Gold Coast Primary Health Network

Needs Assessment 2022

Opportunities, priorities and options

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GOLD COAST

An Australian Government Initiative

Appendix 4 - All 175 Health Needs and services issues identified through the needs assessment process

<table>
<tr><th colspan="6">Opportunities and priorities</th></tr>
<tr><th>Needs Assessment Title</th><th>Priority</th><th>Priority area</th><th>Priority sub-category</th><th>Expected Outcome</th><th>Potential lead agency and/or opportunities for collaboration and partnership</th></tr>
<tr><td>General Practice and Primary care</td><td>Care coordination.
Not all providers using secure messaging.
Clinical handover, particularly to general practice on discharge from hospitals.</td><td>Population Health</td><td>Access</td><td rowspan="2">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,</td><td rowspan="2">GCPHN
Key stakeholders
Gold Coast general practices
Gold Coast Health</td></tr>
<tr><td>General Practice and Primary care</td><td>High number of people requiring chronic wound management services in general practice and Residential Aged Care Facilities.</td><td>Population Health</td><td>Chronic conditions</td></tr>
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<tr><td>General Practice and Primary care</td><td>My Health Record not yet embedded in usual practice for all providers and practices unable to provide detailed support to consumers.</td><td>Digital Health</td><td>System integration</td><td rowspan="3">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:</td><td rowspan="3"></td></tr>
<tr><td>General Practice and Primary care</td><td>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</td><td>Digital Health</td><td>System integration</td></tr>
<tr><td>General Practice and Primary care</td><td>70% of Gold Coast PIP QI 10 improvement measures are below the national rate</td><td>Population Health</td><td>Practice support</td></tr>
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<tr><td>General Practice and Primary care</td><td>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, Dental conditions, Cellulitis and Ear, nose and throat infections.</td><td>Population Health</td><td>Potentially preventable hospitalisations</td><td rowspan="2">• 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.
• 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.</td><td rowspan="2"></td></tr>
<tr><td>General Practice and Primary care</td><td>Low uptake of free translation services in by Gold Coast general practitioners, specialist, pharmacy, and nurse practitioners potentially limiting access and quality of care</td><td>Population Health</td><td>Appropriate care (including cultural safety)</td></tr>
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Opportunities and priorities					
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				• 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.	

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<tr><td>Primary Health Care Workforce</td><td>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.</td><td>Health Workforce</td><td>Health literacy</td><td rowspan="5">• 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.</td><td rowspan="5">• GCPHN</td></tr>
<tr><td>Primary Health Care Workforce</td><td>Evolving service system results in GPs being unclear about available services and the pathways to access these services.</td><td>Health Workforce</td><td>HealthPathways</td></tr>
<tr><td>Primary Health Care Workforce</td><td>High levels of burnout have negative impact on health professionals' wellbeing</td><td>Health Workforce</td><td>Other</td></tr>
<tr><td>Primary Health Care Workforce</td><td>Service providers report that it is difficult to recruit and retain doctors willing to work in the after hours for the remuneration available, which impacts the ability to deliver services to meet demand levels.</td><td>Health Workforce</td><td>Access</td></tr>
<tr><td>Primary Health Care Workforce</td><td>There is a projected shortfall in the GP workforce by 2030</td><td>Health Workforce</td><td>Access</td></tr>
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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**
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	Higher risk of poor wellbeing for children with no parents employed.	*Population Health*	*Social determinants*		
Older Adults	Rate of potentially preventable hospitalisations in the Gold Coast Primary Health Network (GCPHN) region is above the national rate for people aged 65 and over. Top conditions of PPH include: urinary tract infections, iron deficiency anaemia, dental conditions, cellulitis, ear, nose and throat infections.	*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	• GCPHN • Gold Coast Health • Gold Coast Residential Aged Care Facilities
Older Adults	Lack of confidence and skills to provide palliative care needs at resident's place of choice as per Advance Care Plan.	*Population Health*	*Palliative care / End of life care*		
Older Adults	Referral pathways, including available capacity (to prevent navigation to nowhere).	*Population Health*	*Access*		
Older Adults	High prevalence of older people with frailty leads to many complex medical problems and is associated with an increased rate of future falls.	*Aged Care*	*Aged care*		
Older Adults	Falls and wounds lead to increased Emergency Department (ED) presentations and hospitalisations.	*Aged Care*	*Aged care*		

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Older Adults	High estimated number of people in GCPHN region are socially isolated.	*Population Health*	*Social determinants*	• Decrease in avoidable admissions to Emergency Department • Increase in number of Advance Care Plans and upload to My Health Record.	
Older Adults	There are limited culturally appropriate services available for culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander people.	*Aged Care*	*Appropriate care (including cultural safety)*		
Older Adults	Transient workforce in the older people's sector does not necessarily have the skills to manage the high complexity and care needs of older adults.	*Health Workforce*	*Safety and quality of care*		
Older Adults	The rate of people aged 65 and over is projected to grow steadily over the coming decades with limited capacity to meet demand.	*Population Health*	*Other*		
Older Adults	Some acute but low urgency needs such as minor infections are reportedly being admitted to hospital via ambulance as RACFs and home-based carers who are not aware of pathways to treat within the community.	*Aged Care*	*HealthPathways*		
Older Adults (Age care services)	Long wait times for appropriate support and/or aged care services at home lead to a higher level of care provided by a RACF service providers.	*Aged Care*	*Aged care*		
Older Adults (Age care services)	Community services to support longer stays in community are not felt to be adequate and resulting in presentations to EDs as no other options exist or are known.	*Population Health*	*Other*		
Older Adults (Age care services)	RACFs on the Gold Coast do not have sufficient beds to meet permanent or respite care demands, which is resulting in unnecessary and lengthy hospital admissions when care needs cannot be met.	*Aged Care*	*Aged care*		
Older Adults (Age care services)	Residents in RACF are presenting to health services with increasing complexity of care including dementia.	*Aged Care*	*Aged care*		

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Older Adults (Age care services)	Aged care staff lack understating of the language of the aged care system (e.g., Centrelink, My Aged Care).	*Aged Care*	*Aged care*		
Older Adults (Age care services)	Aged care service often employs transient workforce that does not necessarily have the skills to manage the high complexity and care needs of older adults in RACF.	*Aged Care*	*Safety and quality of care*		
Older Adults (Age care services)	There is limited capacity to provide a coordinated and sustained coverage for palliative and end of life care within RACF.	*Aged Care*	*Palliative care / End of life care*		
Older Adults (Age care services)	Lack of role clarity and access to the relevant information to support early identification and management of palliative and end of life care in RACF.	*Aged Care*	*Palliative care / End of life care*		
Older Adults (Age care services)	There is a limited number of registered nurses working in aged care.	*Aged Care*	*Workforce*		
Older Adults (Age care services)	There is lack of a physical support to guide a person through the complex aged care system, and high dependency on a congested My Aged Care phone line.	*Aged Care*	*Aged care*		
Older Adults (Age care services)	RACF adoption of digital health: • clinical software is outdated • lack of access to and use of secure messaging to comply with Privacy Act when communicating with other healthcare providers for their residents • record keeping	*Aged Care*	*Aged care*		
Older Adults (Dementia)	Care needs for older persons are getting more complex, and rates of dementia are on the rise.	*Population Health*	*Aged care*		
Older Adults (Dementia)	Dementia care extends across a continuum from diagnosis through to palliative care, and includes prevention, primary care	*Population Health*	*Aged care*		

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	and hospital care. Inexpert dementia care can cause unnecessary distress.				
Older Adults (Dementia)	Support for families and carers for people with dementia is needed.	*Aged Care*	*Aged care*		
Older Adults (Dementia)	Clinical coordination tools and processes that result in fragmentation of the local health system in patient centered care particularly for patients with dementia are needed.	*Aged Care*	*Care coordination*		
Older Adults (dementia)	There is currently limited understanding of the referral pathways, including available capacity (to prevent navigation to nowhere).	*Health Workforce*	*HealthPathways*		
Palliative Care	There is 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*		

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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	General practitioners understanding of the clinical triggers for commencing palliative care can vary.	*Health Workforce*	*Health literacy*		
Palliative Care	Over half of GPs on the Gold Coast were trained overseas which may affect their understanding of palliative care services.	*Aged Care*	*Health literacy*		
After Hours	There is decreasing availability of face-to-face primary care options in after hours, which impacts older people, palliative patients and vulnerable people who find it difficult to travel.	*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	• GCPHN with partners • Gold Coast Health • Contractors
After Hours	Highest demand for services is 6pm to 8pm.	*Population Health*	*After hours*		
After Hours	Potential areas of higher geographic need for after hours primary care services are the southern (Coolangatta SA3) and less populated western areas (Mudgeeraba-Tallebudgera SA3), as well as the northern corridor (Ormeau- Oxenford SA3) due to sheer demand.	*Population Health*	*After hours*		
After Hours	Among the top reasons for non-urgent presentations (category 4 and 5) to Emergency Department (ED) in the after hours, most relate to injuries (ankle sprains, wounds, and injuries).	*Health Workforce*	*After hours*		

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				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	
After Hours	There are difficulties in recruitment and retention of doctors to deliver primary care services in the after hours.	*Health Workforce*	*After hours*		• GCPHN • Gold Coast Health • Gold Coast general practices
After Hours	Flexible delivery of AODs services outside of usual business hours is a factor in successful completion of treatment.	*Population Health*	*After hours*		
After Hours	Access to support in the after hours for people with mental health concerns is particularly high in the northern corridor (Ormeau- Oxenford SA3).	*Population Health*	*After hours*		
After Hours	RACFs have experienced increasing wait times for after hours doctors and operational issues due to staffing issues.	*Population Health*	*After hours*		
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	Participation in BreastScreen, bowel and cervical cancer screening is below national rate.	*Population Health*	*Early intervention and prevention*		
Cancer	Low participation in all cancer screening in Ormeau-Oxenford.	*Population Health*	*Early intervention and prevention*		

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Cancer	Rate of new cancers diagnosed annually in the Gold Coast region is above the national rate in 2013-2017.	*Population Health*	*Chronic conditions*		
Cancer	Breast cancer and colorectal cancer had the highest number of cases in the Gold Coast region between 2013-2017.	*Population Health*	*Chronic conditions*		
Cancer	Higher rates of melanoma across the Gold Coast region compared to national rates.	*Population Health*	*Chronic conditions*		
Cancer	General practice has limited view of screening data to support proactive steps with patients.	*Population Health*	*Chronic conditions*		
Cancer	Limited BreastScreen translated resources available for people from culturally and linguistically diverse backgrounds.	*Population Health*	*Health literacy*		
Cancer	Low community awareness of eligibility for cancer screening in the Gold Coast region, for men in particular.	*Population Health*	*Health literacy*		
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*		

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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	High rates for children who are developmentally vulnerable across two or more domains in the Ormeau-Oxenford and Gold Coast-north SA3 regions.	*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*		

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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*		
Perinatal and early childhood	Increasing rate of women being diagnosed with perinatal depression.	*Mental Health*	*Early intervention and prevention*		
Persistent Pain	There are 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)*		

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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.	• 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 SA3 regions.	*Population Health*	*Chronic conditions*		
Chronic Disease	Rate of potentially preventable hospitalisations in the Gold Coast Primary Health Network region is above the national rate, with top conditions being: o urinary tract infections o iron deficiency anaemia	*Population Health*	*Potentially preventable hospitalisations*		

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	o chronic obstructive pulmonary disease cellulitis o vaccine preventable conditions			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.	
Chronic Disease	Rates of people in the Gold Coast Primary Health Network region with chronic obstructive pulmonary disease and asthma are above the national rate.	*Population Health*	*Chronic conditions*		
Family and domestic violence	There is a lack of 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	• GCPHN

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Family and domestic violence	Some health professionals do not understand dynamics of domestic violence.	*Health Workforce*	*Health literacy*	information and resources published online to support appropriate, timely referrals and agreed service pathways	• Key partners • Gold Coast Health
Family and domestic violence	Family and domestic violence can have severe consequences 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	Not many mental health clinicians have a high degree of understanding of domestic violence issues.	*Mental Health*	*Health literacy*		
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

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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*		• Contracted providers • Beyond blue • GCPHN
People at risk of developing mild and moderate mental illness	System navigation is difficult for GP's and people	*Digital Health*	*System integration*		
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	Current electronic systems limit communication and shared care planning with consumers across the network or services	*Digital Health*	*System integration*		

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Severe and complex mental illness	System navigation is difficult for GP's and people	*Population Health*	*HealthPathways*		
Severe and complex mental illness	Some people may need ongoing support (e.g., when diagnosed with 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	Many general practitioners feel they do not have the information and resources required to assist patients with severe and persistent mental illness.	*Mental Health*	*HealthPathways*		
Severe and complex mental illness	Evolving service system results in general practitioners being unclear about available services and the pathways to access these services.	*Mental Health*	*Access*		
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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<tr><td>Child, youth and families mental health</td><td>Northern corridor increasing population of young people with limited early intervention and therapeutic services available locally.</td><td>Population Health</td><td>Access</td><td rowspan="4">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.</td><td rowspan="4">Headspace
Contracted providers
GCPHN with potential providers</td></tr>
<tr><td>Child, youth and families mental health</td><td>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</td><td>Mental Health</td><td>Appropriate care (including cultural safety)</td></tr>
<tr><td>Child, youth and families mental health</td><td>Multiple barriers for families and carers to support the health of young people including a consistent understanding of confidentiality and consent for sharing information.</td><td>Population Health</td><td>Appropriate care (including cultural safety)</td></tr>
<tr><td>Child, youth and families mental health</td><td>Funded models often require the service to work with an individual client and do not have the capacity to work with the family unit.</td><td>Health Workforce</td><td>Safety and quality of care</td></tr>
</table>

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

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
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*	mental illness. Improved mental health for clients.	
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*		
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	• GCPHN contracted

Opportunities and priorities					
Needs Assessment Title	Priority	Priority area	Priority sub-category	Expected Outcome	Potential lead agency and/or opportunities for collaboration and partnership
				severe mental illness. Improved mental health for clients.	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*		

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<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Mental health – underserviced</td><td>Limited data on underserviced groups for mental health services</td><td>Population Health</td><td>Other</td><td rowspan="5">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.</td><td rowspan="5">GCPHN contracted providers</td></tr>
<tr><td>Mental health – underserviced</td><td>Underserviced groups not feeling comfortable accessing mainstream services.</td><td>Population Health</td><td>Appropriate care (including cultural safety)</td></tr>
<tr><td>Mental health – underserviced</td><td>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</td><td>Population Health</td><td>Access</td></tr>
<tr><td>Mental health – underserviced</td><td>LGBTIQAP+ organisations are time limited and must facilitate communication with broader health services.</td><td>Population Health</td><td>Other</td></tr>
<tr><td>Mental health – underserviced</td><td>Evolving service system results in GPs being unclear about available services and the pathways to access these services.</td><td>Population Health</td><td>HealthPathways</td></tr>
</table>

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Mental health – underserviced	Low uptake of free translation services in by Gold Coast general practitioners, specialist, pharmacy, and nurse practitioner.	*Population Health*	*Practice support*		
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.	• 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	Low proportions of 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	There are 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*		

Opportunities and priorities					
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	Small number of Aboriginal and Torres Strait Islander health workers	*Aboriginal and Torres Strait Islander Health*	*Workforce*	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.	
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	Service gaps in care coordination between health services, child safety and other services / supports / family.	*Population Health*	*Care coordination*		

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<tr><td>Social & emotional wellbeing for Aboriginal and Torres Strait Islander people</td><td>Limited Aboriginal and Torres Strait Islander health workers.</td><td>Aboriginal and Torres Strait Islander Health</td><td>Workforce</td><td rowspan="4">• 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.</td><td rowspan="4">• GCPHN in partnership with local service providers</td></tr>
<tr><td>Social & emotional wellbeing for Aboriginal and Torres Strait Islander people</td><td>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.</td><td>Aboriginal and Torres Strait Islander Health</td><td>Aboriginal and Torres Strait Islander Health</td></tr>
<tr><td>Social & emotional wellbeing for Aboriginal and Torres Strait Islander people</td><td>Access and awareness of appropriate services limited.</td><td>Aboriginal and Torres Strait Islander Health</td><td>Aboriginal and Torres Strait Islander Health</td></tr>
<tr><td>Social & emotional wellbeing for Aboriginal and Torres Strait Islander people</td><td>System navigation is difficult for GP's and broader community.</td><td>Aboriginal and Torres Strait Islander Health</td><td>Care coordination</td></tr>
</table>

Opportunities and priorities					
Needs Assessment Title	**Priority**	**Priority area**	**Priority sub-category**	**Expected Outcome**	**Potential lead agency and/or opportunities for collaboration and partnership**
Social & emotional wellbeing for Aboriginal and Torres Strait Islander people	Uncoordinated and inconsistent approach to assessment, referrals, and intake.	*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	Changes to the service system result in GPs being unclear about available services and the pathways to access these services.	*Aboriginal and Torres Strait Islander Health*	*Access*		
Social & emotional wellbeing for Aboriginal and	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**
Torres Strait Islander people					
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	*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	• 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.	*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.	*Mental Health*	*Appropriate care (including cultural safety)*		
Crisis Support and Suicide Prevention	When challenges occur during a crisis, it is often at the points of intersection between different sectors.	*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)*		

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	Many people in the community lack the confidence and skills to address people in suicidal distress or crisis.	*Mental Health*	*Other*	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	
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*		
Alcohol and other drugs	Flexible delivery of AODs services outside of usual business hours is a factor in successful completion of AODs treatment.	*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	• 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*		

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	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*	their ability to meet the needs of their client group • Increased capacity of local Indigenous service providers	
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	Limited availability of suitable service options specifically designed to support older population.	*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.	*Alcohol and Other Drugs*	*Access*		
Alcohol and other drugs	Alcohol and other drugs services report challenges in recruiting workers that identify as Aboriginal and Torres Strait Islander.	*Alcohol and Other Drugs*	*Aboriginal and Torres Strait Islander Health*		
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
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