coast Hospice resourced with generally only 1 public bed (and 7 private) a lot of the demand for acute service falls to the public inpatient facilities.
- An opportunity for education to take place through peer-to-peer learning or shared learning with GPs and allied health providers was identified in the region relating to the continuing holistic care (e.g. allied health treatment) of a person once they begin accessing palliative care services.

Gold Coast Primary Health Network Community Advisory Council

In June 2018, GCPHN undertook engagement with their Community Advisory Council (CAC) to review and evaluate the Older Persons Needs Assessment Summary developed in late-2017, which included a component on palliative care. Ninety three percent of CAC members either agreed or strongly agreed on the needs identified in the document.

Additional engagement with the group identified a range of areas where improvement is needed:

- Service Access and Navigation
    - Navigate the right level of care and provider of home support for a loved one is challenging, and there is minimal support for this.
    - Significant modification costs often borne by families.
    - After hours GPs (at their discretion) can decline home visits for palliative patients leaving emergency presentation the only option.
- Members of the CAC identified the importance of their own GP remaining actively involved in their care.

A number of opportunities were raised including:

- The utilisation of volunteers in palliative care to support the individual and their families with housework, physical activity or social support
- Positive feedback was received regarding palliative care nurse services in the Gold Coast region and a call made for more palliative providers in community and RACFs
- Opportunities for more consumer directed care are on the horizon with the upcoming aged care funding changes.

Gold Coast Primary Health Network stakeholder consultation 2017

In September 2017, Gold Coast PHN carried out stakeholder consultation with the intention to identify gaps and explore opportunities to improve coordination and integration of palliative care services across the Gold Coast region. Visions were created to support a more efficient and effective local palliative care system. Some of the emerging visions include:

- Access to flexible 24/7 carer and nursing support.
- Upskilling of general practice/community services/emergency department/RACFs in identifying patients who are at risk of dying within 12/12 and aided through Advance Health Directives and Advance Care Planning (ACP).
- Palliative care embedded as a part of normal patient care and inclusive of family and caregiver.
- Better connected infrastructure/networks and system navigation.

In addition, there were a range or barriers identified to achieving these visions, which included but were not limited to:

- stigma
- lack of access to knowledge
- discharge summaries and handover
- lack of carer support.

Palliative care services co-design workshop

In September 2018, a co design workshop with 41 sector representatives was held with the aim of informing the design and delivery of a regionalised approach to Gold Coast PHN's investment in primary and community based palliative care services. The outcomes of the co-design workshop along with the findings of the needs assessment will directly inform the development of Gold Coast PHN's 3-year strategic service planning report for palliative care.

The co-design workshop was designed to maximise participation, incorporating a variety of feedback mechanisms including small group sessions, whole-of-room sessions or individual opinion in an anonymous format. Informal breaks were included for networking and further discussion and integration amongst the group.

Key themes emerged from the co design workshop included:

Workforce capacity building – The need for meaningful, appropriate, accessible workforce capacity building across primary care and palliative care sectors was a prominent theme. It was reported that confident, skilled, and connected staff would lead to a reduction in potentially preventable hospitalisations.

Community awareness and education - While some difficulties were reported in measuring community awareness and education outcomes, it was still a leading theme throughout the workshop. Some recurring areas for education and awareness identified were Advance Care Planning, service awareness, and health and death literacy.

Advance Care Planning – Advance Care Planning continues to carry significant importance across palliative care sector on the Gold Coast. It has been reported that uptake remains low, which can be attributed to the difficulty and complexity of the paperwork involved. However, it is reported that having an Advance Care Plans in place results in a more informed, seamless, coordinated and appropriate journey for the individual in line with their values, beliefs and wishes at the end of life.

Service navigation and coordination – While activities around service navigation and coordination were strongly supported by attending representatives, measures to improve this can often be challenging in a constantly evolving and time-poor sector. Activities proposed to improve service navigation and coordination on the Gold Coast were dependent on having a key a navigator role to support individuals through their palliative care journey.

Sector collaboration - A key focus area explored at the workshop was sector collaboration, which is particularly important in the palliative care sector due to frequent transitions between emergency department, hospital inpatient wards, residential aged care facilities, community care and GPs. Some of the key activities explored to support sector collaboration included leadership groups, compassionate communities style programs and increased support for case conferencing.

Volunteer programs – The invaluable support of the volunteer workforce in palliative care was widely cited across the palliative care workshop. Volunteer programs are perceived as cost-effective and can prevent or reduce social isolation and loneliness of individuals. The importance of appropriately skilled palliative care volunteers was raised due to the highly emotional and challenging environment they will be exposed to.

Additional Information

Research into awareness, attitudes and provision of best practice advance care planning, palliative care and end of life care within general practice[14] explored the challenges faced by GPs when practicing palliative care, including delivery of care in varied settings, appropriate timing to deliver Advance Care Planning (ACP) conversation and lack of communication between locum services, RACFs, specialists, ambulance services and hospitals.

The study supported a number of opportunities explored in this report including PHNs playing a role in navigating available education and promoting locally applicable education and resources, community ACP awareness, and capacity building around symptom management, service awareness, navigation and referral pathways.

With the recent shift to consumer directed care in the NDIS and Commonwealth Home Support Program (CHSP) Transitioning Australian Respite[15] report reflects on the probable changes to the way respite care is understood and implemented in Australia. With a high focus in the Gold Coast region towards supporting people caring for their loved one and the reported high levels of stress experienced by carers. It is important to consider carers' needs and provide support to them in their own right, something which is not directly addressed in the NDIS and CHSP reforms. Supporting innovative, flexible and informal respite mechanisms is recommended for the Gold Coast region.

[14] https://www.health.gov.au/internet/main/publishing.nsf/Content/EF57056BDB047E2FCA257BF000206168/$File/Palliative-care-and-end-of-life-care-within-gp-research.pdf

[15] https://www.sprc.unsw.edu.au/media/SPRCFile/Transitioning_Australian_Respite.pdf

What we understand works

Integrated models of palliative care are becoming increasingly important as the population ages and as the number of people living with multiple chronic conditions increases leading to more complex care requirements.

The future need for palliative care: with a London focus[16] highlights the importance of supporting people to stay and die at home by embedding two key elements; presence and competence to support people to successfully age and die at home.

- ***Presence***: 24/7 availability and home visits
- ***Competence***: symptom control and communication.

Key learnings from this study should be considered when considering future models of palliative care.

A number of models of care have been identified through a process of consultation with GCPHN, the Leadership Group and GCPHN advisory mechanisms and desktop evidence review. The groups were asked to submit models of care which have worked well in other areas, and which would have successful elements that could be adapted to meet the local health needs and service issues of the Gold Coast region. In general, the identified models are focused towards:

- Supporting people to continue to live die at home
- Reducing preventable emergency department presentations and hospital admissions
- Supporting GPs to remain at the centre of a person's care throughout their palliative care journey.

The examples below are indicative of the type of service responses that could respond to the identified local health needs and service issues.

Model: Personalised packages of palliative care	
Description	The provision of personalised palliative care packages to individuals to support them to continue to live and die at home. Packages can provide specific supports for day, evening and night time to meet the individuals care needs in order to stay at home. Key considerations of this model in a local context include: • Clinical governance remains with the client's GP • Case management remains with the hospital community nursing team • Centralised intake hub for all 5 participating hospital facilities • Coordinated arrangements for medications, equipment and consumables
Program example/s	Palliative Extended and Care Home[17] (PEACH) Model of Care Palliative Care Home Support Program HammondCare
Evidence	McCaffrey N, et. al. Is home-based palliative care cost-effective? An economic evaluation of the Palliative Care Extended Packages at Home (PEACH) pilot. BMJ Support Palliat Care. 2013 Dec;3(4):431-5 Luckett T, et. al. Elements of effective palliative care models: a rapid review. BMC Health Serv Res. 2014 Mar 26;14:136
Alignment to Health Needs and Service Issues	• Community led, after hours in-home (including RACF) care • Delivering coordinated community palliative care • GP-centred model • Advance Care Planning • Use of telehealth/video conferencing to provide after-hours access to clinical nursing support

[16] https://www.kcl.ac.uk/nursing/departments/cicelysaunders/attachments/The-future-for-palliative-care-with-a-London-focus-Irene-J.-Higginson-April-2018.pdf

[17] https://www.swslhd.health.nsw.gov.au/peach/model.html

Model: Nurse Practitioner-led models of palliative care	
Description	There are a range of settings in which nurse practitioner-led palliative care models exist, such as in an RACF, GP clinic, independent or regionally-based. Nurse practitioner-led palliative care focuses on providing clinical care, clinical leadership, education and research. Nurse practitioners can often undertake time intensive aspects of care of older people with complex needs.
Program Example/s	Resthaven Nurse Practitioner Model of Care[18] Nurse Practitioner – Aged Care Models of Practice Initiative[19]
Evidence	Davey, R., Clark, S., Goss, J., Parker, R., Hungerford, C., and Gibson, D. 2015. National Evaluation of the Nurse Practitioner – Aged Care Models of Practice Initiative: Summary of Findings. Centre for Research & Action in Public Health. UC Health Research Institute. University of Canberra. Canberra.
Alignment to Health Needs and Service Issues	• Advance Care Planning • Reduction of avoidable emergency department presentations • Education and capacity building in primary care and RACFs

Model: Palliative Care Day Hospitals	
Description	Models of care providing day hospitals and in-reach nursing services allow access to hospital level services without actually being admitted, easing pressure on rising demand for acute care beds and supporting people to continue to live in their own home until death.
Program Example/s	Hammondcare Home Support Program[20] *Hope Healthcare Specialist Palliative Care Services Evaluation 2009*[21]
Evidence	Elton Consulting, Hope Healthcare Specialist Palliative Care Services Evaluation, 2009 Stevens E, Martin CR, White CA.The outcomes of palliative care day services: a systematic review.Palliat Med. 2011 Mar;25(2):153-69. Bradley SE, Frizelle D, Johnson M.Patients' psychosocial experiences of attending Specialist Palliative Day Care: a systematic review.Palliat Med. 2011 Apr;25(3):210-28
Alignment to Health Needs and Service Issues	• Supports service integration and coordination • Supports palliative patients with complex needs • Improves access to specialist palliative care services • Reduces social isolation

18 https://www.resthaven.asn.au/enhancing-palliative-approach/

19 https://www.canberra.edu.au/research/institutes/health-research-institute/annual-reports/reports/NPACM-Summary-of-Findings-Dist-Low-res.pdf

20 http://www.hammond.com.au/research/palliative-care-home-support-program-qualitative-evaluation

21 Elton Consulting, Hope Healthcare Specialist Palliative Care Services Evaluation, 2009

Model: Compassionate Communities Models	
Description	Compassionate Communities aims to build and enhance existing partnerships with local community groups; identify mechanisms to support these stakeholders in delivering palliative care support; developing information resources for service providers; operating as a central body to showcase and link compassionate communities across Queensland.
Program Example/s	Latrobe University Health End of Life Project (HELP)
Evidence/Rationale	The Nous Group (2018). Final Report: Compassionate Communities Feasibility Study. Available at: http://palliativecare.org.au/wp-content/uploads/dlm_uploads/2018/09/Compassionate-Communities-Final-Report-min.pdf Abel, J et al (2011). Compassionate community networks: supporting home dying. BMJ Supportive & Palliative Care,1:129–133. Samar, AM et al (2018). What sources of bereavement support are perceived helpful by bereaved people and why? Empirical evidence for the compassionate communities' approach, Palliative Medicine, 32(8),1378–1388
Priority Areas	• Service Integration • Community Education • Service provider education • Community development • Community partnerships • Death and compassion literacy

Throughout the consultation with Gold Coast PHN advisory mechanisms, several key components of successful models of generalist palliative care were identified and need to be considered for prospective models of care. These elements include respite care, the use of volunteers and consumer and carer education.

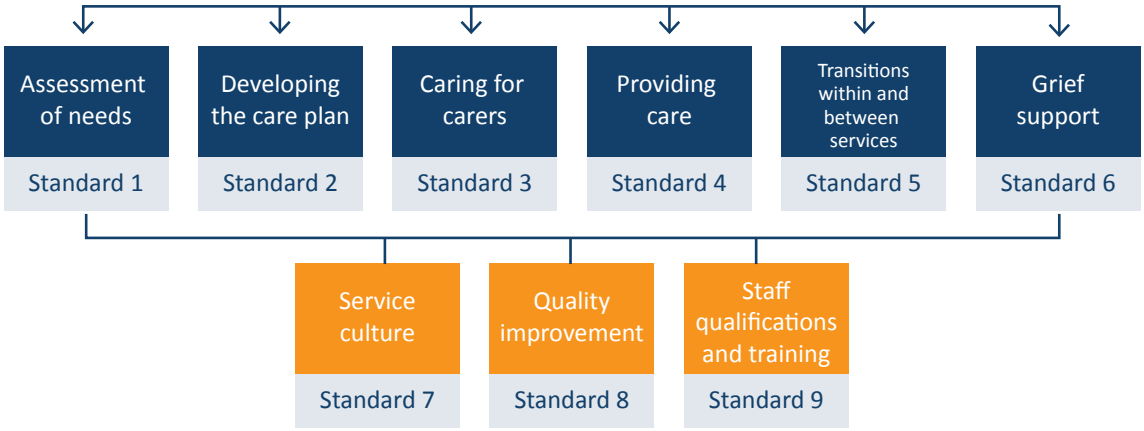
Opportunities

Commonwealth and State priorities

The *National Palliative Care Strategy 2010*[22] represents the combined commitments of the Australian, state and territory governments, palliative care service providers and community-based organisations to the development and implementation of palliative care policies, strategies and services that are consistent across Australia. The National Strategy's four goals include:

- Awareness and Understanding
- Appropriateness and Effectiveness
- Leadership and Governance
- Capacity and Capability

The National Palliative Care Standards (Edition 5)[23] (The Standards) articulate and promote a vision for compassionate and appropriate specialist palliative care. The standards emphasise the importance of delivering patient centred, age appropriate to all people, including those of vulnerable populations. The standards can be referred to below:



The Standards highlight the importance having appropriate governance mechanisms in place to support best practice specialist palliative care.

A range of other strategic reforms, priorities and plans provide an evolving context for the regional planning and development of models of palliative care. This includes:

- Roll-out of My Health Record[24]
- Gold Coast PHN's Strategic Plan 2017 – 2022[25]
- Principles for Palliative and End-of-Life Care in Residential Aged Care[26]
- Queensland Health State-wide strategy for end-of-life care 2015[27]
- Queensland Health Palliative Care Services Review[28] (current)
- Australian Productivity Commission's report entitled Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services[29] (Chapters 3 and 4)
- Australian Commission on Safety and Quality in Health Care's National Consensus Statement: Essential elements for safe and high-quality end-of-life care[30]
- Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020[31]

22 Department of Health, Supporting Australians to Live Well at the End of Life – National Palliative Care Strategy 2010
23 http://palliativecare.org.au/standards
24 https://www.myhealthrecord.gov.au/
25 https://www.healthygc.com.au/GCPHN/media/Site-Pages-Content/GCPHN/Strategic-Plan-2017-2022.pdf
26 http://palliativecare.org.au/wp-content/uploads/dlm_uploads/2017/05/PCA018_Guiding-Principles-for-PC-Aged-Care_W03-002.pdf
27 https://www.health.qld.gov.au/__data/assets/pdf_file/0022/441616/end-of-life-strategy-full.pdf
28 https://www.qld.gov.au/__data/assets/pdf_file/0016/14272/consultation-paper.pdf
29 https://www.pc.gov.au/inquiries/completed/human-services/reforms/report/human-services-reforms.pdf
30 https://www.safetyandquality.gov.au/wp-content/uploads/2015/05/National-Consensus-Statement-Essential-Elements-forsafe-high-quality-end-of-life-care.pdf
31 http://endoflifecareambitions.org.uk/

As part of the 2017-18 Budget, the Commonwealth Government is providing $8.3 million over three years for the *Greater Choice for At Home Palliative Care*[32] measure which will improve palliative care coordination through Primary Health Networks (PHNs). Gold Coast PHN was awarded funding under the measure which aims to better coordinate and integrate primary, secondary, tertiary and community health services to support at home palliative care. It is envisaged that this will achieve the following:

- PHNs will implement sustainable system changes to strengthen integration and coordination of services for people receiving palliative care at home.
- Working in partnership with other palliative care providers such as community services, specialist palliative care providers and aged care facilities, PHNs will develop integrated models of care that will enable early referrals to palliative care and strengthen community support for their families and carers.
- PHNs will enable greater choice for their local communities through staged approaches to improve sector partnerships, networks, programs, tools and resources in collaboration with specialist palliative care providers.
- Specific models of care coordination will respond to local community needs, be placed based and tailored to suit the requirement/needs of each community.
- Implementation will require co-design of coordinated approaches with the local health/hospital network and the local community to implement home based palliative care.
- Clear governance, communication and accountability frameworks, such as Memorandum of Understandings (MOU) will also strengthen care-coordination and service linkage.

Significant opportunities exist on the Gold Coast through this funding, which will improve access to safe, quality, palliative care at home and support palliative care systems and services in primary health care and community care. This includes activities aligned to PHN identified priority areas of developing a new model of care or tool (see below) and capacity building among health professionals.

Concurrently, the Gold Coast Integrated Care Alliance has undertaken significant work in redesigning a palliative care model of care for the Gold Coast region that aligns with best practice guidelines. The model consists of 15 recommendations spanning across Gold Coast Specialist Palliative Care Services, community organisations and primary care. Recommendations include increased resourcing to Gold Coast Specialist Palliative Care Services and community teams, GP capacity building, RACF centres of excellence a pilot study for selected RACFs with increased resources and support aiming to reduce preventable hospitalisations and emergency department presentations, development of a knowledge sharing platform, enhancement of bereavement services, volunteer programs and education for ACP. All recommendations align to consistent themes below:

- Patient and carer-centred approach
- High involvement of the patient's primary care provider (GP)
- Generalist services working with support as needed by specialist palliative care services
- Community-based services designed to navigate the patient and carer to the best available, needs-based services
- Aim to prevent unnecessary hospital admissions.

A key priority for this project is align to the ICA Model of Care recommendations relevant to the scope of the GCPHN and focus on implementation and support required for these activities.

[32] http://www.health.gov.au/internet/main/publishing.nsf/Content/greater-choice-home-palliative-care-measure-faq

A range of other projects happening at a state and federal level will provide GCPHN with further opportunities to leverage existing resources at a local level. National projects funded by the Department of Health include:

- The Palliative Care Education and Training Collaborative (consisting of Palliative Care Curriculum for Undergraduates or PCC4U, and Program of Experience in the Palliative Approach or PEPA)
- Palliative Care Online Training Portal
- Palliative Care Outcomes Collaboration (PCOC)
- Palliative Care Australia for infrastructure support and operational activities
- Advance Care Planning Australia
- CareSearch, an online portal with database of palliative care related evidence and guidance
- End-of-life Essentials for Acute Hospital Clinicians
- The Australian carer toolkit for advanced disease
- caring@home project, Metro South Hospital and Health Service.

Most recently, as part of the 2018-19 Budget, the Commonwealth Government has committed over $32 million over four years from 2018-19 for the Comprehensive Palliative Care in Aged Care measure which will improve palliative care for older Australians living in residential aged care. It supports new and innovative approaches to how care is delivered by state and territory governments to improve palliative and end-of-life care coordination.

Locally Driven Opportunities

Through the needs assessment and consultation several key themes have evolved. These key themes represent opportunities for improvement or enhancement of existing services to lead to improved experience, value and outcomes of the services Gold Coast PHN commission, coordinate and support. These opportunities align to the health needs and service issues.

Opportunity	Alignment to Health Needs and Service Issues
Opportunity one: Workforce capacity building	• Maintaining the role of GPs in coordinating care for palliative patients is important to clinicians, consumers and carers. • GPs and other primary care providers may not regularly provide palliative care to their patients, which may influence levels of knowledge and confidence • Low uptake, awareness and confidence in relation to advance care planning, including documentation, legal requirements and how to approach conversations, for both service providers and community members. • While many palliative care-related training and information resources exist for GPs and other primary and community care providers, there are low levels of uptake and awareness • Limited funding is available to support community services to provide after-hours in-home care, offer respite nursing support or purchase appropriate equipment to enable palliative care to be provided in a patient's home (including residents of RACFs).
Opportunity two: Community awareness and education	• Maintaining the role of GPs in coordinating care for palliative patients is important to clinicians, consumers and carers. • Low uptake, awareness and confidence in relation to advance care planning, including documentation, legal requirements and how to approach conversations, for both service providers and community members. • Fatigue and burnout for families supporting loved ones at home is a significant issue, particularly those with limited practical and social support.

Opportunity three: Volunteer programs:	• Fatigue and burnout for families supporting loved ones at home is a significant issue, particularly those with limited practical and social support.
Opportunity four: Service navigation and coordination	• GPs experience challenges in making palliative care-related attendances, particularly in the after-hours period, due to issues with accessing homes or aged care facilities, availability of medications, coordination with onsite nursing staff and communication with deputising services. • Fatigue and burnout for families supporting loved ones at home is a significant issue, particularly those with limited practical and social support. • Families report difficulty with understanding and navigating the palliative journey of loved ones including equipment requirements. • Only one public hospice bed is typically available on the Gold Coast, with the majority of demand for services met by public inpatient or community outreach or visiting services.
Opportunity five: Sector collaboration	• Care coordination involving a person's different care providers and family is seen as important but can be difficult due to a lack of dedicated resources to operationally support and limited uptake of telehealth models. • GPs and other primary care providers may not regularly provide palliative care to their patients, which may influence levels of knowledge and confidence • Maintaining the role of GPs in coordinating care for palliative patients is important to clinicians, consumers and carers • Effectiveness of local palliative care services in an inpatient setting typically exceeds patient outcome benchmarks, but achieving similar outcomes in the community setting is challenging due to limited resourcing
Opportunity six: Advance care planning	• Embedded throughout all above opportunities
Broader service system issues	• MBS-funded specialist palliative services, such as public outpatient models or privately-delivered services, are utilised much less in the Gold Coast compared to the national rate but are reportedly increasing in the last two years. • A lack of specific MBS items for palliative care-related attendances by GPs means regional data on the utilisation of primary care palliative care services is limited.

Appendices

Service Mapping: Specialist palliative services

Organisation	Type	Program/ Service Name	Location	Accessibility	Description
Gold Coast Health	Inpatient Facility	Specialist Palliative Care	Robina Hospital	Assessment by local palliative care service required before admission 1 public purpose-built 16 bed palliative care unit at Robina Hospital.	Multidisciplinary team Patients are admitted for short periods of pain and symptom control, or care during the last days of life when care at home is not appropriate. Patients not admitted for respite
Gold Coast Health	Consultation and Liaison Service	Specialist Palliative Care	Robina Hospital & Gold Coast University Hospital (GCUH)	Triage and referral by MDT Team. Provides consultative care five days a week. Does not admit patients.	Symptom assessment, support and management advice, family support, case/ family conference, care planning discussion, triage admissions, discharge advice
Gold Coast Health	Outpatient / Community Facility	Specialist Palliative Care	Robina Hospital & GCUH	There is no gap to pay Telehealth service Phone and outpatient support to RACFs	Assessment and ongoing management via outpatient Clinics and community home visits Liaison with GPs and community nurses
Gold Coast Health	Inpatient Facility	Children's Palliative Care Service	GCUH	Children living with life-limiting illness and their families	Works closely with Childrens Health Queensland Not a stand-alone service, staff are shared across multiple services

Service Mapping: Generalist palliative services

Organisation	Type	Location	Accessibility	Description
BlueCare, Ozcare and Anglicare (funded by Gold Coast Health)	Community outreach	Gold Coast-wide	Cost of services determined by patient's eligibility for My Aged Care. Can access through self-funded services.	Complex nursing care, personal care and support to help patient stay at home, includes post-death support Other NGOs including Aquamarine Care, RSL Life Care at Home, Kalwun Home and Community Care are also reported to provide limited services.
Hopewell Hospice	Hospice	Located at Arundel with some outreach	8 beds, 1 public bed used by GCH Inpatient Unit Referrals can be made directly to the Hospice – self-referral, family, a GP or other health professional. A nurse visit will take place prior to admission	Care at the End of life including palliative and end of life care, that includes in home respite care, 24-hr on-site nursing, ancillary services and follow-up bereavement services Also provide short courses for family and carers of people with chronic and terminal conditions and education services for health professionals
Various	Aged care service providers	Gold Coast-wide	Accessible through a range of government-subsidised programs and packages, such as Commonwealth Home Support Programme, Home Care Packages, residential aged care facilities (RACF) and Queensland Community Services.	Numerous aged care providers across the region report providing generalist palliative services, but do not provide specialist palliative care support. This can include domestic and personal care, home maintenance and modifications, equipment, social support, clinical services, respite and counselling.
Various	General practitioners	Gold Coast-wide	759 GPs on the Gold Coast across 180 practices, supported by non-GP staff working in general practice (e.g. nurses, allied health professionals, practice managers and administration).	Critical role in coordinating care and making referrals, identifying and assessing palliative care needs, pain management, medication management, bereavement support and advance care planning.

Gold Coast Primary Health Network

Primary Care Gold Coast (ABN 47152953092), trading as the Gold Coast Primary Health Network.

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Gold Coast Primary Health Network gratefully acknowledges the financial and other support from the Australian Government Department of Health.

Australian Government

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Primary Mental Health Care

November 2018

"Building one world class health system for the Gold Coast."

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LOW INTENSITY MENTAL HEALTH SERVICES

Needs Assessment Summary

2018

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Low Intensity Mental Health Services

Low intensity mental health services aim to target the most appropriate psychological interventions to people experiencing or at risk of developing mild mental illness (primarily low acuity anxiety and/or depressive disorders). Defining target populations, educating consumers and providers and developing low intensity service models will contribute to improved outcomes for a wide group of consumers. Within a stepped care approach, low intensity mental health services target lower intensity mental health needs. This enables the provision of an evidence based and cost-efficient alternative to the higher cost psychological services available through programs such as Better Access and other primary mental health care services.

Identified local health needs and service issues

- Flexible evidence-based services are required and could include the review and possible adaptation of existing funded groups and alternative service models.
- Low uptake of group-based services funded by GCPHN.
- Promotion of low intensity services to General Practice to support complementary use with other primary health interventions.
- Develop effective pathways to increase accessibility to evidence based electronic (digital) mental health services.

Key findings

- While there are a broad range of quality online and telephone services (eMH services) available for people with low acuity mental health issues, there is limited data on local usage.
- There is limited integration of eMH services as complementary service options within existing primary health care service delivery.
- Consultation indicates effective early intervention can prevent deterioration but there are limited soft entry point models (coaching, wellness focussed, peer-support) that focus on social and community connectedness.
- From a client perspective, a significant positive impact on recovery can be gained by General Practitioners referring to services that fit the needs of the client. For example, treatment options can be augmented using community-based self-help groups and soft entry services that use activities to engage clients and build their skills and confidence.

Prevalence, service usage and other data

The National Mental Health Commission estimate there were approximately three million Australians with a mild-moderate mental illness in 2014. This equates to an estimate of around 77,000 people in the Gold Coast community.

Low intensity services can include online, telephone, individual and group-based interventions. As depicted through the below service mapping table, there are myriad telephone and online services that could be accessed by people on the Gold Coast. While there is limited local usage data for these services a 2015 sample from Beyond Blue's telephone counselling service indicated approximately 44% of calls from the Gold Coast related to depression (26%) and anxiety (18%).

Access to online low intensity service options requires internet connectivity, which may present a barrier for some people. In 2016, Gold Coast households that did not access the internet was 11.4%, lower than the state average of 13.6%. Within the Gold Coast the areas with the most households that did not access the internet were in Coolangatta (15.6%, 3,194 households) and Gold Coast North (14.9%, 3,915 households)[2].

[1] National Mental Health Commission, 2014: The National Review of Mental Health Programmes and Services. Sydney: NMHC Published by: National Mental Health Commission, Sydney.

[2] Australian Bureau of Statistics, 2016, Gold Coast (SA 4), Quick Stats

Service Mapping

Services	Number in GCPHN Region	Distribution	Capacity Discussion
Low intensity groups (funded by GCPHN)	15 per year for target groups – CALD, LGBTIQAP+, Dual Diagnosis (mental health and drug/ alcohol) and general participants.	Good geographic spread across the Gold Coast, however service base is around the Southport area.	There has been limited uptake of the low intensity groups funded by GCPHN. NewAccess is a new service with increasing referrals. Due to the paucity of local service usage, it is unclear if there are significant capacity issues with telephone or online services. Issues may arise during peak periods of call volumes and web activity. Potential access barriers include internet infrastructure and associated costs, digital literacy and consumer and health provider awareness.
NewAccess, Beyondblue, Low intensity CBT Coaching (funded by GCPHN)	1 service with 2 FTE coaches that can have an active caseload of 20 each	Service offers online, telephone and face to face services. Outreach locations based in Northern corridor and Varsity lakes.	
Counselling helplines and websites.	10 national help lines (men's line, Veterans and veterans families counselling service, Qlife, CAN, Carers Australia, eheadspace, 1800 Respect, Relationships Australia, Counselling online, Child abuse preventions service).	Online and telephone services. Public knowledge of these services and connectivity capacity would drive uptake/ demand.	
Information and referral helplines and websites.	9 national (MindHealthConnect, Mi networks, SANE Australia, beyond blue, ReachOut.com, R U Ok? Black Dog Institute, Mental Health Online, Commonwealth Health Website).	Online and telephone services. Public knowledge of these services and connectivity capacity needed to drive uptake/ demand.	
eTherapy.	57 (online programs recommended through MindHealth Connect to promote eTherapy and self-care).	Online. Public knowledge of these services and connectivity capacity needed to drive uptake/ demand.	

Consultation

Various consultation activity was undertaken across the 2015-16 period with the Gold Coast community, clinicians and service providers. Mechanisms included broad scale community briefing, consumer journey mapping, one to one interviews, industry presentations, working groups and co-design processes.

Service provider consultation

- Getting the right treatment at the right time can be a way of getting the most out of a low intensity service. Delay in acknowledging need and seeking treatment combined with stigma and discrimination contribute to poor client outcomes.
- The ability of the GP to maintain an awareness of local services and confidently refer clients has a significant positive impact on recovery. It means that the care of the GP can be augmented with services that best fit the needs of the client. Examples are coaching services, community-based self-help groups and soft entry e-services that use activities to engage clients and build skills and confidence.
- If GPs know about and refer patients to online, self-help, low intensity services, it can assist the recovery journey for the patient.
- Balanced against service provider feedback, a comment received from a GP is - “If patients are able to articulate what their needs are this is associated with a level of satisfaction, but sometimes they don’t want what is offered, so it is difficult to find the most appropriate solution or referral pathway”.

Service user consultation

Service users report the identification and development of flexible evidence-based services, would add value to existing available options. Additionally, a campaign to inform General Practice about the services available would add value for consumers. Digital mental health services do fulfil a need for some consumers, and effective pathways can increase the accessibility of these evidence based electronic services.

Consultation and feedback from stakeholders throughout 2018:

- Increasing numbers of middle-aged women who drink to cope which is well suited to low intensity mental health services.
- Hard to reach groups including LGBTIQAP+ and people from CALD communities and those self-medicating can benefit low intensity services.
- Low intensity mental health services must be supported to be the primary referral point for mental health support.
- Concerns with health literacy and awareness of prevention and recognising when people are becoming unwell is an issue especially with mental health.

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NATIONAL PSYCHOSOCIAL SUPPORT (NPS)

Needs Assessment Summary

2018

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National Psychosocial Support

In June 2018 the Commonwealth government announced funding for national psychosocial support measures for people with severe mental illness who are not more appropriately supported through the National Disability Insurance Scheme (NDIS), to be matched by State and Territory governments through bilateral agreements.

The Commonwealth component of the NPS measure is being implemented through purpose specific funding to Primary Health Networks (PHN) to commission these new services. The PHN commissioned services will need to be implemented in a flexible way to complement the State and Territory funded psychosocial support.

National Psychosocial Support (NPS) provides assistance to individuals of all ages who are significantly affected by severe mental illness, which has an impact on their psychosocial functional capacity but who are not more appropriately funded through the NDIS. These individuals are not case-managed by Gold Coast Health, nor are they receiving services from existing community mental health programs such as Partners in Recovery (PIR) or Personal Helpers and Mentors (PHaMs) programs. NPS services, in partnership with families and carers, provide a range of non-clinical, community-based support to help these individuals achieve their recovery goals. This can include individual and group support and rehabilitation services, in both outreach and centre-based settings, focusing on social, recreational, prevocational and physical activities designed to complement existing clinical mental health and physical health services. As a result, NPS should enhance appropriate/optimal use of the health system and simultaneously reduce the need for more intense and acute health services.

Identified local health needs and service issues

- Short-term, non-clinical, recovery-focussed psychosocial support services for people of all ages
- The most frequently identified areas of unmet psychosocial needs include:
  - obtaining employment/volunteering opportunities
  - managing physical health issues
  - engaging in a fulfilling social life
  - participating in daytime activities
- Effective service engagement with people who
  - are from culturally and linguistically diverse (CALD) backgrounds
  - identify as lesbian, gay, bisexual, transgender, intersex, queer, asexual, pansexual and others (LGBTIQAP+)
  - identify as Aboriginal and/or Torres Strait Islander
- A local workforce comprised of peer support workers, life coaches and support workers able to provide client-centred, trauma-informed, culturally appropriate and recovery-orientated support in both outreach and centre-based settings
- Space for partnered services for centre-based service provision, which could include, but is not limited to specialist drug and alcohol providers, physical wellbeing and health care providers, vocational workers, employment providers, financial management specialists, family workers, peer workers and homeless, housing and accommodation providers
- Improved service coordination for individuals with severe mental illness and associated psychosocial functional impairment, while considering supports available across levels of governments, the community and relevant sectors
- Promotion of psychosocial services to General Practice and other stakeholders to support complementary use with other primary health interventions
- Efficient referral pathways to increase accessibility to new psychosocial services

Key Findings

- Individual and group psychosocial support and rehabilitation services for clients and their carers/ families that is focussed on building capacity and connectedness at times when it is most needed rather than providing ongoing support
- Greater support and intervention are required to prevent escalation of mental health conditions to avoid crisis and hospital presentations
- Peer workers are acknowledged by both providers and consumers as important supports for people with severe mental health needs, however the present workforce is small
- It is important for consumers to feel empowered to be involved in decision-making about their care and providers have a key role to act as facilitators to enable this
- General Practice is a key point of contact for people with mental health needs, however many GPs feel they do not have the information and resources required to assist patients with severe mental illness to access psychosocial supports

Prevalence, service usage and other data

The total number of people with severe mental health issues in the Gold Coast region is around 20,000 people. The potential cohort of Gold Coast residents who may be eligible for the National Psychosocial Support measure is estimated to be approximately 4,900.
Service usage for the Partners in Recovery (PIR) program should also provide a reasonable approximation for local need for the National Psychosocial Support measure. Approximately 330 unique Gold Coast residents experiencing severe mental health issues access PIR each year on average, with several experienced, local PIR Facilitators reporting the majority of clients access approximately three psychosocial supports per engagement.

This indicates that in any given year the demand for services from the potential client group is likely to be significantly less than the entire potential cohort of people.

GOLD COAST RESIDENTS

People with severe mental health issue.

People eligible for the National Psychosocial Support.

People with severe mental health issues who access PIR per year.

Service Mapping

Non-clinical psychosocial services	Number in GCPHN Region	Distribution	Capacity Discussion
Employment and volunteering	A number of federally-funded employment providers support clients with a disability and these providers also support clients whose primary disability is a mental health issue	Office locations are based across the Gold Coast	Mental Health NGOs provide support and programs for individuals to engage with employment and volunteering, however, most do not have specific programs dedicated to people with Mental Health issues. Education programs and groups are run by various NGOs aimed at supporting consumers and carers. Active and Healthy Providers who have undertaken Mental Health First Aid Training are noted in the listing on City of Gold Coast website.
Social life/company	9 providers (8 are NGO providers, 1 is an Aboriginal Medical Service, 2 are peer-based providers, 1 employs peer workers).	Programs are a combination of outreach and center-based activities. 3 in Southport, 1 in Arundel, 1 in Mermaid Beach, 1 in Varsity Lakes, 1 in Miami, 2 in Robina, 1 in Oxenford, 1 in Bilinga (11 listed due to multiple locations).	
Physical health (non-clinical)	8 (7 NGO providers and 1 community-based program, "Active and Healthy," funded by City of Gold Coast with 15 providers available)	Activities funded by City of Gold Coast are located across the entire region.	
Daytime activities	5 providers (3 NGO providers, 1 private provider, 1 community-based program funded by City of Gold Coast with 15 providers available)	Distribution is predominately in Palm Beach, Southport and Currumbin. Activities funded by City of Gold Coast are located across the entire region.	

Consultation

A consultation session regarding potential non-clinical psychosocial services was held in August 2018 and included contributions from twenty-one attendees from the Gold Coast Primary Health Network (GCPHN), the GCPHN Consumer and Carer Advisory and Multidisciplinary Advisory Committees and representatives from Primary and Community Care Services.

The top three ideas from the consultation have been included for four of the five most common unmet needs identified by over 700 local service users who experience severe mental health issues. Psychological distress was identified within the top five unmet need however support for this issue is not considered to be of a psychosocial nature.

Potential psychosocial services to address the need for employment and volunteering opportunities include:

- linking people into a Sheila Shack/Men's Shed
- establishing a work experience program with local employers
- the provision of info/support to connect with local volunteering organisations/businesses that already provide vocational skills that lead to a qualification/certification.

A fulfilling social life is an unmet need frequently identified by local service users. The consultation group suggested several options including:

- social groups (art, games, sports, board games and/or social media-based groups
- tea time/meal sharing (preparation, serving, eating together)
- men's shed.

Psychosocial support to assist people with severe mental illness to manage physical health issues could include:

- yoga, meditation and/or tai chi classes
- walking/active groups (beach walks, dog walks, hill walks, adventure activities)
- nutrition education facilitated by a registered dietician and including diet plans and cooking groups.

Participation in meaningful daytime activities has also been raised an unmet need. The consultation group has suggested the possibility of:

- establishing meal preparation service
- self-care and daily living education/programs/workshops that focus of wellbeing including sleep, nutrition and exercise
- mentors/coaches to assist and set daily achievable tasks/schedules.

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MENTAL HEALTH SUICIDE PREVENTION

Needs Assessment Summary

2018

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Suicide Prevention

Suicide is a complex issue with long-lasting impacts on individuals, families and communities. Causes of suicide ideation and behaviour can stem from a mix of factors such as adverse life events, trauma, social and geographical isolation, socio-economic disadvantage, mental and physical health, lack of support structures and individual levels of resilience.

Identified local health needs and service issues

- PHN funded suicide prevention psychological services are well utilised but opportunity exists to better target those most at risk
- Education and support required for General Practice and mental health services workforce particularly in relation to consistent approaches to risk assessment and safety planning
- Work in partnership with Gold Coast Health to ensure care planning and discharge processes are inclusive for all participants.
- Develop clear referral pathways and supported connections to appropriate community supports

Key Findings

- While the Gold Coast suicide rate is consistent with the state rate, it is greater than the national rate.
- Gold Coast data indicates that men account for around 78% of suicides, and 35-54 year age group experiences the highest number of suicides.
- National data indicates the LGBTIQAP+ community is particularly vulnerable.
- The interface with acute services remains problematic, including: patients requiring support may not meet the service threshold for admission; people are not connected or referred to more appropriate services; limited collaborative discharge planning and discharge information; discharge information may not always be received in a timely way by the patient's regular general practitioner (GP).
- For the 2017-18 period, 36% of all referrals to the Psychological Services Program were made through the suicide prevention stream, accounting for 54% of all sessions delivered. This is a noticeable increase from previous years.
- Services that support people struggling with relationship and family breakdowns, financial problems and bereavement are essential elements of the suicide prevention system.

Prevalence, service usage and other data

Suicide was the leading cause of death for young Queenslanders in 2016 with 101 deaths among people aged 15-24 years [1]. In Queensland, the suicide rate increased an average of 1.6% each year between 2006 and 2014. Approximately 80% of deaths from self-harm or suicide were males.

Of the 665 suicides reported in 2016 in Queensland, 52 (7.82%) were by Aboriginal or Torres Strait Islander people. Of these, 37 were male (71.2%) and 15 were female (28.8%). The majority of Aboriginal and Torres Strait Islander suicides were under the age of 35 years (65.9%), while just over a quarter were aged 35-54 years (28.6%) and 5.6% were 55 years or older[2].

Gold Coast had the lowest number of suicides by Aboriginal or Torres Strait Islander people in Queensland for the 2011-13 period. True suicide mortality figures in Aboriginal and Torres Strait Islander populations remain poorly understood due to incomplete data collection processes and inaccurate classification systems.

During the period 2011-2013, there were 225 suicides in the GCPHN region, representing an age-standardised suicide rate of 13.7 per 100,000 people. This is comparable with the Queensland rate of 14.0 in this period, and greater than the national rate of 10.7 per 100,000 people (Table 1)[3].

Table 1. Age standardised suicide rate per 100,000 people, by local, state and national for 2011-13

	GCPHN RATE	QUEENSLAND RATE	NATIONAL RATE
Age standardised suicide rate per 100,000 people	13.7%	14.0%	10.7%

Across the 2011-13 period, the Gold Coast had a lower proportion of suicides among young people aged 34 years and under (24.9%) compared to Queensland (31.3%). Conversely, there was a higher proportion of suicides among people aged 35-54 years (47.1%), greater than the Queensland rate of 41.5%. Gold Coast and Queensland suicide rates for people 55+ years were similar at 28% and 27.2% respectively, although Gold Coast had a slighter higher rate among this age group than other similar regions.

Males accounted for 158 (70%) suicides in the Gold Coast (2011-13), which is the second-smallest proportion of male suicides in all Queensland Hospital and Health Service regions. While this is one of the lowest rates in the state, it still indicates that suicide effects a much higher proportion of men compared to women on the Gold Coast.

The following figures present suicide mortality rates for the Gold Coast region by gender and age group. Figure 1 demonstrates that among males, the highest suicide rates were observed in the age groups 45-54 years, followed by 35-44 years (36.5 and 32.2 per 100,000 people respectively).

1 Australian Bureau of Statistics, 3303.0-Cause of Death.
2 Potts, B., Kõlves, K., O'Gorman, J., & De Leo, D. (2016): Suicide in Queensland, 2011–2013: Mortality Rates and Related Data, Brisbane
3 Potts, B., Kõlves, K., O'Gorman, J., & De Leo, D. (2016): Suicide in Queensland, 2011–2013: Mortality Rates and Related Data, Brisbane
4 State and national rates calculated based on averages across years as reported in above mentioned source.

Figure 1. Male suicide numbers and rates per 100,000 people by age group in the Gold Coast region, July 2011 to June 2013

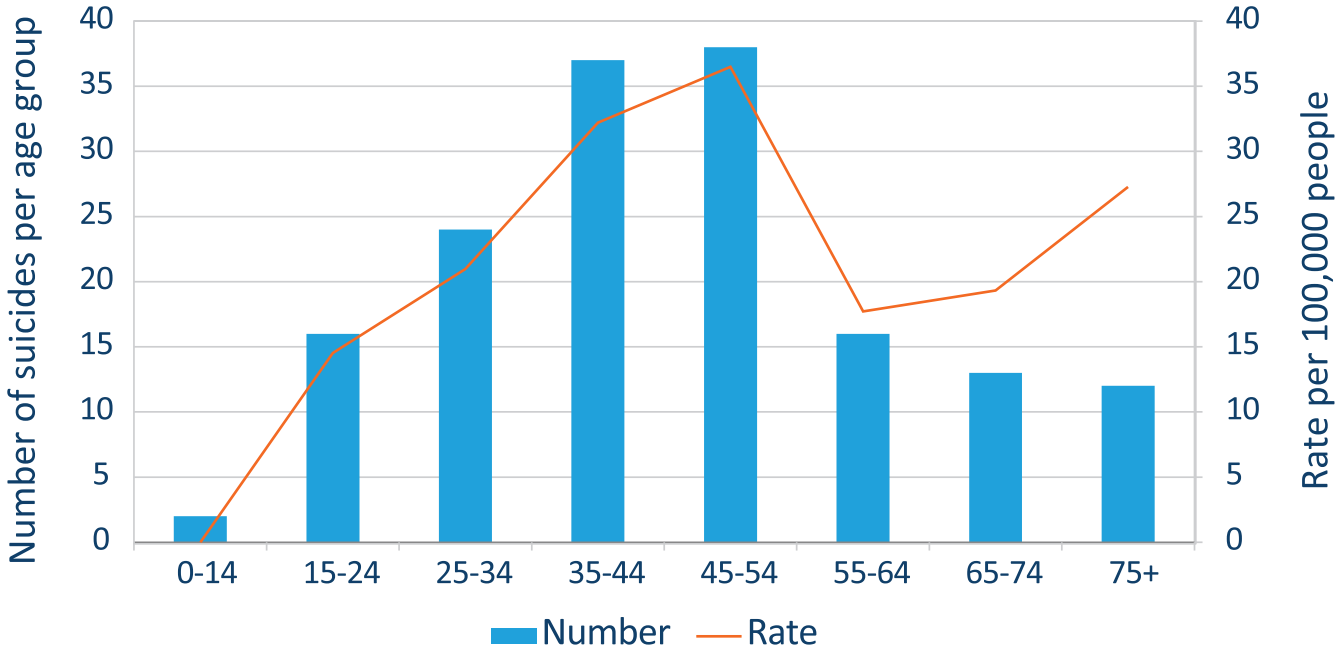
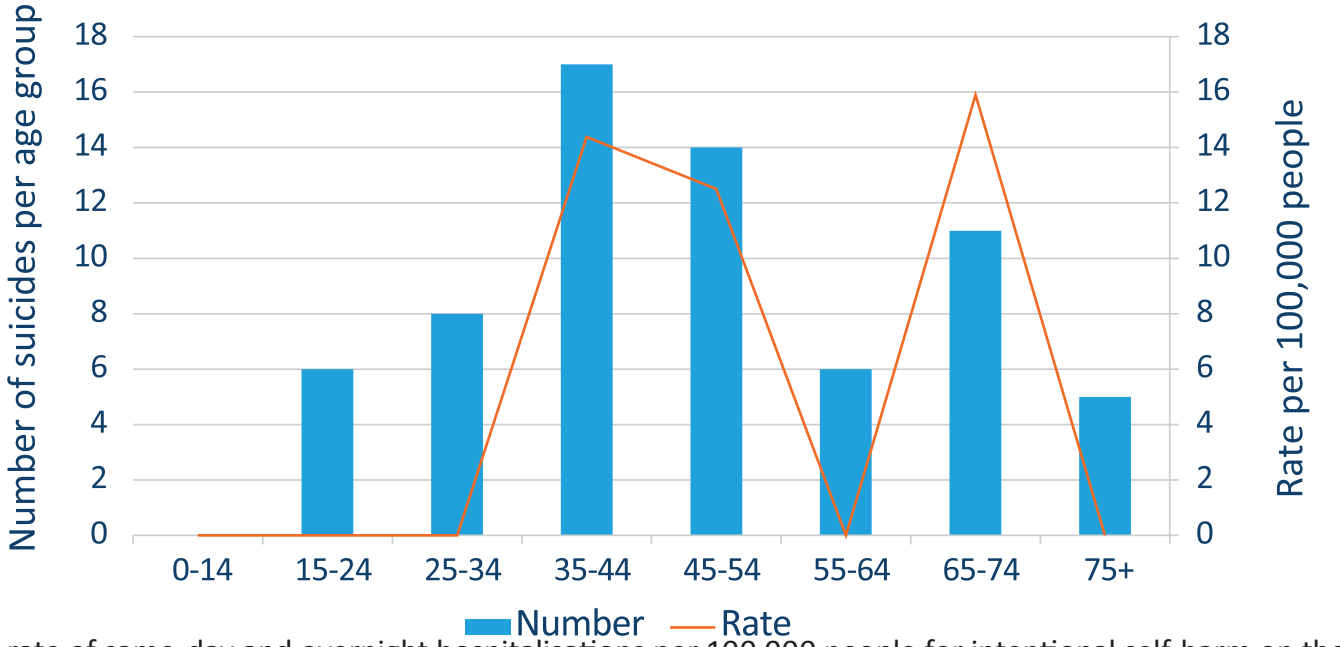


Figure 2 shows that in females, rates of 15.9 and 14.4 per 100,000 people were observed in the 65-74 and 35-44 years age groups, respectively. These rates are among the highest age-standardised rates for females in all regions of Queensland.

Figure 2. Female suicide numbers and rates per 100,000 people by age group in the Gold Coast region, July 2011 to June 2013[5]



The rate of same-day and overnight hospitalisations per 100,000 people for intentional self-harm on the Gold Coast was similar to the national figure across the 2013-2015 period. For 2014-15 within the Gold Coast region there were five areas with rates greater than both national and broader Gold Coast rates, with the highest recorded in Gold Coast Hinterland (211 per 100,000 people) (Table 2).

[5] Rates for ages 15-24, 25-34, 55-64 and 75+ years could not be calculated due to incomplete data.

Table 2. Hospitalisations per 100,000 people for intentional self-harm (age standardised), at national, local and SA3 levels, 2014-15

Region	Hospitalisations per 100,000 people (age standardised) 2014-15	Region	Hospitalisations per 100,000 people (age standardised) 2014-15
National	**161**	Ormeau - Oxenford	175
Gold Coast	**164**	Surfers Paradise	162
Gold Coast Hinterland	211	Nerang	150
Gold Coast - North	204	Broadbeach - Burleigh	142
Southport	199	Robina	105
Coolangatta	177	Mudgeeraba - Tallebudgera	102

Source: Australian Institute of Health and Welfare analysis of the National Hospital Morbidity Database 2014–15; and Australian Bureau of Statistics Estimated Resident Population 30 June 2014.

20% of transgender Australians and 15.7% of lesbian, gay and bisexual Australians report current suicidal ideation (thoughts). Up to 50% of transgender people have attempted suicide at least once in their lives. Same-sex attracted Australians have up to 14 times higher rates of suicide attempts than their heterosexual peers. Rates are 6 times higher for same-sex attracted young people (20-42% cf. 7-13%)
The average age of a first suicide attempt is 16 years – often before 'coming out.'

There are multiple factors recognised as contributing to suicidal behaviour or someone being at risk of suicide. These include personal hardship, difficult life events, poor physical and mental health, harmful substance use and previous self-harm or suicide attempts[6]. It is important to understand these factors when considering suicide prevention. Data from the Queensland Suicide Register identified the prevalence of life events among people who died by suicide (2011-13). Relationship separation was the most frequently recorded life event (27%) among all ages and for both women and men. This was followed by relationship conflict (15.5%), financial problems (14.9%) and bereavement (13.9%). These factors differed slightly between women and men (Table 3). Data from 2013 demonstrated family problems were the most commonly reported life stressor contributing to Queensland ambulance attendances for suicide attempts (27%), suicidal ideation (25%), self-injury (28%) and self-injury threat (32%)[7].

This highlights the importance of considering services that support people struggling with these issues as key elements of the suicide prevention system.

[5] Potts, B., Kõlves, K., O'Gorman, J., & De Leo, D. (2016): Suicide in Queensland, 2011–2013: Mortality Rates and Related Data, Brisbane. & Australian Institute of Health and Welfare 2016. Australia's health 2016.

[6] Lloyd B., Gao C. X., Heilbronn, C., Lubman, D. I. (2015). Self-harm and mental health-related ambulance attendances in Australia: 2013 Data. Fitzroy, Victoria: Turning Point

Table 3. Prevalence of life events in suicide cases by gender, Queensland, 2011-13

LIFE EVENT	MALE	FEMALE	PERSONS
Relationship conflict	15.7%	14.7%	15.5 %
Relationship separation	28.3%	28.3%	27.0%
Financial problems	17.0 %	4.2 %	14.9 %
Bereavement	12.3 %	18.7 %	13.9 %

Source: Potts, B., Kõlves, K., O'Gorman, J., & De Leo, D. (2016): Suicide in Queensland, 2011–2013: Mortality Rates and Related Data, Brisbane

The Psychological Services Program (PSP) provides short term psychological interventions for financially disadvantaged people with non-crisis, non-chronic, moderate mental health conditions or for people who have attempted, or at risk of suicide or self-harm. This program targets seven hard to reach and priority groups including children, people at risk of homelessness and suicide prevention. From the 1st July 2017 to 30th June 2018 there were:

- 1068 referrals (249 were repeat clients)
- 690 clients who exited the program
- 5004 sessions delivered across the seven target areas

A review of clients accessing Psychological Services Program (PSP) for suicide prevention over the last 12 months indicates higher use by females and younger people which are not the most at-risk cohorts in the region. The average number of sessions per client per episode of care ranges from 1 to 29, with an overall average of 8 sessions taken.

The regions with the highest number of children using the service were Upper Coomera (62), Pimpama (50), Coomera (46) and Nerang (24). This data also is consistent with the clients using the service for suicide prevention (which includes adults) with the highest numbers in Upper Coomera (50), Pimpama (40), Nerang (28) and Coomera (31). This data highlights the need for resources in the Northern Gold Coast.

Table 4. Number of persons accessing Psychological Services Program on the Gold Coast, 1st July 2017 to 30th June 2018.

FY 2017/18	Children (under 12 years)	Adult Suicide Prevention	All other target groups
Referrals	395	515	158
Sessions	2733	1690	581

Service Mapping

Services	Number in GCPHN region	Distribution	Capacity discussion
GCPHN funded Psychological Services Program (PSP) suicide prevention	Of the 25 PSP providers, 19 are contracted to provide suicide prevention services	Providers are distributed across the region	Dedicated suicide prevention services on the Gold Coast appear to be limited; however, some mental health services provide information and referral advice on suicide prevention. A 2018 review of clients accessing Psychological Services Program (PSP) suicide prevention service stream indicates strong use but those using the service tend to be females and younger people, which are not the most at risk cohorts in the region. Crisis services on the Gold Coast are available through the public health system in the form of hospital emergency departments and specific crisis support (Acute Care Treatment team, 24hr phone line). There are numerous well known national suicide prevention (and crisis) services that are likely to be accessed by the Gold Coast community. For example Lifeline (phone and online), Suicide call back service (phone and online) and Beyond blue (phone and online). There are no specialised suicide prevention or crisis services for Aboriginal and Torres Strait Islander people on the Gold Coast although the Acute Care Team does employ an Aboriginal and Torres Strait Islander Mental Health Worker.
Gold Coast Health crisis helpline	1 phone hotline (13 MH CALL) for the Acute Care Treatment (ACT) Team	ACT team telephone service available 24hrs	
Gold Coast Health Emergency Departments	2	Located at public hospitals in Robina and Southport	
Support and Transition Program - Suicide Prevention (coordination support for those at-risk of suicide, recently attempted or are recently discharged	1	Accessible via contact with public hospitals in Robina and Southport	
Crisis helplines	4 national (Lifeline, Suicide Call Back Service, Mensline, Kids Helpline)	24 hour, 7 day telephone services. Public knowledge of these services would drive uptake/demand.	
Counselling helplines and websites	12 national help lines (Mensline, Kids Helpline, Open Arms formerly Veterans and Veterans Families Counselling Service, QLife, , Carers Australia, eheadspace, 1800 Respect, Relationships Australia, SANE Australia, ReachOut, BeyondBlue, Counselling Online, Child abuse prevention service)	Online and telephone services.	

Consultation

Various consultation activity was undertaken during 2017 with the Gold Coast community, clinicians and service providers. Mechanisms included broad scale community briefing, consumer journey mapping, one to one interviews, industry presentations, working groups and co-design processes.

Service provider consultation

- People presenting to hospital feeling at risk of self-harm but whose mental health issues are not seen as serious enough for admission with limited follow up provided.
- Training and skills development for school staff that supports enhanced early identification, intervention and referrals was also acknowledged as an important requirement, as was enhancing the skills of mainstream services, GPs, and clinicians to work with at risk and vulnerable populations.
- Limited community support systems and services available for those that have attempted suicide
- Early identification of at risk people who identify as LGBTIQAP+ was also reported as key to suicide prevention.

Service user consultation

- Inadequate response for individuals presenting to hospital feeling unsafe/at risk of self-harm but who are not admitted as their immediate health issues are not seen as serious or acute enough.
- Limited community support systems or services for those that have attempted suicide
- People who have survived suicide attempts want more support, particularly with non-health related issues such as financial support, relationships and housing.
- Individuals being discharged feel excluded from the hospital discharge planning process.
- Due to capacity issues within the Acute Care Team, individuals with high needs and /or at risk of suicide are not being responded too quickly enough.

A common theme expressed amongst service users who had previously attempted suicide was their positive perceptions of the mental health workers who cared for them, to the extent that these workers were credited with having prevented their clients'.

"Building one world class health system for the Gold Coast."

HARD TO REACH GROUPS

Needs Assessment Summary

2018

phn GOLD COAST

An Australian Government Initiative

Hard to Reach Groups

Overall, the Gold Coast has good service coverage and relatively unimpeded access. However, there are people in the community who are vulnerable and/or experience circumstances that can prevent them accessing services without additional support. The term 'hard to reach' is commonly used within the spheres of social care and health, especially in discourse around health and social inequalities.

These characteristics may make it difficult for people to participate, especially if the ways in which they are expected to contribute do not make allowances for the particular barriers they may face. Some of the key factors that can impact people's ability to access and successfully engage in services include: language, age, gender identity, geographic location, income, ethnicity, education, residential status, sexual orientation, health and religion. As a result careful consideration of services to best meet their needs are required.

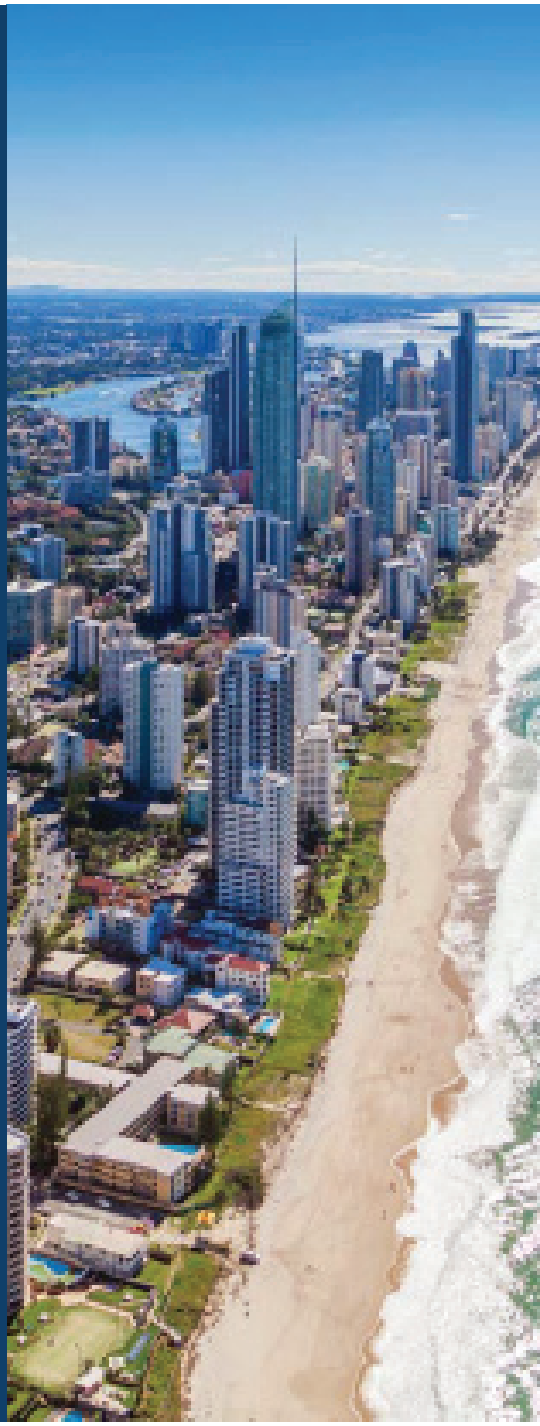
Identified local health needs and service issues

Data, research and consultation with service users, service providers and community members identified the following groups as high risk / hard to reach on the Gold Coast;

- People who are currently homeless, or are at risk of homelessness
- Culturally and Linguistically Diverse people (CALD)
- People who identify as lesbian, gay, bisexual, transgender, intersex, queer, asexual, pansexual and others (LGBTIQAP+)
- Women experiencing perinatal depression
- Aboriginal and Torres Strait Islander people
- Children (aged 0-12) who have, or are at risk of developing a mental, childhood behavioral or emotional disorder (including children in care)
- People who self-harm or who are at increased risk of suicide

In addition

- Housing options are needed to stabilise and support effective engagement with primary care mental health supports for the homeless population (out of scope but will be progressed by PHN)
- Access to psychological services for the homeless population is limited
- Access to psychological services for the CALD population is limited
- Interpreters used in psychological interventions would benefit from training in mental health
- Access to psychological services specifically for LGBTIQAP+ people is limited

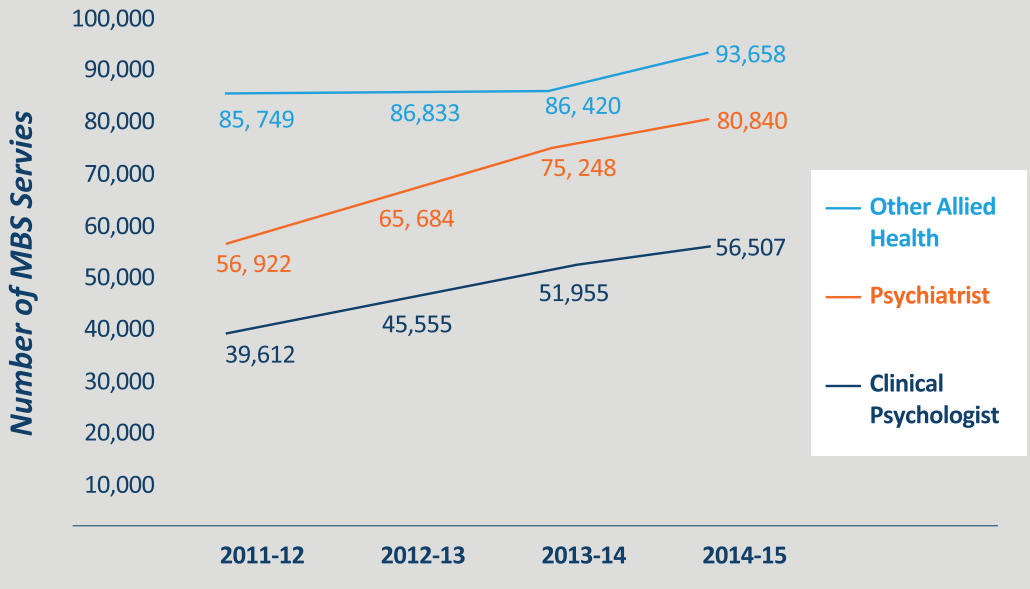


Key Findings

- A broad range of languages are spoken in the Gold Coast region, including growing numbers from countries where trauma and torture issues can impact an individual's ability to access appropriate services.
- Use of interpreter services can be difficult, particularly telephone based services, as interpreters may have limited understanding of mental health issues and cultural sensitivity coupled with the limited capacity of existing CALD services to support mental health clients.
- Stigma, privacy concerns and cultural issues present barriers to people accessing services.
- Flexibility of service provision, such as outreach, is necessary to engage homeless people and those at risk of becoming homeless. There are a high number of homeless people in Southport, Surfers Paradise and Coolangatta. There are high number of soci-economically disadvantaged people in Southport and Gold Coast North.
- Training and education is required for services to ensure safe and appropriate service provision for LGBTIQAP+ people.
- Children (Ages 0-12) particularly children in care have high needs (see Mental Health – Children and Young People Needs Assessment Summary)
- Perinatal depression may affect quite a large number of women but they may seek services due to stigma.

Prevalence, service usage and other data

Australia's MBS system subsidises access to psychological support provided by Psychiatrists, Clinical Psychologists and other allied health professionals (psychologists, occupational therapists and social workers). There has been an increase in the number of these services claimed on the Gold Coast since 2011 with the largest number of claims being for psychological services provided by allied health professionals (Figure 1).



Source: ABS, MBS Mental Health Data by SA3, provided through Department of Health

To support access to psychological services by priority population groups, the Commonwealth Government introduced the Access to Allied Psychological Services Program (ATAPS) in 2001. Although superseded by the Psychological Services Program in 2017, ATAPS data has been included to provide service utilisation context for hard to reach groups in the Gold Coast.

The Psychological Services Program provides short term psychological interventions for financially disadvantaged people with non-crisis, non-chronic, moderate mental health conditions or for people who have attempted, or at risk of suicide or self-harm. This program particulary targets a number of hard to reach groups including children. From the 1st July 2017 to 30th June 2018:

- 1068 referrals (249 repeated clients)
- 690 exits
- 5004 sessions delivered

The regions with the highest number of children using the service were Upper Coomera (62), Pimpama (50), Coomera (46) and Nerang (24). This data also is consistent with the clients using the service for suicide prevention (which includes adults) with the highest numbers in Upper Coomera (50), Pimpama (40), Nerang (28) and Coomera (31). This data highlights the need for resources in the Northern Gold Coast.

Table 1. Number of persons accessing Psychological Services Program on the Gold Coast, 1st July 2017 to 30th June 2018.

FY 2017/18	Children (under 12)	Adult Suicide Prevention	All other target groups
Referrals	395	515	158
Sessions	2733	1690	581

People who are or are at risk of homelessness

Quantifying the prevalence of mental illness among homeless populations is difficult, and estimates have varied considerably. Australia's Welfare 2011 published by the Australian Institute of Health and Welfare (AIHW), reviewed the evidence and observed that while some studies estimated the prevalence of mental illness in the homeless population to be between 72% and 82%, others have found it to be between 12% and 44%. A 2015-16 report on specialist homelessness services found a quarter of all people receiving assistance from these agencies were experiencing a current mental health issue[1].

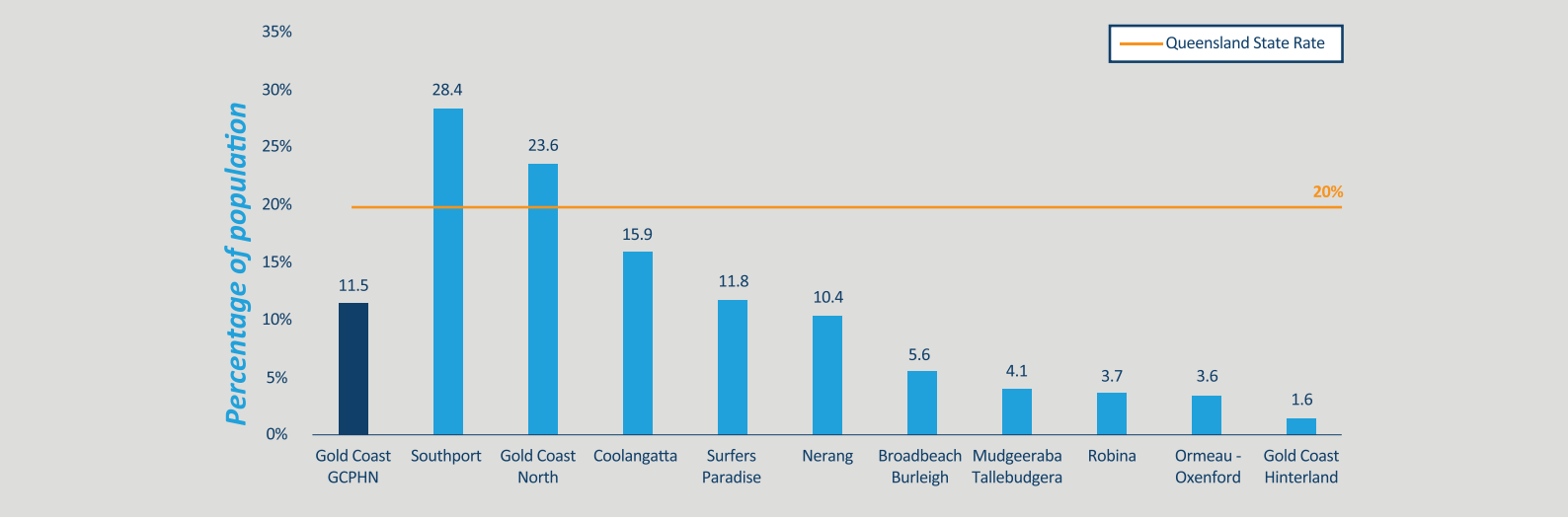
A 2016 study by Australian Institute of Health and Welfare highlights the complexity of people in this group finding that over the 3-year period 2011-2013, more than 1 in every 5 alcohol and drug treatment clients also accessed homelessness assistance, while about 1 in 12 of all homelessness clients received alcohol and drug treatment[2]. The report's analysis further reveals that over three-quarters (77%) of the study population, in addition to their housing and drug and alcohol issues, experienced an additional vulnerability, including mental health problems or domestic and family violence issues.

In 2016, there were 1,723 homeless people on the Gold Coast, a rate of 2.4 per 10,000[3]. This was lower than the Queensland rate of 45.6 per 10,000. However, within the Gold Coast, Southport exceeded the state rate of homelessness with 71.5 persons per 10,000. Two other areas had rates above that of the broader Gold Coast, Surfers Paradise (41.9 per 10,000) and Coolangatta (35.8 per 10,000). Service providers report that this is likely to be an under-representation of the true numbers.

The 2014 Home for Good study found that of the 382 homeless Gold Coasters that participated, 53% reported experiencing physical, emotional or sexual abuse and trauma that they had not sought help for, or that had caused their homelessness[4].

Socio-Economic Indexes for Areas (SEIFA) is a summary measure of the social and economic conditions of geographic areas across Australia. SEIFA comprises a number of indexes, generated by the ABS from the Census of Population and Housing. People in the most disadvantaged quintiles are at greater risk of homelessness. Overall, the Gold Coast had 9.0% of people in the most disadvantaged quintile, half the Queensland figure of 20%. Despite this, the areas of Southport (25.9%) and Gold Coast North (22.6%) exceeded both the broader Gold Coast and Queensland figures as shown in Figure 2 below.

Figure 2. Percentage of population by SEIFA quintile 1 (most disadvantaged), by SA3 area, Gold Coast and Queensland, 2011



Source: ABS 2033.0.55.001, Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia - Data only, 2011, (Queensland Treasury derived)

1 Australian Institute of Health and Welfare. 2016. Report on Specialist Homelessness Services, 2015–16

2 Australian Institute of Health and Welfare. 2016. Exploring drug treatment and homelessness in Australia: 1 July 2011 to 30 June 2014. Cat. no. CSI 23. Canberra: AIHW

3 ABS. 2011. Census. Gold Coast (SA4). Quick Stats.

4 Queensland Council of Social Services. 2014. Home for Good. Gold Coast Registry Week Report.

People from culturally and linguistically diverse (CALD) backgrounds

The prevalence of mental disorders for people born in Australia was higher (19.5% for males and 24.0% for females) than people born overseas (17.7% for males and 19.9% for females)[5]. For people born in non-English speaking countries the prevalence of mental disorders was 8.4% for males and 16.2% for females[6]. While the reasons are not clear it may relate to the fact that people who successfully migrate to Australia are required to complete rigorous health checks and testing which means they are more likely to be physically healthier than the remainder of the population. This may also be true for mental disorders.

Refugees and asylum seekers are at high risk of mental health problems as a direct result of the refugee experience and their displacement. In addition, they come from a range of countries and cultures and have a wide range of experiences that may affect their mental health. While there has been very limited direct resettlement of refugees in the Gold Coast region, there are growing numbers resulting from intra-national migration.

In 2016, 28% of the Gold Coast population were born overseas with 12% of those from a non-English speaking country[7]. Twelve per cent of Gold Coast residents speak a language at home other than English with 10.6% speaking English well or very well, comparable to Queensland figured. For the 1.6% who do not speak English well, or at all, additional support may be required to ensure access to health services, including those related to mental health. Within the Gold Coast, Southport, Surfers Paradise, Gold Coast North and Robina have the greatest number of people who do not speak English well or at all. The most common non-English languages spoken at home for the total population of Gold Coast were Chinese languages (2.3%), Japanese (1%) and Indo Aryan languages (0.9%).

Gold Coast Health data indicates an increase in the number of requests for interpreter services across the health service from 2016 to 2017 with interpreter bookings for mental health almost doubling[8]. The most frequently requested non-English language interpreters across the Gold Coast Health service were Mandarin, Japanese, Korean, Cantonese, Bosnian and Spanish, particular increases for Arabic language have also been observed.

LGBTIQAP+ community

The challenges faced by the LGBTIQAP+ community and the subsequent mental health impacts are well documented. At least 36.2% of transgender people and 24.4% of gay, lesbian and bisexual people were found to meet the criteria for experiencing a major depressive episode, compared with 6.8% of the general population[9]. This rate increases to 59.3% among transgender women in a La Trobe University study.

Lesbian, gay and bisexual Australians are twice as likely to have a high/very high level of psychological distress as their heterosexual peers (18.2% v. 9.2%)[10]. More than twice as many homosexual or bisexual Australians experience anxiety disorders as heterosexual people (31% vs 14%) and over three times as many experience affective disorders (19% vs 6%). The rates are higher across any age group, country of birth, income level, area of residence or level of education/employment[11]. Suicide and self-harm have a disproportionate impact among the LGBTIQAP+ community and are covered in further detail in the 'Suicide Prevention Summary'.

5 ABS. 2007. National Survey of Mental Health and Wellbeing: Summary of Results 2007
6 Ibid
7 ABS. 2016. Census. Gold Coast (SA4). Quick Stats.
8 Internal GCH data
9 Rosenstreich, G. (2013) LGBTI People Mental Health and Suicide. Revised 2nd Edition. National LGBTI Health Alliance. Sydney
10 Ibid
11 Ibid

Women experiencing perinatal depression

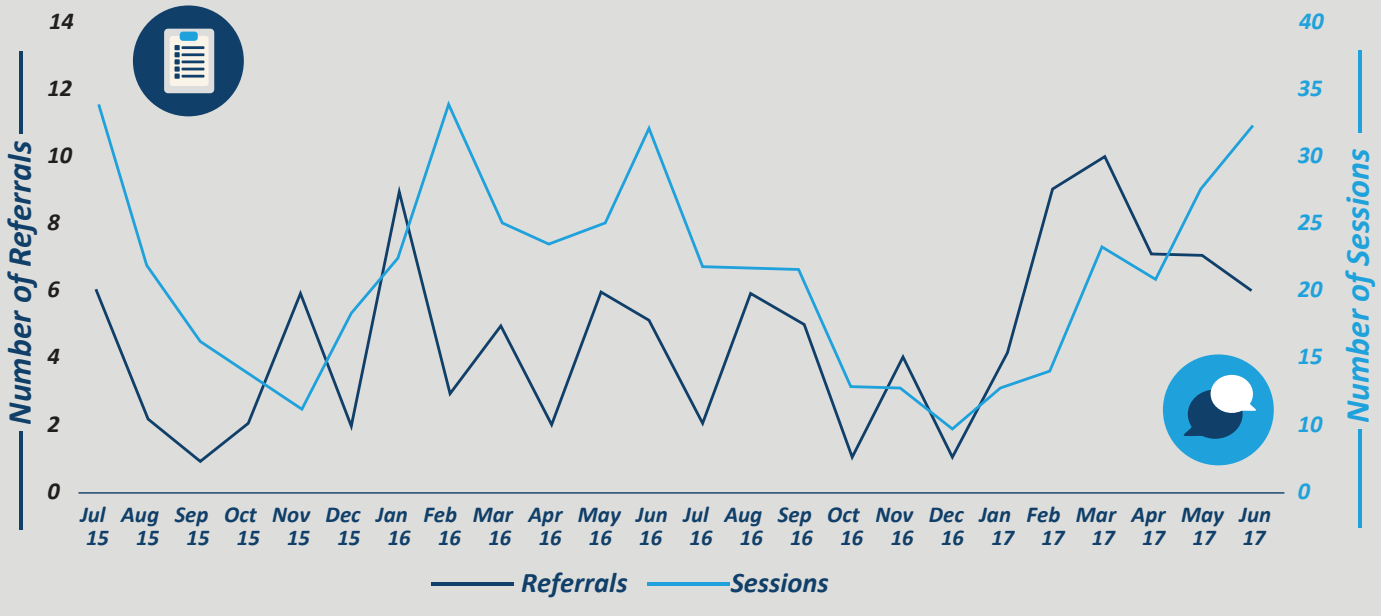
The perinatal period is a highly volatile time and addressing the complex needs of the mother and baby both as individuals and as a dyad is essential to ensure the best possible outcomes. Recognising symptoms early and seeking help minimises the risk of potentially devastating outcomes for new parents and their baby. Data from the 2012, showed that 1 in 7 mothers of children aged 24 months or under had been diagnosed with depression. More than half of these mothers reported that their diagnosed depression was perinatal (that is, the depression was diagnosed from pregnancy until the child's first birthday). Considering that in 2015 there were nearly 7,000 births on the Gold Coast, this leads to an estimate of around 1,000 women experiencing perinatal depression.

The majority of mothers suffering from perinatal depression sought treatment from their General Practitioner and support from family and friends. Perinatal depression was more commonly reported among mothers who:

- **Were younger (aged under 25)**
- **Were smokers**
- **Came from lower income households**
- **Spoke English at home**
- **Were overweight or obese**
- **Had an emergency caesarean section**

Over the period July 2015 to June 2017, ATAPS referral rates for perinatal issues were low compared to other ATAPS streams and fluctuated greatly. 3 shows the ATAPS referral and service frequency relating to perinatal issues over this period.

Figure 3. ATAPS perinatal referral and service frequency per month, GCPHN region, July 2015 to June 2017



Service Mapping

Hard to reach	Services	Number in GCPHN region	Distribution	Capacity discussion
Children (Ages 0-12) particularly children in care	See summary for 'Mental Health, Youth including children'			
People who are or are at risk of Homelessness	Gold Coast Health Community Services - specifically for homeless persons or those at risk.	1 (Homeless Health Outreach Team).	Outreach, whole of Gold Coast region.	There is one service on the Gold Coast that specifically provides mental health and AOD support to homeless people or those at risk of homelessness. While not specifically mental health or AOD services themselves, many homeless support services refer their clients to appropriate providers due to high need among this demographic.
	Community NGO services, (predominantly accommodation, crisis support and case management).	9 NGO providers who provide specific homeless services or refer into mental health services.	5 in Southport, 2 in Bilinga, 1 in Robina, 1 in Miami.	
Culturally and linguistically diverse (CALD) backgrounds	ATAPS psychological services - Culturally and Linguistically Diverse Service	Of the 67 ATAPS Providers (2016-17), 7 are contracted to provide the Culturally and Linguistically Diverse Service. All 67 providers can utilise Translating and Interpreter Services (TIS National) where required.	CALD providers are based in Coomera, Nerang, Benowa, Worongary, Varsity Lakes and Coolangatta (2).	There are 2 CALD facilitators involved in the PIR program. This enables CALD participants with severe and complex mental health needs to choose a CALD facilitator if they wish. There is one program specifically providing mild to moderate support to CALD people, however eligibility is narrow. There is a handful of pharmacies on the Gold Coast registered with the National Translating and Interpreting Service.
	Partners In Recovery (PIR) - service coordination/ facilitation program.	There are 2 PIR workers who identify as CALD.	Program is outreach.	
	Pharmacies	13 of the 148 Queensland pharmacies registered with the National Translating and Interpreting Services (TIS) are on the Gold Coast.	They are clustered in the central coastal region, the most southern in mermaid, most northern in Hope Island and most western in Carrara/ Arundel.	

LGBTIQAP+	Community NGO LGBTI service - support group and information service for young people ages 13-24.	1 drop-in service for youth providing support groups and information.	Southport	There is one service providing support specifically targeted at LGBTIQ youth (13-24). Based in Southport, the drop- in service offers two support groups (ages 13-17 and 18-24) and also information and resources on health, specifically suicide prevention.
	Online health services and information targeted at LGBTI mental health.	4 (Qlife, LGBTIQ Alliance, Queensland AIDS Council, Minus 18).	Online Services. Public knowledge of these services would drive uptake/ demand.	
Women experiencing perinatal depression	ATAPS psychological services - perinatal service	Of the 67 ATAPS Providers (2016-17), 23 are contracted to provide the Perinatal Service.	Providers are across the region but more limited in southern Gold Coast. Last year, based on referrals specific effort was made to recruit additional providers in the Northern Gold Coast.	Two specific services support perinatal depression on the Gold Coast. Both have flexible locations however eligibility requirements of one service may limit access.
	Gold Coast Health Community services (support through pregnancy until 2 years post birth).	1 (Perinatal Infant Mental Health).	Palm Beach	

Consultation

Various consultation activity was undertaken during 2016 with the Gold Coast community, clinicians and service providers. Mechanisms included broad scale community briefing, consumer journey mapping, one to one interviews, industry presentations, working groups and co-design processes.

People who are or are at risk of homelessness

Service provider consultation

- Some community based organisations provide a soft entry point to cater for the homeless and provide an initial point of contact through which to identify and deliver health care.
- Homelessness is on the rise and that it becomes more problematic in winter as the weather which drew people to the Gold Coast in the first instance turns colder.
- The homeless population do not present to mainstream services yet have physical health issues that require regular primary care.
- Domestic violence is often a significant reason behind homelessness and on the Gold Coast, women are more likely to have unstable accommodation due to this problem.
- Service providers identify that it takes considerable time and consistency of staff to develop trust and relationships with this group as many are suspicious of service providers due to past negative experiences. Once trust has been established, engagement with services to provide mental health care is more likely and effective.
- Flexibility on behalf of the service provider was also identified as critical, as keeping appointment times can be challenging for people who are homeless.

Service user consultation

- Consumer journey mapping indicated that for people with mental health conditions who were homeless, often contact with a trusted staff member was the thing that put them on a trajectory to recovery in addition to finding accommodation and taking the step of seeking treatment.

As similarly identified by the service providers, engagement of this group into services often occurred when the service provider had an informal presence where the homeless population visits, such as the food vans and emergency accommodation.

People from culturally and linguistically diverse (CALD) backgrounds

Service provider consultation

- Consultation identified many services for people of CALD backgrounds are concentrated in Brisbane and only limited ones on the Gold Coast.
- Providers indicated providing psychological services to the CALD population was identified as important along with the need to ensure appropriately trained interpreters. Engagements of
- CALD clients with mental health problems is better if the interpreter has a mental health background or mental health training

Service user consultation

- Service users identified that the lived experience of mental health issues of the CALD worker helps relationship building.
- The Community Briefing also revealed that where cross cultural relationships exist and not well accepted, having mental health needs further disenfranchises the individual from their community and the positive effect of a family and friendship network in their recovery.
- Additionally, sections of the CALD community can be affected by myths and falsehoods linked to mental health issues, resulting in stigma

Concern about accessing culturally sensitive interpreters and a further concern about privacy may be compromised in smaller communities.

LGBTIQAP+ community

Research has demonstrated that a disproportionate number of Lesbian, Gay, Bisexual, Transgender, Intersex Queer, Asexual and Pansexual (LGBTIQAP+) people experience poorer mental health outcomes and have higher risk of suicidal behaviours than their peers. These health outcomes are directly related to experiences of stigma, prejudice, discrimination and abuse on the basis of being LGBTIQAP+.

While Australian and international research provide evidence that raises significant concern about mental health outcomes and suicidal behaviours among these groups, it is vital to note that significant knowledge gaps remain. This is due to lack of inclusion of sexual orientation, gender identity and intersex status in population research and data collection by mental health and mainstream services. As data informs evidence-based policy, this exclusion has led to inaccuracy in reporting and significant underestimates that has left this group relatively invisible in mental health and suicide prevention policies, strategies and targeted programs.

Consequently, Australian evidence on the health and wellbeing of the LGBTIQAP+ population nationally relies on a growing but limited number of smaller studies that target the LGBTIQAP+ populations, or part thereof. While uniquely valuable, these can have methodological issues relating to representative data collection and limited ability to provide a comprehensive data analysis that is therefore unable to represent a holistic picture of LGBTIQAP+ people.

When considering data provided in this document it is important to note that this is not a comprehensive literature review, and we urge the reader to consider this broader context where adequately estimating the mental health outcomes and suicidal behaviours for the LGBTIQAP+ populations remains highly challenging.

Service provider consultation

- Lack of local services that specifically focus on service delivery for this group across all ages.
- Mainstream services often do not have the specific skill set, confidence or knowledge to work with this group.
- Administration / intake processes can create a barrier or cause a traumatic experience hindering access e.g. male or female options only on forms.
- Nursing staff are often “too scared to ask the questions” limiting appropriate referral and service options for clients.

Service user consultation

- Service users state from a lived experience perspective that there are limited local services that meet their needs.
- Staff including reception, intake and administration at mainstream services do not always respond appropriately leading to reluctance to engage with services.
- Staff are embarrassed and lack knowledge of how to diffuse conflict and provide a service that the LGBTIQAP+ person requires at the point of patient registration.

A consumer journey for this group was captured from a client who had experienced the full spectrum of experiences from service providers from poor to excellent. Useful interventions were when key people such as guidance counsellors and school nurses reached out to new LGBTIQAP+ students to provide support.

Women experiencing perinatal depression

Service provider and consumer consultation

- Consultation indicates the stigma of not being a good mother and limited outreach options prevents some from accessing support.

Barriers exist for women to access mainstream mental health services in circumstances where they are caring for other children, are isolated due to no transport (for example in Upper Coomera) or are too unwell.

"Building one world class health system for the Gold Coast."

MENTAL HEALTH – CHILDREN AND YOUTH

Needs Assessment Summary

2018

phn GOLD COAST

An Australian Government Initiative

Mental Health – Children and Youth

Intervention early in life and at an early stage of illness can reduce the duration and impact of mental illness. Services that recognise the significance of family and social support and functional recovery are particularly important for children and young people.

In line with a stepped care model it is likely there will be a need to support region-specific, cross sectoral approaches to early intervention for children and young people experiencing, or at risk of mental illness including those with severe mental illness who are being managed in primary care.

While Gold Coast Primary Health Network (GCPHN) generally defines children as 0-14 and youth as 15-25 years. It is not possible to consider age cohorts given age and other access and eligibility criteria vary across service providers and individual programs.

Identified local health needs and service issues

- Wrap around support for youth through outreach opportunities and flexible service entry points
- Early intervention and therapeutic services for children aged 0 to 14 across with a focus on the northern growth corridor
- Limited services in the northern part of the region where there are large child and youth populations and significant demand for Mental Health (MH) services for this cohort, including services for Aboriginal and Torres Strait Islander Children
- Education, training and support to engage schools and broader education workforce in early identification and intervention
- Children in care have significant mental health needs, often associated with traumatic experiences and complicated by other complex health needs. Addressing these issues is hampered by:
- Long wait times for assessment and treatment in the public system
- Costs of private services
- Issues with transfer of information
- Limited knowledge and adherence to guidelines /frameworks by health care providers

Key Findings

- Data indicates potential geographic areas with higher numbers of vulnerable young children are in the northern growth corridor areas of Upper Coomera and Pacific Pines as well as the central Southport areas. Consultation indicates service gaps in the northern growth corridor.
- Broadbeach-Burleigh, Southport and Ormeau-Oxenford are highlighted areas with higher than national rates for prescribing mental health medication for those under 18.
- There is a concentration of services in the Southport area including the large youth health service, headspace. Age and other access criteria varies across the sector and consultation and service mapping indicates that access to services for younger children (aged 0 to 14) is more difficult.

- This is also supported by data from the GCPHN's ATAPs program which saw significant increase in referrals.
- Consultation highlighted the importance of schools as an early intervention opportunity for young people.
- Services report an increase in high complexity for young service users requiring coordinated, family-based and multiple agency response.
- On some indicators, the GCPHN region fairs slightly better than state and national comparators such as: lower rates of prescriptions for antidepressant and anti-psychotic medication for under 18's and a lower rate of youth suicide.
- GCPHN needs to work with stakeholders to improve regional specific data on prevalence and service usage by children and young people for future analysis.
- Children in care are a particularly vulnerable group and service delivery for this cohort is particularly complicated.

Prevalence, service usage and other data

Findings from the Young Minds Matter Survey (2013-14) indicated 1 in 7 Australians aged 4-17 had a mental disorder in the previous 12 months. Severity of disorders varied with 8.3% mild, 3.5% moderate and 2.1% severe. Anxiety and Attention Deficit Hyperactivity Disorder (ADHD) disorders were more likely to be rated as having a mild and moderate impact, whereas major depressive disorder was more commonly rated as having a moderate to severe impact.

While differing age breakdowns between data sets prevent an exact comparison, it is estimated in 2016 there were 14,681 Gold Coast children aged 5-19 years who experienced a mental disorder in the previous 12 months. Students with mental disorders achieve poorer NAPLAN results and have more absences from school. Applying the severity percentages reported in the Young Minds Matter Survey results in an estimated 1,219 mild, 514 moderate and 308 severe cases[1].The Australian Early Development Census (AEDC) is a nationwide data collection of early childhood development. Most recent data (2015) indicates the rates of developmentally vulnerable Gold Coast children in the domains of social competence (11.5%) and emotional maturity (9.9%) are comparable to both Queensland and National figures with small variations (Table 1.)

Table 1. Percentage of developmentally vulnerable children across the Gold Coast, Queensland and Australia, by domain

	GOLD COAST (%)	QUEENSLAND (%)	AUSTRALIA (%)
Social competence	**10.6**	**12.4**	**9.7**
Emotional maturity	**9.9**	**10.1**	**8.4**

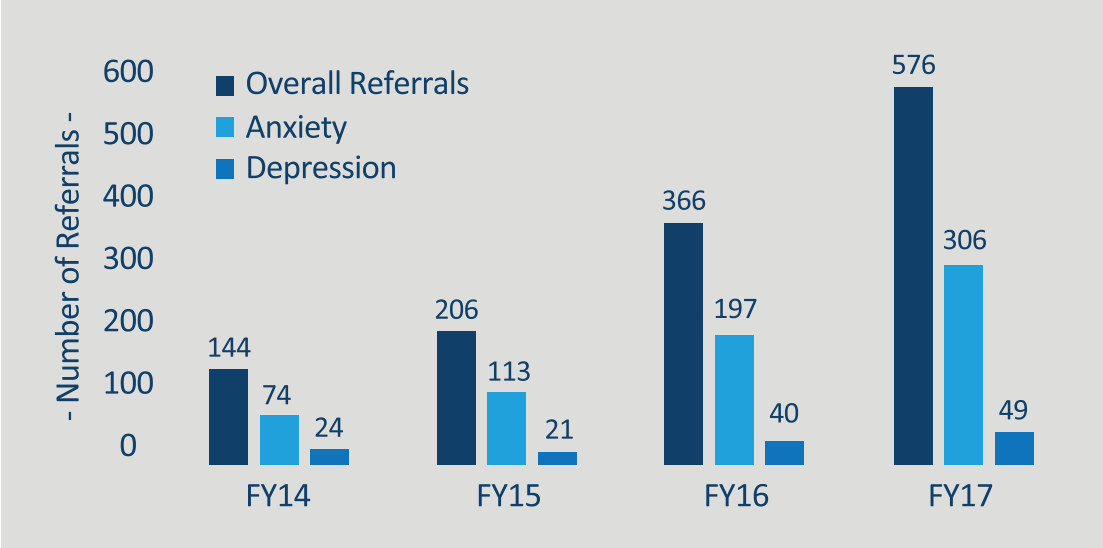
The three regions within the Gold Coast with the highest rate of developmentally vulnerable children in the social competence and emotional maturity domains fluctuated. However, the areas with greatest numbers of developmentally vulnerable children across both domains were Upper Coomera, Pacific Pines and Southport. Furthermore, increasing numbers of children and young people are entering into the child protection system from the northern corridor. This is reflective of the larger populations in these areas.

Analysis of Medicare Benefits Schedule (MBS) data by the Australian Bureau of Statistics (2011) found the Gold Coast had a slightly higher rate of children aged 0-14 and youth aged 15-24 accessing any MBS subsidised mental health- related services, compared with National figures (Table 2).

Table 2. Persons accessing any MBS subsidised mental health-related service, GCPHN region and National, 2011

Persons accessing any MBS subsidised mental health related service	GCPHN Percent (%) of population	GCPHN Percent (%) of population
Population aged 0-14	3.8%	2.9%
Population aged 14-24	9.7%	8.2%

Gold Coast children aged 0-12 years with mild to moderate mental health needs could access psychological services through the Access to Allied Psychological Services (ATAPS) program. Program data indicates a steady increase in referrals across financial years from 2013-2017. While this is likely due to increased awareness among referrers resulting from significant promotion, it demonstrates an ongoing demand within the target population. Most referrals were for children aged 5-12 years, seeking support for anxiety ***(Figure 1). The ATAPS program ceased as of 30 June 2017 and has been replaced by the Psychological Services Program.***



Source: Unpublished ATAPS program data

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FY 2017/18	Children (under 12)	Adult Suicide Prevention	All other target groups
Referrals	395	515	158
Sessions	2733	1690	581

Anecdotal evidence from clinicians is that one of the reasons that PSP is so highly used by the youth population in this area is because of the lack of Hospital / state specialist services in the area.

In relation to prescriptions dispensed for anti-depressant, antipsychotic and ADHD medicines for people aged 17 years and under, the Gold Coast rate was lower than Queensland and comparable to national rates (Table 4). Within the Gold Coast, the highest rates for both anti-depressant (9,408) and antipsychotic (2,485) medicines were in Broadbeach–Burleigh, well exceeding national figures.

Table 4. Age standardised rate of Pharmaceutical Benefit Scheme (PBS) prescriptions dispensed for anti-depressant, antipsychotic and ADHD medicines per 100,000 people aged 17 and under, by Gold Coast, state and national, 2013-14

Age standardized rate of Pharmaceutical Benefit Scheme (PBS) prescriptions per 100,000 people aged 17 and under for:	Gold Coast	Queensland	National
Anti-depressant medicines	8,021	9,072	7,989
Antipsychotic medicines	1,971	2,544	2,070
ADHD medicines	10,799	12,555	10,780

Source: ACSQHC Australian Atlas of Healthcare Variation, 2015

There was a noticable variation between rates among sub-regional areas of the Gold Coast with some exceeding both state and national figures. For anti-depressant medicine dispensing, the three areas within the Gold Coast with the highest rates were Broadbeach–Burleigh (9,408), Southport (8,874) and Ormeau-Oxenford (8,871). These were above both the national and Gold Coast rates, with Broadbeach-Burleigh also exceeding the Queensland rate.

For antipsychotic medicine dispensing, the three areas within the Gold Coast with the highest rates were Broadbeach–Burleigh (2,485), Coolangatta (2,327) and Mudgeeraba-Tallebudgera (2,299). +These were above both the national and overall Gold Coast rates.

For ADHD medicine dispensing, the three areas within the Gold Coast with the highest rates were Nerang (12,621), Gold Coast North (12,525) and Southport (11,810). These were above both the national and overall Gold Coast rates with Nerang also exceeding the Queensland rate.

Source: National survey of Mental Health and Wellbeing

Children in alternate care (children who subject to Child Safety orders) are likely to have poorer mental health as well as physical and developmental health, than their peers, with only 3% of young people in alternate care without health problems)[2].

- More than half (54%) have emotional or behavioral problems.
- 14% have abnormal growth.
- 45% aged 10-17 years have moderate or high health risks associated with substance use.
- 24% have incomplete vaccinations.Up to 63% have an eating disorder or obesity.20% have abnormal vision screening.
- 28% have an abnormal hearing test.
- 30% have dental problems.

Table 5. Infant and child mental health, current service provision, 2015

Age (years)	Meet criteria for a diagnosis	Multiple risk factors indicative of requiring specialist mental health support	Current level of population accessing specialist mental health services
0-5	16-18%	16.1% (0-1 years) 12.1% (2-3 years)	**Commonwealth** MBS any provider 0.9% (0-4 years) ATAPS 0.3% (0-11 years) **State** Ambulatory 0.4% (0-4 years)
4-11	13.60%	19.2% (4-5 years) 25.2% (6-7 years) 28.9% (8-9 years) 32.8% (10-11 years)	**Commonwealth** MBS any provider 5.7% (5-11 years) ATAPS 0.3% (0-11 years) **State** Ambulatory 1.4% (5-11 years)

Service Mapping

Services	Number in GCPHN region	Distribution	Capacity discussion
Psychological Services Program (PSP), Child (0-12) stream. Focus is moderate.	18 providers registered with PSP to provide psychological services to children.	Providers are available across the region	Capacity discussion Community and Gold Coast Health services providing mental health care for youth and children are clustered in Robina and Southport with one located in Burleigh and some outreach. The majority of child and youth mental health services focus on ages 12-25 with eligibility cut offs varying within this age bracket. Mental health services for children aged 0-12 are very limited. While a mix of mild to moderate and severe and complex providers exist, eligibility requirements limit access. The services delivered by the Gold Coast Health are largely located in Robina and Southport. Overall more limited services in the northern part of the Region. Wait times for FASD assessments can be very lengthy (over a year)
Headspace (12-25 years) general practice services, psychological, dietetics, vocation/educational support, family and peer support, home-based care. Focus is mild to moderate.	1 on the Gold Coast. Neighbouring facilities in Tweed Heads to the south and Meadowbrook to the north.	Southport, potential for southern Gold Coast to access headspace in Tweed Heads. Northern Gold Coast residents may have to travel well outside region to access Meadowbrook service.	
Headspace Youth Early Psychosis Program (12- 25 years) psychiatry, psychological, group, family and peer support, case management, community education. (hYEPP)	1 on the Gold Coast. Neighbouring facilities in Meadowbrook to the north.	Hub and spoke model - Hub is headspace Southport with spoke being at Meadowbrook (which is located inis located south of Brisbane). Also accessible via outreach)	
E-mental health services.	E-headspace target to youth.	Online Services. Public awareness knowledge of these services would drive uptake/demand.	
Gold Coast Health inpatient services, ages 0-25 years (varied age and other access/ eligibility criteria)	3 (Robina has 2: child and youth and acute young adult aged 18-25 years. Southport has 1 acute adult unit for ages 16-65 years).	2 in Robina, 1 in Southport.	
Gold Coast Health community services, ages 0-25 years (varied age and other access/ eligibility criteria across programs/services)	8 (Child and Youth Mental Health Service [CYMHS], Evolve therapeutic services, child and youth access, perinatal infant mental health, early psychosis, continuing care teams (18+), eating disorder service (18+), acute care treatment team (18+).	2 CYMHS clinics (Robina and Southport), Early Psychosis (Robina), rest outreach	
Community based mental health NGO services (majority focus on ages 12 -25 with age and other access/eligibility criteria varying within this: 2 services cater to ages 0-18, predominantly facilitator/ service coordination and counselling).	5 separate NGO providers with programs and services specifically for youth mental health.	1 in Southport, 1 in Burleigh, 3 outreach to all of Gold Coast	
Community NGO services, (predominantly counselling and referral services)	8 NGO providers who provide counselling services or refer into specific youth mental health services.	3 in Southport, 2 in Arundel, 1 in Labrador, 1 in Miami, 1 in Robina, 1 in Burleigh.	
Fetal Alcohol Syndrome Disorder (FASD) clinic	1 (1 of 2 in the country).	Gold Coast Health service	

Consultation

Various consultation activity was undertaken during 2016 with the Gold Coast community, clinicians and service providers. Mechanisms included broad scale community briefing, consumer journey mapping, one- to- one interviews, industry presentations, working groups and co-design processes.

Service provider consultation

- Services and support for children who are undergoing gender transitioning or who identify early as LGBTIQAP+ are sparse. Local psychosocial support is difficult to find.
- Family re-unification programs for children with child safety issues whose parents have mental health and alcohol and other drugs needs are managed by community-based agencies; reports that current services in this space are not able to meet demand.
- Increasing complexity and/or acuity of presentations to service providers, school guidance officers and school counsellors reported. Not all are eligible for referral to Child and Youth Mental Health Service (CYMHS) and there are limited options for age-specific services.
- The complex needs assessment panel (CNAP) on the Gold Coast were identified as a critical piece of the service system providing a coordinated and multi-service response for youth with the most
- Complex needs. The CNAP for < 10s has been defunded but is still running with increasing demand for the service.
- Spikes in presentations to services occur for early intervention and therapeutic services between the ages of 10-17 years; these children can fall through the gaps as they don't easily fit eligibility criteria. Furthermore, service providers report that the psychological treatment can have limited outcomes for complex cases due to the time it takes build rapport and the time/session limitations for funded services.
- Transport is an access barrier for youth as public transport can be too costly or not available.
- Alcohol and drug treatment options are limited for the youth and there are no withdrawal management options for those under 18 years.
- Collaboration between mental health nurses and school nurses could be improved to support identification and intervention. Education and information around referral options is needed for people working in the school system.
- Primary Health Care Improvement Committee November 2018 indicate:
    - difficulty in accessing services for children, including Aboriginal and Torres Strait Islander Children with or at risk of mental health issues, particularly in the northern growth corridor area (Coomera, Upper Coomera, Oxenford and surrounds)
    - approximately 2 out of 3 families needing mental health support for children are in "chaos" hindering ability to access services

Service user consultation

Children themselves were not engaged in providing direct feedback. Dialogue occurred with young people, adult carers, adults with a lived experience of child/adolescent mental illness and service providers.

- School was often identified as a critical early intervention opportunity that was missed or neglected. This was also the case for those with experiences of sexual abuse, childhood trauma and domestic violence who are broadly accepted as being 'at-risk', highlighting that these target groups can still slip through cracks.
- School identification/intervention relating to mental health is limited and can be dependent on which school a child attends.
- Limited opportunities for children or young people to speak out or seek help.
- There are not enough community-based support options for children with mild to moderate needs, therfore these children miss out on the benefit of early intervention.
- Children and young people not connected with education or engaged with other support are hard to reach.
- Access to family support services is limited due to capacity issues.
- Young people reported experiencing severe distress and chaos resulting from the impact of social determinants and contributing to mental health issues and AOD use.
- Many young people stated that meeting a significant adult at the right time was a key factor marking the commencement of their recovery journey.

Significant stakeholder consultation was undertaken in 2018 as part of a project focused on strengthening the health assessment response for children and young people in Alternate Care and found:

- Limited health professional awareness of the National Clinical Assessment Framework for children and young people in out of home care.
- There are no MBS Items numbers for conducting health assessments for children and young people in out of home-care despite widespread evidence of the poor health outcomes upon entry to care and throughout life.
- Many children enter the protection system without any documentation such as Medicare number thus, detrimentally postponing their access to health care including the public health system and primary care.
- Paediatric health in recommended in the National Clinical Assessment Framework
- Reliance on the public health system for paediatric referrals does not enable timely health assessments in accordance of the three-month guideline recommended in the National Clinical Assessment Framework for Children and Young people in Out of Home care.
- High cost is associated with cognitive and behavioral assessments, done privately with no specific MBS funding for the assessments.
- A long waiting list (approximately 2 years) at Gold Coast University Hospital for fetal alcohol spectrum disorder (FASD) for 7-10-year old. Limited services are doing FASD assessments due to the need for a multidisciplinary team and the time to do testing is 32-64 hours a week.
- Limited availability of appropriate and targeted therapy for FASD and it is often misdiagnosed as behavioural issues such as ADHD, finding the right therapy for the disorder is difficult.

- Concern that funding allocations are a barrier for carers supporting the health needs for their children and especially those with complex needs. This is compounded by limited MBS and PHN funded services that meet the intensity required for long term health outcomes.
- Misdiagnosis of trauma as ADHD and ASD is an extensive problem for children in care meaning they may not receive the right treatment at the right time leading to long term complex problems.
- Some children are referred to other health services that cannot provide treatment until the trauma is addressed by a psychologist.
- Information sharing is a barrier to managing health needs for this cohort and there are multiple challenges with the My Health Record as a tool to do this. Challenges also relate to health care teams working together to support the outcomes of the child/young person.
- Limited understanding of trauma-informed care among some professionals, including lack of screening for trauma, re-traumatisation and clinical approaches/environment leading to children and young people's disengagement from the health system.
- Parents of children in care feel stigmatised and disempowered by the health system due to the power imbalances between carers, Child Safety, health professionals and parents. Parent want to be provided opportunities to be involved in the health care of the children and evidence suggests that doing so increases long term positive health outcomes for the young person.
- While there are some exemplars in delivery of services to Aboriginal and Torres Strait Islander children in care, many mainstream services may have more limited understanding of what is culturally appropriate.

"Building one world class health system for the Gold Coast."

SEVERE AND COMPLEX

Needs Assessment Summary

2018

phn GOLD COAST

An Australian Government Initiative

Severe and Complex

Approximately 690,000 Australians are estimated to have severe mental illness[1]. The needs of people with severe mental illness are not homogenous. Some have episodic illness which can be supported through time-limited clinical services in the primary care setting. Others have persistent illness requiring acute hospital-based services coupled with some form of social support, ranging from group-based activities to extensive and individualised disability support.

Within the primary care setting, almost half the people with severe mental illness are currently managed by a Psychiatrist[2]. Many others rely primarily on General Practitioners (GPs) to provide both mental and physical health services. Given many people with severe and complex mental illness also experience poor physical health outcomes[3], it is critical that Psychiatrists and GPs are supported to deliver care to this vulnerable group.

Identified local health needs and service issues

- Coordinated shared care planning that is available across primary care, community and the hospital and health service.
- Education and training for General Practice to better support severe and complex patients, including physical health and referral pathways.
- Increased opportunities to support greater engagement in service delivery by peer workers and people with a lived experience.
- Centralised intake across the stepped care model to ensure people receive the appropriate support and referral based on their needs.
- Develop efficient pathways to support person centered transfer of care between acute and primary services (general practice, allied health and community services).
- Transition to NDIS creates uncertainty for providers in their sustainability to provide services to individuals that are not NDIS eligible.

[1] National Mental Health Commission, 2014: The National Review of Mental Health Programmes and Services. Sydney: NMHC
[2] Australian Government. Department of Health, PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance
[3] Equally Well Consensus Statement, 2017

Key Findings

- General Practice is a key point of contact for people with mental health needs, however many GPs feel they do not have the information and resources required to assist patients with severe and persistent mental illness. Time limited consultations and appropriate referral pathways were identified as issues.
- Improved pathways are needed to support person centered care and effective transfer between acute, specialist and primary care.
- Southport is the area most frequently identified as having the highest rates and greatest numbers related to severe and complex metal health.
- PBS data indicates rates of prescriptions for medication for adults are higher than national average for anxiolytics but lower for anti-depressants and anti-psychotics. Further exploration required to understand variation. Southport had the highest rate of prescriptions across all three medication types.
- There are three regions within the Gold Coast with rates of mental health overnight hospitalisations per 100,000 people above the national rate.
- There is variation between regions within the Gold Coast area of Psychiatry services per patient.
- Peer workers are acknowledged by both providers and consumers as important support for people with severe and complex mental health needs, however the present workforce is small.
- A greater focus on early intervention is required to prevent escalation of mental health conditions to avoid crisis and hospital presentations, with a particular focus on improving health literacy and self-management. This is relevant for both community and service providers.
- It is import for consumers to feel empowered to be involved in decision-making about their care, providers have a key role to act as facilitators to enable this.

Prevalence, service usage and other data

The National Mental Health Commission estimate 3.45% of Australians aged 16-85 experience severe mental illness at any one time[1]. While differing age breakdowns between data sets prevent an exact comparison, applying this to the Gold Coast equates to an estimate of 16,095 people aged 15 and over in 2016[2]. This can further be described as;

9,331 people with severe episodic mental illness

4,665 people with severe and persistent mental illness

2,099 people with severe and persistent illness with complex multiagency needs

It is difficult to pinpoint the areas of the Gold Coast with the greatest severe and complex metal health need. However, a review of PBS, MBS, hospital and service usage data indicate Southport is the area most frequently identified as having the highest rates and greatest numbers related to severe and complex metal health. In addition to this, Southport is a highly disadvantaged area with multiple characteristics of vulnerability.

[1] National Mental Health Commission, 2014: The National Review of Mental Health Programmes and Services. Sydney: NMHC

[2] Numbers are synthetic estimates based on the National Mental Health Commission 2014 Review of Mental Health Programs and Services and Census 2016 usual residence population and are intended as a guide only.

The Socio-Economic Indexes for Areas (SEIFA) is a summary measure of social and economic conditions including low-income, education attainment, high unemployment and dwellings without motor vehicles. Southport has the largest percentage of people ranked as being the most disadvantaged using SEIFA[3]. This disadvantage is further compounded by Southport accounting for the highest percentage and number of people who are homeless, people who did not speak English well or at all, the largest percentage of one parent families and the second highest percentage of people requiring assistance with a profound or severe disability on the Gold Coast[4].

The Partners in Recovery (PIR) program supports people with severe mental illness, experiencing severe and persistent symptoms. This group of people have significant functional impairment and psychosocial disability, may be disconnected from social or family support networks and have complex multiagency needs. It is likely many of these people will be the focus of the National Disability Insurance Scheme (NDIS) Tier 3 individual support packages in the future.

The GCPHN PIR program has supported 1025 people with severe mental illness. While this does not represent the entire Gold Coast population with severe and complex mental health conditions, PIR program data provides insight to the health needs of this group of service users.

Among PIR participants, more than half (52.1%) identified a mood (affective) disorder as their primary mental health diagnosis with schizophrenia the second most common at 19% (Figure 1). These figures indicated that Gold Coast participants were more likely to have a primary mental health diagnosis of mood (affective disorder) compared to the PIR national average reported in 2015 (38%). Gold Coast participants were also somewhat less likely to have a diagnosis of schizophrenia (PIR national average was 25%), they were also more likely to have a diagnosis of adult personality and behaviour (PIR national average was 6%).

Figure 1. Primary Mental Health Diagnosis for Closed and Active Participants (% N = 1025), 2013-2017

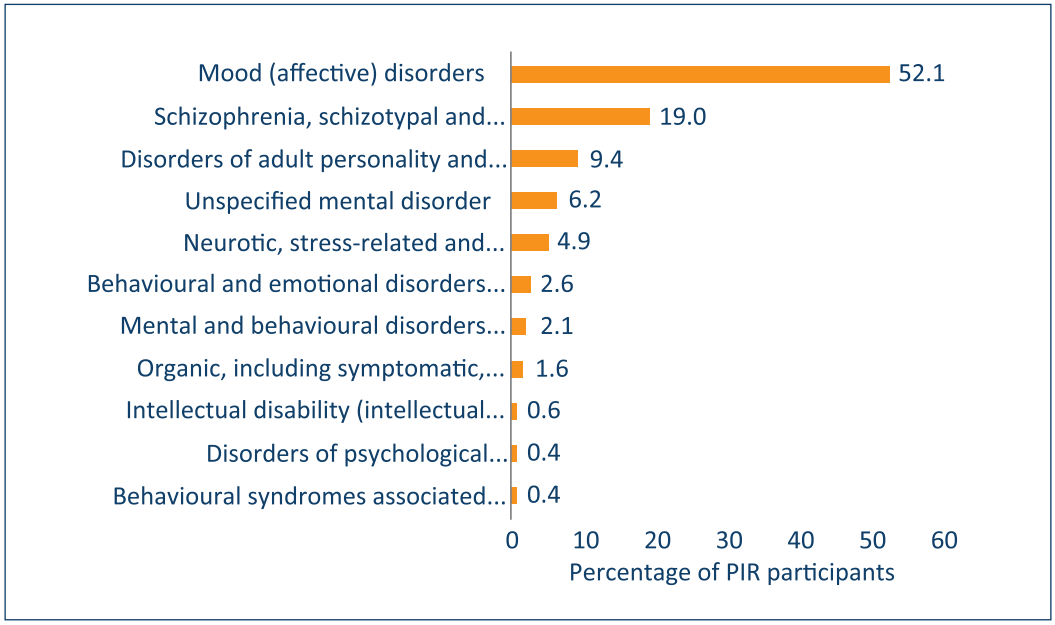
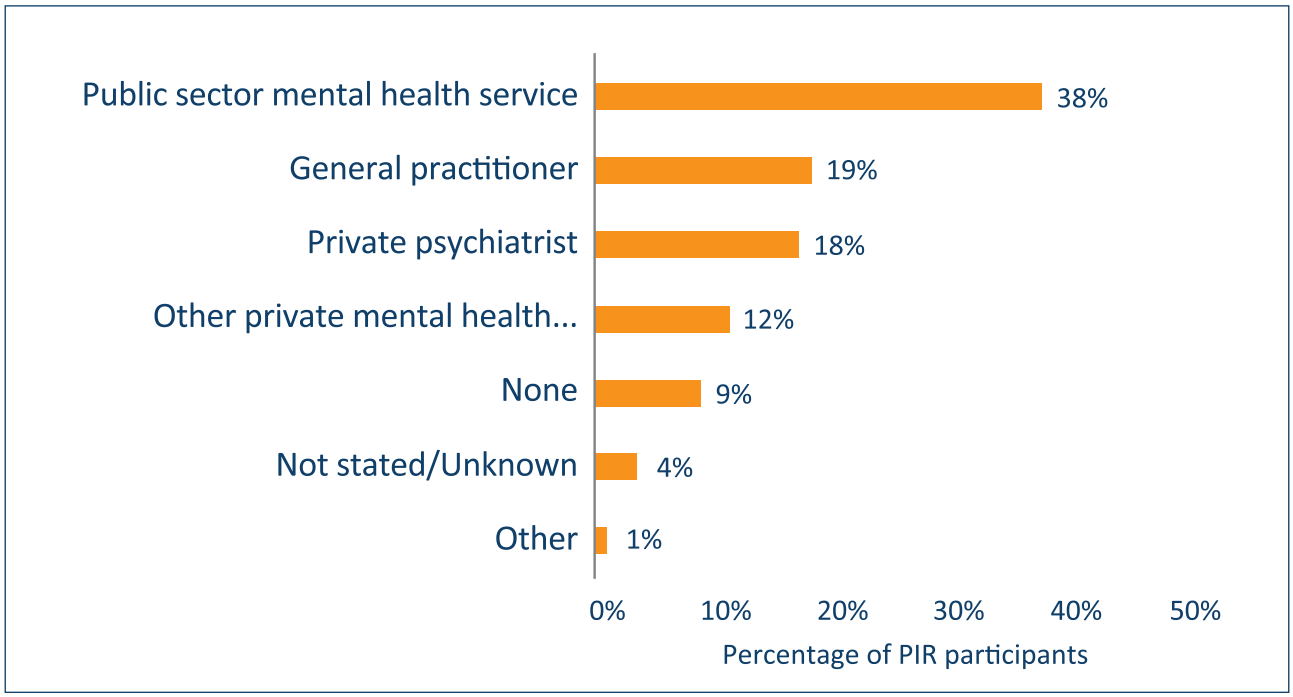


Figure 2 illustrates 38% of the participants were principally being supported by public sector mental health services, 19% by a GP and 18% by a private psychiatrist. Notably, one in nine are not being supported by any mental health service at the time of intake. When compared to national averages, Gold Coast participants appeared to be more likely to have a public sector mental health service supporting them (35% of all PIR participants were supported by the public sector in the 2015 annual report). Furthermore, Gold Coast participants were less likely to be supported by a GP (28% for all PIR participants nationwide) but more likely to be supported by a private psychiatrist (9% nationwide).

[3] Queensland Government Statistician's Office, Queensland Treasury, Queensland Regional Profiles: Resident Profile for Gold Coast Statistical Area Level 4

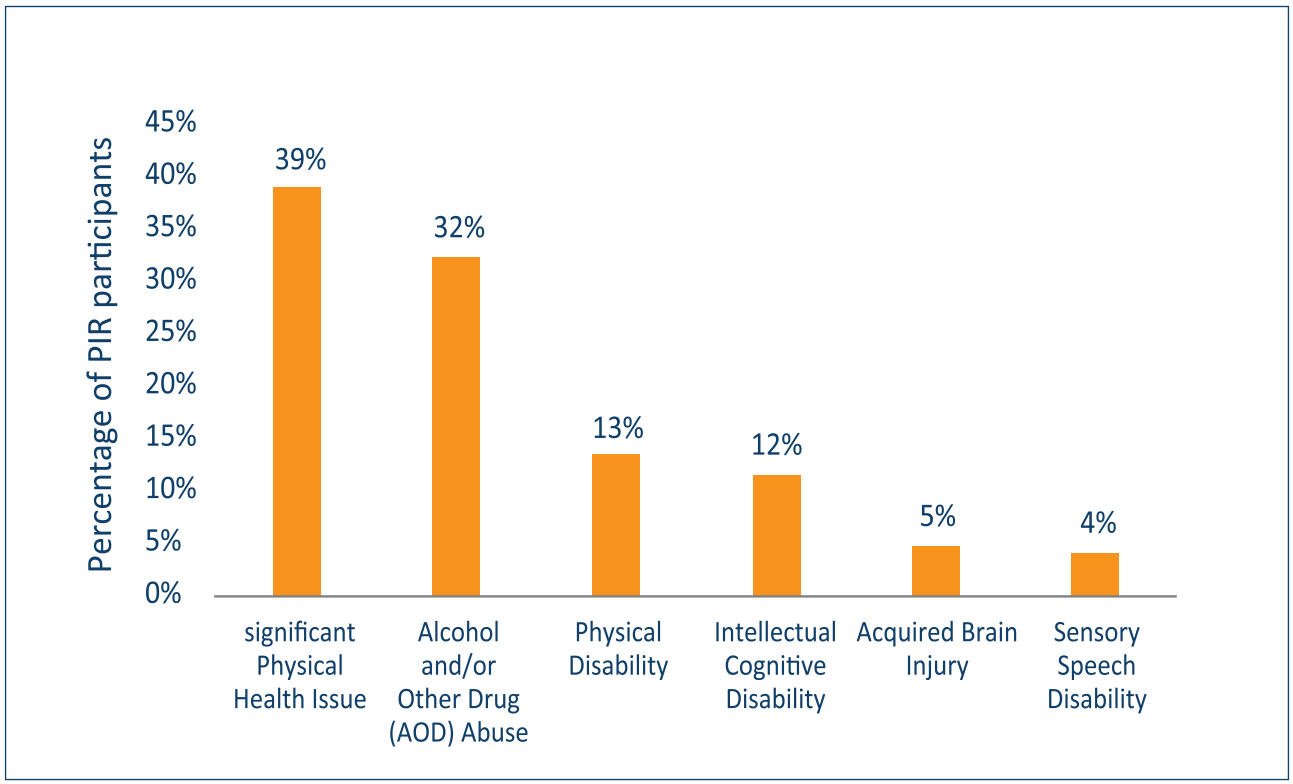
[4] Ibid.

Figure 2. PIR Participant Principal Mental Health Service Providers for Closed and Active Participants (% N = 1025), 2013-2017



People living with mental health illness often experience poor physical health and this reflected among the PIR population with 40.1% reporting a significant physical health issue and 13.5% a physical disability (Figure 3). Multiple other co-existing factors contributing to disadvantage were reported by PIR participants including 12.8% living with an intellectual disability and just under one third (29%) with alcohol or other drug abuse (AOD).

Figure 3. Co-existing factors for Closed and Active Participants (N = 1025), November 2013 to August 2017



The complexity and high level of support required by people experiencing severe and complex mental illness is further exemplified by the prevalence of co-morbid AOD abuse among PIR participants (Table 1). Unfortunately, national PIR comparator data was not available.

Table 1. Closed and Active Participants with co-morbid AOD abuse and/or Physical Health Concerns (N = 556), November 2013 to August 2017

Co-existing factors	GCPHN rate
AOD and significant physical health issue	13.0%
AOD and physical disability	3.3%
AOD and significant physical health issue and physical disability	2.8%

The rate of mental health overnight hospitalisations per 100,000 people on the Gold Coast was below the national figure across the 2015-16 period. However, for 2015-16, within the Gold Coast region there were three areas with rates above the greater national rate, with the highest recorded in Southport (139) (Table 2).

Table 2. Mental health overnight hospitalisations per 100,000 people (age standardised), by national, local and SA3, 2015-16

Region	Overnight Hospitalisations per 100,000 people (age standardised) 2015-16	Region	Hospitalisations per 100,000 people (age standardised) 2014-15
National	**102**	Gold Coast Hinterland	90
Gold Coast	**92**	Surfers Paradise	90
Southport	139	Robina	80
Coolangatta	113	Mudgeeraba - Tallebudgera	75
Gold Coast - North	112	Nerang	66
Broadbeach - Burleigh	102	Ormeau - Oxenford	66

Source: Australian Institute of Health and Welfare analysis of the National Hospital Morbidity Database 2015–16; and Australian Bureau of Statistics Estimated Resident Population 30 June 2015.

Gold Coast Health report increasing episodes of hospital care in terms of numbers and rates for anxiety and depression, schizophrenia and personality disorder across the ten years from 2002-2012. In the 2013-14 period, approximately 4,500 episodes of care were provided through Gold Coast Health for anxiety and depression, schizophrenia and personality disorders.

The Commonwealth Government's Medicare Benefits Schedule (MBS) supports subsidised access to a limited number of psychiatry visits. Across the 2011-2012 to 2014-2015 period, the number of visits to Psychiatrists on the Gold Coast increased by 42% across all age groups. The number of individuals visiting Psychiatrists also increased by 38% over the same period, resulting in a small increase (3%) in services per patient. This increase in service coverage is contary to the national trend (6% decrease).

The rate of psychiatry services per patient for the Gold Coast (2014-15) was 6.4 (Table 3). Within the Gold Coast, Ormeau-Oxenford is the most populated area and had the greatest number of both patients and services, however the lowest services per patient (5.9). The reverse was true for Gold Coast Hinterland which is the least populated area and had the lowest number of patients and services, yet the highest services per patient (7.6). This finding requires further investigation to understand the variation.

Table 3. MBS visits to Psychiatrists, number of patients, services and service rate for Gold Coast by area, 2014-15

Region	Patients	Services	Services per patient
Gold Coast	12,958	80,842	6.4
Broadbeach - Burleigh	1,499	9,460	6.3
Coolangatta	1,381	9,012	6.5
Gold Coast - North	1,703	10,542	6.2
Gold Coast Hinterland	363	2,757	7.6
Mudgeeraba - Tallebudgera	702	4,206	6.0
Nerang	1,540	9,462	6.1
Ormeau – Oxenford	2,095	12,366	5.9
Robina	1,011	6,125	6.1

Pharmaceutical Benefits Scheme (PBS) data provides insight into medication dispensing relating to anxiety, depression and psychosis. Compared to state and national figures, the Gold Coast had lower rates for antidepressant and antipsychotic medication dispensing but higher rates for anxiolytics (Table 4).

Table 4. Age standardised rate of Pharmaceutical Benefit Scheme (PBS) prescriptions dispensed for antidepressant, anxiolytic and antipsychotic medicines per 100,000 people aged 18-64, by Gold Coast, state and national, 2013-14

Age standardized rate of Pharmaceutical Benefit Scheme (PBS) prescriptions per 100,000 people aged 18-64 for:	Gold Coast	Queensland	National
Antidepressant medicines	96,751	113,350	101,239
Antipsychotic medicines	14,566	16,961	17,844
Anxiolytic medicines	22,119	19,091	17,201

Source: ACSQHC Australian Atlas of Healthcare Variation, 2015

Further analysis of PBS data reveals significant variation of these medication dispensing rates between areas within the greater Gold Coast region. Table 5 below identifies Gold Coast sub-regions with rates exceeding those for the greater Gold Coast, state and/or nationally. Southport has the highest rate across all three medication types with antipsychotic and anxiolytic rates 1.2 and 1.6 times the national figures respectively. Similarly, Gold Coast North stands out as an area with high rates, exceeding national figures for all three medication types.

Table 5. Age standardised rate of Pharmaceutical Benefit Scheme (PBS) prescriptions dispensed for antidepressant, anxiolytic and antipsychotic medicines per 100,000 people aged 18-64, by Gold Coast SA3, Gold Coast, state and national, 2013-14

Region	Antidepressant medicines	Antipsychotic medicines	Anxiolytic medicines
National	**101,239**	**17,844**	**17,201**
Queensland	**113,350**	**16,961**	**19,091**
Gold Coast	**96,751**	**14,566**	**22,119**
Broadbeach - Burleigh	94,720	12,648	23,802
Coolangatta	96,506	18,168	26,048
Gold Coast - North	104,711	19,540	26,578
Gold Coast Hinterland	102,009	14,049	17,627
Mudgeeraba - Tallebudgera	92,484	11,802	19,442
Nerang	99,275	13,581	18,881
Ormeau - Oxenford	99,385	8,906	14,882
Robina	88,169	9,510	18,210
Southport	107,558	24,181	28,102
Surfers Paradise	82,697	13,279	27,620

Source: ACSQHC Australian Atlas of Healthcare Variation, 2015

Service Mapping

The below information excludes youth specific services, see summary 'Youth Mental Health, including Children' for more detail relating to services for this population group.

Services	Number in GCPHN region	Distribution	Capacity discussion
PlusSocial service funded by GCPHN	1 which offers after hours safe space as well as clinical care coordination.	Mermaid Beach	Currently still building towards full capacity.
Community based NGO programs - specifically for severe and complex mental health.	2 (predominantly service coordination/facilitation programs, provided through multiple services).	Programs are outreach.	Outside of emergency departments or police stations, there is one community based, non-clinical services available after-hours for people experiencing mental health related distress to go to for face to face assistance. While peer workers are acknowledged as important elements of the service system, current capacity and access are limited. Large provider FSG ceased operations in 2018. Clients were transferred to other providers but there was confusion and concern.
Community NGO services, mental health focus	6 NGO providers (predominantly case coordination, brief intervention, counselling and referral services). 2 of these employ peer workers.	3 in Southport, 1 in Arundel, 1 in Varsity Lakes, 1 in Miami, 2 in Robina, 1 in Oxenford, 1 in Bilinga (10 listed due to multiple locations).	
Crisis helplines.	6 (life line, suicide call-back service, mens line, kids helpline, 13 health, 1300 MH call).	24hour telephone services. Public knowledge of these services would drive uptake/demand	
Gold Coast Health crisis services.	3 (1 Acute Care Treatment Team [ACT], 2 emergency departments).	Emergency departments at Robina and Southport. ACT team telephone service available 24hrs. Clinic in Southport and outreach to all of Gold Coast region.	
Gold Coast Health Inpatient services	5 (Acute Adult (16-65), Older Persons (65+, 16 beds) and an Extended Treatment Unit (16 bed) all located at Robina.Acute Adult unit (16- 65) available in Southport. A 27-bed mental health rehabilitation unit is located at Robina and focuses on adults with severe and complex needs that cannot be serviced by current community support).	4 in Robina, 1 in Southport.	

Services	Number in GCPHN region	Distribution	Capacity discussion
Gold Coast Health Community services	4 (Mobile intensive rehabilitation team, Older persons mental health, Continuing Care Teams, Eating Disorder Service).	Southport, Palm Beach and outreach.	Education programs and groups are run by various NGOs aimed at supporting consumers and carers. 4-5 peer navigators and a mental health navigator to be appointed by Gold Coast Health in 2018.
Gold Coast Health Consumer and Carer consultants	4 (Mobile intensive re-habilitation team, Older persons mental health, Continuing Care Teams, Eating Disorder Service).	Southport, Palm Beach and outreach.	
Gold Coast Health Consumer and Carer consultants	1 team comprising both consumer and carer peer consultants.	Across all Gold Coast Health locations as needed.	
Private mental health facility	2 (fully comprehensive private mental health facilities equipped to support people with severe and complex needs).	1 in Currumbin and 1 in Robina	

Consultation

Various consultation activity was undertaken with the Gold Coast community, clinicians and service providers. Mechanisms included broad scale community briefing, consumer journey mapping, one to one interviews, industry presentations, working groups and co-design processes.

Service provider consultation

The following key findings emerged through the consultation process with community mental health service providers, Gold Coast Health and community members.

- Psychological services don't adequately meet the needs of someone with severe and persistent mental illness, childhood trauma or complexity in their lives.
- Often limited capacity to be responsive to consumer needs and provide timely access due to demand and existing waitlists.
- Concern there are people utilising Mental Health Nurses who do not have severe and/or complex needs, this impacts access for people who do.
- Current services are limited in their ability to support people who are escalating and require face to face support in a non-clinical environment
- Concern that implementation of the National Disability Insurance Scheme (NDIS) will create gaps in service delivery particularly for individuals that are not eligible for NDIS
- Multi agency care plans, or shared care planning, identified as a priority throughout the sector to support sharing of information and timely communication between services.
- Existing integration, communication and coordination across services, including non-health services can be improved
- Variation exists among providers as to how they define and therefore service the needs of, people with severe and complex mental health conditions.
- Recognise the value of including Peer Workers in the care approach, however capacity to do so is limited.
- Addressing the physical wellbeing of people with severe and complex mental health conditions must be prioritised, the collaboration between mental health and primary care services should be strengthened.
- Some GPs reported limited confidence in working with severe and complex mental illness, not having access to enough information about most appropriate services available and referral pathways into the community.

Service user consultation

- Consumers often feel they do not have adequate support to actively participate in the decision-making and planning of their care.
- There is a desire for more formalised opportunities to build confidence in their ability to self-manage.
- The importance of including families and carers in the care planning process was identified.
- Families and carers require support to maintain their capacity to assist loved ones.
- Consumer, families and carers want opportunities to be involved in the planning, design, delivery and evaluation mental health services.

- Consumers have limited options to access face to face support outside an emergency department or clinical setting when they are feeling distressed, particularly acute in the after-hours.
- Consumers identify accessing the right information and services at the time they need it is challenging due to a lack of local centralised system navigation.
- The capacity of GPs to respond to the needs of this client group was variable.
- GPs don't have the time to adequately meet the needs of severe and complex or acutely ill patients in the brief, time limited consultations that are generally available.
- Trust in the worker, consistency in the support provided, having someone available to provide advice, care coordination, and flexibility made a significant difference to user satisfaction and outcomes.
- Stigma was identified as a significant issue and a barrier to seeking support and maintaining wellness.
- Broader social determinants of health such as access to transport, employment, adequate housing and effective social support impact on the capacity to recover and remain well.

Consultation and feedback from stakeholders throughout 2018:

- Limited awareness for some clinicians of the services and supports available.
- It has been identified that clients can become dependent on one support provider, making it difficult to move to new provider and some clinicians may at times enable client dependence, not referring to services that may better suit their non-clinical needs.
- Emerging issues / concerns regarding NDIS
    - Limited service provers to provide support coordination in national disability insurance scheme plans.
    - The impact of the closure of FSG a large NGO service provider in 2018 reducing choice for participants who will need to access NDIS services.
    - Primary Health Clinicians are supporting patients with their NDIS application but there is no suitable MBS item number given the time required.
    - Limited understanding for some of the role primary health care providers in assisting people to access NDIS for life long support.
    - A lag time has been identified between NDIS services commencing for eligible patients and current service ceasing.
- 25% of patients with frequent presentations to the ED have a mental health issue.
- Limited access to safe spaces in the northern Gold Coast with the large and growing population.
- Concern with homeless with clients with mental health issues and accessing services or meeting with service providers.
- Psychosocial supports with a focus on accessing training and education, increased physical activity and wellbeing groups, social groups and activities that are flexible to access and is inclusive of family and carers, and use of peer workers to step individuals up for more intense support or less support as needed.

Alcohol & Other Drugs

November 2018

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ALCOHOL AND OTHER DRUGS

Needs Assessment Summary

2018

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Alcohol and Other Drugs

Alcohol and drug use contribute to a range of harms for individuals, families, communities and broader society. Health impacts can be short term, such as injury, or long term, such as cancer. There is a strong relationship between harmful drug and alcohol consumption and mental health conditions. Drugs are often classified as illicit and licit, meaning illegal substances and those that are legal (such as alcohol) but are misused or abused.

The alcohol and drug treatment system on the Gold Coast spans public, private and non-government sectors. These services are delivered across a range of settings including primary care, hospitals and the community. Evidence indicates drug and alcohol treatment is a good investment and positively impacts the status of a range of social, health and psychological matters.

Identified local health needs and service issues

Needs (mainstream)

- Current capacity of detoxification, residential rehabilitation and aftercare services limit the provision of flexible support and follow up for clients.
- Flexible outreach treatment services with a focus on vulnerable target groups including young people.
- Provision of training and resources, including referral pathways, for General Practice to support patients with substance use issues including ice.
- 62.6% of clients accessing treatment were male, with 37.3% female on the Gold Coast.

Needs (Aboriginal and Torres Strait Islander)

- Barriers to accessing residential rehabilitation due to upfront financial costs, child care responsibilities and funds to cover housing costs while in rehabilitation.
- Small Aboriginal and Torres Strait Islander workforce which limits the capacity of providers to work with clients who require treatment.
- Cultural competency of mainstream alcohol and other drugs treatment services requires improvement to confidently, safely and effectively work with Aboriginal and Torres Strait Islander people.

Key findings

- Cannabis, alcohol and amphetamines are the most common drugs of concern in the GCPHN region, with ice reported by service providers to be fast emerging as a significant concern across the sector and community.
- There is a strong correlation between mental health problems and alcohol and other drug use. With many people who use alcohol or other drugs not seeking treatment for their mental health.
- Gold Coast has a particularly high rate of younger people (under 20) seeking treatment with 26.9% of all clients seeking treatment in the 10-19-year-old age bracket. However, treatment options for people aged under 18 is limited.

- People with families struggle to access alcohol and other drug treatment services This is concerning given Child Safety data indicates parental use of ice is high among families with ongoing interventions on the Gold Coast.
- A significant barrier to accessing residential rehabilitation is the requirement to pay upfront costs, continue to pay rent and limited options for single parent families in relation to the care of their children while in the residential rehabilitation clinic etc.
- Limited detoxification services are available on the Gold Coast. Current providers report they often have no capacity to accept new clients without delays.
- Service gaps exist in the northern growth corridor with most treatment services located from Southport to Burleigh.
- More information, resources and support are required for General Practice to support people with alcohol and other drug use, particularly methamphetamines.

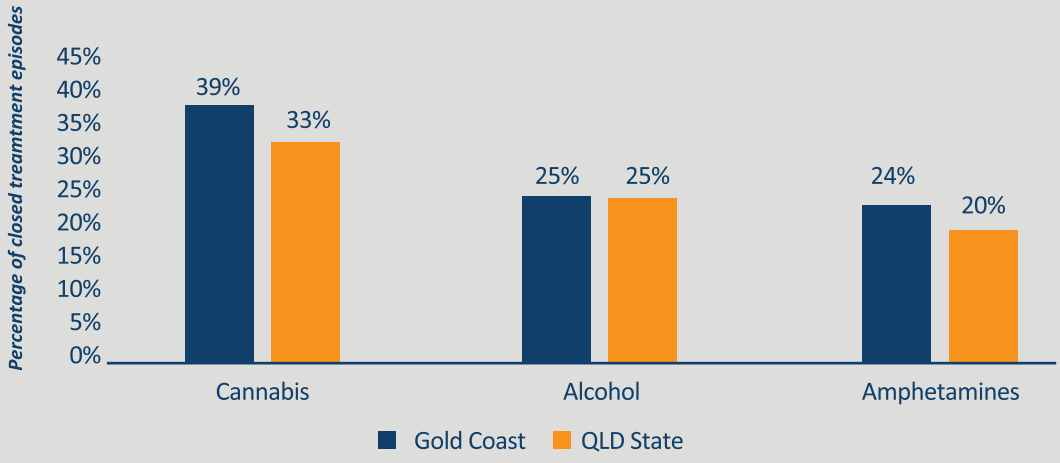
Prevalence, service usage and other data

Illicit drugs

The National Drug Strategy Household Survey 2016, found the proportion of Australians illicitly using drugs has remained relatively stable, however there has been a gradual increase in numbers since 2007 from 2.3 to 3.1 million. Around 15.6% of people aged 14 and over had used an illicit drug in the previous 12 months, with misuse of pharmaceuticals accounting for approximately 3% of this[1].

Cannabis was the most commonly used drug with 10.2% of people aged 14 and over reporting use in the previous 12 months. Gold Coast data for 2016-17 confirms cannabis as the most common principal drug of concern among people receiving treatment at 38.6%, slightly above the Queensland figure of 33.3% (Figure 1)[2]. Nationally, there was a significant increase among people aged 40 and above reporting recent illicit drug use between 2001-2016, with those aged 50 and over mainly using cannabis while those aged over 60 were mainly misusing pharmaceuticals. In Queensland, 60% of those who used cannabis or misused pharmaceutical drugs had only used the one drug[3]. This was much lower than poly-drug use among people who used methamphetamine or cocaine, with 94% and 86% respectively using at least one other illicit drug.

Figure 1. Closed treatment episodes by principal drug of concern, Gold Coast and Queensland, 2016-17

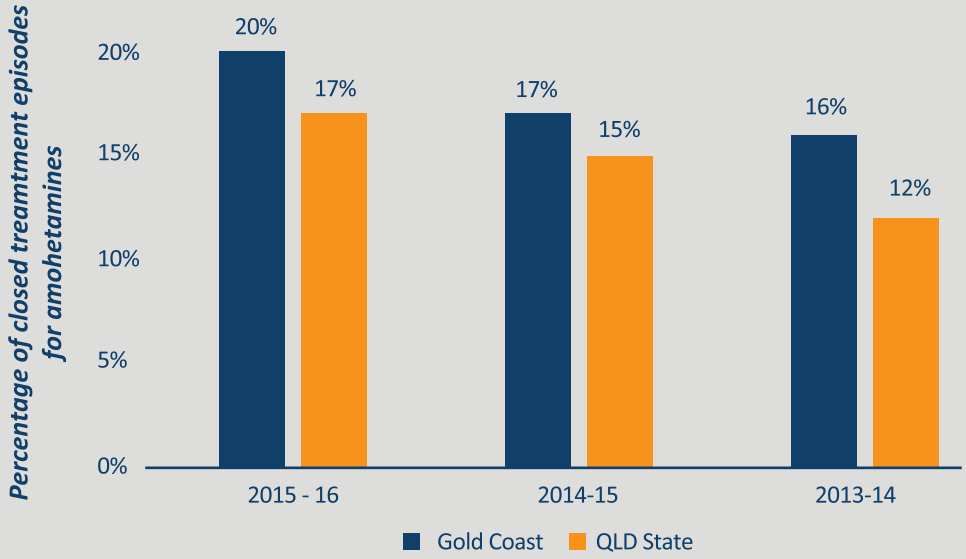


[1] Australian Institute of Health and Welfare. Alcohol and other drug treatment services in Australia 2016-17 key findings
[2] Australian Institute of Health and Welfare. AODTS NMDS closed treatment episodes by PHN and Queensland SA3 geographical area of agency location 2012-
[3] Queensland Health. The health of Queenslanders 2016. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2016.

Methamphetamines

Nationally, declines were seen in recent use of methamphetamines across the 2013 to 2016 period reducing from 2.1% to 1.4%. However, findings from the 2016 Illicit Drug Reporting System reveal recent use among people who inject drugs has consistently increased over the three years with 73% reporting using ice in the previous 6 months[4]. Among methamphetamine users, those reporting misuse of prescription amphetamines for non-medical purposes increased from 14.1% to 28% between 2013 to 2016. The proportion reporting prescription amphetamines as their main form of amphetamine (used in the last 12 months) also increased over this period from 3% to 11.1%[5]. Ice continues to increase as the main form of methamphetamine used, frequency of use is also increasing and is highest among ice users, with 32% using at least weekly [6 7]. Gold Coast data confirms an increase in amphetamines as the principal drug of concern among people receiving treatment, increasing from 13.1% to 20.3% across the 2013 to 2016 period (Figure 2)[8].

Figure 2. Closed treatment episodes by principal drug of concern, Gold Coast and Queensland, 2013-14 to 2015-16



Queensland emergency department presentations for persons aged 16 and older that related to methamphetamines increased five-fold between 2009-10 and 2014-15, approximately a third of presentations were admitted[9]. A fifteen-fold increase was observed for methamphetamine related hospitalisations for the same period. Of the presentations recorded in 2014-15, males accounted for 68% and people aged 16-34 accounted for 74%. Similarly, among hospitalisations across the five-year period, 66% were for males and the highest rates were among people aged 16-34.

The Queensland Department of Communities, Child Safety and Disability report that across a one-year period to December 2016, 75% of children (1,755) that were admitted to ongoing intervention with the Department had a parent with a current or previous drug and/or alcohol problem. Of these, 1 in 3 children (749) had one or both parents using methamphetamine of which 75% (562 children) were using ice. Findings indicate that in 68% of cases (381 children), parents had only begun using ice in the previous twelve months and not used it prior.

[4] Stafford, J., Breen, C. & Burns, L. (2016) Australian Drug Trends 2016: Findings from the Illicit Drug Reporting System (IDRS). 2016 NDARC Annual Research Symposium, Sydney. National Drug and Alcohol Research Centre, University of New South Wales, Australia.

[5] Australian Institute of Health and Welfare. 2016. National Drug Strategy Household Survey. Preliminary Findings.

[6] Stafford, J., Breen, C. & Burns, L. (2016) Australian Drug Trends 2016: Findings from the Illicit Drug Reporting System (IDRS). 2016 NDARC Annual Research Symposium, Sydney. National Drug and Alcohol Research Centre, University of New South Wales, Australia.

[7] Ibid.

[8] Australian Institute of Health and Welfare. AODTS NMDS closed treatment episodes by PHN and Queensland SA3 geographical area of agency location 2012–13 to 2015–16

[9] Queensland Health. The health of Queenslanders 2016. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2016.

Based on child safety service boundaries, 40% of parental ice use impacting 208 children, was in the two regional corridors of Ipswich North and Brisbane North to Caloundra and Gold Coast, including Beenleigh. When combined with three other child safety regions, these areas account for slightly over half of all children admitted to ongoing intervention for the period of December 2015 -16, yet represent almost three-quarters of parental ice use.

Problem drinking of alcohol by parents was less prevalent among those who used ice compared to those who used other substances. However, the rate of co-occurrence of marijuana, amphetamine and heroin was found to be two to three times higher among parents using ice than those using other substances with 69% (385) of children whose parents were using ice also using other drugs. This highlights the importance of service providers in the AOD space being confident in how to refer and support people using ice who may have children and poly-drug use.

The proportion of children impacted by parental use of ice was similar regardless of Aboriginal and Torres Strait Islander status. However, the household characteristics of children whose parents had used ice differed from other children with an ongoing intervention and were more likely to have a parent with a criminal history, a current or previously diagnosed mental illness, experienced domestic and family violence in the past year and been homeless. Sixty percent of children whose parents had used ice were under the age of five, including unborn children (Table 1).

Table 1. Age of child with an ongoing intervention where parental ice use was recorded (Dec 2015-16)

CHILD AGE	%	CHILDREN
Unborn	7%	41
0	16%	89
1	10%	58
2	10%	54
3	8%	48
4	9%	49
5 years or older	40%	223
All children where parental ICE use was recorded	100%	562

Source: Queensland Government, Department of Communities, Child Safety and Disability, 2016

While the region above data relates to a large region, of which the Gold Coast is only one part, this reinforces the critical importance of service providers and government departments committing to work together to support individuals, children and families affected by ice and other drugs.

Licit drugs; Alcohol and Pharmaceuticals

Alcohol

Alcohol plays a significant role in Australian culture and is widely accepted in society. The lifetime risk of harm increases with the amount of alcohol consumed. Lifetime risk is defined as people consuming more than 2 standard drinks per day on average over a 12-month period[10]. While consumption at levels of lifetime risk have trended downward for Australia since 2004[11], both Queensland and the Gold Coast had higher proportions of people consuming alcohol at lifetime risky levels than the national figure in 2016 (Table 2).

Across all three regions, males were more than twice as likely to drink at levels of lifetime risk of alcohol-related disease or injury with the highest proportions in Queensland and on the Gold Coast. However, among females the Gold Coast had the highest proportion, larger than both state and national figures.

Local treatment data for the Gold Coast indicates that while most people undertaking treatment for alcohol are men (60%), the proportion of women being treated (40%) is above the broader Queensland average (35%)[12].

Table 2. Lifetime risky alcohol consumption, by sex, for local, state and national

Percentage of people exceeding guideline 1 of no more than 2 standard drinks on average per day	Gold Coast % (2015-16) *	Queensland % (2015-16) *	National % (2016) **
Persons	21.4	21.8	17.1
Males	30.5	32.4	24
Females	12.8	11.4	9.8

Source: *Queensland Department of Health. Queensland Survey Analytics System, Regional detailed data. 2016. ** Australian Institute of Health and Welfare. National Drug Strategy Household Survey (NDSHS) 2016 preliminary findings

People who are homeless are particularly vulnerable to poor mental health and drug and alcohol issues, they are also less likely to seek assistance or access services than the general population. Results of the 2014 “Home for good registry week” survey conducted by Queensland Council of Social Services found just over 50% (215 people) of participants reported problematic use of alcohol with a higher prevalence among adults (61.7%) and young people (56.7%) (Figure 3).

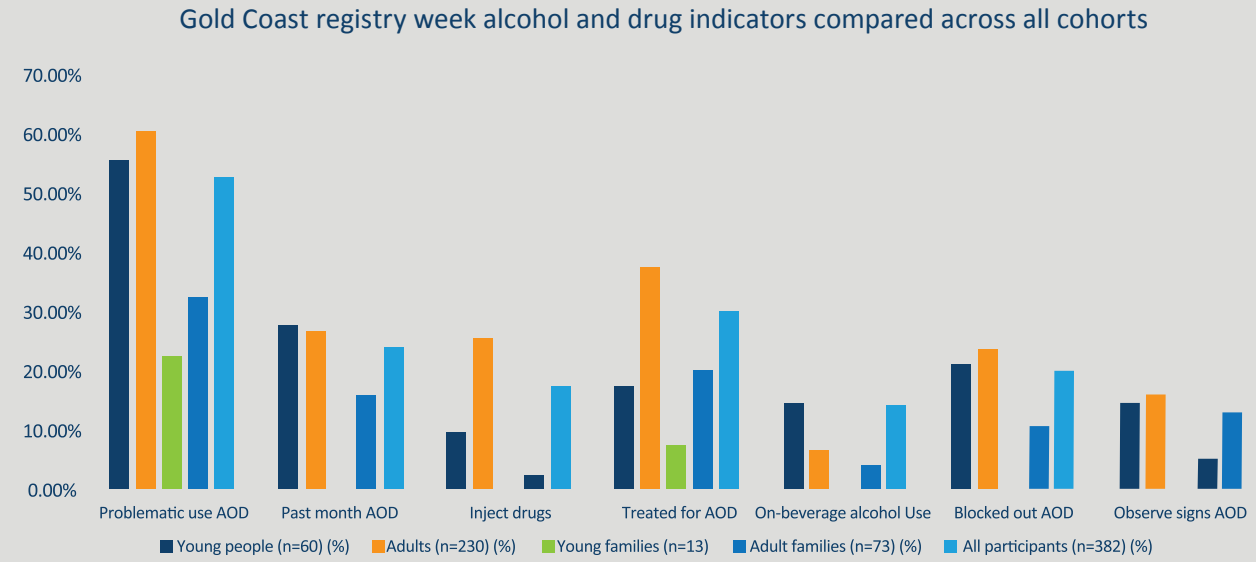
Despite having the second highest self-identification of problematic alcohol and or other drug use (53.7%), only 30.4% of young people were treated for these issues. On average, people experiencing homelessness on the Gold Coast were aged 28.5 years and were younger than the general population. This reflects the broader national picture of young people being overrepresented in the homeless population (Mission Australia, 2016).

[10] Guideline 1: No more than 2 standard drinks on average per day. National Health and Medical Research Council. March 2009

[11] National Drug Strategy Household Survey (NDSHS) 2016 preliminary findings

[12] Australian Institute of Health and Welfare. AODTS NMDS closed treatment episodes by PHN and Queensland SA3 geographical area of agency location 2012–13 to 2015–16

Figure 3. Percentage of alcohol and drug indicators among homeless people, by registry week participant cohort, 2014

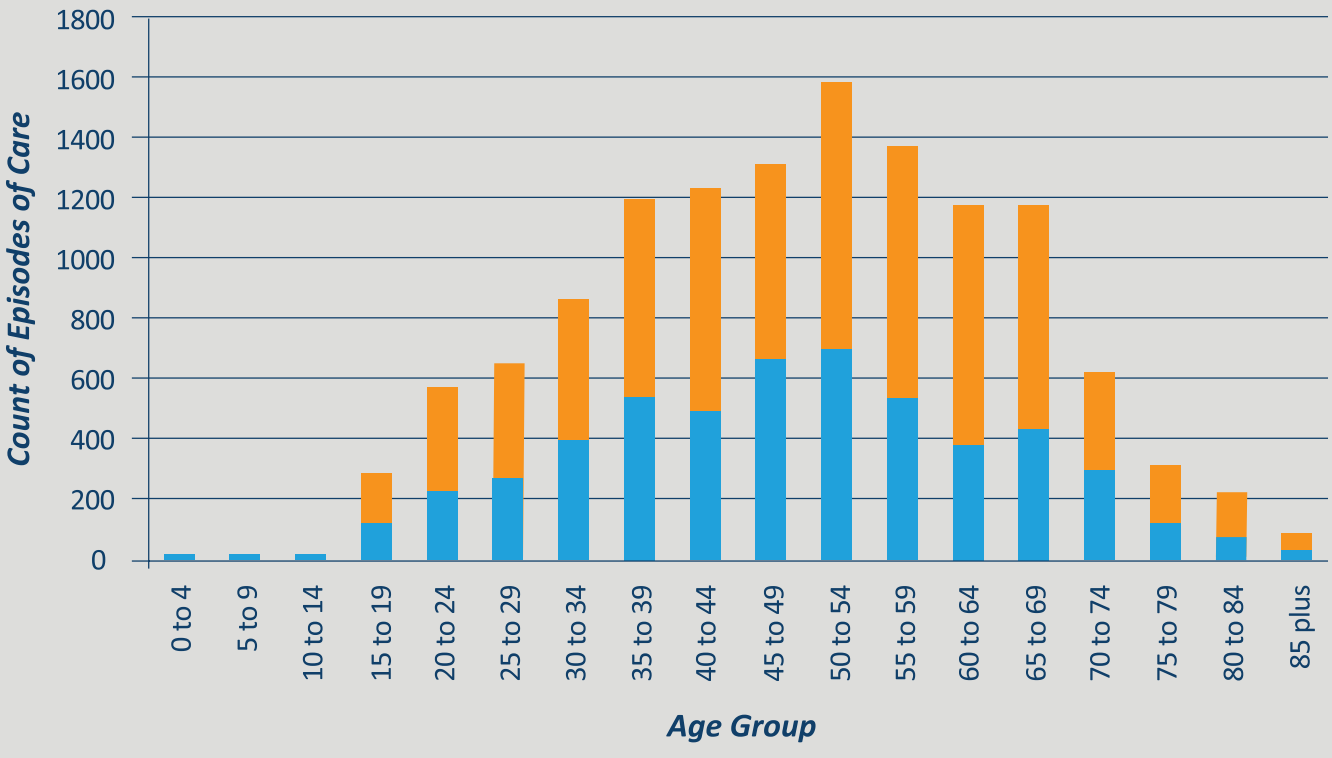


Source: Queensland Council of Social Services. Home for Good registry week results – Gold Coast. 2014.

The impact of alcohol on broader health and wellbeing can be both short and long term. In 2011, 70% of the disease burden associated with alcohol was attributed to alcohol dependence and harmful use (38% of hospitalisations due to alcohol), falls (12%) and other unintentional injuries (14%), coronary heart disease (4%) and suicide and self-harm (4%)[13].

In 2013-14 there were 4,549 alcohol related episodes of care at Gold Coast Health. Figure 4 shows alcohol related episodes of care at Gold Coast Health over a 3-year period and identified the largest number of episodes of care occurring in the 50-54 age group. The larger proportion of males is reflective of broader trends.

Figure 4. Alcohol related episodes of care Gold Coast Hospital and Health Service over 3 years, 2011-14



[13] Queensland Health. The health of Queenslanders 2016. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2016.

The rate of hospitalisations for drug and alcohol use per 100,000 people on the Gold Coast was below the national figure across the 2014-2015 period. However, within the Gold Coast region there were five areas with rates above the broader Gold Coast rate, three of these areas had rates above the national figure, with the highest recorded in Coolangatta (245) (Table 3).

Table 3. Drug and alcohol hospitalisations per 100,000 people (age standardised), by national, local and SA3, 2014-15

Region	Hospitalisations per 100,000 people (age standardised) 2014-15	Region	Hospitalisations per 100,000 people (age standardised) 2014-15
National	**180**	Broadbeach - Burleigh	170
Gold Coast	**163**	Robina	159
Coolangatta	245	Nerang	146
Gold Coast - North	213	Gold Coast Hinterland	124
Southport	200	Mudgeeraba - Tallebudgera	122
Surfers Paradise	199	Ormeau - Oxenford	101

Source: Australian Institute of Health and Welfare analysis of the National Hospital Morbidity Database 2014–15; and Australian Bureau of Statistics Estimated Resident Population 30 June 2014.

Pharmaceuticals

In 2016, approximately one in 20 Australians aged 14 or older had misused pharmaceuticals in the last year, with pain-killers/opiates being the most common[14]. Pharmaceutical misuse includes the non-medical use or abuse of a drug available from a pharmacy, by prescription such as opioid-based pain relief, or over the counter such as codeine. Three quarters of recent users reported misusing over the counter codeine[15]. Codeine is an opioid in the same family of compounds as opioids such as morphine, methadone and heroin[16]. In Queensland (2013), pain-killers/analgesics were the second most commonly used illicit drug (3.3%)[17]. Opioid based pain-killers (including codeine) can be highly addictive and there is increasing evidence of serious harm when they are not used appropriately[18]. This has resulted in national reform to medicine containing codeine, with access restricted to prescription only from early 2018[19].

Research has found people with codeine dependence are generally older and include a higher representation of females than is often observed among illicit drug users[20]. They are also more likely to report chronic pain and have mental health co-morbidity[21].

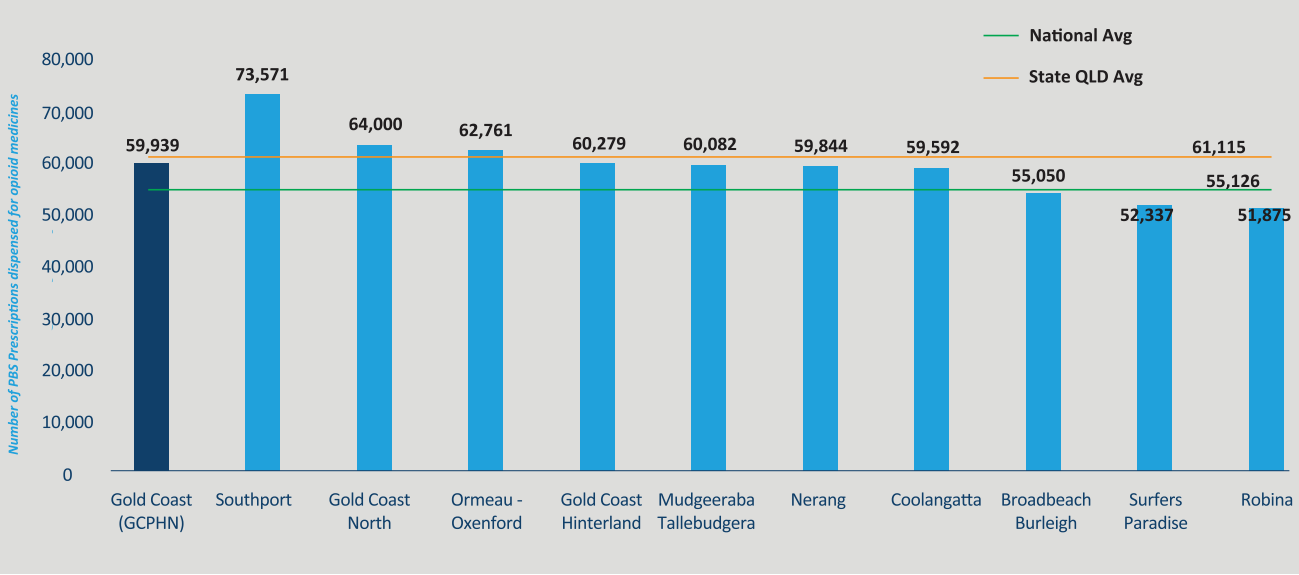
Many people with codeine dependence had not sought help despite recognising they had a problem, negative perceptions of evidence-based treatments such as opioid substitution, were also observed.

14 Australian Institute of Health and Welfare. National Drug Strategy Household Survey (NDSHS) 2016 preliminary findings
15 Ibid.
16 Turning Point Alcohol and Drug Centre. Over the counter codeine dependence. 2010.
17 Queensland Health. The health of Queenslanders 2016. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2016.
18 Australian Government Department of Health. Therapeutic Goods Administration. Changes to patient access for medicines containing codeine. 2017.
19 Ibid.
20 Turning Point Alcohol and Drug Centre. Over the counter codeine dependence. 2010.
21 Ibid.

Nationally the rate of accidental opioid overdose deaths is increasing. In 2013, the national rate of accidental overdose deaths due to opioids was 46.7 per million persons aged 15 to 54 years, the Queensland rate was slightly lower at 44.32. Seventy percent of accidental overdose deaths were due to prescription opioids including strong painkillers, rather than heroin. Increases in deaths among Australians aged in their 50s and 40s have been recorded, with deaths among those aged 35-44 more than doubling since 2007. More than two thirds of accidental opioid overdose deaths were among men.

The number of opioids dispensed through the Pharmaceutical Benefits Scheme (PBS) increased fifteen-fold over the twenty years from 1992, reaching 7.5 million in 2012. Almost half the prescriptions for opioids from general practice are to treat chronic pain[23], however evidence does not support using opioids for this condition[24]. In 2013-14, the Australian rate for opioid dispensing was 55,126 per 100,000 people, both the Queensland and Gold Coast rates exceeded this at 61,115 and 59,939 respectively (Figure 5). Within the Gold Coast, Southport had the highest rate of 73,571 per 100,000 people. It is important to consider that these figures do not include over the counter medicines and are therefore an underestimate of the use of opioid medicines in the community.

Figure 5. Rate of PBS prescriptions dispensed for opioid medicines per 100,000 people, age standardised, by local, SA3, state and national, 2013-14



Source: Australian Atlas of Healthcare Variation, Chapter 5. 2015

22 Roxburgh, A. and Burns, L. (2015). Accidental drug-induced deaths due to opioids in Australia, 2011. Sydney: National Drug and Alcohol Research Centre.

23 Alcohol and Drug Foundation. Prevention research: is there a pill for that? 2016

24 Australian Commission on Safety and Quality in Health Care. Australian Atlas of healthcare Variation. Chapter 5 opioid medicines. 2015.

Service Mapping

There is an AOD treatment service on the Gold Coast specifically for Aboriginal and Torres Strait Islander people. This was established in response to the 2016 needs assessment finding that while there were no AOD services that excluded Aboriginal and Torres Strait Islander people, there was also no services specifically tailored to meet their needs. The impact of the new service will continue to be monitored.

Service	Number in GCPHN region	Distribution	Capacity discussion
Community based NGO service – mainstream	4 (drop in centre, education and support, individual and group counselling, case management and referrals)	Burleigh, Nerang, Southport. Outreach with a focus on Northern Gold Coast	There is recognition from mainstream AOD service providers they need to engage staff that identify as Aboriginal and Torres Strait Islander to effectively meet the needs of more Aboriginal and Torres Strait Islander clients. Some services report that Aboriginal and Torres Strait Islander people leave AOD programs early due to concerns regarding cultural appropriateness. There are limited transitional services connected to residential rehab facilities. Currently, there are no detox services available for young people (under 18 years). Parents and families have access challenges as few residential services can accommodate their needs. The Queensland Health 24-hour Alcohol and Drug Information Service provides low intensity AOD services to the Gold Coast community. AOD navigator with Gold Coast Health focusing on frequent presentations. Male Aboriginal and Torres Strait Islander clients are accessing these services at a higher rate compared to Aboriginal and Torres Strait Islander females. This has shifted from when the service was first established as the demand was higher for female clients.
Community based NGO service - focus on AOD for Aboriginal and Torres Strait Islander people	2 (education and support, counselling, case management and referrals)	Services provided throughout region with locations based in Bilinga, Oxenford, Miami	
Private medical detox	1 (43 beds)	Currumbin	
Private day program and inpatient rehabilitation unit	1	Currumbin	
Residential detox facility	1 (11 beds)	Eagle Heights	
Community based NGO residential rehabilitation facility	3 (43 beds, 40 beds and 28 beds)	Eagle Heights, Burleigh, Southport	
Needle exchange program	2	Southport, Burleigh	
Gold Coast Health – nurse navigator.	1 (Drug and alcohol brief intervention treatment).	Southport	
Gold Coast Health Community services.	2 clinics (delivering opioid replacement therapy and a mix of programs (5) and support services such as assessment, referral, counselling, hospital liaison and information).	Southport, Palm Beach	
Low intensity	6 (Queensland Health AOD info line, cannabis information helpline, national cannabis prevention and information service, Hello Sunday Morning, Youth substance abuse service, national drug and alcohol services directory).	Online and telephone services. Public knowledge of these services and connectivity capacity would drive uptake/demand.	
Community based NGO services - focus on AOD for youth (aged 12-25)	2 (predominantly a mix of brief intervention,counselling, education and referrals).	1 in Southport, 1 in Burleigh. Majority of outreach and colocation for service options	
Community based NGO services – focus on AOD needs of pregnant women and new parents	3 (information & education, support groups, connection with services, relapse prevention, counselling).	3 in Southport, 1 Robina, 1 Burleigh, 3 also provide services through outreach to all of Gold Coast.	
Community based NGO services - focus on AOD for families	6 (predominantly a mix of brief intervention, counselling, education and referrals)	2 in Burleigh, 3 in Southport, 1 in Robina. 1 Southport provider conducts outreach between Runaway Bay and Coolangatta.	

Consultation

Various consultation activity was undertaken across the Gold Coast community, clinicians and service providers. Mechanisms included broad scale community briefing, consumer journey mapping, one to one interviews, industry presentations, working groups and co-design processes.

Service provider consultation

- Strong referral pathways between mental health, housing, youth, justice, child safety, emergency relief and AOD services.
- Providers report difficulty recruiting AOD workers that are Aboriginal or Torres Strait Islander which limits capacity to provide culturally appropriate services to these clients.
- Individuals requiring residential rehabilitation are limited due to upfront fees required, and financial costs required to maintain their home.
- Many services expressed demand for treatment outstrips capacity, and wait lists are common, people often disengage while waiting to get in to treatment.
- Limited options for young people and people with children. There are no withdrawal management options for under 18's and services are often considered not 'youth friendly'.
- Some individuals seeking AOD treatment will 'down-play' their mental health problem to secure treatment, particularly for residential services
- Parents are not seeking treatment for AOD use for fear of losing their children. Treatment services do not accommodate children, limiting parents' options for accessing treatment
- Limited detox capacity on the Gold Coast. Barrier for people wanting to access rehabilitation as they are required to detox prior to rehabilitation (must not be using). Flexible options including in-home detox are required to meet this need.
- General Practitioners advised they require further information about availability of services, treatment options and appropriate referral pathways, particularly for methamphetamines
- Limited in-home outreach services with a gap identified in the Coomera / Northern Corridor area. Transport is often a barrier to accessing services
- Small operational budgets limit AOD staff to receive ongoing professional development, impacting workforce quality, planning and sustainability.
- Individuals with AOD problems often face difficulty accessing mental health or accommodation services due to those services not being funded or skilled to support AOD needs.

Service user consultation

- Individuals trying to access treatment services such as detox and residential rehabilitation, encountered a consistent barrier due to service capacity issues. This compromised their recovery and motivation to engage and seek help again.
- Greater dual diagnosis capacity is needed within services as many people felt AOD use was often a self-medicating strategy to cope with mental health issues.
- Relationships with key staff in the service were identified as critical for consumers to maintain recovery and engagement in their treatment. This is supported by considerable evidence in the field.
- The one size fits all approach to treatment does not work for people i.e. fitting into program timeframes, required pathways. Flexibility is required.
- Moving straight from seeking treatment to detox or rehab is too hard for many people.
- A bridging approach is required to support people still using to access services and support.
- Some sort of childhood trauma (mostly sexual abuse) featured in the majority of service user stories. This was often cited by the person as the reason why they start using substances.
- Judgement from police officers, hospital staff, ambulance staff and General Practitioners was often cited as negatively impacting on the service user's motivation to seek help
- Family members often do not know what services are available or where to go to get their loved one help.

Consultation and feedback from service providers throughout 2018:

- There is a demand for drug and alcohol first aid training from general practice, community services, social worker students and community members.
- The capacity building working group identified complexity in relation to residential detox or rehabilitation treatment. The issue is not solely being lack of beds but also consumer readiness for the service and matching the consumer to the type of service.
- Referral pathways are still quite unclear, particularly for clients engaged with HHS that are transferred to community services and then have readmissions to hospital.
- There isn't a clear process regarding transfer of care and who remains the primary care coordinator of the client and for how long.
- Rehabilitation options for single parent families Is limited, no one to watch the children, lack of funds to cover housing cost while in rehabilitation which has created a barrier.
- There is a demand for more Aboriginal and Torres Strait Islander workers, particularly male workers for both mental health and alcohol and other drugs.

Aboriginal & Torres Strait Islander Health

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ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Needs Assessment Summary

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Aboriginal and Torres Strait Islander Health

Identified local health needs and service issues

- Cultural competency, transport and cost affect access to services for Aboriginal and Torres Strait Islander people
- Focus on chronic disease early identification and self-management
- Large growth in Aboriginal and Torres Strait Islander population in Ormeau-Oxenford
- Gaps remain in terms of life expectancy and many contributing factors
- Higher rates of Aboriginal and Torres Strait Islander people with diabetes and COPD in the region and higher rates of smoking
- Some indication that maternal health may be an issue but there are very small numbers involved

Key findings

The proportion of Aboriginal and Torres Strait Islander people is relatively smaller in the Gold Coast Primary Health Network (GCPHN) region than other parts of Australia. Health outcomes for Aboriginal and Torres Strait Islander people across Queensland and Australia are generally poorer when compared to the non-Indigenous population, particularly for chronic conditions. Almost two-thirds of Aboriginal and Torres Strait Islander people in Queensland have a long-term health condition.

On the Gold Coast, maternal and child health outcomes for Aboriginal and Torres Strait Islander people are generally more positive than other regions but still trail non-Indigenous outcomes. Maternal smoking and limited uptake of antenatal care visits may be adversely impacting birth and health outcomes, it is difficult to determine due to small numbers.

While the Gold Coast region has some services targeted to Aboriginal and Torres Strait Islander people, including one Aboriginal Medical Service with three clinics, there are issues identified with accessibility, awareness and appropriateness of services, particularly for mental health services. Cultural competency, transport and cost are factors that affect access.

Evidence

Demographics

Aboriginal and Torres Strait Islander population

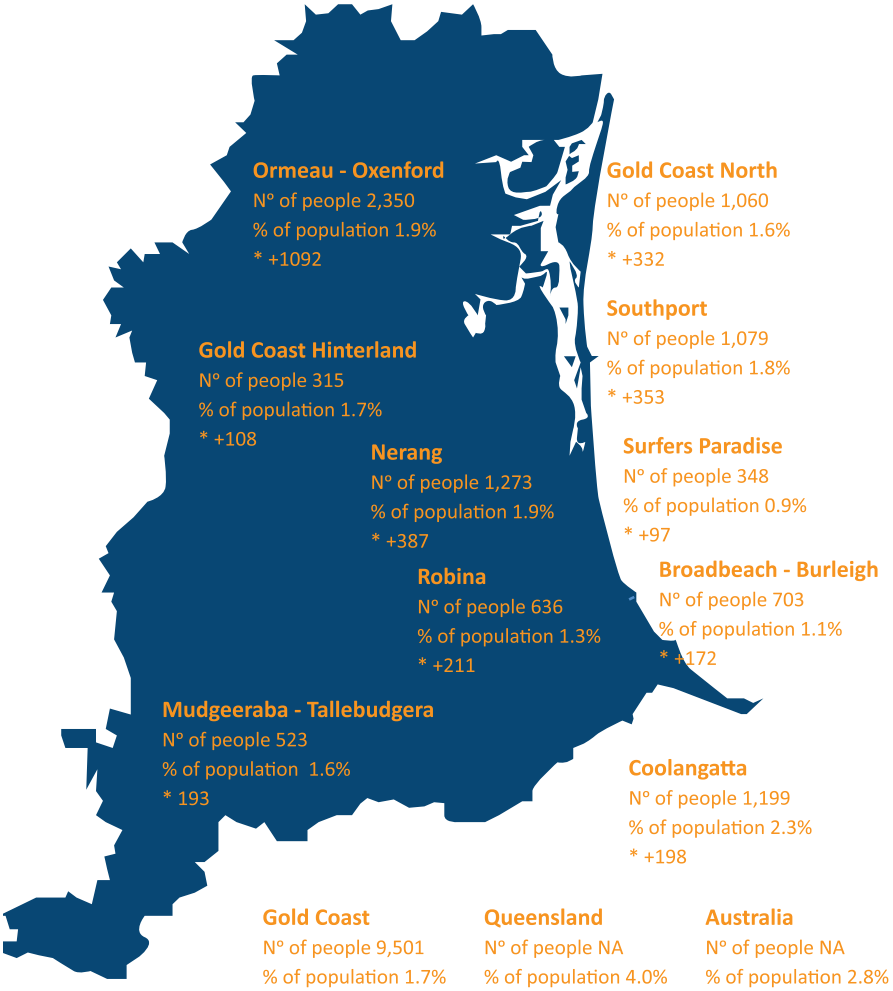
Based on figures from the 2016 Census, there are 9,501 Aboriginal and Torres Strait Islander people living within the Gold Coast region, which represents approximately 1.7% of the total Gold Coast resident population. This is lower than the proportion of Aboriginal and Torres Strait Islander people across the Queensland (4.0%) and Australian (2.8%) populations.

Figure 1 below shows the SA3 regions with the highest number of Aboriginal and Torres Strait Islander people include Ormeau-Oxenford, Nerang and Coolangatta. The population of Aboriginal and Torres Strait Islander people in Ormeau-Oxenford has almost doubled since the 2011 Census.

Figure 1: Number of Aboriginal and Torres Strait Islander people within Gold Coast region, by SA3 region, 2016

Source: Australian Bureau of Statistics, 2016 Census of Population and Housing, Aboriginal and Torres Strait Islander Peoples Profile (Cat. No. 2002.0)

* Note: Adding sub-totals of SA3 regions does not equal 9,501 due to rounding adjustments made by ABS for small figures



Approximately 51% of Aboriginal and Torres Strait Islander people living in the Gold Coast region are female and 49% are male, which is similar for the overall regional population. However, there is a significant difference in the age profile. The median age for Aboriginal and Torres Strait Islander people living in the Gold Coast region is around 23 years, whereas the median age for all people living in the region is 38 years.

Census data shows median weekly household income for Aboriginal and Torres Strait Islander people living in the Gold Coast region was $1,486, which is higher than Aboriginal and Torres Strait Islander people across both Queensland and Australia. The median weekly rent was $390 and median monthly mortgage repayments were $2,000, which was again higher than both Queensland and Australia. These median figures are comparable to all people living in the Gold Coast region.

Maternal and child health outcomes

The proportion of babies born at low birth weight (i.e. less than 2500 grams) to Aboriginal and Torres Strait Islander mothers in the Gold Coast region in 2015-16 was 6.0% (total of 7 births), the 3rd lowest rate of all 16 Hospital and Health Service (HHS) regions across Queensland. The proportion of low birth weight for all births across the Gold Coast region during the same period was 4.0%. However, the low number of Aboriginal and Torres Strait Islander children born in the Gold Coast region is likely to affect the reliability.

A total of 30 Aboriginal and Torres Strait Islander women from the Gold Coast region who gave birth in 2015-16 (25.0%) reported smoking during pregnancy. This was the lowest rate amongst Queensland Hospital and Health Service (HHS) regions but was still significantly higher than the non-Indigenous population at 5.3%. Maternal smoking is a known risk factor for low birth weight and pre-term births[2].

The Gold Coast region recorded the 4th lowest rate of mothers that attended five or more antenatal visits out of all 16 HHS regions at a rate of 83.2%, compared to the Queensland average of 87.8%.

Table 2 below shows that immunisation rates for Aboriginal and Torres Strait Islander children in 2016-17 were only slightly lower than for non-Indigenous children at 1 year and 2 years and are higher at 5 years.

Table 2: Proportion of children fully immunised in the Gold Coast PHN region by Indigenous status, 2016-17

Source: Australian Institute of Health and Welfare analysis of Department of Human Services, Australian Immunisation Register statistics 2016-2017

1 year	**91.6%** Aboriginal and Torres Strait Islander children	**92.9%** All children
2 years	**88.1%** Aboriginal and Torres Strait Islander children	**89.5%** All children
5 years	**98.8%** Aboriginal and Torres Strait Islander children	**90.8%** All children

[1] Queensland Health, Closing the Gap - Performance Report 2016

[2] Queensland Health Perinatal Data Collection, Statistical Services Branch, Department of Health

Chronic disease risk factors

The National Aboriginal and Torres Strait Islander Social Survey, conducted by the Australian Bureau of Statistics every 6-8 years, provides data for a range health and wellbeing items for Aboriginal and Torres Strait Islander persons aged 15 years and over across Queensland. Findings from the 2014-15 survey include:

- 64.3% of Aboriginal and Torres Strait Islander people in Queensland had a long-term health condition, including 28% with a mental health condition
- 38.1% were a current daily smoker
- 49.9% had inadequate daily fruit consumption, and 95.4% had inadequate daily vegetable consumption
- 29.0% had used substances in the last 12 months
- 33% had exceeded the guidelines for alcohol consumption for single occasion risk, while 15.2% had exceeded guidelines for lifetime risk.

Data regarding the prevalence of chronic health conditions and risk factors such as smoking, poor nutrition, obesity, hypertension and physical inactivity for Aboriginal and Torres Strait Islander people at the Gold Coast regional level is not readily available. General practice data provides some information at a local level.

Table 3 below provides a snapshot of the numbers of Aboriginal and Torres Strait Islander patients serviced by general practices in the Gold Coast region. This data is reported by practices to the GCPHN and extracted from the PATCAT system[1]. The data is differentiated into Aboriginal and Torres Strait Islander patients receiving services at mainstream practices and patients receiving services at the Kalwun Health Service, the sole Aboriginal Community Controlled Health Organisation (ACCHO) in the Gold Coast region. This data demonstrates the important role played by mainstream general practice in supporting Aboriginal and Torres Strait Islander people in the region.

Table 3: Reported health status for Aboriginal and Torres Strait Islander patients at mainstream general practices and Kalwun Health Service within the Gold Coast PHN region, as at June 2018

Source: Gold Coast PHN PATCAT data. Source data provided by general practices reporting to Gold Coast PHN via PATCAT system.

	Kalwun Health Service (non-adjusted)		All practices excluding Kalwun (adjusted)		All practices excluding Kalwun (adjusted)	
	Indigenous Patients (non-adjusted)		Indigenous Patients (non-adjusted)		Non-Indigenous Patients (adjusted)	
	Number	%	Number	%	Number	%
Active Patients (3 visits in 2 years)	3,476		9,633		419,303	
Diabetes (Type 1, Type 2 or not defined as Type1 or Type 2) excludes Gestational	191	5.5%	486	5.0	19,389	4.6
Chronic Obstructive Pulmonary Disease (COPD)	103	3.0%	248	2.6	9,622	2.3
Coronary Heart Disease (CHD)	94	2.7%	258	2.7	14,151	3.4
Chronic Renal Heart Failure	36	1.0%	85	0.9	4903	1.2
Daily smoker	749	21.5%	1,919	19.9	48,058	11.5
Drinker	1,184	34.1%	3,096	32.1	166,169	39.6
Total patient with BMI recorded (last 24 months)	3408	98.0%	6,550	68.0	226,913	54.1
Obesity (BMI>=30)	656	19.2%	1,334	20.4	48,979	21.6

1 Disclaimer: This report includes data from 144 general practices in the Gold Coast PHN region that submit data to PATCAT (PenCS - data aggregation tool). While there are limitations to general practice data, the data is still able to provide valuable insights into population cohorts that access primary care in the Gold Coast PHN region. Adjusted figures are used for total patient population to reduce the duplication of patient data as patients can visit multiple practices. Patients may be represented in both Kalwun and mainstream general practices if they attend both.

This data indicates that the Gold Coast Aboriginal community had higher rates of diabetes, COPD and smoking. For other conditions and drinking the Gold Coast Aboriginal and Torres Strait Islander community had comparable or lower rates than the nonindigenous population. The data also indicates that patients attending the AMS generally have a higher rate of disease burden than patients being treated in mainstream services.

Mortality outcomes

The Gold Coast HHS region recorded the 5th lowest rate of all-cause mortality for Aboriginal and Torres Strait Islander persons of the 16 Queensland HHS regions between 2009-2013 of 697.0 deaths per 100,000 persons, which represented a total of 95 deaths during this period. Data is not available at a regional level for cause of death, but across Queensland the leading cause of death during this period was cardiovascular disease (25%), followed by 'other' causes (24%) and cancers (21%).

Aboriginal and Torres Strait Islander people in the Gold Coast region have higher rates of premature death than non-Indigenous Australians. Table 4 below shows the median age at death over the period 2011 to 2015 for males and females by Indigenous status.

Table 4: Median age at death by Indigenous status within Gold Coast region, by sex, 2011-2015

Source: Data compiled by PHIDU, Torrens University from deaths data based on the 2011 to 2015 Cause of Death Unit Record Files.

Aboriginal and Torres Strait Islander 71.5
Non-Indigenous 84.0

Aboriginal and Torres Strait Islander 57.0
Non-Indigenous 78.0

All Persons

Aboriginal and Torres Strait Islander 61.0
Non-Indigenous 81.0

Health Service utilisation data

Table 5 below shows the number of hospital discharges reported for Aboriginal and Torres Strait Islander people increased over the last three reporting years. A hospital discharge refers to the cessation of care for a patient that was admitted to hospital.

Table 5: Number of hospital discharges for Aboriginal and Torres Strait Islander people at GCHHS facilities

Source: Data provided by Gold Coast HHS Health Informatics Directorate

Gold Coast Hospital (Southport)	**Robina Hospital**	**Transition Care Program**	**Total**
2013/14 - 1,548	2013/14 - 870	2013/14 - 9	**2,427**
2014/15 - 2,073	2014/15 - 930	2014/15 - 4	**3,007**
2015/16 - 2,680	2015/16 - 1,188	2015/16 - 4	**3,872**
Total - 6,301	**Total - 2,988**	**Total - 17**	**9,306**

In addition to hospital admissions, there were over 30,000 outpatient appointments at Gold Coast Health facilities for Aboriginal and Torres Strait Islander patients completed during 2013-14 to 2015-16. The top three clinics for outpatient appointments based on activity in 2015-16 were all related to maternal or child health services.

Gold Coast Health also provides data on the number of 'avoidable' admissions. Between May 2013 and December 2016, there were a total of 862 avoidable admissions recorded for Aboriginal and Torres Strait Islander people in the Gold Coast region, which represented 1.9% of all admissions. The number of patients was 583, indicating that some individuals were admitted more than once. Admissions were highest in the 40-64 years age group, followed by the 20-39 years age group. The five leading categories for avoidable admissions amongst Aboriginal and Torres Strait Islander people during this period were:

- UTI including pyelonephritis—107 admissions (12.4% of all Indigenous admissions)
- Cellulitis—98 admissions (11.4%)
- Convulsions and epilepsy—98 admissions (11.4%)
- Ear, nose and throat infections—94 admissions (10.9%)
- COPD—79 admissions (9.2%)

All Aboriginal and Torres Strait Islander people, regardless of age, are eligible for an annual health check listed as item 715 on the Medicare Benefits Schedule (MBS). It aims to support early detection, diagnosis and intervention for common and treatable conditions. Table 6 below demonstrates there has been a increase in the total number of Aboriginal and Torres Strait Islander health checks within the Gold Coast PHN region over the last few years. The figures indicate that an estimated 33.93% of Aboriginal and Torres Strait Islander people in the Gold Coast region accessed a health check in 2016-17.

Table 6: Number of MBS –funded Aboriginal and Torres Strait Islander health checks (MBS Item 715) claimed within Gold Coast PHN region, 2013-14 to 2016-17

Source: Analysis of Medicare Australia Statistics, Department of Human Services.

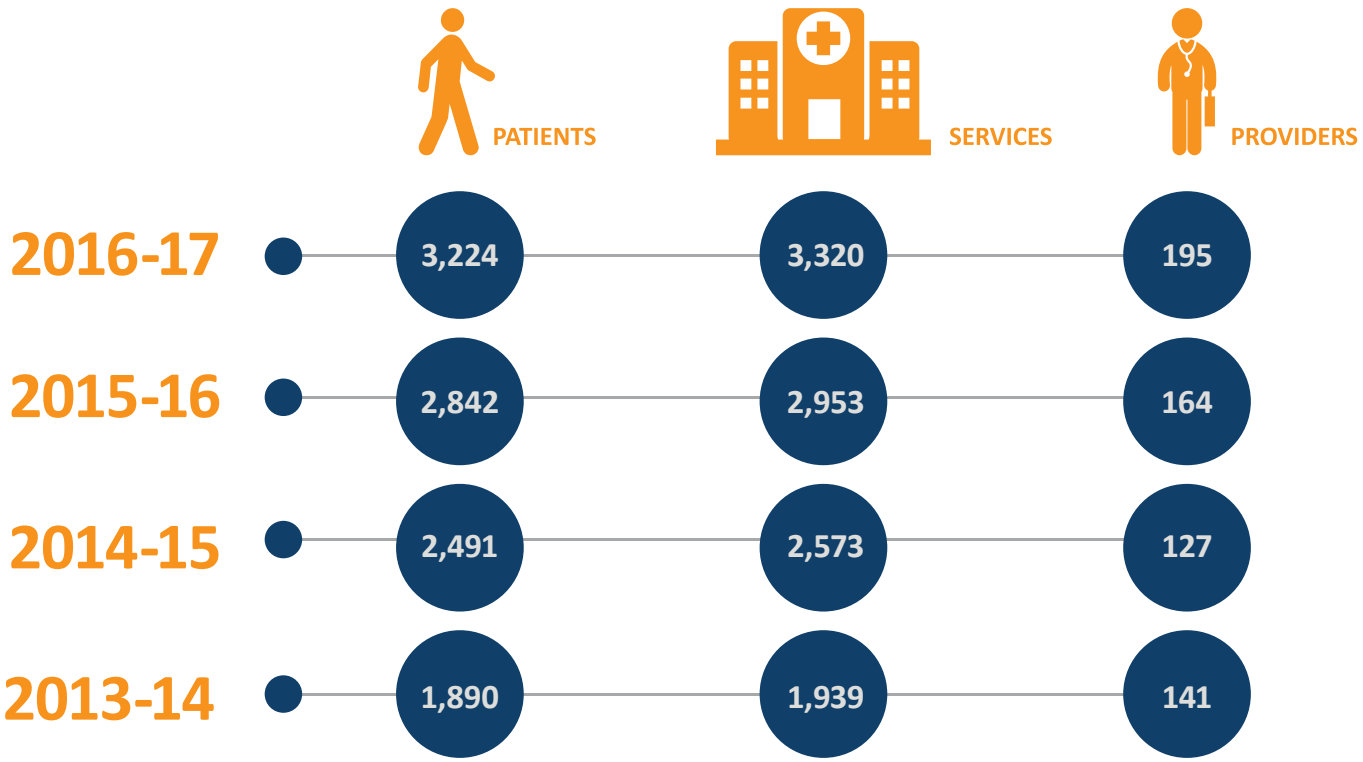


Table 7 provides a detailed breakdown of the delivery of Aboriginal and Torres Strait Islander health checks across the sub-regions of the Gold Coast.

Table 7: Regional breakdown of Aboriginal and Torres Strait Islander health checks (MBS Item 715), by SA3 region, 2016-17

Source: Analysis of Medicare Australia Statistics, Department of Human Services.

Note: MBS Schedule data is based on the location of the practice where services are processed, whereas population estimates are based on Census data of where people reside. People travelling to access services in different locations to where they reside accounts for the proportion in Broadbeach – Burleigh being >100%.

Sub-region (SA3)	Number of providers	Number of patients	% of Indigenous people receiving services*	Change in patients since 2015-16
Broadbeach – Burleigh	21	977	139%	+69
Coolangatta	N/A	N/A	N/A	N/A
Gold Coast – North	16	142	13%	-54
Gold Coast Hinterland	4	7	2%	7
Mudgeeraba – Tallebudgera	5	11	2%	11
Nerang	21	85	7%	+5
Ormeau – Oxenford	45	1047	45%	+188
Robina	17	49	8%	+11
Southport	29	90	8%	+33
Surfers Paradise	8	44	13%	+10

The higher figures seen in Table 7 in Broadbeach-Burleigh and Ormeau-Oxenford are likely to be associated with the location of Kalwun Aboriginal Medical Service. In these areas, Indigenous people may travel to these services from outside the immediate area.

Based on information provided by the Gold Coast Hospital and Health Service (GCHHS), 1.9% of all hospital admissions that were considered 'potentially avoidable' were for Aboriginal and Torres Strait Islander people during 2013-16, while accounting for approximately 1.7% of the population.

Service Mapping

Services	Number in GCPHN Region	Distribution	Capacity Discussion
General practices	197	Clinics are generally well spread across Gold Coast; majority in coastal and central areas.	• Health Workforce data suggests around 1% of GPs on the Gold Coast identify as Aboriginal and Torres Strait Islander • There are some Indigenous GPs on the GC who do not openly identify due to their own professional, cultural and privacy preferences
Kalwun Develoment Corporation including the Kalwun Health Service	1	3 Aboriginal Medical Service locations (Bilinga, Miami, Oxenford) 1 community care service for frail aged or disability (Bonogin) Dental and allied health (Miami) Family wellbeing service (Burleigh and Coomera)	• Kalwun run 3 Medical clinics GP clinics offering a comprehensive suite of services • Locations offer reasonable accessibility and there are a range of comprehensive services at each site • While services target Aboriginal and Torres Strait Islander patients, most services are open to all patients • Transport assistance provided to patients who need it • Kalwun also provide support and programs for Indigenous people with chronic conditions
Mungulli Wellness Clinic, Gold Coast Health	1	Helensvale and Robina Outreach clinics also available	• Adults who identify as either an Aboriginal or Torres Strait Islander person are eligible • A culturally safe chronic disease management program for people with complex needs relating to respiratory, kidney disease, heart failure or diabetes. Aboriginal and Torres Strait Islander Health Worker is the first point of contact for clients • Demand remains stable—GPs are referring clients into programs
Aboriginal Health Service, Gold Coast Health	1	Gold Coast University Hospital (Southport) and Robina Hospital	• Provides service navigation support to Indigenous patients • Access to mainstream primary health services is supported through two Closing the Gap staff members • This service is a member of the Karulbo Aboriginal and Torres Strait Islander Health Partnership
Yan-Coorara, Gold Coast Health	1	Palm Beach	• Program aimed to support social and emotional health

Services	Number in GCPHN Region	Distribution	Capacity Discussion
COACH Indigenous-specific stream, Queensland Health	State-wide	Phone service	• Free phone coaching service is available to support Indigenous people with chronic disease self-management • Very low awareness of Indigenous specific stream of COACH • Limited information on how service differs from mainstream COACH • Very low referrals to COACH program in general, unsure if any indigenous referrals
Kirrawe Indigenous Mentoring Service	1	Labrador	• Formal mentoring program • Aims to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander young people • Provides individual support, advice and guidance and help in practical ways at important transition points in their life
Institute for Urban Indigenous Health	1	Staff based in each Kalwun clinic at Bilinga, Miami and Oxenford	• GCPHN funded care coordination services for Aboriginal and Torres Strait Islander patients with chronic disease • Numbers of patients involved have been steadily increasing

Consultation

Consultation with the Karulbo Aboriginal and Torres Strait Islander Partnership Council (September 2017) indicated:

- Potential service gaps in coordination of medication across Gold Coast Health and primary care support for transition to NDIS, services for young people transitioning out of Department of Child Safety care
- Most commonly identified issues affecting access to mainstream services included transport, cultural competency and cost.
- Most commonly identified issues affecting access to indigenous specific services included transport and cost.
- Coordination of holistic care was seen as very important with information sharing and collaboration being seen as key elements to support this
- Barriers to coordinated care include limited knowledge of roles and responsibilities, funding and red tape, lack of culturally specific roles in programs such as PIR, transport, limited outside of work hours service and limited access to specialists
- There was strong belief Gold Coast Aboriginal and Torres Strait Islander Community are more likely to access services if they are provided by an Aboriginal and Torres Strait Islander health professional
- Cultural competence for mainstream service providers was seen by all as very important and this was across all areas of health care

Over the last few years, 81 people from General Practice and various Allied Health providers representing over 61 organisations across the Gold Coast have undertaken GCPHN cultural training. Of the total of 197 General Practices on the Gold Coast, 94 (52%) are recorded as Closing the Gap registered. Most respondents to the 2017 Primary Care Opinion Survey had not undertaken cultural safety training through GCPHN, but those who had indicated it improved their ability to work with Aboriginal and Torres Strait Islander people. There was significant interest from respondents in this area, practice nurses and practice managers were the most likely to indicated an interest in cultural safety training while general practitioners were the least likely.

More broadly, the Gold Coast PHN's Community Advisory Council (CAC) met in February 2017 as part of the needs assessment process and identified that marginalised groups such as Aboriginal and Torres Strait Islander people "continually seem to fall through the cracks". The CAC recommended a focus on health inequality, respectful and appropriate care, inclusion and the impact of stigma.

Consultation and feedback from stakeholders throughout 2018 confirms:

- The most commonly identified issue affecting access to Indigenous specific services is transport
- Housing issues, rental arrears and lack of funds for food are ongoing system issues that are difficult to overcome
- There is a demand for more Aboriginal and Torres Strait Islander workers, particularly male workers for both mental health and alcohol and other drugs.

"Building one world class health system for the Gold Coast."

ABORIGINAL AND TORRES STRAIT ISLANDER MENTAL HEALTH AND SUICIDE

Needs Assessment Summary

2018

phn GOLD COAST

An Australian Government Initiative

Aboriginal and Torres Strait Islander Health Mental Health and Suicide

Aboriginal and Torres Strait Islander people require access to mental health services that are joined up, integrated, culturally appropriate and safe, and designed to holistically meet their mental health and healing needs of the individual at the local level. Services need to complement and link with other closely connected activities, such as social and emotional wellbeing services, mental health services, suicide prevention approaches and alcohol and other drug services. Culturally appropriate health service providers facilitate more effective mental health service delivery and improved mental health outcomes for Aboriginal and Torres Strait Islander people. This requires cultural awareness, cultural respect, cultural safety and an understanding of the broader cultural determinants of health and wellbeing.

Identified local health needs and service issues

- Access and awareness of appropriate services
- Mainstream services that are culturally appropriate and safe
- Limited Australian and Torres Strait Islander workforce in specialist mental health services including suicide support

Key findings

- Gold Coast has a relatively small Aboriginal and Torres Strait Islander population with greater density in Coolangatta, Nerang, Ormeau-Oxenford and Southport.
- While there is limited local data, national trends indicate high rates of mental health issues for Aboriginal and Torres Strait Islander people
- There are limited Aboriginal and Torres Strait Islander specific mental health services and workers; cultural needs are not well met by mainstream service providers.
- There can be stigma associated with Aboriginal and Torres Strait Islander people seeking treatment, and for men there can be “shame” associated with accessing services.
- Men’s groups in the north and south of the region are engaging Aboriginal and Torres Strait Islander men well and could be expanded.

Prevalence, service usage and other data

In 2016 there were 9,501 people living on the Gold Coast who identified as Aboriginal and/or Torres Strait Islander of which is 1.7% of residents. This is less than the greater Queensland rate of 4%. Local Aboriginal and Torres Strait Islander service providers report that the identified population are likely to be an underestimation.

The Statistical area (SA3) regions with the highest numbers of Aboriginal and Torres Strait Islander residents were Ormeau-Oxenford (2,353 people), Nerang (1,274 people) and Coolangatta (1,200 people).

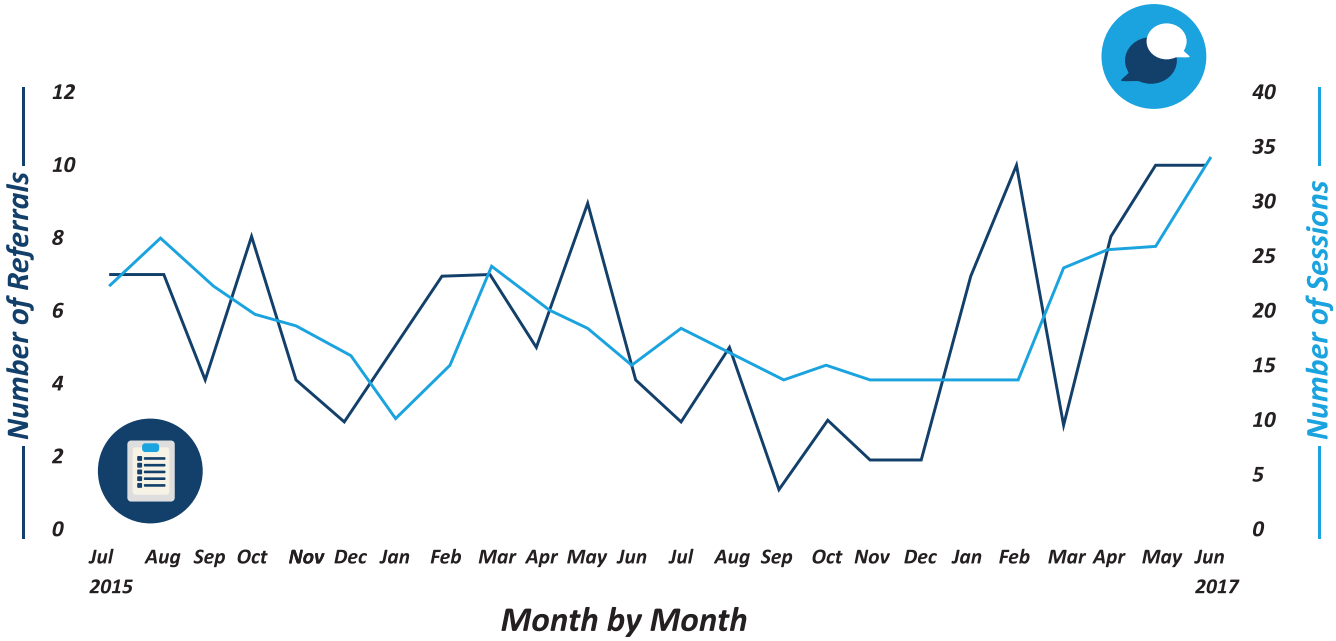
The 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey collected information on wellbeing and found most (nine-in-ten) Aboriginal and Torres Strait Islander people felt happy some, most, or all of the time. However, findings also indicated Aboriginal and Torres Strait Islander adults were almost three times more likely to feel high, or very high, levels of psychological distress (in the 4 weeks prior to the survey) than non-Indigenous adults. This was about 30% of people aged over 18 years. Applying this figure to the Gold Coast's 5,748 Aboriginal and Torres Strait Islander people aged over 18 in 2016, leads to an estimate of 1,724 people.

Of the 665 suicides reported in 2016 in Queensland, 52 (7.82%) were by Aboriginal or Torres Strait Islander people. Of these, 37 were male (71.2%) and 15 were female (28.8%). The majority of Aboriginal and Torres Strait Islander suicides occurred in people under the age of 35 years (65.9%), while just over a quarter were aged 35-54 years (28.6%) and 5.6% were 55 years or older.

Gold Coast had the lowest number of suicides by Aboriginal and/or Torres Strait Islander people in Queensland for the 2011-13 period. True suicide mortality figures in Aboriginal and Torres Strait Islander populations remain poorly understood due to incomplete data collection processes and inaccurate classification systems.

Over the period July 2014 to June 2017, Access to Allied Psychological Services (ATAPS) referral rates for Aboriginal and Torres Strait Islander individuals were small and fluctuated greatly. Figure 1 shows the ATAPS Aboriginal and Torres Strait Islander referral and service frequency over the period July 2014 to June 2017. The ATAPS program ceased as of 30 June 2017 and has been replaced by the Psychological Services Program.

Figure 1. ATAPs referrals for and service utilization by A&TSI clients, 2015-2017



For many Aboriginal and Torres Strait Islander people in the community, being able to access culturally safe and competent health care is key to the accessibility and effectiveness of health services. The visible presence of Aboriginal and Torres Strait Islander staff members (such as Aboriginal Health Workers) has been demonstrated to help manage the risk of services unintentionally alienating Aboriginal and Torres Strait Islander people.

Based on 2015 workforce data there very small numbers of clinicians who identified as Aboriginal and Torres Strait Islander people as noted in Table 1.

Table 1 Number of clinicians who identified as Aboriginal and Torres Strait Islander, GCPHN region and National, 2015

General Practitioners

(GCPHN) region total number of clinicians **693.** Percentage who identified as Aboriginal and Torres Strait Islander **1.2%** ***Nationally 0.4 %***

Psychiatrists

GCPHN region total number of clinicians **66.** Percentage **who identified as Aboriginal** and Torres Strait Islander **0%** ***Nationally 0.5 %***

Psychologists

GCPHN region total number of clinicians **66.** Percentage **who identified as Aboriginal** and Torres Strait Islander **0.7%** ***Nationally 0.7 %***

Service Mapping

Services	Number in GCPHN Region	Distribution	Capacity Discussion
GCPHN funded Psychological Services Program (PSP), Aboriginal and Torres Strait Islander Social and Emotional Wellbeing service.	Of the 67 PSP providers (2016-17), 19 are contracted to provide Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Services.	Providers are situated across the region.	There are limited mental health services on the Gold Coast that are specifically for Aboriginal and Torres Strait Islander people. While many service providers identify Aboriginal and Torres Strait Islander people as a target group within their broader programs, only the Gold Coast Aboriginal Medical Service (AMS), Krurungal and Gold Coast Health offer specific Aboriginal and Torres Strait Islander services. The Aboriginal and Torres Strait Islander Health service (Gold Coast Health) deliver one Indigenous specific mental health and Alcohol and Drugs program providing supported access for Aboriginal and Torres Strait Islander people to mainstream mental health and AOD services. Aboriginal Mental Health Navigator to be appointed by Gold Coast Health 2018.
e-mental health services.	AIMhi Stay Strong App.	Online Services. Public and health professional awareness of these services would drive uptake/ demand.	
Gold Coast Health – 2 programs specifically for Aboriginal and Torres Strait Islander people (focus is on supporting access to mainstream services), also client liaison support outside of programs.	2 (Aboriginal and Torres Strait Islander Health & Yan-Coorara).	Palm Beach and outreach.	
Kalwun - Gold Coast Aboriginal Medical Service - counselling, psychology, mental health nurse, case manager, suicide prevention worker, Alcohol and Other Drugs clinician and General Practitioners. GCPHN funds the social and emotional wellbeing, suicide prevention and Alcohol and other drugs services.	1	3 clinics (1 in Bilinga, 1 in Miami and 1 in Oxenford)	
Krurungal- GCPHN funded non-clinical care coordination for alcohol and other drug issues	1	Outreach, office based at Bilinga	
Krurungal - Partners In Recovery (PIR) - service coordination/facilit ation program.	There are 2 part-time ATSI identified positions as PIR workers.	Outreach. Office based at Bilinga. Partners In Recovery due to end in June 2019	

Consultation

Service provider consultation

The consultation with service providers identified that there is a clear need for capacity building to ensure cultural capability exists in all mental health services. Wrap-around care and more formalised care coordination and case management as well as support worker options need to be available for Aboriginal and Torres Strait Islander service users. This best promotes client satisfaction and engagement in their care. A holistic approach, outreach models, specific Aboriginal and Torres Strait Islander workers that support mainstream services and establishing strong relationships between mainstream and Aboriginal and Torres Strait Islander services were identified as essential elements to ensure this client group benefit from effective and trusted referral pathways. The limited presence of Aboriginal and Torres Strait Islander workers in the region was a key point throughout the consultation. Particularly the need was identified for an Aboriginal and Torres Strait Islander worker that is skilled in providing suicide prevention.

Service user consultation

Service users stated that enhancing the Aboriginal and Torres Strait Islander workforce to enable workers to provide care coordination and specialist mental health services such as suicide support would be received positively. Accordingly, feedback also suggested that service user satisfaction could be improved through increasing the coordination of services by using established, well-developed and trusted pathways to support client referrals into culturally appropriate services. Likewise, client satisfaction could also be improved by increasing the cultural competency of mainstream services to safely and effectively work with Aboriginal and Torres Strait Islander clients.

There is limited data or input provided through direct consultation with this group. However, feedback did identify that stigma and the “shame factor” can prevent people in this group seeking help. There are some groups on the Gold Coast that provide soft entry points for Aboriginal and Torres Strait Islander men and it is reported that these are working effectively and have the potential to be expanded.

Consultation and feedback from stakeholders throughout 2018 found:

- The most commonly identified issue affecting access to Indigenous specific services is transport, with secondary issues including access to brokerage funds to cover expenses such as public transport cards, phone credit and fuel.
- Housing issues, rental arrears and lack of funds for food are ongoing system issues that are difficult to overcome. Increase in clients and families that are experiencing or at risk of homelessness.
- There is a demand from community for more Aboriginal and Torres Strait Islander workers, particularly male workers for both mental health and alcohol and other drugs. There is a limited pool of workers and recruitment to new positions is challenging.

Opportunities, priorities and options

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

- *may be considered in the development of the Activity Work Plan, and supported by Gold Coast Primary Health Network (GCPHN) flexible funding;*
- *may be undertaken using programme-specific funding; and*
- *may be led or undertaken by another agency.*

General Population Health

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
General Practice and Primary Care • While accreditation rates are currently high, there may be additional support required due to changes in RACGP Standards and Quality Practice Incentive Payment • Significant growth in general practice and general practitioners • Comparatively high rates of potentially preventable hospitalisations, with particular growth in vaccine preventable conditions (particularly pneumonia and influenza) • Potential to increase use of data in general practice software to proactively plan care	General practice support Tier 1: • Support the adoption of a Clinical Audit tool with practice data being submitted to GCPHN. • Information, resources and education (delivery of clinician and patient resources) provided though face-to-face, telephone, electronic bulletins, email networks and mail out for areas including: ○ public health (immunisation and cancer screening) ○ e-referrals from primary to secondary/tertiary and non-government agencies ○ transition to 5th Edition Standards of Accreditation ○ compliance with ePIP and QPIP. Entry Level Quality Improvement Tier 2	• General practice is supported to adopt evidence based best practice methods and meaningful use of digital systems to inform quality improvement • • Increase uptake of practice accreditation and Practice Incentive Payments • Timely provision of information, resources and or education to support changes in programs and policy that impact on general practice. • Embed continuous quality improvement methodologies and utilisation of health information management and other building blocks of high performing primary care • Increased access to high quality population health data to inform current and future GCPHN activities such as needs assessment and service development.	GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead

	• Practices enrolled are provided with quarterly reports which includes
	  ○ a practice profile and
	  ○ analysis of clinical data identifying key trends and areas for improvements
	• Support for effective data entry, data cleaning and quality assurance processes
	
	Continuous quality improvement (CQI)
	Tier 3 Practice Support
	• Supported implementation of continuous quality improvement methodologies using practice data to drive improvements and other building blocks of high performing primary care
	• Collection and use of clinical data to improve the population's health
	• The General Practice determines priority areas for improvement through review of their clinical data
	• Development of an action plan utilising a CQI methodology through peer to peer conversations
	• Develop tailored clinical audit reports to determine baselines measures and monitor improvement over time
	• Review and monitor progress towards achievements/improvements
	• Access to decision support tools including cycles of care through GCPHN website.
	
	Population health management
	Tier 4 Practice Support
		• Improved management of patient health care in general practice
		• Reducing unnecessary referrals and admissions to hospital.
			GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	• Allocated Practice Support Officer to facilitate improved comprehensive and patient centred care planning • Develop person centred, goal orientated care plans that align with MBS requirements. • Provide education and training in the use of the care plans template which support utilisation of systematic cycles of care requiring recall and reminder where necessary to support improved patient management. • Provide regular data reports to monitor improvement in care management of patients. • Links with Primary Sense in section below		
General Practice and Primary Care • Clinical handover, particularly to general practice on discharge from hospitals remains a significant issue • Comparatively high rates of potentially preventable hospitalisations, with particular growth in vaccine preventable conditions (particularly pneumonia and influenza • Access to Information about services and resources to support general practice in key areas required • Potential to increase use of data in general practice software to proactively plan care • Current systems (including MBS payments and data) do not support population health approach and care-coordination	Integrated Care Alliance • Support the implementation of new integrated models of care. • Preliminary work to develop models of care have been completed for a range of disease conditions. Implementation requirements are currently being scoped. • A major body of work for GCPHN involves the implementation of a e-library solution to enable all clinicians on the Gold Coast to review and utilise new pathways to care resulting from the re-design work. Primary Sense Continue refinement and implementation in trial practices of automated pseudonymised data extraction and analysis of the health profile of the entire practice population. This includes generating actionable optimal care reports and	Create a single integrated healthcare system for the Gold Coast by: • Improving the coordination of care to ensure consumers receive the right care at the right place at the right time by the right person. • Increasing the effectiveness and efficiency of health services for consumers. • Engaging and supporting clinicians to facilitate improvements in our health system. Primary Sense will support general practices to make timely decisions for better health care for their respective populations by: • Integrating diagnosis, medications and pathology data from practice management systems and applying evidenced based algorithms.	GCPHN with Gold Coast Health (GCH) GCPHN with key stakeholders

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	medication safety alerts for general practices, analysed population health data for the practice to inform the service response and for GCPHN needs assessment and other commissioning purposes. Primary Sense: • Highlights patients with complex and comorbid conditions to target proactive and coordinated care • Highlights patients at risk of hospitalisation for coordinated care (some cross over with group above) • Highlights patients at risk of chronic disease to target proactive health assessment • Highlights patients at risk of polypharmacy for medication review • Alerts of patients at immediate risk from medication prescribing safety issues	• Identifying high risk groups for proactive care. • Relaying analysed de-identified patient information as data becomes available, enabling the practices to plan and coordinate care in an efficient way so patients get the right care at the right time. • Providing clinical audit functions e.g. pre-accreditation data checks, and a risk stratified profile of the entire practice patient population including high impact conditions, multi-morbidity and polypharmacy profiles. Primary Sense will also enhance the level and detail of service planning that GCPHN can do based on historic and current pseudonymised patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time.	
General Practice and Primary Care • While categories 4 and 5 ED presentations have remained stable, there has been strong growth in higher acuity categories, increasing demand on ED services • Access to Information about services and resources to support general practice in key areas required	Emergency Alternatives This will involve promotion of after-hours doctor's services, online and telephone services to improve awareness of options and help people make appropriate and informed decisions. We anticipate this will assist to reduce the burden in Emergency departments by reducing the number of unnecessary or inappropriate presentations. Activities include: • Collateral development and distribution, including magnets, brochures and posters, to be distributed through general practice and GCH emergency department. • Online advertising, social media and radio advertising • Usual GCPHN and GCH publications • Tonic advertising at pharmacy	Contribute to prevention of increasing numbers of Cat 4 and 5 presentations to ED	GCPHN with GCH

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	• Advertising through GCUH screens in foyer and emergency waiting areas. Primary Sense Continue refinement and implementation in trial practices of automated pseudonymised data extraction and analysis of the health profile of the entire practice population. This includes generating actionable optimal care reports and medication safety alerts for general practices, analysed population health data for the practice to inform the service response and for GCPHN needs assessment and other commissioning purposes. Primary Sense: • Highlights patients with complex and comorbid conditions to target proactive and coordinated care • Highlights patients at risk of hospitalisation for coordinated care (some cross over with group above) • Highlights patients at risk of chronic disease to target proactive health assessment • Highlights patients at risk of polypharmacy for medication review • Alerts of patients at immediate risk from medication prescribing safety issues	Primary Sense will support general practices to make timely decisions for better health care for their respective populations by: • Integrating diagnosis, medications and pathology data from practice management systems and applying evidenced based algorithms. • Identifying high risk groups for proactive care. • Relaying analysed de-identified patient information as data becomes available, enabling the practices to plan and coordinate care in an efficient way so patients get the right care at the right time. • Providing clinical audit functions e.g. pre-accreditation data checks, and a risk stratified profile of the entire practice patient population including high impact conditions, multi-morbidity and polypharmacy profiles. Primary Sense will also enhance the level and detail of service planning that GCPHN can do based on historic and current pseudonymised patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time.	GCPHN with key stakeholders
General Practice and Primary Care • Access to Information about services and resources to support general practice in key areas required	Access to information and resources GCPHN will continue to host, develop the I.T. infrastructure, update and market the existing web portal featuring: • Localised referral guidelines and templates for Gold Coast Health, updated to reflect the Clinical Prioritisation Criteria protocols introduced in Queensland • Review and update of existing referral templates to ensure they align to current evidence and GCH systems and protocols	• Achieving increased access to contemporary evidence-based resources and localised service and referral information. • Increase direct links to local service provider information in health topic areas and information and resources published online to support appropriate, timely referrals and agreed service pathways.	GCPHN with GCH

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	• Other clinical and service navigation support information including the emerging new models of care • Professional resources • Patient facing resources • A detailed local service directory. In addition, other software options as well as the structure of the current HealthyGC website will be reviewed and compared to ensure the service continues to function in the most effective and efficient way. Work cooperatively with the National Health Service Directory to ensure effective information sharing. This activity links closely with practice support activities and other program activities.		
Cancer • High rates of melanoma across the region. • Higher rates of colorectal cancer and breast cancer but lower rates of screening compared to national rates. • Low community awareness of eligibility for screening in Gold Coast region, men in particular.	Public Awareness - Cancer Public awareness campaigns promoting screening and skin checks through usual communication channels including information and resources on the website "HealthyGC", GCPHN publications, social and traditional media, targeting particular hot spot areas. General practice support – help desk Help desk support to general practice to support general enquiries including access to resources for cancer. General Practice Support – Quality Improvement Quality improvement activities (tier 3) in general practice support to include prevention as potential focus area including recall and reminder of potentially eligible patients for screening options through Health Assessments and skin checks.	• Increase in awareness and uptake of screening services for breast, bowel and cervical screening. • Increased skin cancer and prostate cancer check.	GCPHN GCPHN GCPHN
Immunisation	Public Awareness – Immunisation		GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
• Lower rates of children fully immunised in the Gold Coast particularly hinterland, Surfers Paradise and Mudgeeraba-Tallebudgera. • Lower rates of HPV vaccination in Gold Coast compared to the national figure. • Higher rates of hospitalisation for pneumonia and influenza in Gold Coast compared to the national figure.	Public awareness campaigns promoting early childhood, HPV and influenza vaccinations through usual communications channels including information and resources on the website "HealthyGC", GCPHN publications, social and traditional media, targeting particular hot spot areas. General practice support – help desk Help desk support to general practice to support general enquiries including access to resources for immunisation. General Practice Support – Quality Improvement Quality improvement activities (tier 3) in general practice support to include prevention as potential focus area including recall / reminder of potentially eligible patients for vaccinations	• Increase in awareness and uptake of vaccinations.	GCPHN
Persistent Pain • High rates of musculoskeletal conditions in Gold Coast North and Coolangatta • Ageing population means more musculoskeletal conditions projected • Pain management frequently focusses on medication • High levels of opioid dispensing across region, particularly Southport • Need for more awareness and support for prevention and self-management • Focus on multidisciplinary and coordinated care	Continuation of Persistent Pain Program Turning Pain Into Gain program has the following service components: • Patient self-management education program • Individual patient assessment including support to navigate service providers and recommendations to patient's GP • Access to additional allied health services where required • GP and allied health services education • Peer-to-peer support group lead by previous participants • Refresher workshops for participants at 6 months, 9 months and 12 months' post program Evaluation using validated tools	• Improved self-management of pain • Reduced use of pain medication • Reduced hospital presentations	Contractor
Chronic Disease	Integrated Care Alliance	Create a single integrated healthcare system for the Gold Coast by:	GCPHN with GCH

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
• Better systems to support care coordination. • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients. • Need for greater focus on prevention, early identification and self-management. • High rates of smoking and harmful alcohol intake across the region.	• Support the implementation of new integrated models of care. • Preliminary work to develop models of care have been completed for a range of disease conditions. Implementation requirements are currently being scoped. • A major body of work for GCPHN involves the implementation of a e-library solution to enable all clinicians on the Gold Coast to review and utilise new pathways to care resulting from the re-design work.	• Improving the coordination of care to ensure consumers receive the right care at the right place at the right time by the right person. • Increasing the effectiveness and efficiency of health services for consumers. • Engaging and supporting clinicians to facilitate improvements in our health system.	
Chronic Disease • Better systems to support care coordination. • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients. • Need for greater focus on prevention, early identification and self-management. • High rates of smoking and harmful alcohol intake across the region.	Primary Sense Continue refinement and implementation in trial practices of automated pseudonymised data extraction and analysis of the health profile of the entire practice population. This includes generating actionable optimal care reports and medication safety alerts for general practices, analysed population health data for the practice to inform the service response and for GCPHN needs assessment and other commissioning purposes. Primary Sense: • Highlights patients with complex and comorbid conditions to target proactive and coordinated care • Highlights patients at risk of hospitalisation for coordinated care (some cross over with group above) • Highlights patients at risk of chronic disease to target proactive health assessment • Highlights patients at risk of polypharmacy for medication review • Alerts of patients at immediate risk from medication prescribing safety issues	Primary Sense will support general practices to make timely decisions for better health care for their respective populations by: • Integrating diagnosis, medications and pathology data from practice management systems and applying evidenced based algorithms. • Identifying high risk groups for proactive care. • Relaying analysed de-identified patient information as data becomes available, enabling the practices to plan and coordinate care in an efficient way so patients get the right care at the right time. • Providing clinical audit functions e.g. pre-accreditation data checks, and a risk stratified profile of the entire practice patient population including high impact conditions, multi-morbidity and polypharmacy profiles. • Primary Sense will also enhance the level and detail of service planning that GCPHN can do based on historic and current pseudonymised patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time.	GCPHN with key stakeholders

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Chronic Disease • Better systems to support care coordination. • Referral pathways and care coordination including self-management systems to identify suspected at-risk patients. • Need for greater focus on prevention, early identification and self-management. • High rates of smoking and harmful alcohol intake across the region.	Access to information and resources GCPHN will continue to host, develop the I.T. infrastructure, update and market the existing web portal featuring: • Localised referral guidelines and templates for Gold Coast Health, updated to reflect the Clinical Prioritisation Criteria protocols introduced in Queensland • Review and update of existing referral templates to ensure they align to current evidence and GCH systems and protocols • Other clinical and service navigation support information including the emerging new models of care • Professional resources • Patient facing resources • A detailed local service directory. In addition, other software options as well as the structure of the current HealthyGC website will be reviewed and compared to ensure the service continues to function in the most effective and efficient way. Work cooperatively with the National Health Service Directory to ensure effective information sharing. This activity links closely with practice support activities and other program activities. Population health management Using the learnings from previous Comprehensive Over 75 Care Plan project evaluation, support implementation of comprehensive proactive management of complex and at-risk patients through a quality improvement model in general practice.	• Achieving increased access to contemporary evidence-based resources and localised service and referral information. • Increase direct links to local service provider information in health topic areas and information and resources published online to support appropriate, timely referrals and agreed service pathways.	GCPHN with GCH GCPHN GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	General Practice Support – Quality Improvement Quality improvement activities (tier 3) in general practice support to include prevention as a potential focus area including recall and reminder of potentially eligible patients for health checks and referral to lifestyle modification programs.		

Aged Care
• High numbers of preventable hospital admissions for older adults are recorded for Chronic Obstructive Pulmonary Disease (COPD), urinary tract infections, angina and heart failure
• Lack of established clinical coordination tools and processes that result in fragmentation of the local health system in patient centred care – management and problematic after-hours management
• Low use of advanced care directives, plans and deficits in confidence and capacity of staff to provide adequate and/or quality palliative care.
• Over 80% of residents in residential aged care presenting with increasing complexity of care, including dementia behaviour management, mental health, palliative and end of life care.
• Limited uptake of existing Education, training and resources to RACF's, GPs and health care professionals in early identification and management of Palliative Care – End of Life.
• Limited capacity to provide a coordinated and sustained coverage for palliative and end of life care within RACF's out of hours.
	Enhanced Primary Care In RACFs
	• Engage RACF staff to "champion" and support GPs to drive comprehensive multidisciplinary care planning including completion and use of advance care planning utilising evidenced based pathways and resources (including My Health Record).
	• Embedding RACGP Silver Book guidelines by providing access to a simplified cycle of care and decision support tools aligned to the guidelines
	• Provision of education and training to support General Practitioners and RACF Clinical Nurses and other RACF staff on:
	  • Qld End of Life Care planning and advanced care planning.
	  • ISBAR clinical communication tool
	  • Use of My Health Record
	
	After hours advice and support
	Provide a point of contact for RACF clinical staff to communicate with expert clinical staff to provide advice and guidance to facilitate an alternative to hospital transfer for acute, subacute and outpatient services and to facilitate early and proactive planning of transfers between GCHHS and RACFs.
	
	Dementia advice and support
		• Development of strong partnerships with community palliative care supports and services and GPs
		• Implementation and adoption of clinical guidelines and protocols focused on key best practices for generalist primary palliative care within RACFs
		• Engagement of RACF staff in training to increase role appropriate competence in primary palliative care skills
		• Enhanced clinical competency of professionals within RACF in primary palliative care management
		• Increased awareness of palliative care clinical management and its integration into patient centred care
		• Decrease in avoidable admissions to emergency department
		• Increase the number of Advance Care Plans and uploads to My Health Record.
			GCPHN with partners
			
			Gold Coast Health / other contractor

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	Explore opportunities to build capacity in the sector to deliver improved care particularly for people with increasing complexity of care needs, specifically behaviour management for people with dementia. Mental Health and wellbeing for RACF residents Explore opportunities to build capacity in the sector to deliver improved mental health and wellness services in RACFs.		
Palliative Care • Maintaining the role of GPs in coordinating care for palliative patients is important to clinicians, consumers and carers but this is difficult because: o Some GPs and other primary care providers may not regularly provide palliative care, influencing levels of knowledge and confidence o Low levels of uptake and awareness of existing palliative care-related training and information resources o Care coordination involving a person's different care providers and family is seen as important but can be difficult due to funding arrangements and lack of dedicated resources to operationally support o GPs experience challenges in making palliative care-related attendances particularly in the after-hours period due a range of factors including MBS payments, capacity, limited access to information on current treatment/medications. For RACFs there are also issues with accessing facilities, coordination with onsite	Primary Health Palliative Care Project: Support for general practice to deliver palliative care services • Web based platform providing general practitioners with easy access to localised information and existing evidence based resources • Care coordination with specialist palliative care services and other members of MDT including optimum business processes (e.g. MBS item numbers) • Training and education • Trialling a GP Palliative Care Network for RACF's which will support GPs interested in providing quality palliative care, accepting transfer of care from other GPs, etc. If successful, this approach will be extending across the district • Developing shared care palliative care models with GPs providing most of the care, supported by ready access to specialists as needed • Ongoing educational opportunities for GPs provided by the GCH Palliative Care Service through annual in-service programs about symptom management and medication, and use of Program in the Experience of the	• Improved practical advice and support for families • Improved awareness by health, community and aged care providers regarding family access to bereavement support.	GCPHN through Greater Choices for At Home Palliative Care with Gold Coast Health and other key stakeholders

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
nursing staff and communication with deputising services. • Fatigue and burnout for families supporting loved ones at home is a significant issue, particularly those with limited practical and social support • There is low uptake, awareness and confidence reported for advance care planning amongst both service providers and community members. • Effectiveness of local palliative care services in an inpatient setting typically exceeds patient outcome benchmarks, but achieving similar outcomes in the community setting is challenging due to limited resourcing. • Limited funding is available to support community services to provide after-hours in-home care, offer respite nursing support or purchase appropriate equipment to enable palliative care to be provide in a patient's home (including residents of RACFs) • Families report difficulty with understanding and navigating the palliative journey of loved ones including equipment requirements	Palliative Approach (PEPA). This provides GPs with an opportunity to work in palliative care units. • Strengthening the approaches used by GPs to advance care planning and exploring ways to involve practice nurses in advance care planning and ongoing care • Providing education to community and hospital pharmacists about current palliative care medications, dosing regimens and side effects. **Palliative Care Volunteers Network** Commission suitable service provider to recruit, train, manage and provide ongoing support to volunteers to support palliative patients and carers with appropriate tasks and activities. **Community Awareness and Education** Modest media campaign and leveraging community engagement opportunities to encourage people to talk more openly about dying, death and bereavement, and to make plans for the end of life inclusive of Advance Care Plans. **Enhanced Primary Care** • System navigation for people requiring palliative care and primary care providers supporting them with a focus on proactive coordinated care. • Agreed pathways developed and evaluated that provides triage, consultancy, clinical support, and advice for patients, carers , clinical staff and GPs, so patient care can be delivered in the facility where appropriate, and transfer to hospital is avoided.	• Increased network of volunteers to support palliative care patients and their carers • Increased knowledge and uptake of Advance Care Plan (ACP) • Improved health, community and aged care provider understanding of end-of-life care, and appropriate referrals to specialist palliative care • The generalist healthcare workforce supported and mentored to increase capacity, knowledge and skills • Workforce better equipped to support an ageing population • Improved public understanding of end-of-life and palliative care • Increased uptake of ACP	

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	• Training and education for implementation of clinical care coordination to GPs and MDS • Develop a regional palliative patient centered management strategy and process that can be implemented regionally • In consultation with local partners develop a quality improvement system to better support general practitioners ensuring coordinated care for their palliative and end of life patients • Dedicated support for GP practices including services to enhance palliative care co-ordination and to develop and implement comprehensive proactive care plans.		

Primary Mental Health Care (including Suicide Prevention)

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Low intensity mental health services • Flexible evidence-based services are required and could include the review and possible adaptation of existing funded groups and alternative service models. • Low uptake of group-based services funded by GCPHN. • Promotion of low intensity services to General Practice to support complementary use with other primary health interventions. • Develop effective pathways to increase accessibility to evidence based electronic (digital) mental health services.	Psychological group programs Review of commissioned psychological group programs aimed at people with mild mental health issues from hard to reach groups as listed under target population cohort.	• Improve targeting of evidence based psychological interventions to most appropriately support people with, or at risk of, mild mental illness.	Contracted providers
	New Access Review beyond blue New Access program, with a focus on the northern growth corridor of the Gold Coast, which commenced 1st January 2018.	• Increased service delivery options for people with mild mental health needs particularly in the northern growth corridor	Beyond blue
	Public Awareness Public awareness campaign promoting increased referrals across the stepped care continuum in particular low intensity mental health services.	• Increased access to services	GCPHN
	Access to information and resources Access to information and resources that supports referrals and access to appropriate evidence based electronic (digital) mental health services. See also Access to Information	• Enhance the capacity and effectiveness of the funded organisations, General Practice	GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	and Resources above General Population Health section.	and the broader sector to meet the needs of their client group	
National Psychosocial Services • Short-term, non-clinical, recovery-focussed psychosocial support services for people of all ages • Ensure effective engagement with key vulnerable groups • Local workforce comprised of peer support workers, life coaches and support workers able to provide client-centred, trauma-informed, culturally appropriate and recovery-orientated support in both outreach and centre-based settings • Promotion of psychosocial services to general practice and other stakeholders to support complementary use with other primary health interventions • Efficient referral pathways to increase accessibility to new psychosocial services	Commission services with existing provider Work with existing contracted provider delivering clinical care coordination services for people with severe mental illness to implement the provision of psychosocial support for people with severe mental illness. Commission short-term, non-clinical, recovery-focussed psychosocial support services to address the most frequently identified areas of unmet psychosocial need: - Obtaining employment/volunteering opportunities - Managing physical health issues - Engaging in a fulfilling social life - Participating in daytime activities Ensure effective engagement with key vulnerable groups: - Culturally and linguistically diverse - (CALD) backgrounds - Those who identify as lesbian, gay, bisexual, transgender, intersex, queer, asexual, pansexual and others (LGBTIQAP+) - Identify as Aboriginal and/or Torres Strait Islander Public Awareness Public awareness campaign promoting increased referrals across the stepped care continuum in psychosocial support services. Access to information and resources Access to information and resources that supports referrals and access to appropriate to evidence based electronic (digital) mental	• Continuity of support and services for previous Partners In Recovery clients particularly those who are not eligible for NDIS services. • Alignment with Gold Coast Health service provision to ensure maximum coverage of potential clients without duplication of services.	Contracted provider GCPHN GCPHN

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	health services. See also Access to Information and Resources.		
Mental Health - Suicide Prevention • GCPHN funded psychological services for suicide prevention are well utilised but opportunity exists to better target those most at risk. • Education and support required for general practice and mental health services workforce particularly in relation to consistent approaches to risk assessment and safety planning. • Work in partnership with Gold Coast Health to ensure care planning and discharge processes are inclusive for all participants. • Develop clear referral pathways and supported connections to appropriate community supports and reinforcing the central coordinating role of the medical home (linking back to the GP)	Post Hospital Suicide Prevention Review of commissioned service, Lotus – a non-clinical support and transition services to people who may have recently attempted suicide, or are at risk of suicide, and have presented at either Robina or Gold Coast University hospitals, or be an inpatient being discharged from one of these facilities. Community workers provide coordination, linkage and referrals to services who can provide longer term support, in line with the individual's needs. Look for additional opportunities to expand the capacity of this or similar services to ensure coverage for this target cohort. Expanded Horizons Continue funding group programs specifically for LGBTIQAP+ youth, residing on the Gold Coast. Psychological Services Program (PSP) Continue provision of psychological services through the hard to reach response detailed below. Additionally, GPs can refer through to the Better Access program. Regional Plan Development of a regional mental health and suicide prevention plan	Reduction in suicide presentations	GCPHN with GCH Wesley Mission Brisbane Contracted providers GCPHN GCH and other key stakeholders
Mental Health – hard to reach Data, research and consultation with service users, service providers and community members identified the	Psychological Services Program (PSP) Continue to commission PSP targeting identified high need/hard to reach groups.	Psychological services provided with adequate coverage for each target group.	Contracted providers

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
following groups as high risk / hard to reach on the Gold Coast: • People who are currently homeless, or are at risk of homelessness • Culturally and Linguistically Diverse people (CALD) • People who identify as lesbian, gay, bisexual, transgender, intersex, queer, asexual, pansexual and others (LGBTIQAP+) • Women experiencing perinatal depression • Aboriginal and Torres Strait Islander people • Children (aged 0-12) who have, or are at risk of developing a mental, childhood behavioral or emotional disorder (including a specific focus on children in care) • People who self-harm or who are at increased risk of suicide.	Review model to further refine and target most at risk clients. See also Suicide prevention, Children and Young People and Aboriginal and Torres Strait Islander Mental Health, and Severe and Complex Mental Health sections above and below.		
Mental Health – children and youth • Wrap around support for youth through outreach opportunities and flexible service entry points. • Early intervention and therapeutic services for children aged 0 to 14 with a focus on the northern growth corridor. • Limited services in the northern part of the region where there are large child and youth populations and significant demand for Mental Health (MH) services for this cohort, including Aboriginal and Torres Strait Islander children.	headspace In accordance with the DoH funding agreement, continue to commission headspace while undertaking a co-design process with key stakeholders, including consumers and carers. Review model of care to align clinical staging model Psychological Services Program (PSP) Continue to fund PSP services for children and review considering children in care as a particular focussed target group. Northern Gold Coast	Headspace funded under current arrangement until June 2019 See above	headspace Contracted providers

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
• Education, training and support to engage schools and the broader education workforce in early identification and intervention. • Children in care have significant mental health needs, often associated with traumatic experiences and complicated by other complex health needs. Addressing these issues is hampered by: ○ Long wait times for assessment and treatment in the public system ○ Costs of private services ○ Issues with transfer of information ○ Limited knowledge and adherence to guidelines	Explore opportunities to increase service delivery options for children in northern Gold Coast area. Multi-agency coordinated care planning Support mechanisms which enable multi-agency coordination for children and young people with complex needs to address the full range of health and social issues who are currently receiving services from a range of health and social services providers	Increased service options in northern Gold Coast area Coordinated care planning	GCPHN with potential providers
Mental Health - Severe and Complex • Coordinated shared care planning that is available across primary care, community and the hospital and health service. • Education and training for general practice to better support severe and complex patients, including physical health and referral pathways. • Increased opportunities to support greater engagement in service delivery by peer workers and people with a lived experience. • Centralised intake across the stepped care model to ensure people receive the appropriate support and referral based on their needs. • Develop efficient pathways to support person centered transfer of care	Clinical Care Coordination Monitor and review the newly established Clinical Care Coordination Service "Plus Social" targeting people with severe and complex mental health conditions and offering access through and after hours drop in centre to further refine support provided to clients. Public Awareness Public awareness campaign promoting increased referrals across the stepped care continuum in particular for severe and complex. Access to Information and resources Access to information and resources that supports referrals and access to mental health	Increased access to services for people with severe and complex mental health issues Improved mental health for clients	Contracted providers

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
between acute and primary services (general practice, allied health and community services).	services. See also Access to Information and Resources above. Multi-agency coordinated care planning Support mechanisms which enable multi-agency coordination for people with complex needs to address the full range of health and social issues who are currently receiving services from a range of health and social services providers		
Aboriginal and Torres Strait Islander Mental Health	See Aboriginal and Torres Strait Islander Health and Alcohol and other drugs section below		
Mental Health Overarching Stepped Care Approach	Regional Plan Development of a regional mental health and suicide prevention plan. Public Awareness Public awareness campaign promoting increased referrals across the stepped care continuum. Access to Information and resources Access to information and resources that supports referrals and access to mental health services. See also Access to Information and Resources above. Centralised information intake and triage This will assist GCPHN funded services to support more appropriate referral of clients	People requiring mental health support will be able to access the right care, at the right time, in the right place, from the right provider.	GCPHN with GCH and other stakeholders GCPHN GCPHN with GCH Contracted provider

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
	according to their needs across the stepped care continuum. ### Education and training Training and education as part of workforce and sector support including: demand management, commissioning general practice training, sector capacity building and general practice referral pathways (links with workforce). ### Multi-agency coordinated care planning Support mechanisms which enable multi-agency coordination for people with complex needs to address the full range of health and social issues who are currently receiving services from a range of health and social services providers		GCPHN with content experts

Alcohol and Other Drug

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Alcohol and Other Drug • Capacity of detoxification, residential rehabilitation and aftercare services is limited to the provision of flexible support and follow up for clients. • Flexible outreach treatment services with a focus on vulnerable target groups including young people is needed.	AOD Mainstream Monitor and evaluate effectiveness of services which commenced 1 January 2017 (AOD Mainstream) to deliver innovative responses to increase existing treatment sector capacity (focused in Northern Gold Coast) in the following areas: • early treatment support • post treatment support Review services with a view to driving continuous quality improvement and alignment with State and Commonwealth government investment. AOD Youth Outreach Monitor and evaluate effectiveness of services to deliver innovative outreach AOD intervention services to young people. Review services with a view to driving continuous quality improvement and alignment with State and Commonwealth government investment. Multi-agency coordinated care planning Support mechanisms which enable multi-agency coordination for people with complex needs including alcohol and other drug use to address the full range of health and social issues who are currently receiving services from a range of health and social services providers.	Timely access to services to capture clients wanting to address their drug use and maximize the effectiveness of the intervention. Increased access for young people to AOD services	GCPHN with Lives Lived Well GCPHN with Lives Lived Well

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Alcohol and Other Drug • Provision of training and resources, including referral pathways, for General Practice to support patients with substance use issues including ice.	Access to information and resources Access to information and resources that supports referrals and access to appropriate services above.	Enhance the capacity and effectiveness of the funded organisations, General Practice and the broader alcohol and other drugs (AOD) treatment sector and their ability to meet the needs of their client group.	GCPHN
Alcohol and Other Drug • Provision of training and resources, including referral pathways, for general practice to support patients with substance use issues including ice.	Training and Education Training and education as part of workforce and sector support including: demand management, commissioning general practice training, sector capacity building and general practice referral pathways (links with workforce).	Enhance the capacity and effectiveness of funded organisations, General Practice and the broader alcohol and other drugs (AOD) treatment sector and their ability to meet the needs of their client group.	Key stakeholders with GCPHN support
Aboriginal and Torres Strait Islander - Mental Health and Suicide • Access and awareness of appropriate services.	Access to information and resources Access to information and resources that supports referrals and access to appropriate services. See also Access to Information and Resources above.	Facilitate local relationships and partner with mainstream and Indigenous services for the delivery of primary care services. Improve health equity for Aboriginal and Torres Strait Islander people by addressing access issues.	GCPHN in partnership with local service providers
Aboriginal and Torres Strait Islander - Mental Health and Suicide • Mainstream services that are culturally appropriate and safe.	See Cultural Competency section in Indigenous Health below	See Cultural Competency below	Kalwun with support from GCPHN
Aboriginal and Torres Strait Islander - Mental Health and	Coordinated Mental Health, AOD and suicide prevention		GCPHN with subcontractors Kalwun and Krurungal

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Suicide • Holistic service response for Indigenous clients, including mental health, suicide prevention and AOD.	services Monitor and evaluate effectiveness of services which commenced 1 January 2017 to deliver a holistic service response for Indigenous clients and identify opportunities for driving continuous quality improvement and alignment with State and Commonwealth government services.	Higher rates of successful engagement with Indigenous clients and more effective treatment.	
Alcohol and Other Drug • Small Aboriginal and Torres Strait Islander workforce which limits the capacity of providers to work with clients who require treatment. • Cultural competency of mainstream alcohol and other drugs treatment services requires improvement to confidently, safely and effectively work with Aboriginal and Torres Strait Islander people.	Capacity building Capacity building activities with the current GCPHN funded provider. Monitor and evaluate effectiveness of services and identify opportunities for driving continuous quality improvement and alignment with State and Commonwealth government services.	Increased capacity of local Indigenous service providers	GCPHN with subcontractor Krurungal

Indigenous Health (including Indigenous chronic disease)

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Aboriginal and Torres Strait Islander Health Cultural competency affects access to services for Aboriginal and Torres Strait Islander people	Continue current arrangements with Kalwun Health Services including employment of Indigenous Health Project Officer (IHPO) mainstream to deliver Cultural Competency training. Review current curriculum content to ensure appropriateness and contemporary and establish systematic process to ensure currency in training. Embed processes to more effectively monitor Cultural Competency training for local service providers particularly those funded by GCPHN.	Increased number of Aboriginal and Torres Strait Islander health assessments by culturally competent trained workforce; improved coordination of care, supporting mainstream service providers to provide culturally appropriate services.	Kalwun with support from GCPHN
Aboriginal and Torres Strait Islander Health Focus on chronic disease early identification and self-management Gaps remain in terms of life expectancy and many contributing factors High numbers of Aboriginal and Torres Strait Islander people with diabetes, COPD and smoking in the region	Integrated Team Care Continue current Integrated Team Care arrangements with IUIH (DoH stipulated contracting IUIH to deliver the Care Coordination and Supplementary Services (CCSS) component through Brisbane North PHN as lead commissioner) and Kalwun Health Services locally. Continue to increase awareness of services for Aboriginal and Torres Strait Islander people. Explore further ability to obtain more detailed data to support monitoring of care coordination and self-management and the impact of access to transport and supplementary services. De-identified data collection, analysis and report generation on the clinical indicators (Diabetes, CKD, COPD, and CHD).	Improve health equity for Aboriginal and Torres Strait Islander people through culturally appropriate mainstream primary care, provide assistance to Aboriginal and Torres Strait Islander people to obtain primary health care as required. Provide care coordination services to eligible people with chronic disease who require coordinated, multidisciplinary care. Improve service users' capacity to self-manage conditions/health.	GCPHN in partnership with IUIH (via Brisbane North PHN) and Kalwun Health Services and mainstream primary care services.
Aboriginal and Torres Strait Islander Health Focus on chronic disease early identification and self-management	Primary Sense See Primary Sense above		GCPHN
Aboriginal and Torres Strait Islander - Mental Health and	Access to information and resources	Facilitate local relationships and partner with mainstream and Aboriginal and	GCPHN in partnership with local service providers.

Opportunities, priorities and options			
Priority	Possible Options	Expected Outcome	Potential Lead
Suicide Access and awareness of appropriate services.	Access to information and resources that supports referrals and access to appropriate services. See also Access to Information and Resources above.	Torres Strait Islander services for the delivery of primary care services. Improve health equity for Aboriginal and Torres Strait Islander people by addressing access issues.	
Aboriginal and Torres Strait Islander - Mental Health and Suicide Mainstream services that are culturally appropriate and safe.	See Cultural Competency above	See Cultural Competency above	Kalwun with support from GCPHN
Aboriginal and Torres Strait Islander - Mental Health and Suicide Holistic service response for Aboriginal and Torres Strait Islander clients, including mental health, suicide prevention and AOD.	Coordinated Mental Health AOD and suicide prevention services Monitor and evaluate effectiveness of services which commenced January 2017 to deliver a holistic service response for Aboriginal and Torres Strait Islander clients and identify opportunities for driving continuous quality improvement and alignment with State government services.	Higher rates of successful engagement with Aboriginal and Torres Strait Islander clients and more effective treatment.	GCPHN with subcontractors Kalwun and Krurungal
Alcohol and Other Drug Small Aboriginal and Torres Strait Islander workforce which limits the capacity of providers to work with clients who require treatment. Cultural competency of mainstream alcohol and other drugs treatment services requires improvement to confidently, safely and effectively work with Aboriginal and Torres Strait Islander people.	Aboriginal and Torres Strait Islander service capacity building Capacity building activities with current PHN funded provider.	Increased capacity of local Aboriginal and Torres Strait Islander service providers.	GCPHN with subcontractor Krurungal

Checklist

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