2021

Opportunities, priorities and options

Needs Assessment

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GOLD COAST
An Australian Government Initiative

Opportunities, priorities and options - All 168 Health Needs and services issues identified through the needs assessment process

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**

General Practice and Primary care	Care coordination.
	• Not all providers using secure messaging.
	• Clinical handover, particularly to general practice on discharge from hospitals.
		Population Health	*Access*	• General practice is supported in the adoption of evidence based best practice methods and meaningful use of digital systems to inform quality improvement, promoting the uptake of practice accreditation and ensuring timely provision of information, resources and or education to support changes in programs and policy that impact on general practice.
				• General practice adoption of evidence based best practice methods to achieve high performing primary care in the Gold Coast. This aims to improve the quality of care through supporting continuous quality improvement methodologies and utilisation of health information management and other building blocks of high performing primary care to inform quality improvements in health care, specifically, the collection and use of clinical data.
				• Clinical and social expected outcomes of secure exchange of clinical information through secure messaging
				  • Facilities access to clinical information to improve patient care
				  • Reduced time managing paper-based correspondence
				  • Improved communication between health care providers as part of an end-to-end clinical workflow
				  • Improved privacy and security of patient information
				• 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.
				• General Practices and Pharmacy ae equipped with PPE
				
				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 system and applying evidenced based algorithms.
				• dentifying 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 by the right person.
				• 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 PHNs can do based on historic and current de-identified patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time.
				• Contribute to prevention of increasing numbers of Emergency Department presentations
				• Reduce the burden in Emergency Departments by reducing the number of unnecessary or inappropriate presentations
				• 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
					• Key stakeholders
					• Gold Coast general practices
					• Gold Coast Health

General Practice and Primary care	Difficult for general practices and pharmacies to adopt to digital health including: • New systems that need to be integrated in general practice systems and workflow • Initially low uptake of video conferencing under telehealth	*Digital Health*	*System integration*		
General Practice and Primary care	70% of Gold Coast PIP QI 10 improvement measures are below the national rate	*Population Health*	*Practice support*		
General Practice and Primary care	Increasingly challenging to engage with general practices who are feeling the strain of responding to COVID-19.	*Digital Health*	*Health literacy*		
General Practice and Primary care	Ensuring accurate and timely information provided to general practices in relation to COVID-19	*Population Health*	*Health literacy*		
General Practice and Primary care	Gold Coast rate of potentially preventable hospitalisations above the national rate: Six highest number of PPHs on the Gold Coast are - Urinary tract infection, Iron deficiency anaemia, COPD, Cellulitis and vaccine preventable	*Population Health*	*Potentially preventable hospitalisations*		
General Practice and Primary care	Low uptake of free translation services in by Gold Coast general practitioners, specialist, pharmacy, and nurse practitioners potentially limiting access and quality of care	*Population Health*	*Appropriate care (including cultural safety)*		

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Primary Health Care Workforce	Variability in formal education, practical experience, and resources in relation to alcohol and other drugs, mental health, and domestic violence limits capacity of GPs to identify issues and have conversations with patients.	*Health Workforce*	*Health literacy*	• 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
Primary Health Care Workforce	Evolving service system results in GPs being unclear about available services and the pathways to access these services.	*Health Workforce*	*HealthPathways*		
Primary Health Care Workforce	Burnout and wellbeing of health professionals.	*Health Workforce*	*Other*		
Primary Health Care Workforce	Currently there are long waitlist to see a private psychologist despite a strong private market, resulting in decreasing access to psychology services on the Gold Coast.	*Health Workforce*	*Access*		
Determinants of Health	Numerous SA3 regions on the Gold Coast have a high rate of need for assistance with a profound or severe disability compared to Queensland rate.	*Population Health*	*Social determinants*	• Increased uptake of Translating and Interpreting services in health settings on the Gold Coast	• GCPHN and key stakeholders
Determinants of Health	Language barrier for people accessing health services.	*Population Health*	*Social determinants*		
Determinants of Health	Limited of social housing on the Gold Coast.	*Population Health*	*Social determinants*		
Determinants of Health	Wellbeing of children with no parents employed.	*Population Health*	*Social determinants*		
Older people with a focus on Residential Aged care Facilities (RACF)	High numbers of potentially preventable hospital admissions for older adults across many conditions. Six highest number of PPHs on the Gold Coast are - Urinary tract infection, Iron deficiency anaemia, COPD, Cellulitis and vaccine preventable	*Population Health*	*Potentially preventable hospitalisations*	• 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 in number of Advance Care Plans and upload to My Health Record.	• GCPHN • Gold Coast Health • Gold Coast Residential Aged Care Facilities
Older people with a focus on Residential Aged care Facilities (RACF)	Established clinical coordination tools and processes that result in fragmentation of the local health system in patient centred care particularly for patients with dementia	*Health Workforce*	*System integration*		
Older people with a focus on Residential Aged care Facilities (RACF)	Residential Aged Care Facilities (RACF) limited adoption to digital health: • My health record use. • Clinical software is outdated. • Lack of access to and use of secure messaging to comply with Privacy Act when communicating with other health care providers for their residents. • Record keeping	*Digital Health*	*Aged care*		
Older people with a focus on Residential Aged care Facilities (RACF)	Lack of confidence and skills to provide palliative care needs at resident's place of choice as per Advance Care Plan (ACP).	*Health Workforce*	*Palliative care / End of life care*		
Older people with a focus on Residential Ages Care Facilities (RACF)	Falls among older people leading to emergency department presentations and hospitalisations.	*Aged Care*	*Aged care*		
Older people with a focus on Residential Aged care Facilities (RACF)	Slow uptake of COVID-19 vaccination of RACF residents and staff	*Population Health*	*Immunisation*		
Older people with a focus on Residential Aged care Facilities (RACF)	Residents in residential aged care presenting with increasing complexity of care including dementia	*Aged Care*	*Chronic conditions*		
Older people with a focus on Residential Aged care Facilities (RACF)	Transient and workforce that does not necessarily have the skills to manage the high complexity and care needs of older people in RACF.	*Health Workforce*	*Aged care*		
Older people with a focus on Residential Aged care Facilities (RACF)	Lack of role clarity and access to the relevant information to support early identification and management of palliative care - end of life in RACF	*Health Workforce*	*Palliative care / End of life care*		
Older people with a focus on Residential Aged care Facilities (RACF)	Limited capacity to provide a coordinated and sustained coverage for palliative and end of life care within RACF's out of hours	*Health Workforce*	*After hours*		

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Palliative Care	Limited uptake of Advanced Care Plans (ACPs).	*Health Workforce*	*Palliative care / End of life care*	• Improved practical advice and support for families • Improved awareness by health, community and aged care providers regarding family access to bereavement support • 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 uptake of ACP	• GCPHN • Gold Coast health • Gold Coast general practices • Kalwun Health Services • Cura Multicultural
Palliative Care	Limited systems to support care coordination and support to general practice to be the centre of care where possible	*Health Workforce*	*Practice support*		
Palliative Care	Current systems not always supportive to ensure planning, commissioning, and delivery of integrated and coordinated service matrix.	*Health Workforce*	*System integration*		
Palliative Care	Limited access to integrated palliative care system across the health and social sector.	*Population Health*	*Access*		
Palliative Care	Limited access to good quality end of life care 24/7.	*Population Health*	*Palliative care / End of life care*		
Palliative Care	General practitioners understanding of the clinical triggers for commencing palliative care.	*Health Workforce*	*Palliative care / End of life care*		
Palliative Care	Limited access to clear communication, and accessible information for patients, families, and healthcare professionals.	*Population Health*	*Palliative care / End of life care*		
Palliative Care	Over half of general practitioners on the Gold Coast were trained overseas which may affect their understanding of palliative care services.	*Health Workforce*	*Health literacy*		
Palliative Care	The rate of people aged 65 and over is projected to grow steadily over the coming decades with limited capacity to meet demand.	*Aged Care*	*Continuity of care*		
After Hours	Coolangatta Statistical Area Level 3 (SA3) region had the highest rate of lower urgency after hours emergency department (ED) presentations while also having the lowest rate of after-hours GP presentations among all Gold Coast SA3 regions.	*Population Health*	*After hours*	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 system 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 by the right person. • 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 PHNs can do based on historic and current de-identified patient level, practice level, and regional level data, enabling predictive modelling, and tracking outcomes over time. • Direct links to local service providers information in health topic areas and information and resources published online to support appropriate, timely referrals and agreed service pathways	• GCPHN with partners • Gold Coast Health • Contractors
After Hours	Increasing rate of non-urgent general practice after-hours services among people aged 80 years and over.	*Population Health*	*Potentially preventable hospitalisations*		
After Hours	After-hours ED presentations increasing above Gold Coast population growth rate.	*Population Health*	*After hours*		
After Hours	Limited after-hours mental health services on the Gold Coast, in particular Ormeau-Oxenford SA3 region.	*Population Health*	*After hours*		
Unplanned Hospital care	Gold Coast rate of potentially preventable hospitalisations above the national rate. Six highest number of PPHs on the Gold Coast are - Urinary tract infection, Iron deficiency anaemia, COPD, Cellulitis and vaccine preventable	*Population Health*	*Potentially preventable hospitalisations*	• Reduce the rate of potentially preventable hospitalisations • Reduce the rate of triage category four and five Emergency Department presentations among Gold Coast residents	• GCPHN • Gold Coast Health • Gold Coast general practices
Unplanned Hospital care	Gold Coast rate of potentially preventable hospitalisations has been increasing since 2012/13 at a higher rate compared to the population growth rate	*Population Health*	*Potentially preventable hospitalisations*		
Unplanned Hospital care	Lower urgency care (triage category four and five) Emergency Department (ED) presentations have been increasing annually above the Gold Coast population growth rate.	*Population Health*	*Emergency response*		
Unplanned Hospital care	Chronic obstructive pulmonary disease (COPD) has the most potentially preventable hospitalisation bed days in 2017-18 on the Gold Coast	*Population Health*	*Potentially preventable hospitalisations*		

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Cancer	Participation in BreastScreen, Bowel and Cervical cancer screening below national rate. • Lower screening rates for breast, cervical and bowel cancer in 2020 due to COVID	*Population Health*	*Access*	• Increase in awareness and uptake of screening services for breast, bowel and cervical screening. • Increased skin cancer and prostate cancer checks.	• GCPHN • Gold Coast Health
Cancer	Low participation in all cancer screening in Ormeau-Oxenford	*Population Health*	*Early intervention and prevention*		
Cancer	Gold Coast rate of new cancers diagnosed annually above the national rate in 2013-17. Breast cancer and Colorectal cancer had the highest number of cases on the Gold Coast between 2013-2017	*Population Health*	*Chronic conditions*		
Cancer	Higher rates of melanoma across the region compared to national rates.	*Population Health*	*Chronic conditions*		
Cancer	Low community awareness of eligibility for cancer screening in Gold Coast region, for men in particular.	*Population Health*	*Health literacy*		
Cancer	General practice has limited view of screening data to support proactive steps with patients	*Digital Health*	*Access*		
Cancer	Limited BreastScreen translated resources available for Culturally and Linguistically Diverse consumers.	*Population Health*	*Appropriate care (including cultural safety)*		
Immunisation, communicable diseases and COVID 19	Gold Coast rate of children fully immunised for one, two, and five-year old's below the national rate.	*Population Health*	*Immunisation*	• Increase in awareness and uptake of vaccinations.	• GCPHN • Gold Coast health • Gold Coast general practices
Immunisation, communicable diseases and COVID 19	High number of children (aged 1, 2 and 5) not fully immunised in Ormeau-Oxenford SA3 region.	*Population Health*	*Immunisation*		
Immunisation, communicable diseases and COVID 19	Lower rates of HPV vaccination on Gold Coast compared to the national figure.	*Population Health*	*Immunisation*		
Immunisation, communicable diseases and COVID 19	Vaccine potentially preventable hospitalisations on the Gold Coast have increased 322% between 2012-13 to 2017-18	*Population Health*	*Potentially preventable hospitalisations*		
Immunisation, communicable diseases and COVID 19	Ensuring accurate and timely Information to general practices in relation to COVID-19	*Health Workforce*	*Practice support*		
Immunisation, communicable diseases and COVID 19	Slow uptake of COVID-19 vaccination for RACF residents and staff				
Perinatal and early childhood	Ormeau-Oxenford and Gold Coast-north SA3 regions above the Gold Coast rate for children who are developmentally vulnerable across two or more domains.	*Population Health*	*Vulnerable population (Non-First Nations specific)*	• Younger mothers can receive the right care in the right place at the right time by the right person	• GCPHN • Gold Coast Health • Key partners • Key stakeholders
Perinatal and early childhood	Younger Mothers (aged under 20) have higher rates of smoking while pregnant, low birthweight babies and are less likely to breastfeed compared to mothers aged 20 years old and over on the Gold Coast	*Population Health*	*Social determinants*		
Perinatal and early childhood	Aboriginal and Torres Strait Islander women have higher rates of smoking while pregnant and low birthweight babies compared to non-Aboriginal and Torres Strait Islander women on the Gold Coast.	*Aboriginal and Torres Strait Islander Health*	*Social determinants*		
Perinatal and early childhood	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. • Cost of private services. • Barriers sharing information and centralised depository from medical history that non-health professionals can contribute to. • Limited availability of low-cost assessments for diagnosis and NDIS applications.	*Mental Health*	*Access*		

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Perinatal and early childhood	Increasing rate of women being diagnosed with perinatal depression.	*Mental Health*	*Early intervention and prevention*		
Persistent Pain	High rates of musculoskeletal conditions in Southport, Coolangatta, Ormeau-Oxenford, and Gold Coast-North.	*Population Health*	*Chronic conditions*	• Improved self-management of pain management	• Contractor
Persistent Pain	Pain management frequently focusses on medication.	*Population Health*	*Appropriate care (including cultural safety)*		
Persistent Pain	High levels of opioid dispensing across region, particularly Southport.	*Alcohol and Other Drugs*	*Social determinants*		
Persistent Pain	Limited awareness and support for prevention and self-management on persistent pain.	*Population Health*	*Health literacy*		
Persistent Pain	Suboptimal focus on multidisciplinary and coordinated care.	*Health Workforce*	*Multi-disciplinary care*		
Persistent Pain	Concerns for potentially ineffective and unnecessary treatments for persistent pain.	*Population Health*	*Care coordination*		
Chronic Disease	Limited systems to support care coordination	*Digital Health*	*Care coordination*	Create a single integrated healthcare system for the Gold Coast by: • Improving the coordination of care to endure consumers receive the right care at the right place by the right person • Increasing effectiveness and efficiency of health services for consumers • Engaging and supporting clinicians to facilitate improvements in our health system. • Improvement in health outcomes in the community. 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 system 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 PHNs can do based on historic and current de-identified patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time	• GCPHN • Gold Coast health • Key stakeholders including RACGP
Chronic Disease	Minimal focus on prevention, early identification, and self-management.	*Population Health*	*Early intervention and prevention*		
Chronic Disease	High numbers of people with chronic disease in Ormeau-Oxenford and Gold Coast North.	*Population Health*	*Chronic conditions*		
Chronic Disease	Gold Coast rate of chronic potentially preventable hospitalisations above national rate. Six highest number of PPHs on the Gold Coast are - Urinary tract infection, Iron deficiency anaemia, COPD, Cellulitis and vaccine preventable	*Population Health*	*Potentially preventable hospitalisations*		
Chronic Disease	Rate of people on the Gold Cost with chronic obstructive pulmonary disease and asthma above the national rate.	*Population Health*	*Chronic conditions*		
Family and domestic violence	Clear health pathways within primary care for domestic and family violence victims and perpetrators.	*Population Health*	*HealthPathways*	• Direct links to local service providers information in health topic areas and information and resources published online to support appropriate, timely referrals and agreed service pathways	• GCPHN • Key partners • Gold Coast Health
Family and domestic violence	Some health professionals do not understand dynamics of domestic violence.	*Health Workforce*	*Health literacy*		
Family and domestic violence	The impacts of family and domestic violence on child development.	*Population Health*	*Early intervention and prevention*		
Family and domestic violence	People who experience domestic violence have higher rates of mental health issues.	*Mental Health*	*Social determinants*		
Family and domestic violence	Access to mental health clinicians who have a high degree of understanding of domestic violence issues.	*Mental Health*	*Access*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
People at risk of developing mild and moderate mental illness	Evolving service system results in GPs being unclear about available services and the pathways to access these services.	*Health Workforce*	*HealthPathways*	• Improve targeting of evidence based psychological interventions and models of service to most appropriately support people with, or at risk of, mild mental illness. • Enhance the capacity and effectiveness of the funded organisations, General Practice, and the broader sector to meet the needs of their client group.	• GCPHN • Gold Cold Coast Health • Contracted providers • Gold Coast general practices
People at risk of developing mild and moderate mental illness	Limited promotion and support of low intensity services to general practice support	*Health Workforce*	*Health Pathways*		• GCPHN, • Cold Coast Health • Contracted providers • Gold Coast general practices
People at risk of developing mild and moderate mental illness	Limited use and accessibility of evidence based electronic (digital) mental health services.	*Digital Health*	*Access*		
People at risk of developing mild and moderate mental illness	System navigation is difficult for GP's and people	*Digital Health*	*System integration*		• Contracted providers • Beyond blue • GCPHN
People at risk of developing mild and moderate mental illness	Increasing demand for all mental health services	*Mental Health*	*Access*		
People at risk of developing mild and moderate mental illness	Timely access to services for people seeking mental health support	*Mental Health*	*Access*		
Severe and complex mental illness	Evolving service system results in GPs being unclear about available services and the pathways to access these services.	*Health Workforce*	*HealthPathways*	• Increased access to services for people with severe and complex mental health issues. Improved mental health for clients	• Contracted providers • Gold Coast health • Key stakeholder
Severe and complex mental illness	Current electronic systems limit communication and shared care planning with consumers across the network or services	*Digital Health*	*System integration*		
Severe and complex mental illness	System navigation is difficult for GP's and people	*Population Health*	*HealthPathways*		
Severe and complex mental illness	People may need ongoing support (e.g. personality disorders) but do not meet the criteria for care coordination or supports designed for severe and complex mental illness.	*Mental Health*	*Continuity of care*		
Severe and complex mental illness	Limited access to mental health clinicians who have a high degree of understanding of domestic violence issues	*Mental Health*	*Access*		
Severe and complex mental illness	Many GPs feel they do not have the information and resources required to assist patients with severe and persistent mental illness.	*Mental Health*	*HealthPathways*		
Sever and complex mental illness	Increasing demand for all metal health services	*Mental Health*	*Access*		
Severe and complex mental illness	Timely access to services for people seeking mental health support.	*Mental Health*	*Access*		

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Child, youth and families mental health	Northern corridor increasing population of young people with limited early intervention and therapeutic services available locally.	*Population Health*	*Access*	• Increased access to care for young people (aged 12-18) who are at significant risk or have severe mental illness. Improved mental health for clients.	• Headspace • Contracted providers • GCPHN with potential providers
Child, youth and families mental health	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 *Cost of private services *Barriers sharing information and centralised depository from medical history that non-health professionals can contribute to *Limited availability of low-cost assessments for diagnoses for NDIS applicants	*Mental Health*	*Appropriate care (including cultural safety)*		
Child, youth and families mental health	Multiple barriers for families and carers to support the health of young people including a consistent understanding of confidentiality and consent for sharing information.	*Population Health*	*Appropriate care (including cultural safety)*		
Child, youth and families mental health	Funded models often require the service to work with an individual client and do not have the capacity to work with the family unit.	*Health Workforce*	*Safety and quality of care*		
Child, youth and families mental health	Evolving service system results in GPs being unclear about available services and the pathways to access these services	*Health Workforce*	*Appropriate care (including cultural safety)*		
Child, youth and families mental health	Limited services that provide support for young people with highly complex situations.	*Health Workforce*	*Continuity of care*		
Child, youth and families mental health	Increasing demand for all mental health services	*Health Workforce*	*Access*		
Child, youth and families mental health	System navigation is difficult for GP's and people	*Population Health*	*System integration*		
Child, youth and families mental health	Timely access to services for people seeking mental health support.	*Mental Health*	*Access*		
Adult mental health	Evolving service system results in GPs being unclear about available services and the pathways to access these services.	*Mental Health*		• * Increased access to care for adults (aged 19-64) who are at significant risk or have severe mental illness. Improved mental health for clients.	• GCPHN contracted providers
Adult mental health	People who may need ongoing support (e.g. personality disorders) but do not meet criteria for care coordination or supports designed for severe and complex mental illness.	*Mental Health*	*Continuity of care*		
Adult mental health	There are unmet psychosocial needs for people with severe mental illness who are not eligible for assistance through the NDIS, and who are not receiving psychosocial services through National Psychosocial Support Measure programs.	*Mental Health*	*Continuity of care*		
Adult mental health	System navigation is difficult for GP's and people	*Population Health*	*System integration*		
Adult mental health	People with an existing mental health concern through the perinatal stage.	*Mental Health*	*Social determinants*		
Adult mental health	Increasing demand for all mental health services	*Mental Health*	*Access*		
Adult mental health	Timely access to services for people seeking mental health support	*Mental Health*	*Access*		

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Older people mental health	Mental health and aged care related issues (e.g., dementia) are often treated in isolation of each other or as separate disciplines.	*Mental Health*	*Aged care*	• * Increased access to care for older people (aged 65+) who are at significant risk or have severe mental illness. Improved mental health for clients.	• GCPHN contracted providers Gold Coast RACF
Older people mental health	Evolving service system results in GPs being unclear about available services and the pathways to access these services.	*Mental Health*	*HealthPathways*		
Older people mental health	Limited access to assessment and treatment by public sector geriatricians to patients in the community.	*Health Workforce*	*Access*		
Older people mental health	Gaps in clinical resources, knowledge and supports in the community result in people referring to Older Person's Mental Health unit (tertiary service) as a default option or last resort.	*Mental Health*	*HealthPathways*		
Older people mental health	High levels of isolation and loneliness among older people on the Gold Coast	*Aged Care*	*Social determinants*		
Older people mental health	System navigation is difficult for GP's and people	*Population Health*	*HealthPathways*		
Older people mental health	Timely access to services for people seeking mental health support	*Mental Health*	*Access*		
Older people mental health	Increasing demand for all mental health services	*Mental Health*	*Access*		
Mental health – underserviced	Limited data on underserviced groups for mental health services	*Population Health*	*Other*	• Psychological services are provided for each target group. • Improve targeting of evidence based psychological interventions and models of service to support people most appropriately with, or at risk of, mild and moderate mental illness.	• GCPHN contracted providers
Mental health – underserviced	Underserviced groups not feeling comfortable accessing mainstream services.	*Population Health*	*Appropriate care (including cultural safety)*		
Mental health – underserviced	Access and awareness of appropriate services limited for underserviced groups: • Psychosocial • Psychological • primary health • Mental health services for people within the mild to moderate range	*Population Health*	*Access*		
Mental health – underserviced	LGBTIQAP+ organisations are time limited and must facilitate communication with broader health services.	*Population Health*	*Other*		
Mental health – underserviced	Evolving service system results in GPs being unclear about available services and the pathways to access these services.	*Population Health*	*HealthPathways*		
Mental health – underserviced	Low uptake of free translation services in by Gold Coast general practitioners, specialist, pharmacy, and nurse practitioner.	*Population Health*	*Practice support*		

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Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Aboriginal and Torres Strait Islander health	Cultural competency, transport and cost all affect access to services for Aboriginal and Torres Strait Islander people.	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*	• 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. • 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, and provide care coordination services to eligible people with chronic disease who require coordinated, multidisciplinary care. Improve service users' capacity to self-manage conditions/ health. 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 system 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 by the right person. • 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 PHNs can do based on historic and current de-identified patient level, practice level, and regional level data, enabling predictive modelling and tracking outcomes over time.	• Kalwun with support from GCPHN • GCPHN in partnership with IUIH (Via Brisbane North PHN) and Kalwun Health Services and mainstream primary care services. • GCPHN
Aboriginal and Torres Strait Islander health	Limited services in northern Gold Coast for Aboriginal and Torres Strait Islander people	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		
Aboriginal and Torres Strait Islander health	Chronic disease early identification and self-management.	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		
Aboriginal and Torres Strait Islander health	Some indication that maternal health may be an issue but there are very small numbers involved.	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		
Aboriginal and Torres Strait Islander health	Low number of Aboriginal and Torres Strait Islander health assessments completed for Gold Coast Aboriginal and Torres Strait Islander people compared to national rate	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		
Aboriginal and Torres Strait Islander health	Small number of Aboriginal and Torres Strait Islander health workers	*Aboriginal and Torres Strait Islander Health*	*Workforce*		
Aboriginal and Torres Strait Islander health	Low rate of cancer screening among Aboriginal and Torres Strait Islander people.	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		
Aboriginal and Torres Strait Islander health	Care coordination between health services, child safety and other services/supports/family.	*Population Health*	*Care coordination*		
Social & emotional wellbeing for Aboriginal and Torres Strait Islander people	Limited Aboriginal and Torres Strait Islander health workers.	*Aboriginal and Torres Strait Islander Health*	*Workforce*	• Facilitate local relationships and partner with mainstream and Aboriginal and 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. • See cultural competency section above • Higher rates of successful engagement with Aboriginal and Torres Strait Islander clients and more effective treatment. • Increased capacity of local Aboriginal and Torres Strait Islander service providers.	• GCPHN in partnership with local service providers
Social & emotional wellbeing for Aboriginal and Torres Strait Islander people.	Mental health, suicide prevention, alcohol and other drugs services continue to actively work towards reconciliation and health equity, cultural needs improving in mainstream service providers.	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		
Social & emotional wellbeing for Aboriginal and Torres Strait Islander people	Access and awareness of appropriate services limited.	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		
Social & emotional wellbeing for Aboriginal and Torres Strait Islander people	System navigation is difficult for GP's and people.	*Aboriginal and Torres Strait Islander Health*	*Care coordination*		
Social & emotional wellbeing for Aboriginal and Torres Strait Islander people	Low uptake to Aboriginal and Torres Strait Islander Social and Emotional wellbeing service in Psychological Services Program.	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		
Social & emotional wellbeing for Aboriginal and Torres Strait Islander people	Evolving service system results in GPs being unclear about available services and the pathways to access these services.				
Social & emotional wellbeing for Aboriginal and Torres Strait Islander people.	Low rate of Aboriginal and Torres Strait Islander people with a coded mental health diagnosis in Gold Coast mainstream general practices.	*Aboriginal and Torres Strait Islander Health*	*Aboriginal and Torres Strait Islander Health*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**

Crisis Support and Suicide Prevention	Suicidal people often visit primary care providers in the weeks or days before suicide but often their suicide risk is not identified and people do not receive the care or follow up support they need at this critical time.	*Mental Health*	*Appropriate care (including cultural safety)*	• Improve targeting of evidence based psychological interventions and models of service to most appropriately support people at risk of suicide.
				• Commissioned providers will improve access to high-quality aftercare to support at risk individuals to stay safe; connect individuals to community-based services; connect individuals with support networks including families, friends and careers; and reduce distress and improve wellbeing.
				• The Joint Regional Plan has aligned future needs assessment and service planning while also identifying key pieces of work in the short term that developed new ways of working together to improve outcomes with existing resources. The Joint Regional Plan aims to lay the groundwork for collaborative action by:
				  • Developing a better shared understanding of current service system
				  • Identifying specific opportunities for the future service system
				  • Establishing joint governance structures to leverage in the future
					• GCPHN with contracted providers
					• Gold Coast Health
					• Beyond Blue

Crisis Support and Suicide Prevention	Limited supports are available for people in distress who end up in ED by default or on a mental health trajectory, but many times their distress is related to a situational crisis in their lives.	*Mental Health*	*Potentially preventable hospitalisations*		
Crisis Support and Suicide Prevention	Carers are at the frontline of suicide prevention and many sit daily with this risk and responsibility but may not having any training or skills to equip them for this. In addition, they may not know where to go for help or how to access the unique supports they require at this time.	*Mental Health*	*Appropriate care (including cultural safety)*		
Crisis Support and Suicide Prevention	Suicide prevention efforts are often fragmented and have not always been strategically planned or coordinated.	*Mental Health*	*System integration*		
Crisis Support and Suicide Prevention	When challenges occur during a crisis, it is often at the points of intersection between different sectors. These entities have their own points of entry, and staff with significant variation in skills, training, and experience in mental health crisis. It can be unclear who should take the lead for certain situations and how information is communicated between agencies.	*Mental Health*	*System integration*		
Crisis Support and Suicide Prevention	Service providers do not always know what the best evidence- based treatments are for people experiencing suicidal thoughts and behaviours or how to access local services and supports.	*Mental Health*	*Access*		
Crisis Support and Suicide Prevention	Organisations can be very risk averse due to a culture of blame. People in suicidal crisis can be passed back and forth between organisations without receiving the care they need.	*Mental Health*	*Care coordination*		
Crisis Support and Suicide Prevention	Many mental health clinicians do not have specific training in suicide prevention or know what the best evidence based treatments are for people experiencing suicidal thoughts and behaviours.	*Mental Health*	*Appropriate care (including cultural safety)*		
Crisis Support and Suicide Prevention	Many people in the community lack the confidence and skills to address people in suicidal distress or crisis.	*Mental Health*	*Other*		
Crisis Support and Suicide Prevention	Representations and portrayals of suicide in the media can be sensationalised and can increase the risk of suicide for vulnerable people and can perpetuate stigmatising attitudes towards people experiencing suicidal thoughts or behaviours, or towards people who have died by suicide.	*Mental Health*	*Vulnerable population (Non-First Nations specific)*		
Crisis Support and Suicide Prevention	Many GPs are unaware of referral points and current best practice care and treatment	*Mental Health*	*Appropriate care (including cultural safety)*		
Crisis Support and Suicide Prevention	Default referral options for suicide prevention and crisis may not match the person to the right level of care.	*Mental Health*	*Appropriate care (including cultural safety)*		
Crisis Support and Suicide Prevention	People with a lived experience of suicide have the potential, to inform, influence and enhance local suicide prevention solutions but may lack the confidence, skills and readiness to participate.	*Mental Health*	*HealthPathways*		
Crisis Support and Suicide Prevention	Confidentiality and legal concerns along with lack of formal arrangements limit information sharing between providers.	*Mental Health*	*Access*		
Crisis Support and Suicide Prevention	Limited understanding of which evidence-based suicide prevention treatments are being delivered in the region, by whom or what the quality of these services is.	*Mental Health*	*Care coordination*		
Crisis Support and Suicide Prevention	Consultation and data identified the below groups/ regions are at elevated risk of suicide: o Males (Gap is shortening of gender of those dying by suicide in Gold Coast region) • o Northern Gold Coast • o LGBTIQAP+ • o Aboriginal and Torres Strait Islander population • o Culturally and Linguistically diverse populatio	*Mental Health*	*Vulnerable population (Non-First Nations specific)*		
Crisis Support and Suicide Prevention	With lived experience workers a central component of new service models to address crisis, the region needs to ensure there are enough lived experience workers and appropriate support systems are in place.	*Mental Health*	*HealthPathways*		

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Alcohol and other drugs	Individual needs are often not matched with the appropriate intensity of treatment. Sometimes this is due to available services in the region being at full capacity and onward referral being made to alternate services who are not at full capacity.	*Alcohol and Other Drugs*	*Care coordination*	• 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. • 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 • Increased capacity of local Indigenous service providers	• GCPHN with commissioned providers
Alcohol and other drugs	Limited availability of withdrawal management often impacts an individual's ability to access residential rehabilitation support given that adequate detoxification is often a pre-requisite to enter residential treatment	*Alcohol and Other Drugs*	*Access*		
Alcohol and other drugs	High demand and limited AOD service options in the northern Gold Coast region	*Alcohol and Other Drugs*	*Access*		
Alcohol and other drugs	Variability in formal education, practical experience, and resources in relation to alcohol and other drugs limits capacity of GPs to identify AOD issues and have conversations with patients related to AOD use.	*Alcohol and Other Drugs*	*Health literacy*		
Alcohol and other drugs	Evolving service system results in GPs being unclear about available services and the pathways to access these services. There is a need for timely and accurate information to support GPs to connect people to suitable AOD services.	*Alcohol and Other Drugs*	*Care coordination*		
Alcohol and other drugs	Inefficient transitions between services, particularly from inpatient services to community-based services, can lead people to disengaging from treatment	*Alcohol and Other Drugs*	*Care coordination*		
Alcohol and other drugs	Older population with problematic drinking are less likely to seek treatment and often have multiple additional health issues that require monitoring. There is limitation in availability of suitable service options specifically designed to support this cohort.	*Alcohol and Other Drugs*	*Access*		
Alcohol and other drugs	People with AOD use issues commonly have significant limitations in their financial resources. They often would benefit from psychological and/or psychiatric treatment however limitation in bulk-billing options, including lengthy wait times, for these services mean that these clients do not receive the treatment they require.	*Alcohol and Other Drugs*	*Access*		
Alcohol and other drugs	Barriers exists to accessing residential rehabilitation due to upfront financial costs, childcare responsibilities, and funds to cover housing costs while in rehabilitation. The region has limited service offerings in the community for people with co-occurring mental health and AOD issues.	*Alcohol and Other Drugs*	*Access*		
Alcohol and other drugs	AOD services report challenges in recruiting workers that identify as Aboriginal and Torres Strait Islander. This can impact on services' capacity to deliver culturally responsive care.	*Alcohol and Other Drugs*	*Aboriginal and Torres Strait Islander Health*		
Alcohol and other drugs	Some services report that Aboriginal and Torres Strait Islander clients leave AOD programs early due to concerns regarding cultural appropriateness	*Alcohol and Other Drugs*	*Aboriginal and Torres Strait Islander Health*		
Alcohol and other drugs	Community members and service providers perceive that frequent changes made to the the local service system results in providers and people in the community being unclear about available services and the pathways to access these services. There is a need for timely and accurate information and easily identifiable access points for individuals seeking care, so there is a clear understanding on service options and which services suitably match their needs.	*Alcohol and Other Drugs*	*Access*		
Alcohol and other drugs	It can be difficult for service providers to know what capacity services have, particularly for withdrawal and rehabilitation bed availability, which can delay access for clients while capacity is confirmed.	*Alcohol and Other Drugs*	*Access*		
Alcohol and other drugs	An inconsistent approach to assessment (e.g various tools) leads to inconsistent assigned levels of care, resulting in discrepancies in the type of care provided across providers for similar clinical presentations.	*Alcohol and Other Drugs*	*Care coordination*		

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Gold Coast Primary Health Network

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

Level 1, 14 Edgewater Court, Robina 4226 | PO Box 3576 Robina Town Centre QLD 4230

P: 07 5635 2455 | F: 07 5635 2466 | E: info@gcphn.com.au | www.gcphn.org.au

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