Australian Government
Department of Health

phn
An Australian Government Initiative

Primary Health Network Program

Needs Assessment Reporting Template

This template may be used to submit the Primary Health Network's (PHN's) Needs Assessment to the Department of Health (the Department) by **15 November 2018**.

Name of Primary Health Network

Gippsland

When submitting this Needs Assessment to the Department of Health, the PHN must ensure that all internal clearances have been obtained and the Report has been endorsed by the CEO.

Instructions for using this template

Overview

This template is provided to assist Primary Health Networks (PHNs) to fulfil their reporting requirements for Needs Assessment.

The template includes sections to record needs for:

- General population health of the PHN region
- Primary Mental Health Care
- Indigenous Health (including Indigenous chronic disease)
- Alcohol and Other Drug Treatment Needs

Further information for PHNs on the development of needs assessments is provided on the Department's website (www.health.gov.au/PHN), including the *PHN Needs Assessment Guide*, the Mental Health and Drug and Alcohol PHN Circulars, and the Drug and Alcohol Needs Assessment Tool and Checklist (via PHN secure site).

The information provided by PHNs in this report may be used by the Department to inform program and policy development.

Format

The Needs Assessment report template consists of the following:

Section 1 – Narrative

Section 2 – Outcomes of the health needs analysis

Section 3 – Outcomes of the service needs analysis

Section 4 – Opportunities, priorities and options

Section 5 – Checklist

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

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

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

Submission Process

The Needs Assessment report must be submitted to the Department, via a mechanism specified by the Department, on or before **15 November 2018**.

Reporting Period

This Needs Assessment report will be for a three year period and cover 1 July 2019 to 30 June 2022. It can be reviewed and updated as needed during this period.

Section 1 – Narrative

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

Needs Assessment process and issues (500-1000 words)
– in this section the PHN can provide a summary of the process undertaken; expand on any issues that may not be fully captured in the reporting tables; and identify areas where further developmental work may be required (expand this field as necessary. Where relevant please also nominate which process your input is relevant to i.e. General population health, Primary Mental health care, Alcohol and other drug treatment or Indigenous health needs assessment.

Gippsland PHN has a Health Planning Governance Framework which emphasises this work as a cross organisational responsibility. A Population Health Planning Working Group meets bimonthly to advise the Health Planning, Research and Evaluation team. Representatives from the Gippsland PHN Community Advisory Committee and three sub-regional Clinical Councils act in Population Health Planning Adviser roles and are called on for advice including; engagement activities, resource development, co-design activities and tender evaluations. The Victorian PHN Alliance provides a platform for links to other Victorian PHNs.

Information collected from engagement with stakeholders including community, consumers and carers as well as clinicians and other professionals is crucial to effective population health planning. Continued work with regional stakeholders has included involvement with Municipal Public Health and Wellbeing Planning across Gippsland's six local government areas (LGAs), collaboration with Victorian Department of Health and Human Services (DHHS) and work with the region's four Primary Care Partnerships (PCP). In addition, strong links with the Indigenous sector, including elders, service providers and the Gippsland Aboriginal Health Advisory Committee have been formed. In the mental health and alcohol and other drug (AOD) sector key links include the Partners in Recovery Advisory Group, the Gippsland Mental Health Alliance (GMHA), consumer and carer groups and the Gippsland Alcohol and Drug Service Providers Advisory (GADSPA) group. A comprehensive strategy for on-going community, consumer and carer engagement is underway after internal re-structure which will allow additional resources for this important work.

The Gippsland PHN 2019-22 needs assessment is informed by previous needs assessments and the methods developed for on-going population health planning work during this time. A growing data and information base will ensure its relevance throughout this period and beyond. A summary of work to date;

<u>March 2016</u>

- Quantitative data was analysed by LGA and the Gippsland Population Health Profile 2016 was published.
- A desktop analysis of existing reports including consumer and/or other stakeholder input on health issues from local organisations in Gippsland.[77]
- Semi-structured interviews with 69 key stakeholders representing general practice, health services, bush nursing centres, Aboriginal Controlled Community Health Organisations (ACCHOs), local and state government organisations and non-government organisations.[78]
- The service needs analysis included an overview of workforce and service provision by LGA, based on information available on web sites.
- Assessment and triangulation of information from each component was undertaken to identify priorities. Initially, a modified version of the method described in the guidelines provided by the Department was applied. The identified potential priorities were provided to the Gippsland PHN Clinical Councils and to interviewed key stakeholders for ranking. Subsequently, additional

triangulation incorporating the ranking results, measures of the size, severity and changeability of the issue and a measure of the PHNs role in addressing the potential priority was conducted. Resulting draft priorities were then distributed to the Steering Committee, the Gippsland PHN Clinical Councils and interested stakeholders who provided information about suggested options to address them.

November 2016

A focus on community consultation included a region wide survey (n=1,009) and interviews (n=234) in September 2016; the "Tell Maria" campaign.[79] The methodology was developed with input from the Gippsland PHN Consumer Advisory Committee with the aim to ensure that the views of vulnerable people were captured, including those in remote communities and across all Gippsland LGAs.

Target groups:

a. People aged 60 years or older
b. Indigenous people
c. Children (0-14 years)
d. People with disabilities
e. People with low socio-economic status
f. Young people (12-25 years)

November 2017

- A method for on-going updates of quantitative data (indicators) was developed and the Population Health Planning Hub was created as an internal resource to facilitate access to health data. It also includes information about data sources and keeps a record of update status.
- Community engagement using short "Tell Maria" postcard surveys at events was piloted. A response rate of 14-18% of total attendees at two events was achieved.[35]
- A local health needs analysis in far East Gippsland was undertaken, including a community engagement component.[98] This project informed a developing model for place-based needs analysis.
- Engagement with clinical and other professional stakeholders was undertaken through Gippsland PHN teams; HealthPathways, practice support, vulnerable communities and digital health.
- Detailed qualitative work using focus groups to explore barriers to cancer screening among men and women in Latrobe as part of the Latrobe Health Innovation Zone (LHIZ) activities.[33]
- Data extracted from 56% of Gippsland's 80 GP practices were included for the first time, analysed using POLAR Explorer and including benchmarking with the BEACH study.[1, 2]

November 2018

Public resources are available on the Gippsland PHN web site:

- The **Population Health Planning Hub** is a downloadable Excel spreadsheet with more than 300 indicators showing Local Government Area (LGA) variation and highlighting indicators high or low compared to State or National data. It can be filtered by population group, health issue or data type.
- One-page **LGA Health Needs Snapshots** were developed to provide an overview of local health needs.
- One-page **Health Issue Fact Sheets** were published for eight health issue priorities including quantitative data and qualitative information.
- Continued use of "Tell Maria" postcard surveys at events to engage community, with a focus on My Health Record expansion. [35]
- Data extracted from 70% of Gippsland's 81 GP practices were analysed using improved reporting capabilities in POLAR Explorer.[3] Some selected indicators are included throughout the document.
- Stakeholder engagement through Gippsland PHN teams has continued and expanded to include qualitative feedback from commissioned services[127], input from regional organisations[57] and projects[109, 99].

Future plans

- A project plan outlining the work to develop a Regional Mental Health and Suicide Prevention Plan for Gippsland is due to be complete by December 2018. This will incorporate consumer and carer engagement as a key component, both through the Gippsland PHN Community Advisory Committee and additional methods using existing groups and community. It will utilise the National Mental

Health Service Planning Framework[4] and will build on regional stakeholder groups including the GMHA and GADSPA and the suicide prevention work in two LGAs.
- Work to further improve the usefulness of GP data in determining health needs is on-going by improving practice coverage and data quality.
- Refined triangulation methods to be developed to strengthen the process and improve other stakeholder's input to achieve a shared understanding and agreed outcomes.
- Improved methods for community, consumer and carer engagement.
- Improved methods for engagement with clinicians and other professionals.
- The PHN Performance and Quality Framework will be implemented to ensure alignment.[5]

Additional Data Needs and Gaps (approximately 400 words)

– in this section the PHN can outline any issues experienced in obtaining and using data for the needs assessment. In particular, the PHN can outline any gaps in the data available on the PHN website, and identify any additional data required. The PHN may also provide comment on data accessibility on the PHN website, including the secure access areas. (Expand field as necessary). Where relevant please also nominate which process your input is relevant to i.e. General population health, Primary Mental health care, Alcohol and other drug treatment or Indigenous health needs assessment.

Gippsland PHN has a population of just over 270,000 people and consists of six Local Government Areas (LGAs) and five Statistical Area 3 (SA3). The relatively small population leads to limited reliability of some estimates for the region, especially where sample size has not been set to allow for LGA/SA3 level analysis and when analysing measures with small numbers.

The Department of Health's PHN web site is useful for PHN level analyses and work undertaken by the Australian Institute of Health and Welfare (AIHW) recently using PHN geography has added valuable resources. Further improvements can be made by keeping these points in mind;
- Where possible, calculations of standardised rates to facilitate comparisons of rates between PHNs and sub-regions.
- Analysis by small geographical areas to smallest geography possible, LGA/SA3 as a minimum and including SA2 where possible.
- Timely provision of new and updated data.
- Analysis of patient numbers as well as occasions of service wherever possible.
- Ensure notes on definitions and limitations relevant to each data set are readily available. This has improved and the AIHW generally do this very well.
- Availability of downloads of regional data plus reference area averages / rates (PHN, State and National) without the entire dataset needing to be downloaded.
- Spreadsheets that can be easily filtered, sorted and used for pivot tables make analysis much easier (that is, avoid extra lines between sections, merged cells etc).
- Additional detail for data sets such as the MBS and PBS would be helpful. Consider inclusion on platforms such as the My Healthy Communities web site.
- Consolidate the mapping platforms available for data visualisation. Currently there is overlap between AIHW My Healthy Communities, PHIDU Social Health Atlas and GEN Aged Care. A common platform would be beneficial to minimise duplication in resource allocation and allow visualisation of multiple data sets and their associations.
- Inclusion of additional data sets such as pathology and family violence.
- Inclusion of information on federally funded programs delivered in the community sector, including counselling programs.
- Inclusion of data on calls made to federally funded telephone support services including Lifeline.
- Inclusion of data for the National Disability Insurance Scheme (NDIS), My Aged Care and Healthcare Homes.
- There is a need for financial information relating to health, including actual and comparative unit costs of health care delivery at community and institutional care level.

- Consideration of PHN geography and breakdown to LGA/SA3 when conducting national surveys such as the Disability, Ageing and Carers survey, National Health Survey and others. Even better, collaboration with State surveys such as the Victorian Population Health Survey to maximise sample size and ensure consistency in methods.
- Addition of available benchmarked data on rates of dental disease and treatment and information on federally funded dental programs.
- Addition of benchmarked data on projected and actual rates of usage of Patient Transport Assistance Scheme.
- Evidence-based triangulation models would be a helpful addition on the PHN website.

Additional comments or feedback (approximately 500 words)

– in this section the PHN can provide any other comments or feedback on the needs assessment process, including any suggestions that may improve the needs assessment process, outputs, or outcomes in future (expand field as necessary).

The new template provided in late September 2018 is an improvement to the earlier version and inclusion of all the information in one document is beneficial. The change to three yearly reporting for needs assessments is also welcomed. Some suggestions for further improvements are provided:
- allow formatting within the narrative section to allow copying and pasting into the document without losing formatting such as dot points and tables
- it would be helpful to consider that health and service needs often have a significant overlap; attempting to separate the two has created un-necessary work and artificial divisions
- including definitions of key words such as 'issues' and 'needs' would be helpful

The Australian Bureau of Statistics remoteness categories for Gippsland LGAs fail to adequately describe the isolation of very small communities, where distance and challenging terrain coupled with a lack of transport options, low socio-economic status and more challenging digital connectivity can lead to isolation well beyond the expected level for an Inner Regional or Outer Regional area.

Future developments include;
• Developing an ongoing proactive approach to community consultation in conjunction with the Community Advisory Committee to ensure ongoing consultation and improved targeting of vulnerable groups through ongoing linkages to grass roots organisations such as neighbourhood houses and collaboration with local government. Progress in this area includes internal restructure reflecting the recognised importance of engagement throughout the organisation.
• Strengthened collaboration through the Victorian PHN Alliance, especially in the areas of mental health and population health planning through two new positions which will allow shared resource for mental health planning and tools to streamline health planning.
• Improved collection and analysis of data to low geographical levels linked with placed based service delivery approach in the commissioning of services.
• Continued development of relationships with regional planning staff and local government, with the aim of expanding the sharing of data and approaches to data collection and analysis.
• Improved consultation and process for determining options to address priorities to ensure relevant, evidence-based and locally supported options are considered.
• Partnering with other Victorian PHNs and relevant organisations to progress work in areas such as workforce; the three regional PHNs, DHHS, Monash University Department of Rural Health (MUDRH), the Rural Workforce Agency Victoria (RWAV), the Royal Flying Doctors Service and Gippsland Regional Integrated Cancer Services to improve patient access to services.
• We will further foster our relationship with universities in the region (MUDRH and Federation University) and researchers further afield where relevant, to assist us in qualitative and quantitative data collection and analysis and specific research projects that can shape our understanding of our catchment.

Acronyms

ABS	Australian Bureau of Statistics
ACAS	Aged Care Assessment Service
ACSO	Australian Community Support Organisation
ACCHO	Aboriginal Community Controlled Health Organisation
ACP	Advance Care Planning
ADHD	Attention Deficit Hyperactivity Disorder
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and Other Drugs
ASIST	Applied Suicide Intervention Skills Training
ATAPS	Access to Allied Psychological Services
ATSI	Aboriginal and Torres Strait Islanders
BCH	Bass Coast Health
BEACH	Bettering the Evaluation and Care of Health
CALD	Culturally and Linguistically Diverse
CCV	Cancer Council Victoria
COPD	Chronic Obstructive Pulmonary Disease
DALY	Disability Adjusted Life Years
DET	Department of Education and Training
DoH	Department of Health (Federal)
DHHS	Department of Health and Human Services (Victoria)
DVA	Department of Veterans Affairs
ED	Emergency Department
EFT	Equivalent Full Time
GADSPA	Gippsland Alcohol and Drug Service Providers Advisory
GCASA	Gippsland Centre Against Sexual Assault
GEGAC	Gippsland and East Gippsland Aboriginal Co-Operative
GLCH	Gippsland Lakes Community Health
GMHA	Gippsland Mental Health Alliance
GP	General Practitioner
GPHN	Gippsland Primary Health Network
GRICS	Gippsland Regional Integrated Cancer Services
GRPCC	Gippsland Region Palliative Care Consortium
GSHS	Gippsland Southern Health Service
GWH	Gippsland Women's Health
FTE	Full Time Equivalent
HACC	Home and Community Care
HIC	Health Issues Centre
HPV	Human Papilloma Virus
HRV	Harm Reduction Victoria
ITC	Integrated Team Care
LCHS	Latrobe Community Health Service
LEAP	Law Enforcement Assistance Program
LGA	Local Government Area
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer
LHIZ	Latrobe Health Innovation Zone
LRH	Latrobe Regional Hospital

MBCP	Men's Behaviour Change Programs
MBS	Medicare Benefits Schedule
MCHN	Maternal and Child Health Nurse
MH	Mental Health
MHCSS	Mental Health Community Support Services
MHNIP	Mental Health Nurse Incentive Program
MoU	Memorandum of Understanding
MSRH	Monash School of Rural Health
MUDRH	Monash University Department of Rural Health
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
NMHSPF	National Mental Health Service Planning Framework
OCP	Optimal Care Pathway
PBS	Pharmaceutical Benefits Scheme
PCP	Primary Care Partnership
PHN	Primary Health Network
PIP	Practice Incentive Payment
PIR	Partners in Recovery
POLAR	Population Level Analysis and Reporting
PPH	Potentially Preventable Hospitalisations
RACF	Residential Aged Care Facility
RAPHS	Rural Access to Primary Health Services
RWAV	Rural Workforce Agency Victoria
S2S	Service-to-Service (eReferral software)
SA2	Statistical Area 2
SA3	Statistical Area 3
SDAC	Survey of Disability, Ageing and Carers
SEIFA	Socio-Economic Index for Areas
SES	Socio-Economic Status
SSAGD	Same Sex Attracted and Gender Diverse
STD	Sexually Transmitted Disease
VAADA	Victorian Alcohol and Drug Association
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VAED	Victorian Admitted Episodes Dataset
VEMD	Victorian Emergency Minimum Dataset
VPHS	Victorian Population Health Survey
YSAS	Youth Support and Advocacy Service

Section 2 – Outcomes of the health needs analysis

This section summarises the findings of the health needs analysis in the table below. For more information refer to Table 1 in '5. Summarising the Findings' in the Needs Assessment Guide on www.health.gov.au/PHN.

Additional rows may be added as required.

General Population Health

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Population group: Carers	*Carer support is recognised as a significant factor for people living in the community with a disability or chronic disease but was not identified as a priority by professional stakeholders in Gippsland. Community consultation identifies carers as a vulnerable group with significant barriers to accessing services and significant strain put on families who care for older people and people with mental health issues.*	• *Consumers mentioned carers as very important for their health and wellbeing.*[79] • *Support for families and carers was raised in stakeholder interviews.*[78] • *Service use reported by carers was higher compared to all respondents for GPs, nursing in the home, pharmacy visits and dentist visits according to the community survey.* [79] • *40% of carers reported that nothing stopped them from getting health care they needed in the past 12 months. Main barriers were:* [79] ○ *Long wait for appointments 37%* ○ *Cost 33%* ○ *Couldn't get there 17%* ○ *Didn't feel comfortable accessing the service 6%* ○ *Didn't understand how to access the service 6%* • *54% of carers of a person 15 years or over reported problems accessing a GP within business hours in a community survey.* [79] • *Carers were mentioned in community interviews, both as important facilitators and in need of respite;* [79] "Carers are often full-time caring for the client and they don't have the time or may not have the skills to know where to go or to advocate" "Respite care for carers with children with additional needs" • *A national study of PHN mental health outcomes highlighted stigma as a strong theme for consumers and carers, particularly that mental health diagnosis and labelling needs to be accurate and clearly*

Outcomes of the health needs analysis		
		communicated. Also, carers spoke about stigma and how access to mental health services remained a barrier for treatment as well as becoming more involved in advocating for system improvement.[6] "I think consumers and carers need to be involved much more. They'll see the roadblocks better, and where things need to be improved. They know where things get stuck and what needs to change. Sometimes the change needs to come the other way – bottom up rather than top down. It's not until you get to the other end to see it."
Population group: Children 0-14 years	*A high proportion of children in Gippsland are developmentally vulnerable on two or more domains and up to 21% of children grow up in jobless families. At school entry, many children have speech and language problems and/or emotional or behavioral problems.* *Family incidents with children present are more common in Gippsland and the rate of substantiated child abuse is high. The rate of children in out of home care is high. In addition, prescribing rates for medications related to mental conditions are high.* *Variation between Gippsland LGAs is evident, in many cases related to socio-economic status. Consumer and other stakeholder feedback identified service gaps related to children, especially in more remote areas. Community input notes cost and long waiting times as key barriers to accessing services for children, including GPs, specialists and mental health. It was noted that early assessment and intervention is key to improved outcomes.*	• *The fertility rate is higher across Gippsland (1.9-2.2 children per woman)) compared to Victoria (1.9), especially in Bass Coast, Baw Baw, East Gippsland and South Gippsland.[7]* • *The teenage birth rate in Gippsland is 14.0 births per 1,000 girls compared to 9.5 for Victoria; it is especially high in Bass Coast (15.4), and Latrobe (21.5).[7]* • *The proportion of low birth weight babies is gradually decreasing but is still high in Latrobe (7.2%), Wellington (6.8%) and East Gippsland (8.6%), compared to Victoria (6.8%).[7]* • *A low proportion of infants are fully breastfed at 3 months in Latrobe (43%) and Wellington (46%), compared to Victoria (52%).[7]* • *The proportion of children attending 3-year-old maternal and child health checks is low in Bass Coast (51%), compared to Victoria (66%).[8]* • *The number of Child FIRST assessments were high in Gippsland (17.1 per 1,000 eligible population), compared to Victoria (10.1); Bass Coast (24.6) and East Gippsland (19.6) has even higher rates.[8]* • *The proportion of children who are developmentally vulnerable on two or more domains is high in Latrobe (18.0%) compared to Victoria (9.9%).[25]* • *There is a high proportion of children with speech and language problems at school entry in Gippsland (17.4%); compared to Victoria (14.2%), especially in East Gippsland (19.8%).[8]* • *The proportion of children with emotional or behavioral problems at school entry is high across Gippsland (7.4%), compared to 4.6% in Victoria, especially in Latrobe (8.5%).[8]* • *Gippsland has a high proportion of children living in a low income or welfare dependent family (30.2%), compared to 21.5% for all Victorian children; especially in Latrobe (37.3%), Bass Coast (33.3%), East Gippsland (31.1%) and Wellington (27.4%).[25]* • *The proportion of children aged less than 15 living in jobless families is high in Gippsland (13.8%); especially in Latrobe (18.6 %), East Gippsland (13.3%) and Bass Coast (14.0%), compared to 10.5% in Victoria. [25]* • *The rate of family incidents remains high in Latrobe (3,482 per 100,000), Baw Baw (2,705), and Wellington (1,867), compared to Victoria (1,177). Latrobe had the highest rate of any Victorian LGA.[74]* • *The rate of child protection substantiations is high in Gippsland (20 per 1,000 eligible population), especially in Latrobe (26), East Gippsland (23), Bass Coast (21) and Wellington (18), compared to*

Outcomes of the health needs analysis		
		Victoria (11) Gippsland has the highest rate of Victorian regions.[8] • *The rate of children in out of home care is high in Latrobe, Wellington, Bass Coast and East Gippsland.[8]* • *Prescribing rates for anti-depressants, antipsychotics and ADHD medicines in Gippsland are high for those aged 17 or less, with some variation between LGAs.[31]* • *Prescribing of asthma medicines for 3-19-year olds is high in most Gippsland LGAs. [31]* • *Consumer input highlighted some service gaps relevant for children, including parenting support, autism spectrum disorder support, pediatric speech services and access to a pediatrician.[77]* • *Stakeholder (professionals) identified service gaps including access to pediatrician, pediatric allied health, public speech therapy and support for children with a disability. Access to services is especially challenging in more remote areas.[78]* • *The Gippsland PHN Clinical Council identified children as an important population group (2016).* • *The health issues rated as most important by parents of children aged 0-14 years were mental health, healthy living and immunisation as identified in a community survey.[79]* • *77% of parents reported knowing how to find mental health support; 44% felt they would be able to afford the support they would need for themselves or their children, and 55% felt that they would be able to take time away from work or study to care for themselves or their children if they were experiencing a mental health issue.[35]* • *Service use reported by parents of children aged 0-14 years was higher than for all respondents for ED attendances and dentist visits according to a community survey. [79]* • *32% of parents of a child aged 0-14 years reported that nothing stopped them from getting health care they needed in the past 12 months in the survey. Main barriers were: [79]* ○ *Cost 41%* ○ *Long wait for appointments 39%* ○ *Couldn't get there 13%* ○ *Didn't feel comfortable accessing the service 7%* ○ *Didn't understand how to access the service 3%* *Most commonly, the barriers related to accessing medical specialists, but GPs, dental and mental health services were also commonly mentioned. Concerns with the quality of the service was also a reported barrier by a few parents.* "On multiple occasions, I believe doctors have been quick to prescribe "band aid" medications without doing appropriate testing to reach an accurate diagnosis." • *57% of parents reported problems accessing a GP within business hours in a community survey. [79] The main reason for this was un-availability of an appointment or a long wait for an appointment. Wanting*

Outcomes of the health needs analysis		
		to see a preferred GP was also a common concern. "We have had 2 occasions where we were unable to get an appointment on the day for our baby as there were no appointments available. We did not go to the ED." • *Community interviews identified health issues relating to children; child mental health, access to pediatric medical and allied health and assessment and early intervention services.* [79] *Co-location was mentioned as a model that works well;* "The mix of childcare, kinder, neighborhood house (with free community café), Anglicare, MCHN, men's shed and library works really well…" • *Service gaps specifically relating to children were in the top six themes in community interviews and included early assessment and intervention services; child mental health services, pediatric allied health and one stop children's services.* [79] "It's a lot harder here [East Gippsland] if you have a disabled child. Not as much here for child (speech therapy and tutoring) as in [other more central location] and it's very expensive." "Early childhood supports; you can get extra early childhood support if you are willing to travel 4 hours for it …" • *A South Gippsland survey of children and parents/service providers identified needs for children:* [35] ○ *Increased awareness of, and access to mental health services for children* ○ *Affordable access to emergency care facilities* "Cost you a fortune to see your child if it is out of hours and make you feel bad for calling a doctor in." ○ "greater awareness and understanding to support children with autism" ○ "I am of ethnic background I'd say this community is one of the worst I've ever lived in." [in response to question about children being respected regardless of their colour, religion, nationality, culture or disabilities.] • *Parents who were interviewed as part of the community consultation identified things that are working well in terms of health.* [79] "Some Drs are really good" "Quite close to Melbourne to see specialists" "Ronald McDonald House was unreal. Being in Melbourne is OK if you have family support there" "Access to immunisation is really easy and great" • *Parents also had suggestions for how to improve the health of children; access to children's services and activities along with education and facilities to promote exercise and a healthy diet were*

Outcomes of the health needs analysis		
		mentioned. [79] "… we have a visiting pediatrician but to have access to a team of allied health would be fantastic" "Less wait lists" "Education programs for children between 7-14 steering them towards community …" "More community activities that don't cost anything that kids and parents can do together …" "Mental Health services for children could improve a lot" "General practice & dentist coming to the school would be great" "Group where people who are having trouble could go and have a chat without it costing too much" • *8% of the activity at Gippsland GP practices was provided for children aged 0-14 years, with an average of 3.9 activities per patient;*[3] ○ *70% of 0-14-year olds recorded a respiratory condition* ○ *25% of 0-14-year olds recorded a mental health condition* • *A state funded partnership identified key issues for keeping children safe and secure with their family: including family violence often co-occurring with AOD and mental health issues; entry into child protection is most prominent in the early years; generational poverty, unemployment and trauma require multiple lens interventions; and increasing complexity of issues facing families.*[9]
Population group: CALD (Culturally and Linguistically Diverse) people	*The proportion of the Gippsland population with a non-English speaking background or diverse culture is relatively low. However, the needs of this group are high and can be poorly understood by service providers who do not often service people from diverse backgrounds. In addition, community acceptance of diverse cultures is low, leading to added stress.*	• *6.5 % of Gippsland's population speak a language other than English at home, compared to 27.8% of the Victorian population.*[10] • *Gippsland has a low rate of new settler arrivals, including humanitarian arrivals.* • *37.2% of adults in Gippsland believe multiculturalism makes life better; this is the lowest proportion for a Victorian region, and much lower than 51.0% for Victoria as a whole.*[73] • *5.7% of the Gippsland population is estimated to be experiencing racism. This is a lower proportion than Victoria (9.0%). Gippsland adults were more likely to feel angry when experiencing racism compared to Victoria (44% compared to 27%).*[11] • *Victorian adults who frequently experience racism are almost five times more likely than those who do not experience racism to have poor mental health.* [11] • *Victorian adults who frequently experience racism are 2.5 times more likely than those who do not experience racism to have poor physical health.* [11] • *The Gippsland Multicultural Strategic Plan 2017-2020 identifies a need for programs specific to Gippsland's multicultural community and inclusion of multiculturalism in health policy at all levels of*

Outcomes of the health needs analysis		
		government.[12] Needs identified based on stakeholder engagement include; ○ *Having a procedure to guide the use of interpreters* ○ *Strengthening community awareness about existing services* ○ *Celebrating diversity more* ○ *Cultural awareness training about specific needs of the CALD community*
Population group: People with a disability	*The proportion of working age people on a disability support pension in Gippsland is high. While disability was not directly mentioned by many stakeholders, themes related to access and mobility issues were common. In addition, service gaps related to pediatric care and mental health were reported by many stakeholders.* *The introduction of the NDIS is a key factor to consider in terms of the impact on the service system and consumers broadly, and specifically for pediatric services, the private allied health provider system and mental health.* *Community input revealed that people with a disability are heavy users of health services, but they experience significant barriers for accessing required services. Cost and waiting times were top barriers (as for other groups), but transport was more often an issue for people with a disability.*	• *The proportion of 16-64 year olds on a disability support pension is high in Gippsland (8.9% compared to 4.9% in Victoria), especially in Bass Coast (9.0%), East Gippsland (10.4%) and Latrobe (9.8%).[25]* • *The rate of eligible people on the disability support pension in Gippsland is high (86.6 per 1,000), compared to Victoria (51.3); especially in East Gippsland (106.3), Latrobe (100.0) and Bass Coast (91.9).[8]* • *The number of Home and Community Care (HACC) clients aged 0-64 years per 1,000 target population is high in Gippsland (479), compared to Victoria (305), especially in South Gippsland (877), East Gippsland (881), Bass Coast (497) and Wellington (508). In contrast, rates in Latrobe are low (260).[8]* • *In total, there are over 17,000 people in Gippsland living with a profound or severe disability (5.7% of Victoria).[10]* • *Around 28,000 people in Gippsland provide unpaid assistance to a person with a disability (5.0% of Victoria).[10]* • *The prevalence of disability among people with a chronic disease is high (51%), especially among people aged 65 years or older.[13]* • *There were 76 people aged 59 years or younger in residential aged care in Gippsland in 2017.[19]* • *Disability was not ranked highly in qualitative reports, but consumer and other stakeholder analyses identified strong themes around the need to have built infrastructure that enables access to services, mobility, social participation and community connectedness.[77, 78, 79]* • *Service gaps were identified in relation to children with autism, especially in the more remote parts of the catchment.[, 79]* • *Workforce shortages related to disability were reported in pediatric speech therapy, pediatric care, and in child and adult mental health.[78]* • *The roll out of the National Disability Insurance Scheme (NDIS) was mentioned by many stakeholders and there is concern about the impact of changes.[78]* • *Service use reported by people with a disability was higher compared to all respondents for most service types, including GPs, ED attendances, community health services, allied health services, ambulance service and pharmacy visits according to the community survey.[79]* • *30% of survey respondents with a disability reported that nothing stopped them from getting health*

Outcomes of the health needs analysis		
		care they needed in the past 12 months, compared to 48% for all respondents. Main barriers were: [79] ○ *Cost 48%* ○ *Long wait for appointments 36%* ○ *Couldn't get there 23%* ○ *Didn't understand how to access the service 7%* ○ *Didn't feel comfortable accessing the service 5%* • *26% of survey respondents with a disability reported that they did not think they could get the help they needed if they had a health problem (compared to 10% of respondents overall).* [79] • *Community interviews noted barriers for accessing services for people with a disability, including transport/travel support, parking and wheelchair access. Social isolation was noted as especially problematic for people with a disability and there are also housing and employment concerns. There are service gaps for children with autism.* [79] "[Services] Are in Melbourne and as there is no one else the carers have to take them and that takes a whole day." • *People with disabilities who were interviewed as part of the community consultation identified several things that are working well in terms of health.* [79] "[Local health service] is great for mainstream things like allied health …" "… medication review at home was good - they explain everything." "Pathology people are very good" "Community health is very good - if they don't know they usually ring you back with the answer" "Having people around is really important … a lot of support from the staff at nursing home and from the neighborhood house" "GP sees this person at nursing home where she lives and that works well for her" • *A Victorian survey of people with an intellectual disability found that a lower proportion reported having excellent or very good health (38%), compared to the general population (49%).*[14] • *Obesity was more prevalent among people aged 18-39 years with an intellectual disability (31%), compared to the general population (15%).*[14] • *Depression and heart disease were more common among people with an intellectual disability, while arthritis was less common in the 60 years or over age group.*[14] • *More people with an intellectual disability had sought professional help for a mental health problem compared to the general population.* [14] • *People with a disability were less likely to get the help they need from family (63%), compared to the general population (83%). They were also less likely to get the help they need from friends and*

Outcomes of the health needs analysis		
		neighbors and to have social connections through education and employment. [14]
Population group: People with low socioeconomic status	*Gippsland rates poorly on numerous socio-economic indicators, with the LGAs of Latrobe and East Gippsland particularly low, but pockets of disadvantage are evident across Gippsland. Low socioeconomic status is associated with poor health outcomes in general and for specific issues including chronic disease, mental health, capacity to adopt healthy lifestyles and access to services.* *Stakeholder input from consumers, clinicians and other stakeholders show strong support for addressing issues faced by this population group. Community input confirmed that people with low socio-economic status experience significant barriers accessing health services, especially significant for this group were cost and transport.*	• *The SEIFA (Socio-Economic Indexes for Areas) is lower than the national index of 1,000 for each Gippsland LGA, indicating more disadvantage; especially in East Gippsland (937) and Latrobe (916).* [10] *Analysis by smaller geographical areas highlight pockets of disadvantage within each LGA.* • *The number of people (and proportion of the total population) with highest disadvantage (among the 10% most disadvantaged in Australia) for Gippsland's LGAs in 2016 were;*[10] ○ *Bass Coast 3,784 (11.5%)* ○ *Baw Baw 3,766 (7.8%)* ○ *East Gippsland 6,363 (14.2%)* ○ *Latrobe 20,526 (28.0%)* ○ *South Gippsland 338 (1.2%)* ○ *Wellington 5,696 (13.3%)* *This is an extra 3,000 people in Gippsland since 2011.* • *10.4% of 0-64-year olds in Gippsland held a Healthcare card in 2016 compared to 8.3% of people in Victoria. The proportion varies between 8.7% in South Gippsland to 12.0% in East Gippsland.*[25] • *The proportion of the population who believe there are good facilities and services is 76% in Gippsland compared to 85% for Victoria; Bass Coast and South Gippsland rate even lower.*[8] • *Gippsland rates poorly on several other social indicators;* ○ *Median weekly income in Gippsland ($540); especially Bass Coast ($507) and East Gippsland ($506), compared to Victoria ($644).*[10] ○ *Children in low income / welfare dependent families; 30.2% compared to 21.5% in Victoria; especially high in Latrobe (37.5%) and Bass Coast (33.3%).*[25] ○ *Population with food insecurity; 6.8% compared to 4.6%*[8] ○ *Rental stress (low income households spending 30% or more on rent); 39.2% compared to 27.2%.*[25] ○ *School leavers participating in higher education; 20.7% compared to Victoria (39.3%); especially East Gippsland (12.0%) and Bass Coast (17.4%).*[25] ○ *People 16-64 year receiving an un-employment benefit; 8.2 % compared to 4.9%; especially high in Latrobe (10.2%), East Gippsland (9.6% and Bass Coast 8.5%).*[25] • *Pokies machines are common in Wellington (9.7 per 1,000 adults), Latrobe and East Gippsland (9.2).*[15] *The same LGAs have high gaming machine losses per head of adult (18+) population; Latrobe ($769), Wellington ($657) and East Gippsland ($638), compared to Victoria ($553).*[8]

Outcomes of the health needs analysis		
		• *Socio-economic determinants of health (including education, employment, affordability of services and housing) was a key theme in both consumer and other stakeholder feedback.*[77] • *Service gaps identified include family support and housing and legal support.* [77] • *The Gippsland PHN Clinical Councils identified the population with a low socio-economic status as a priority (2016).* • *28% of people with low SES reported that nothing stopped them from getting health care they needed in the past 12 months – the lowest proportion of any group. Main barriers were:* [79] ○ *Cost 55%* ○ *Long wait for appointments 32%* ○ *Couldn't get there 16%* ○ *Didn't feel comfortable accessing the service 9%* ○ *Didn't understand how to access the service 8%* • *16% of survey respondents with low SES reported that they did not think they could get the help they needed if they had a health problem (compared to 10% of respondents overall).*[79] • *Overall, survey respondents did not rate Work and Study Opportunities among the most important issues for health, but for young people and Indigenous people it was in the top three.* [79] • *Consumer interviews revealed that affordability of healthcare is a common barrier to accessing health services, including GPs, specialists and allied health. There were also mentions of unemployment, pension changes and poverty, all as health issues of note.* [79] • *Transport was the 3rd most commonly reported health issue in community interviews; in many cases directly mentioned as a barrier to accessing health care, especially for people with low SES.* [79] "Public transport - we get 2 buses a day …" "Transport is enormous …. too hard …" "There are transport programs … but how you get on to that I have no idea … • *Community interviews identified service gaps, often specifically relating to affordable health services. This included GPs, medical specialists and allied health services.* [79] • *Community interviews also identified things that are working well for people with low socio-economic status.* [79] "Do what they can. They are exceptional & they are on 24-hour call but there are limits to what you can expect them to do" "Public and private dentist comes to the bush nursing " "Bush nurses are great for your basics" "Informal networks e.g. no meals on wheels but roadhouse or pub will make contact…"

Outcomes of the health needs analysis		
		"Strong community - very community minded, happy to support local businesses, so many things going on" "[Local health service] does really well with the amount of pressure that must be on them for low income people - they have emergency relief, but it runs out in under 5 minutes per day" "They've got everything you need in the one spot" "More stuff like neighborhood house - its affordable, its cheap and you don't have to be good at it - as soon as you make it expensive people can't go" "ED can also work well with triage and being able to see a nurse and not have to wait for a Dr…" "… having Drs appointments online available is good" • *The following things to improve health were identified.* [79] "More GPs" (3) "More jobs "(3) • *The Victorian Population Health Survey (VPHS) found that across Gippsland, 18.7% of adults report being socially isolated compared to 17.3% for Victoria; highest rates are reported for East Gippsland (24.4%), South Gippsland (22.5%) and Latrobe (20.6%).*[37] ○ *Latrobe has a high proportion of people with fewer than five social contacts per day (27%), compared to 20% in Victoria.* [37] ○ *People lacking in perceived social support and/or social and civic trust, and being socially isolated, are more strongly associated with <u>mental</u> ill-health than the lifestyle risk factors of smoking and obesity.*[37] ○ *Similarly, the VPHS found that lacking in perceived social support and/or social and civic trust, and being socially isolated, are more strongly associated with <u>physical</u> ill-health than lifestyle risk factor such as smoking.* [37] • *A theme identified among comments provided in the 'Have your say' web survey was the importance of employment for health;*[79] "Create more employment opportunities to give more of the population a sense of purpose and wellbeing" • *Qualitative research in Latrobe has highlighted the day to day challenges faced by people:*[127] "You can justify it [buying cigarettes], I haven't been to a butcher's or bought proper meat in about 4 years I've been separated, or vegetables, or fruit…I have two-minute noodles mate. I had a pack of two-minute noodles for dinner last night. I went down and bought a packet of smokes this morning." (M, 50+)
Population group: Men	*While men in Gippsland have a low life expectancy and a significantly higher rate of premature deaths, stakeholder input did not*	• *Males in Gippsland have a high smoking rate; 23.3% compared to 14.7% in Victoria.*[73] • *Male life expectancy is low in Gippsland, 78.4 years compared to 80.4 years for Victoria.*[26] • *Potentially avoidable death rates for males are high in Gippsland (166 per 100,000 age-standaridised)*

Outcomes of the health needs analysis		
	identify men's health as a priority. *Community input indicates that men are less likely to report barriers to accessing health services. Health outcomes suggest that there is an opportunity to improve outcomes with increased service use.*	*compared to Australia (139); especially in Latrobe (192) and East Gippsland (186).* [26] • *Prostate biopsy rates are low for men aged 40 or above in Gippsland.* • *Men's health was a minor theme in stakeholder input.*[78] • *60% of males reported that nothing stopped them from getting health care they needed in the past 12 months.* [79] *Main barriers were:* ○ *Cost 23%* ○ *Long wait for appointments 14%* ○ *Couldn't get there 7%* ○ *Didn't feel comfortable accessing the service 6%* ○ *Didn't understand how to access the service 3%*
Population group: People 65 years or over	*The proportion of Gippsland's population aged 65 years and older is high and is also increasing at a high rate. A high proportion of Gippsland's older population is on an age pension and / or are HACC clients.* *Stakeholders identified some existing service gaps related to the ageing population and identified the challenge to provide services to this growing population. Community input from older people noted access to GPs, specialist and mental health services as main gaps with transport an important barrier for access. Mental health issues and pain were noted as issues not well managed.* *The experiences of older people highlight the importance of empathy and effective communication by service providers for older people to stay engaged with health and social service providers as their health declines.*	• *The proportion of the Gippsland population aged 65 years or more is 22.4% compared to 15.6% in Victoria; with Bass Coast (27.7%) and East Gippsland (28.2%) especially high.*[10] *At the smaller geographical level (SA2) there is great variation; from 11.8% in Longford – Loch Sport to 48.6% in Paynesville. The Australian estimate is 15.1% and 18 of Gippsland's 25 SA2s have a higher proportion than this, while 7 have a lower estimate.* • *The population over 65 years is increasing faster than any other age group in Gippsland.*[16] • *The rate of age pension recipients is high in Gippsland, especially in Bass Coast, East Gippsland and Latrobe.*[8] • *Life expectancy among males in Gippsland is low (78.4 years) compared to Australia (80.4), while female life expectancy is 83.0 compared to 84.6 in Australia.*[26] *Life expectancy in Latrobe is even lower for both males (76.9 compared to 80.3 in Victoria) and females (82.2 compared to 84.4 in Victoria). There is even a decline in life expectancy for Gippsland in recent years.* • *The rate of HACC clients aged 65 years or over is high in Gippsland, especially in Bass Coast, East Gippsland and South Gippsland.* [8] • *The rate of prescribing of anti-depressant medications for people aged 65 and over is high in Latrobe, while anxiolytic and antipsychotic prescribing for this age group is lower than the Victorian rate across Gippsland.*[31] • *Rates of anticholinesterase prescribing for persons aged 65 or over is low in Gippsland.* [31] • *The top ambulatory care sensitive conditions among people aged 60 years or older were diabetes complications (29%), chronic obstructive pulmonary disease (12%), inflammation of the kidney (12%), congestive heart failure (11%) and hypertension (10%).*[54] • *Some 25% of Category 4 and 5 primary care type presentations (semi-urgent, non-urgent) to emergency departments in Gippsland were for people aged 60 years or older.*[17]

Outcomes of the health needs analysis		
		• *Gippsland equals an Aged Care Planning Region and includes:*[19] ○ *34 home support services* ○ *38 home care services* ○ *52 residential aged care services* • *There are 3,288 aged care beds available in Gippsland (30 June 2018), (up from 3,039 in 2015); Bass Coast 474 (476), Baw Baw 532 (409), East Gippsland 536 (577), Latrobe 941 (916), South Gippsland 288 (288) and Wellington 517 (373).* [19] • *Gippsland has 77.1 residential aged care places per 1,000 people 70 years or older, compared to 80.1 for Victoria as a whole.* [19] • *The number of RACF beds by LGA range between 63 per 1,000 people aged 70 or older in East Gippsland to 102 in Latrobe; other LGAs under the target of 78 South Gippsland (65) and Bass Coast (77).* [19 + GPHN calculations] • *There were 3,522 Aged Care Assessment Program (ACAS) assessments completed in Gippsland in 2014-15.*[18] *The mean number of days between referral and end of assessment varied between 14.6 (Wellington) and 22.8 days in East Gippsland.* • *Gippsland had a total of 1,469 people in a home care package (31 March 2018), up by 174 since 31 December 2017.*[19] *This was 6.9% of the Victorian population in a home care package.* • *Stakeholders identify a lack of available home care packages in level 4 as a need (2018). In 2017, 87 Gippsland residents were admitted to a level 4 home care package.*[19] • *The Health Issues Centre (HIC) was commissioned by Gippsland PHN to learn about the experiences of people aged over 65 years. Key findings include;*[20] ○ *Loss of capacity and incremental decline was a major concern* “I can no longer take a holiday, or go and visit my family, I can’t even see a movie…” “The depression changed my life a lot. I shut myself up which seems to be typical. I withdrew. I lost interest. I couldn’t be bothered watching TV.” ○ *A struggle to maintain their own identity was common* “I have a taxi card, but I can’t use it very often as I can’t afford the amount I have to pay with each trip, I use it for emergencies such as doctors or specialist, but how I’d love to be able to visit a friend now and again without worry about how I’m going to pay the fare.” ○ *Health and social service providers’ inability to demonstrate empathy and validation was a key barrier* “Some doctors just don’t want to listen. You’re just there for a reason and let’s deal

Outcomes of the health needs analysis		
		with that and they don't want to listen past what your complaint is." "Being invisible and being talked down to." ○ *Concern about doctors not taking the time to explain their diagnoses, reasons for treatments and treatment instructions, both among people with dementia and those with high cognitive function* "Lots of older people say 'Couldn't understand a word they said so I just left it', and we're then called when it hits a crisis." (professional) ○ *The 'traditional' role of older women often extends to a responsibility to access home care and health services for their male partners.* "Men who lost their wives … at risk of social isolation, which in turn affects their mental health." (professional) ○ *Adult children of ageing parents highlighted the burden of responsibility on families to provide care for people in advanced stages of health decline and dependency* "I'm so tired. I waited over 12 months for a carers pension to be approved and although I did receive back pay it put tremendous strain on my marriage which still hasn't recovered." ○ *Access logistics create barriers including; long wait times, cost of services and travel, distance and transport to and from services, limited access to technology and dependence on accommodation near services* "…don't want to use money for themselves, just for the farm, and for the family. They put things off but saying 'working harder will make it better." (professional) "Dad refuses help and walks to appointments but has had falls on the way." (carer) "People are kind, but generally, specialists are completely ignorant of the rural situation, and the inconvenience some of their recommendations and appointments have." "When people finally get to see a GP they take a big list with them of things to talk about, and the GP only has a few minutes so has to prioritise on the day." (professional) ○ *The importance of health and social service interaction was highlighted as a critical intervention point which can either exacerbate or delay further physical or mental decline* "We've got endless websites and brochures but it's not helping people." (professional) "… a need for public health messaging about primary care as a way to help people maintain their independence, not remove it, so they can age safely at home for as long as possible."

Outcomes of the health needs analysis		
		• *Population changes were raised by stakeholders as an issue, but few raised the older population as a priority group. However, chronic diseases, diabetes and cardiovascular diseases were key themes which are closely linked to ageing.* [78] • *Service gaps related to the older population were identified:*[77] ○ *dementia assessment services* ○ *allied health services and dementia beds in Residential Aged Care Facilities* ○ *podiatry* ○ *falls clinic* ○ *respite care, including alternative to RACF* ○ *access to specialists; neurologist and geriatrician* ○ *wound care.* • *Pain management was identified as a service gap in stakeholder analysis as well as by the Gippsland PHN Clinical Council.* [78] • *Older people ranked cancer screening / services as the 3rd most important health issue in the community survey.* [79] • *Service use reported by older people was higher compared to all respondents for nursing in the home, pharmacy visits and allied health according to the community survey.* [79] • *61% of older people reported that nothing stopped them from getting health care they needed in the past 12 months.* [79] *Main barriers were:* ○ *Cost 21%* ○ *Long wait for appointments 17%* ○ *Couldn't get there 6%* ○ *Didn't feel comfortable accessing the service 3%* ○ *Didn't understand how to access the service 3%* • *The most common health issues that had not been well managed reported by older people were mental health issues, followed by pain and a range of other less frequent issues.* [79] *Most of the issues were related to GPs, with ED the second most common service provider.* "I've been prescribed medication I should never have been on. I kept telling my doctor things weren't right as I was getting worse and feeling suicidal." "we put too much trust in GP's and don't ask enough questions, a lot of people don't know what questions to ask anyway…" "…perhaps we need more nurse practitioners to do the "caring talk" like GP's used to, its really like a conveyor belt at the moment..."

Outcomes of the health needs analysis		
		• *The top health issues for older person (60+) identified in interviews was transport, including transport/schemes that assist with access to health services. The second most important issue was access to GPs, specialists and mental health.* [79] • *Top service gaps identified in interviews for older people were GPs, dental, transport and specialists.* [79] • *A survey of aged care stakeholders in Gippsland identified that access to services for older people was the top theme. Dementia and cognitive issues and concerns about exploitation were also commonly mentioned in relation to older people.*[35] *Main service gaps were;* ○ *Mental health services* ○ *Transport* "Transport to get to medical appointments is a huge issue" ○ *Specialist services* ○ *Allied health services* ○ *Carer support* • *A survey of allied health stakeholders in Gippsland identified that issues around aged care was a top concern, especially coordination between providers.* [35] • *As part of municipal planning for Age-Friendly Communities, local surveys have been undertaken. In South Gippsland transport was the top need, with medical services and better access to doctor's appointments in second place.* [21] *Transport, social inclusion and respect and improved access to community support and health services in remote locations were identified as needs in East Gippsland.*[22] • *People aged 60+ who were interviewed as part of the community consultation identified several things that are working well in terms of health.* [79] "My eye specialist put people on a bus from here all the way through Gippsland and took them to him - it was so organized" "After hours we ring nurse on call and it's a great benefit -they work in well with the ambulance" "GP will do everything - home visits - he's a good man. He's starting to get in the other options e.g. diabetes nurse" "A lot of health activities … " 'Strong family/community networks who would help if I was sick" • *People over 60 also had the following suggestion to improve health.* [79] "Exercise programs that are affordable - I don't exercise but I would if there was an affordable exercise class here" "Transport"

Outcomes of the health needs analysis		
		"Programs for people who are getting older" "Script days at the Drs - where you don't have to pay $50 just for a script" "Should be more hospital in the home … "Another Dr's surgery" "More money in the health system" • *51% of the activity at Gippsland GP practices was for people aged 60 years or older with an average of 12.6 activities per patient;[3]* ○ *39% recorded a cardiovascular condition* ○ *14% recorded a musculoskeletal condition*
Population group: Same Sex Attracted and Gender Diverse (SSAGD) people	*While little information specific to Gippsland is available for SSAGD people, strong evidence exists that this group experience unique barriers to accessing health care and this is likely to also apply in Gippsland.*	• *LGBT people are between 3.5 and 14 times more likely to attempt suicide compared to the national average.[23]* • *Non-heterosexual people are more likely to suffer a range of mental health problems, including anxiety, affective disorders and substance abuse.[23]* • *Drug and alcohol use is more common among SSAGD people.[23]* • *SSAGD people have poorer health outcomes because of systemic stigma and discrimination. SSAGD people suffer from higher rates of violence, social isolation and alienation which are associated with reduced physical and mental health. [23]* • *SSAGD people under utilise health services and delay seeking treatment due to actual or anticipated bias from service providers. [23]* • *In Victoria, 21% of headspace clients identified as LGBTI. [23] Gippsland data indicate a similar proportion of clients identify as LGBTI.* • *Mental health and AOD services generally have a lack of understanding of issues specific to LGBTIQ+ people. [60]*
Population group: Young people (12-25 years)	*Young people in Gippsland have a low participation in secondary education and in higher education. The rate of bullying is high and so is the teenage birth rate. Youth mortality is high.* *Prescribing for mental health conditions is also high across the region with some LGAs recording rates double that of Victoria. Stakeholders also identified youth as a*	• *10.7% of the Gippsland population are aged 15-24 year compared to 13.0% for Victoria as a whole.[10]* • *There were 43,047 full time students (studying locally) across Gippsland in 2015.[8]* • *80.8% of 16-year olds participated in secondary education in Gippsland (compared to 86.1% for Victoria); only South Gippsland had a higher proportion (86.3%).[25]* • *Year 9 students attaining minimum literacy standards are low at 89.7% compared to Victoria (92.0%), especially in Latrobe (85.4%).[8]* • *Year 9 students attaining minimum numeracy standards are similar at 95.1% compared to Victoria (95.6%), but low in Latrobe (92.3%).[8]* • *20.7% of 17-year olds in Gippsland participated in higher education compared to 39.3% for Victoria.[25]* • *22% of adolescents report being bullied, compared to 18% for Victoria; the rates are even higher in East Gippsland (30%) and Latrobe (23%).[8]*

Outcomes of the health needs analysis		
	priority issue and identified a need for youth specific services, especially in mental health and sexual health. *Community input from young people identified healthy living, mental health and work and study opportunities as most important. Barriers included cost and long wait times (as for other groups), but not feeling comfortable accessing the service was more common among young people, leading to health issues not being well managed.*	• *Youth mortality (15-24-year olds) is high across Gippsland (39.9 annual age-standardised rate per 100,000 youth), especially in Latrobe (59.5), East Gippsland (58.4) and Bass Coast (51.7) compared to 31.1 in Victoria.* [25] • *Gippsland has a high proportion of girls aged less than 19 years becoming mothers (14.0 live birth per 1,000) compared to Victoria (9.5) and even higher in Bass Coast (15.4) and Latrobe (21.5).*[17] *These 2015 rates are lower than in 2012 (20.8 births per 1,000).* • *Prescribing rates for anti-depressants, antipsychotics and ADHD medicines in Gippsland are high, with some variation between LGAs.*[31] • *Prescribing of asthma medicines for 3-19-year olds is high in most Gippsland LGAs.* [31] • *Stakeholder consultation identified youth as a vulnerable group.*[78] • *Service gaps identified for youth included youth specific services (youth clinics), mental health, sexual health and drug and alcohol services.* [77, 78] • *The Gippsland PHN Clinical Council identified youth as a priority group.* • *In Victoria, 21% of headspace clients identified as SSAGD, compared to 28.5% in Gippsland.*[23] • *The three most important health issues for young people were healthy living, mental health and work and study opportunities in the community survey.* [79] • *42% of young people reported that nothing stopped them from getting health care they needed in the past 12 months.* [79] *Main barriers were:* ○ *Cost 42%* ○ *Long wait for appointments 16%* ○ *Couldn't get there 15%* ○ *Didn't feel comfortable accessing the service 14%* ○ *Didn't understand how to access the service 8%* • *Health issues that had not been well managed reported by young people were mental health and attitudes by service providers were mentioned as a common reason.* [79] "…stigma and lack of respect… " "…mental health … dealt with just by prescribing medication." • *Overall, survey respondents did not rate Work and Study Opportunities among the most important issues for health, but for young people and Indigenous people it was in the top three.* [79] • *The most common health issues for young people were GPs, mental health and alcohol and other drugs as identified in the community interviews.* [79]*Affordable services were also sought.* "Youth Access Clinic for sexual health and anything else" • *People aged under 25 who were interviewed as part of the community consultation identified several things that are working well in terms of health.* [79] *"*Good bus service - has been going about 12 months"

Outcomes of the health needs analysis		
		"Public transport has helped" "Drs here work damn hard" "People need to take responsibility for themselves" "Its OK for kids health … but nothing for teens to do" • *Young people also had the following suggestion to improve health.* [79] "More training opportunities so I can get a job. Local training/TAFE has limited courses" "More money for people on newstart - I can't afford to get my health fixed." "Closer access to any sort of General health service - Dr, psychologist etc having it delivered in the community" "More regular GPs" "Spend more on health and education" • *8% of the activity at Gippsland GP practices was provided for young people aged 10-24 years, with an average of 5.8 activities per patient;*[3] ○ *46% of 12-25-year olds recorded a mental health condition* ○ *42% of 12-25-year olds recorded a respiratory condition* • *Comments provided in the 'Have your say' web survey included a need for*;[35] "Youth specific mental health services"
Blood borne viruses	*Hepatitis C infection rates in Gippsland are high.*	• *Gippsland had 53 Hepatitis C (unspecified) notifications per 100,000 people (2017); high compared to Victoria (35); highest rates were found in Latrobe (87), East Gippsland (61) and Wellington (57).*[56] • *Education and training about new treatments for people with Hep C (introduced in 2016) providing patients and GPs access to new treating clinical guidelines and antiviral medication.*
Cancer	*Cancer is a leading cause of death with lung cancer, colorectal cancer, prostate cancer and breast cancer in the top ten causes of death for males and/or females in Gippsland. Cancer is also the third cause of disability (based on DALY) in Gippsland. The rates of cancer deaths are high in Gippsland, especially due to lung cancer.* *Community input demonstrates strong support for cancer screening and services as a priority, while clinician input does not suggest it is a priority. Cancer screening rates*	• *Bowel cancer screening rates across Gippsland continue to be higher than the rates for Victoria at 48.6% (compared to 41.9%). Coverage rates are lower for males, younger age groups (50-55 years) and there is variation by LGA.*[24] • *The proportion of positive bowel cancer screening results for Gippsland were a little higher than for Victoria with 8.1% of males (Vic 7.7%) and 6.8% of females (6.2%) returning a positive result in 2014-15.*[25] • *Cervical cancer screening rates in Gippsland were 56.9%, very similar to Victoria (56.6%) in 2015-16, with regional variation; Baw Baw (60.7%), East Gippsland and Bass Coast / South Gippsland (58.3%), Latrobe (54.4%) and Wellington (55.1%). Variation by age group is noted with screening rates generally lower for younger age groups.*[24] • *Cervical cancer screening was significantly more likely to detect a high-grade abnormality among women in Latrobe (16.6 per 10,000 screened women) and South Gippsland (15.2); Victoria (12.5).* [25] • *Cervical cancer screening was more likely to detect a low grade abnormality among women in South*

Outcomes of the health needs analysis		
	are generally good in Gippsland, but improvements in some LGAs, for males and for certain age groups is an opportunity for improved outcomes.	*Gippsland (51.4 per 10,000 screened women) and Latrobe (49.5); Victoria (44.2).[25]* • *Breast cancer screening rates for 2015 – 2016 show that 56.3% of Gippsland women aged 50-74 were screened, compared to 53.8% of Victorian women. Variation by age group is noted with screening rates lowest for the 70-74-year age group. [24]* • *Breast cancer screening was not more likely to detect breast cancer among women in Gippsland (range of 29 to 44 cancers detected per 10,000 screened women – age-standardised); Victoria (35.3). [25]* • *Age-standardised cancer incidence rates for all cancers are similar to national rates (499 new cancers per 100,000 people compared to 498 for Australia).[26]* • *Cancer incidence rates for colorectal cancer are high in Gippsland (69 per 100,000 people) compared to Australia (63).[26]* • *Cancer incidence rates for lung cancer are high in Gippsland (50 per 100,000 people) compared to Australia (44).[26]* • *Nationally, cancer is the leading cause for burden of disease (as DALY), accounting for 19%.[27]* • *A high proportion of the disease burden from cancer is fatal and overtakes mental and substance use disorders as the major cause from age 40 years.[27]* • *Malignant cancer is the third cause of disability (based on Disability Adjusted Life Years [DALY]) in Bass Coast, East Gippsland, Latrobe and South Gippsland, while it is the fifth cause of disability in Baw Baw and Wellington.[28]* • *Lung cancer deaths have become relatively more common (2012-16) and was the 2nd cause of death among males in five of six Gippsland LGAs (3rd in East Gippsland); (Australia 2nd).[29]* • *For females, lung cancer was the 4th cause of death in Bass Coast, Baw Baw, East Gippsland and South Gippsland while it was the 5th in Latrobe and Wellington (Australia 4th).[29]* • *Prostate cancer was the 2nd cause of death for males in East Gippsland, 3rd in Baw Baw and Wellington, 5th in South Gippsland and Latrobe and 6th in Bass Coast (Australia 6th).[29]* • *Breast cancer has become relatively less common (2012-16) and was the 5th cause of death for females in Bass Coast, Baw Baw and South Gippsland, 6th in East Gippsland and Wellington and 9th in Latrobe (Australia 6th). [29]* • *Colorectal cancer has become relatively less common (2012-16) and was the 7th cause of death for males in East Gippsland 8th in Wellington and Latrobe and 9th in Bass Coast (Australia 8th); for females colorectal cancer was 8th in Wellington, 9th in East Gippsland and less common in other LGAs (Australia 9th).[29]* • *Cancer mortality rates due to all cancers are high in Latrobe (193 age-standardised rate per 100,000 people), East Gippsland (194) and Wellington (202) compared to Australia (167).[30]*

Outcomes of the health needs analysis		
		• *Lung cancer mortality rates are high across Gippsland (age-standardised rate of 32 per 100,000 people), compared to Australia (27), except in Baw Baw.*[30] • *Colorectal cancer mortality rates are high in East Gippsland (age-standardised rate of 19 per 100,000 people), compared to Australia (16).*[30] • *Breast cancer mortality rates are high in Gippsland (age-standardised rate of 23 per 100,000 women), compared to Australia (21), especially in Wellington, Bass Coast and South Gippsland.*[30] • *Prostate cancer mortality rates are high in Gippsland (age-standardised rate of 32 per 100,000 men), compared to Australia (27), especially in East Gippsland, Wellington and Latrobe.*[30] • *Melanoma mortality rates are high in Baw Baw and Latrobe (age-standardised rates of 9 per 100,000 people), compared to Australia (6).*[30] • *Colonoscopy rates vary across Gippsland, being high in Baw Baw and low in Latrobe and Wellington.*[31] • *Prostate biopsy rates are low for men aged 40 or above in Gippsland.*[31] • *Stakeholder input identified cancer as a minor theme.*[78] • *Cancer screening (pap smear / mammogram) was the 3rd most commonly identified service gap identified by a Gippsland Women's Health survey.*[32] • *Cancer screening / services was rated 4th most important health issue in the community survey and older people ranked it 3rd most important.*[79] *Five people made a comment related to cancer, illustrating barriers to early diagnosis and management;* "Follow up on my breast cancer, breast reconstruction. The surgeon is in Melbourne. The problem is with my lymphedema arm. There is so much else in my life that I don't have the time to look at my own health." "I am also skeptical of tests like mammograms, I have heard they can start cancers. I would take a blood test for breast cancer but not a mammogram." "Skin cancer was ignored." "Family history of breast cancer in middle age. Requested earlier scanning/testing … was told age limit (50) still applies … it was up to me to examine and report any changes to the breast (which I am not confident in doing)." "I need to have an endoscopy done to look at things and I cannot afford it" • *A few people mentioned cancer in community interviews; two were concerned about incidence of cancer in the community, two saw chemotherapy as a service gap and another two made mention of accessing specialists;*[79] "Reasonably good cancer specialists. There are only visiting specialists - not ever enough but they are visiting."

Outcomes of the health needs analysis		
		"Travel to Melbourne and Traralgon for specialist treatment. Understand why this is so but it's a hassle ..." • *A detailed analysis of cancer screening rates in Latrobe showed great variation in screening rates between age groups, genders and smaller geographical areas.*[33] • *Focus groups and community engagement via vox pops and social media to identify barriers and enablers to screening has occurred in Latrobe.*[33] *Findings include;* o *Main reasons for not screening were; lack of awareness, fear of results, worry about costs and lack of time.* "Price worst thing … too high income for health care card but still scrape from week to week " o *Men expressed a fear of bowel screening results being bad. They were more likely to be reactive rather than proactive and many don't see the benefit of screening, are worried about privacy and focused on looking after others.* *"*Don't want to know – rather die quickly*"* o *Women were worried about not knowing the process of breast screening and any follow up care, had issues with appointments and recall and were concerned about transport, cost and the impact on others.* *"I'm due to have a screen but am very scared"* o *It was not that "*disadvantaged groups are difficult to reach and there is a large proportion of disadvantaged people here." o *Enablers were identified;* ▪ *Reliance on personal reminders from GPs with written reminders to screen seen as useful* ▪ *Awareness raising through media campaigns and at locations including shopping centers, community health centers and newsagents* "Trust is a big part of testing, and there's such a high turnover of GPs locally, it's too hard to build a relationship, so there's no trust." o *60% of young women (aged 18-25 years) surveyed in a University setting were unaware of new recommended cervical screening practices*
Cardiovascular diseases	*The rate of cardiovascular disease in Gippsland is high and this is reflected by a high rate of death, disability and service use. Variation between LGAs is evident.*	• *Coronary heart disease is the leading cause of death for both males and females in Gippsland (and for both males and females in Australia).*[29] • *Cerebrovascular diseases (includes stroke) is the third cause of death for females and 4th for males in Gippsland (Australia 3rd for males and females).* [29]

Outcomes of the health needs analysis		
	Stakeholder consultation confirmed cardiovascular diseases as an important health issue. *Community input also confirms heart health as an important health issue for people in Gippsland.* *Recent data from GP practices show that high blood pressure remains a concern for many people in Gippsland.*	• *Cardiovascular disease is the fifth cause of disability (based on Disability Adjusted Life Years) in Bass Coast, East Gippsland, Latrobe and South Gippsland.[28]* • *Nationally, cardiovascular disease is the second cause for burden of disease (as DALY), accounting for 15%.[27]* • *Much of the disease burden from cardiovascular disease is fatal but with a notable non-fatal component. It becomes prominent from age 50 as a major cause of disability. [27]* • *Hypertension and congestive heart failure are both among the top five conditions leading to potentially preventable hospitalisations (PPH) in Gippsland, relevant for 15% and 8% of PPH respectively.[31]* • *It is estimated that 29.7% of adults in Gippsland have high blood pressure, compared to 25.9% across Victoria; LGAs with the highest estimates were Latrobe (37.1%), Wellington (29.1%) and Baw Baw (28.4%).[73]* • *27% of Gippsland GP patients (15 years or older) have a high blood pressure recorded (>140 systolic), (19% of patients did not have a blood pressure recorded).[3]* • *High blood pressure was the most common diagnosis for patients visiting their GP in Gippsland in 2017-18, and among the top 5 for patients over the age of 40 years. [3]* • *Survey data shows that 80.1% of the adult population had a blood pressure check in past two years, compared to 79.9% for Victoria; highest rate was in Latrobe at 86.6%.[73]* • *Survey data shows that 57.0% of the adult population had a cholesterol check in the past two years, compared to 59.5% for Victoria; highest rate was in Latrobe (62.2%) and lowest in Bass Coast (51.5%).[73]* • *The proportion of people reporting heart disease is highest in South Gippsland (8.7%) and Latrobe (8.5%), compared to 7.2% for Victoria. [73]* • *Admission rates to hospital due to heart failure are high for Latrobe residents.[31]* • *The rate of potentially preventable hospitalisations due to congestive heart failure are similar in Gippsland (206 per 100,000 age-standardised) compared to Australia (211) with some variation across the region (180 to 235).[26]* • *The rate of potentially preventable hospitalisations due to angina are high in East Gippsland (208 per 100,000) compared to Australia (130). The Gippsland rate was 144 with some variation for LGAs from a low of 94 in Baw Baw. [26]* • *Cardiovascular diseases was a key theme in stakeholder consultation.[79]* • *Cardiovascular diseases was a top priority identified by Gippsland PHN's Clinical Council members (2016).* • *Heart health was identified as one of the most important health issues by survey respondents,*

Outcomes of the health needs analysis		
		especially by older people. [79] *Six people mentioned heart disease as an issue that has not been managed well;* "I attended ED last week after the chemist told me my blood pressure was dangerously high and that I could have a stroke or heart attack. They brought it down … I was told to attend my GP in the morning but was refused due to there being no appointments available." "After having chest pains my doctor inferred that I had IHD and that my cholesterol was too high and wanted me to take aspro and statins, I said that I didn't want to take those and suggested that I would like to try and reduce my cholesterol with diet, he said no and said if I had a heart attack that it would be fatal which I took to be rather threatening and intimidating, seeing how I have never had a heart attack! I went and had the prescribed tests for IHD which came back all clear, changed my diet … and have never felt better." • *Cardio-vascular disease was mentioned as a health issue in interviews and cardiologists were mentioned as a service gap.* [79] "Timely and local access to "basic specialist" (mental health, heart, ortho)…" "Some charge some bulk bill and you have no choice - you go where you are sent. 6-8 weeks wait to see heart specialist…" "Visit monthly or fortnightly and then they are too busy to get in so you have to go to Melbourne" • *A study of heart disease in Australian electorates identified Gippsland (including the LGAs of East Gippsland, most of Latrobe and Wellington) as having a high rate of coronary artery disease among people aged 35 or older.*[34] • *39% of Gippsland GP patients (15 years or older) have high cholesterol recorded (>5.5 mmol/l), (47% of patients did not have a cholesterol level recorded).* [3] • *High cholesterol was among the top 5 diagnoses for patients aged 50 years or over with GP activity in 2017-18.*[3] • *13% of South Gippsland Dairy Expo attendees reported that they or someone in their household had experienced heart disease in the past 12 months. Of these, 23% expressed some dissatisfaction with the services they received either wanting more and/or different support.*[35]
Chronic respiratory diseases	*Chronic respiratory disease is a top health issue in Gippsland leading to disability, death and high service use and prescribing across age groups. Some variation between LGAs is evident.*	• *Chronic obstructive pulmonary disease (COPD) was the third cause of death for males in Gippsland and the fifth for females.*[29] ○ *For males COPD is the 3rd cause of death in Latrobe, 4th in Bass Coast and South Gippsland, 5th in Baw Baw, East Gippsland and Wellington (Australia 5th).* ○ *For females, COPD was the 4th cause of death in Baw Baw, Latrobe and Wellington (not in*

Outcomes of the health needs analysis		
	Stakeholder consultation confirmed chronic respiratory conditions as a health priority and identified a lack of respiratory specialists, both medical and nursing, as a service gap across the region. *Community input confirm lung health as an issue of note, especially for Indigenous people and older people. Local concern is evident in Latrobe and linked to air pollution and coal mines.*	*top 5 elsewhere), (Australia 5th).* • *COPD is the fourth highest condition contributing to 8% of potentially preventable hospitalisations in Gippsland.[31]* • *The proportion of persons reporting asthma is high in Bass Coast (14%) and Wellington (14%). [8]* • *Avoidable death rates due to COPD are high in Latrobe (15 per 100,000 age-standardised) compared to Victoria (8).[25]* • *Admission rates to hospital due to asthma and related respiratory conditions for 3-19-year olds is high in Baw Baw and Latrobe.[31]* • *Admission rates to hospital due to asthma for 20-44-year olds is high in East Gippsland and Latrobe. [31]* • *Admission rates to hospital due to asthma and COPD for people aged 45 years and over is high in Wellington. [31]* • *Prescribing rates for asthma medications for 3-19-year olds is high in Baw Baw, Latrobe and Wellington. [31]* • *Prescribing rates for asthma medications for 20-44-year olds is high in Baw Baw, East Gippsland, Latrobe and Wellington. [31]* • *Prescribing rates for asthma and COPD medications for people aged 45 years and older is high in Latrobe. [31]* • *The rate of potentially preventable hospitalisations due to COPD are high in Latrobe (369 per 100,000) and East Gippsland (313), but low in Baw Baw (138), compared to Australia (260). [26]* • *Chronic disease was identified as key issue in stakeholder interviews, with COPD a common sub-theme.[79]* • *The Gippsland PHN Clinical Council identified chronic respiratory disease as an important health condition (2016).* • *Service gaps related to chronic respiratory disease were identified and include the need for respiratory specialists (medical and nursing) across the catchment.[77,78]* • *Reports produced by the Hazelwood mine fire inquiry were reviewed and include recommendations to address respiratory health in the Latrobe Valley through the creation of the Latrobe Health Innovation Zone.[36]* • *Lung health was rated as the 6th most important health issue by community survey respondents, with older people and Indigenous people rating it as a top health issue. [79] Three people mentioned asthma as an issue that has not been managed well by their GP.* • *Respiratory issues were reported as a health issue in community interviews, including mentions from the Latrobe area relating to air pollution and coal mines, including the mine fire. [79]* "Respiratory – it's part of being around here [Latrobe] - not just about the fires – it's always been like it - if you live around here you just expect it - asthma and lung disorders are a huge issue"

Outcomes of the health needs analysis		
		• *12% of patients seeing a GP in Gippsland in 2017-18 had a current diagnosis of (any) asthma.[3]* • *Asthma was among the top 5 diagnoses for patients aged 5-54 years seeing a GP in 2017-18.[3]*
Community connectedness	*The Gippsland population has a low acceptance of diverse cultures, a high proportion report high or very high psychological distress and a low proportion believe there are good facilities and services.* *Stakeholder and consumer input identified a lack of community connectedness as an issue underlying many health conditions.* *Community input confirms that social isolation is a real concern, especially for people with a disability, for older people and for Indigenous people.*	• *The proportion of the community who think multiculturalism makes life better is low in Gippsland (40%), compared to Victoria (55%); especially in Wellington (31%), Latrobe (32%) and East Gippsland (37%).[73]* • *A low proportion of Gippsland residents are born in a non-English speaking country, ranging from 4.6% in Baw Baw to 8.5% in Latrobe, compared to 20.9% in Victoria.[10]* • *The proportion of the population who believe there are good facilities and services is 76% in Gippsland compared to 85% for Victoria; Bass Coast and South Gippsland rate even lower.[73]* • *There is a high proportion of people who volunteer in Gippsland (29%), compared to Victoria (23%); especially in South Gippsland (35%), Wellington and Baw Baw (33%), Bass Coast (32%) and East Gippsland (30%).[73]* • *The overall crime rate is high in Latrobe (18,884 per 100,000) and Wellington (10,477) compared to Victoria (8,659); the same two LGAs also have the highest rates of crimes against the person. Latrobe has the second highest crime rate of Victorian LGAs.[74]* • *The proportion of persons experiencing high or very high psychological distress was high in Gippsland (14.3%), compared to 12.6% in Victoria in 2014; especially in South Gippsland (20.5%), Latrobe (17.0%) and Bass Coast (15.4%).[73]* • *Transport was identified as an issue across Gippsland impacting on isolation, both due to lack of public transport options and due to the sheer distance to access many services even if they exist within Gippsland.[77, 78, 79]* • *Community connectedness was a key theme in consumer and other stakeholder consultations identified in existing reports and stakeholder interviews.[77, 78, 79]* • *Consumer and other stakeholder analyses identified strong themes around the need to have built infrastructure that enables access to services, mobility, social participation and community connectedness.[77]* • *The Gippsland PHN Clinical Council identified community connectedness as a priority factor affecting health.* • *Feeling part of the community was rated as the 7th most important health issue by community survey respondents, with older people and Indigenous people rating it higher.[79]* "Feeling that you are part of the community, many people these days feel isolated." • *Social isolation was the 8th most common health issue theme in community interviews and was specifically mentioned in relation to people with a disability.[79] Social support groups were mentioned as*

Outcomes of the health needs analysis		
		a service gap. • *Post Hazelwood Mine Fire, community surveys conducted by Latrobe City identified that creating pride of place is a key factor in improving health. There is a lesson here to ensure a positive message about opportunities and strength is communicated rather than the often miserable picture of communities in crisis.*[52] • *Attendees at the 2017 Latrobe Children's Expo expressed some concern about discussing mental health issues; 61% reported feeling comfortable discussing their own or family mental health with family or friends and 37% expressed comfort in discussing mental health at their school or workplace.*[35] • *10% of survey respondents expressed concerns about mental health stigma and acceptance.* [35] • *The Victorian Population Health Survey (VPHS) found that lacking in perceived social support and/or social and civic trust, and being socially isolated, are more strongly associated with mental ill-health than the lifestyle risk factors of smoking and obesity.*[37, 73] • *Similarly, the VPHS found that lacking in perceived social support and/or social and civic trust, and being socially isolated, are more strongly associated with physical ill-health than the lifestyle risk factor of smoking.* [73] • *A theme identified among comments provided in the* 'Have your say' *web survey was the importance of community activities.*[79]
Diabetes	*Diabetes is a priority health issue in Gippsland with a high proportion of the population reporting diabetes in Latrobe and Wellington. Potentially preventable hospitalisations are high across Gippsland, especially in Latrobe and Baw Baw. Deaths due to diabetes are also high, especially in Latrobe.* *Stakeholder consultation identified diabetes as a top priority, especially in the Aboriginal population. Community perception of diabetes as an important health issue is not as strong as from clinicians, possibly due to lack of awareness.*	• *Avoidable deaths due to diabetes are high in Gippsland as a whole (7 per 100,000 people), especially in Latrobe (12) and Bass Coast (7), compared to 5 for Victoria.* [25] • *Diabetes is the 7th cause of death for males in Gippsland and the 8th for females;*[29] ○ *For males, diabetes is the 5th cause of death in Bass Coast, Baw Baw, 6th in South Gippsland, 7th in Latrobe, 9th in Baw Baw, 10th in East Gippsland and 12th in Wellington (Australia 7th);* ○ *For females, diabetes is the 6th cause of death in Latrobe, 8th in South Gippsland, 9th in Bass Coast, 10th in Wellington, 11th East Gippsland and 12th in Baw Baw (Australia 7th).* • *Diabetes mellitus is the fourth cause of disability (based on Disability Adjusted Life Years) in Baw Baw and Wellington LGAs.* [28] • *The proportion of persons reporting type 2 diabetes is high in Bass Coast (6.8%), Latrobe (6.4%) and Wellington (5.9%), compared to 5.3% for Victoria.*[73] • *Diabetes prevalence is 17.4% for people 65 years or over compared to 3.1% of people under 65.*[38] • *Diabetes prevalence is increasing and was 8.5% for people aged 65 years or older in 1995 compared to 17.4% in 2015.*[38] • *The rate of potentially preventable hospitalisations due to diabetes complications are high in Gippsland as a whole (241 per 100,000); especially in Baw Baw (381) and Latrobe (274), compared to Australia*

Outcomes of the health needs analysis		
		(183). Gippsland has the third highest rate of any PHN in Australia. [26] • *The prevalence of certain conditions is much higher among people with diabetes, including heart disease, stroke, depression, vision loss and kidney disease.*[39] • *In a national analysis, self-reported type 2 diabetes was significantly higher among those living in the most disadvantaged areas when compared to those living in the least disadvantaged areas (5.6% and 2.5%, respectively).*[40] *The same report highlights many indicators for diabetes by priority population groups.* • *According to a national analysis of MBS data, 7.9% of the Gippsland population made a diabetes related MBS claim in 2014-15 (this is the highest proportion for any PHN); with the highest proportion in Latrobe (8.6%). 4.6% of the Gippsland population made a diabetes related PBS claim in the same year.*[41] • *Survey data shows that 50.2% of the adult population had a blood sugar or diabetes check in past two years, compared to 53.1% for Victoria; highest rate was in Latrobe (60.2%) and lowest in East Gippsland (38.6%).*[73] • *The rate of hospital admissions for Aboriginal people due to diabetes is almost six times that of non-Aboriginal people.*[28] • *Diabetes was the most frequently identified health issue in stakeholder interviews.*[78] • *Service gaps related to diabetes include diabetes education, care coordination and lack of endocrinologist.*[78,79] • *The Gippsland PHN Clinical Council ranked diabetes as the top health condition (2016).* • *Diabetes was rated as a health issue by community survey respondents, no sub-group rated it as a top issue.*[79] *Five people mentioned diabetes as a condition that was not well managed, but there was also mention of diabetes educators and good experiences;.* "Having a chronic illness, Type1 diabetes, I will often put off seeking medical treatment that is not urgent just because it's too hard to access." "I have diabetes that is being managed properly." • *Diabetes was mentioned as a health issue in community interviews, but there was also mention of diabetes nurses and having well managed diabetes.* [79] • *A survey of allied health stakeholders in Gippsland identified diabetes as a key issue among clients.*[35] • *6.5% of South Gippsland Dairy Expo attendees reported that they or someone in their household had experienced diabetes in the past 12 months.* [35] • *9.0% of patients with GP activity in 2017-18 had (any) diagnosis of diabetes; 18.6% of these patients had completed a diabetes cycle of care.*[3]

Outcomes of the health needs analysis		
		• *Diabetes was among the top 5 diagnoses for patients aged 70-84 years with GP activity in 2017-18.* [3] • *5% of people in Gippsland with a GP activity recorded a diabetes related diagnosis in 2017-18.* [3] • *Nine practices in Gippsland received the diabetes incentive outcomes payment for the November 2017 quarter.*[42]
Dementia	*Dementia, including Alzheimer's disease, has become the top cause of death for females in parts of Gippsland and the prevalence is projected to increase. An increasing need for appropriate health services has been noted in the past years due to higher numbers of affected people.*	• *Neurological and sense disorders is the leading cause of disability (based on Disability Adjusted Life Years) in Bass Coast and East Gippsland, while it is the second leading cause in Baw Baw, Latrobe, South Gippsland and Wellington.*[28] • *Dementia is the 2nd cause of death for females in Gippsland and the 6th for males.* [29] ○ *For males, dementia was the 3rd cause of death in Bass Coast, 6th in Baw Baw, East Gippsland, Latrobe and Wellington and 7th in South Gippsland (Australia 4th);* ○ *For females, dementia was the top cause of death in East Gippsland and Wellington, 2nd in Bass Coast and Latrobe, and 3rd in Baw Baw and South Gippsland (Australia 2nd).* • *Projections show that 2.0% of the Gippsland population are expected to have dementia by 2020, compared to 1.6% in Victoria; with even higher rates in Bass Coast (2.3%), East Gippsland (2.4%) and South Gippsland (2.1%).*[43] • *40.3% of people using permanent residential aged care in Gippsland had a dementia diagnosis.* [19] • *GP data for Gippsland indicate that 1.2% of people 65 years and over had an active dementia related diagnosis in 2017-18; rising to 5% for people 85 years and over.*[3] • *Dementia was identified as a theme in stakeholder feedback.* [78] • *Dementia was mentioned as an issue in the community survey.*[79] • *Gippsland PHN's Clinical Councils have noted an increased demand for services suitable for dementia patients, both in residential aged care and support in the community setting (2018).* • *Stakeholders identified a lack of understanding of dementia, both in the community and among professionals:*[20] "There is a stigma [associated with dementia]. People are worried about being judged for it. They also think "oh well, there's no cure no tablet to fix it". There's a lack of awareness. GPs and nurses are not particularly good at identifying it or taking action if they even get a diagnosis. There are people that never receive a diagnosis. Doctors and nurses aren't dementia-literate; they need help with early identifying."
Dental health	*Poor dental health was identified as an issue in some parts of Gippsland and is known to be associated with health conditions such as cardiovascular disease. However,*	• *The rate of potentially preventable hospitalisations due to dental issues are high in Gippsland as a whole (301 per 100,000 people); especially in Wellington (461), compared to Australia (284).* [26] • *A high proportion of people reported poor dental health in East Gippsland (8.3%) and South Gippsland (7.6%), compared to Victoria (5.6%), while Latrobe residents were less likely to report poor dental*

Outcomes of the health needs analysis		
	stakeholders did not identify it as a priority. Community survey and interviews revealed that affordable dental services are a top service gap in the Gippsland community.	*health (4.4%).[73]* • *Dental health was identified a minor theme by stakeholders and was mentioned as a service gap. [78, 79]* • *Dental care was the 8th most commonly reported health issue and dental as a service gap rated 3rd in community interviews. [79] In most cases, the affordability of dental services (including denture services) was the key concern, but things appear to have improved in some areas;* "Up to 2 years wait for public affordable dental" "There is now affordable dental in town and its reasonably good" • *30% of community survey respondents had not seen a dentist in the past 12 months.[79] The main barrier to accessing services was cost and dental services was the most commonly reported service for which cost was a barrier.* "I've needed a filling for 2-3 years and have to cope with pain every day because it's not available on Medicare benefits." • *Dental issues were reported as not well managed by a few respondents in the community survey.[79]* "…poor dental work - all the fillings have fallen out and teeth chipped and broken off after thousands of dollars of pain and agony for nothing."
Emergency management	*Emergency management was identified as a theme by stakeholders but not a priority. Community input revealed specific concern around fires.*	• *Comments related to fires, floods, extreme heat and other emergencies was a theme in stakeholder feedback. This included preparedness for climate change and its impact on coastal communities in Gippsland. [78, 79]* • *Fires were mentioned as a health issue in community interviews and communication and information was called for. [79]* "Far more honest discussion about the fires as it affects us and our children…" • *Concerns about health effects of fires were also mentioned in community surveys. [79]*
Family violence	*Gippsland has a high rate of family incidents and of family incidents with children present. Alcohol related family violence is also high as is the rate of substantiated child abuse.* *It has been shown that the health costs of violence are very high and stakeholder input in Gippsland identified family violence as a key health issue. The Gippsland PHN Clinical Council also identified family violence as an important factor affecting health. Service*	• *There is a high rate of family incidents in Latrobe (3,482 per 100,000 people), Baw Baw (2,705), and Wellington (1,867), compared to Victoria (1,177). Latrobe had the highest rate of any Victorian LGA.[74]* • *The rate of child protection substantiations is high in Gippsland (20 per 1,000 eligible population), especially in Latrobe (26), East Gippsland (23), Bass Coast (21) and Wellington (18), compared to Victoria (11) Gippsland has the highest rate of Victorian regions.[8]* • *The rate of family violence incidents where alcohol was involved is very high in much of Gippsland with 835 incidents per 100,000 people in Latrobe, 768 in East Gippsland, 56.5 in Wellington and 45.0 in Bass Coast, compared to Victoria (313).[74]* • *A national report on family violence notes that;[44]* ○ *1 in 6 Australian women has experienced physical or sexual violence by a partner since age*

Outcomes of the health needs analysis		
	gaps were identified related to family violence. *Community input noted service gaps for family violence, including sexual assault.*	*15 years (1 in 16 men)* ○ *1 in 4 women have experienced emotional abuse by a partner since age 15 (1 in 6 men)* ○ *Intimate partner violence contributed to more burden of disease than any other risk factor for women aged 25–44, primarily due to mental health conditions including anxiety and depression* ○ *A leading cause of homelessness for women with children* ○ *The cost of violence has been estimated to at least $22 billion (2015-16)* ○ *Indigenous women and children are more likely to be affected* ○ *There are still data gaps and many victims do not contact police* • *Family violence was identified as a key theme across consumer and other stakeholder input.* [78, 79] • *The Gippsland PHN Clinical Councils and the Community Advisory Committee continue to identify family violence as a priority issue to improve health (2018).* • *'Services for victims of domestic violence' was the 2nd most commonly identified service gap in a Gippsland Women's Health survey.* [32] • *Service gaps related to family violence were identified by stakeholders and include; support for women and children who have suffered trauma, increased awareness and knowledge in the primary care setting and education for men.'* [78] • *Family violence was mentioned as a health issue in community interviews and service gaps were noted.* [79] "…it's not easy to get a termination [of pregnancy] around here [remote] and that impacts on Family Violence etc." "[Service for] Family violence including elder abuse" "I wanted a supportive environment when escaping 'family violence' in middle of the night (police station can exacerbate the trauma) - but multidisciplinary sexual assault service is only open business hours?!"
Immunisation	*While childhood immunisation rates in Gippsland are relatively high, improvement is needed to reach the target of 95% of children being fully immunised for all age-groups and for sub-groups of the population, which may have lower coverage rates. Community input supports immunisation as important and already working well for many.*	• *Influenza and pneumonia was the 16th cause of death among males in Gippsland and 15th among females (Australia 13th and 11th).* [29] • *The rate of potentially preventable hospitalisations due to acute and vaccine-preventable conditions are high in Wellington (1,762 per 100,000); compared to Australia (1,456).* [26] • *Immunisation rates for Gippsland children continue to be higher than the national average (fully immunised children), 2016-17;* [26] ○ *94.9% of 1-year-olds compared to 93.8% across Australia* ○ *93.6% of 2-year-olds (92.2%)*

Outcomes of the health needs analysis		
		○ *95.7% of 5-year-olds (93.5%)* • *There is variation in the proportion of children fully immunised across Gippsland's LGAs; lowest rates are found in Bass Coast / South Gippsland for 2-year olds.* [26] • *In 2016-17, 87.4% of Indigenous 1-year olds in Gippsland were fully immunised, compared to 87.0 % of 2-year-olds and 96.4% of 5 –year-olds.*[26] *More recent quarterly data indicate that these rates have improved.* • *Notification rates for pertussis were high in South Gippsland and Wellington compared to Victoria in 2018.*[56] • *Notification rates for influenza are high in Wellington compared to Victoria in 2018.* [56] • *Immunisation rates were identified as an issue by a number of early childhood workers.* [78] • *Coverage rates of HPV immunisation in Gippsland are above the Victorian rate (75.8% for boys and 80.9% for girls); Gippsland boys (81.2%) and girls (81.6%).* [26] *Coverage rates for boys in Wellington were low at 68.1%.* • *Immunisation was rated as 5th most important health issue in the community survey, especially by parents.* [79] *It was noted that immunisation is working well by some in the community interviews, while others still have concerns;* "Access to immunisation is really easy and great" "Better research into immunisation (enforced) even when Drs don't even realize that there is mercury in them"
Inflammation of the kidney	*Inflammation of the kidney is a common reason for potentially preventable hospitalisations in Gippsland but was not identified as a priority.*	• *Kidney failure was the 17th cause of death among males and females in Gippsland (Australia 17th and 16th).*[29] • *The rate of potentially preventable hospitalisations due to kidney and urinary tract infections are similar to national rates across most of Gippsland (260 per 100,000); compared to Australia (288).* [26] • *Kidney issues were mentioned in the community survey and a renal specialist was mentioned as a service gap.* [79] *One respondent noted a kidney issue that was not well managed;* "Last year I had … a kidney infection. I was very sick and should have been in hospital. Instead, I was put on one antibiotic after another and sent home… it was mismanaged and misdiagnosed from start to finish." • *Kidney health was the only health issue Gippsland Dairy Expo attendees indicated was missing from the list of health priorities mentioned by 1% of attendees.*[35]
Injuries	*While the rate of unintentional injuries is high in Gippsland, stakeholder input did not identify this as a priority area.*	• *Accidental falls is the 12th cause of death for male and the 10th for females in Gippsland (Australia 16th and 15th).* [29] • *Land transport accidents were the 15th cause of death for males in Gippsland (Australia 20th) and not in*

Outcomes of the health needs analysis		
	Note that intentional injuries are included under mental health.	*top 20 among females.* [29] • *Avoidable deaths due to external causes (not including suicide) are high in Gippsland (20 deaths per 100,000 people age-standarided), especially in South Gippsland and Latrobe.* [25] • *Avoidable deaths due to transport accidents are also high in Gippsland (13 PER 100,000)), especially in South Gippsland and Baw Baw.* [25] • *Unintentional injuries treated in hospital are high in Bass Coast (113 per 1,000 people), Wellington (112), Baw Baw (102), East Gippsland (101) and Latrobe (98), compared to Victoria (61).* [8] • *The proportion of unintentional injuries due to falls is low in Bass Coast (35%), Baw Baw (33%) and Wellington (31%), compared to Victoria (39%).* [8] • *Stakeholder input did not rate injuries highly as a health issue.* [78] • *Injuries were mentioned in the community survey in relation to issues that have not been well managed.* [79] "I feel the process of my injury that I have may have been a different outcome had the specialists / doctors been available sooner, to make decisions and treat the disability sooner rather than years apart …"
Iron deficiency anaemia	*Gippsland has a high rate of potentially preventable hospitalisations due to iron deficiency anaemia.*	• *The rate of potentially preventable hospitalisations (PPH) due to iron deficiency anaemia are high in Gippsland as a whole (397 per 100,000); especially in Latrobe (706), East Gippsland (361), and Wellington (276) compared to Australia (206). Latrobe had the highest rate of iron deficiency anaemia PPH of any SA3 in Australia in 2015-16.* [26]
Lifestyle factors	*Smoking rates in Gippsland are among the highest in Victoria. Alcohol consumption at levels likely to cause short and long-term harm are high in many parts of Gippsland. Obesity rates and soft drink consumption are high across the region.* *Lifestyle factors was a key theme identified by consumers and other stakeholders. The Gippsland PHN Clinical Council also identified lifestyle factors as a priority in addressing poor health outcomes in Gippsland.* *Community focus group highlight the*	• *It is estimated that 20.0% of the Gippsland population are current smokers (2014 VPHS) which is high significantly higher than Victoria (13.1%); LGAs with significantly higher rates were Baw Baw (29.7%) and Latrobe (24.4%).* [73] • *It is estimated that 16.8% of the Gippsland population are daily smokers (2014 VPHS) which is significantly higher than Victoria (9.8%); LGAs with significantly higher rates were Baw Baw (19.7%) and Latrobe (22.4%).* [73] • *23.3% of males and 16.4% of females were current smokers in Gippsland; both significantly higher than Victoria (14.7% and 11.6% respectively).* [73] • *20% of Gippsland GP patients (15 years or older) with smoking status recorded are current smokers (19% of patients did not have smoking status recorded).* • *Obesity rates are high in all Gippsland LGAs, except Baw Baw, according to the 2014 VPHS (estimates range from 14.8% in Baw Baw to 22.8% in South Gippsland, compared to 18.8% in Victoria).* [73] • *46.7% of adults met the dietary guidelines for fruit consumption, similar to Victoria 47.8%.* [73] • *6.8% of adults met the dietary guidelines for vegetable consumption, similar to Victoria 6.4%.* [73]

Outcomes of the health needs analysis		
	challenges in reducing smoking rates among people with social and financial worries.	• *41.8% of adults met the physical activity guidelines (sufficient time and sessions) was similar to Victoria 41.4%.*[73] • *Social isolation (extreme) has been found to be more strongly associated with physical ill-health than obesity.* [37] • *41% of Gippsland GP patients with BMI information recorded in POLAR Explorer were obese (30+ BMI score), while 34% were overweight (25-30 BMI score) (49% of patients did not have a BMI specified).* [3] • *In 2014, all Gippsland LGAs had a higher consumption of sugar sweetened drinks (range 12.8% to 20.6% in Wellington) compared to Victoria (11.2%).*[73] • *41.8% of adults in Gippsland are sufficiently physically active; compared to 41.4% across Victoria. Variation across Gippsland show the lowest levels in Latrobe (35.4%) and the highest in East Gippsland (54.1%).*[73] • *Lifestyle factors were identified as a major theme by both stakeholder and consumers in the analysis of existing reports, and by interviewed stakeholders.*[77, 78] • *Consumer and other stakeholder analyses identified strong themes around the need to have built infrastructure that enables access to services, mobility, social participation and community connectedness.* [77, 78] • *The Gippsland PHN Clinical Councils identified lifestyle factors as a priority (2016).* • *Obesity was a major theme identified by stakeholders*[78] *and the Clinical Council suggested it be included among lifestyle factors (2016).* • *Healthy living (quit smoking, eating well, exercise) was rated as the most important health issue by community survey respondents.*[79] *A few respondents pointed out the importance of exercise to manage symptoms;* "Prevention of … problems through diet! Focus more on prevention rather than dealing with problems once they arise." "… cheaper fitness programs like at a gym or regular dance class for mature age (not old!) folk like me, as I find these help me to maintain flexibility and help with the pains." • *Community interviews identified issues relating to recreation as the 8th most commonly reported health issue, noting barriers as affordability of activities, especially for youth. A healthy diet was also noted as important. Recreation opportunities such as hydrotherapy pool and physical infrastructure such as footpaths were mentioned as gaps.* [79] • *Community interviews provided information about suggestions for improving health. There were many suggestions involving prevention; both by improved access to exercise and a healthy diet, and about education in these areas.* [79]

Outcomes of the health needs analysis		
		• *Community interviews identified obesity among the top 15 most commonly reported health issues, with children a specific concern.* [79] *Survey respondents also mentioned obesity as an issue that has not been well managed.* • *There is community support for prevention activities and support for individuals to lead a healthy lifestyle including access to healthy food and a community that makes it easy and cheap to be physically active. Local governments' Municipal Public Health and Wellbeing Plans are the foundation for work in this area.* [45, 46, 47, 48, 49, 50] • Significant barriers to addressing smoking rates have been documented among vulnerable groups. Qualitative research undertaken in Latrobe highlights poverty, hopelessness and a generally challenging life where many struggle to see past their immediate future. Long term risks become insignificant.[33] The research included smokers who were young (some were mothers), Indigenous, un-employed and blue-collar workers. "I don't know, I just smoke, like I've watched my parents smoke, and they're fine, um and so it's just sort of like, it's part of life to me I guess, like when you watch somebody, like, especially your parents, smoke all the time, and like you grow up and then you're like, 'oh, well we're supposed to do this then' like you know." (F, 18-21) "I'd like to stop, I just don't know when. Probably if I had something that made me stop, like a job or something, just something that prevented me from smoking." (M, 18-21) "I am a person who struggles with mental illness …because it is so easy to pick up a smoke and that is the quick fix ..." (F, 21-29) "In relation to smoking in pregnancy "Yeah, I've cut down to like five a day, I didn't quit completely, there was never a day that I went without one, probably would have died if I did." (F, 18-21)
Mine fire (Hazelwood) - Latrobe Health Innovation Zone	*The Hazelwood Mine Fire Inquiry is an important development in the Latrobe Valley that has led to opportunities to improve health through the Latrobe Health Innovation Zone. Gippsland PHN are funded by the State government to improve cancer screening rates, reduce the smoking rate and improve opportunistic screening.*	• *Reports produced by the Hazelwood mine fire inquiry include the finding that it is likely that there was an increase in deaths in the Latrobe Valley and that the fire contributed to this increase.*[51] • *The mine fire was mentioned by one person during interviews with stakeholders.*[79] • *During 2016, the Victorian Government outlined its response to the recommendations of the Inquiry, including the creation of a Latrobe Valley Health Innovation Zone and the establishment of the Latrobe Health Assembly. The response has a focus on engagement with the local community to identify local priorities.* [51] • *Post Hazelwood Mine Fire community surveys conducted by Latrobe City identified priorities for the Morwell community in addressing their health and wellbeing. Key opportunities for improvement were;*

Outcomes of the health needs analysis		
	The Hazelwood power station closed in March 2017 and this continues to influence opportunities for employment and health, especially in Latrobe.	*addressing traffic issues, improving the local environment and safety. In addition, creating pride of place and employment opportunities, especially for youth, were common suggestions for improvement.*[52] • *The Hazelwood power station was closed 31 March 2017 and this will have implications for employment and more broadly, especially in Latrobe.* • *The response by the Victorian Department of Health and Human Services to address health concerns by the mine fire has led to additional resources available in Latrobe through the Health Innovation Zone. Gippsland PHN has been appointed to lead work in Early Detection and Screening including Tobacco, focusing on increasing participation in National Screening Programs, increasing risk and opportunistic screening and increasing smoking cessation.* • *During 2018, a Health Advocate has been appointed to provide independent advice to the Victorian Government on behalf of the Latrobe Valley community on system and policy issues affecting the Latrobe community's health and wellbeing. The role will provide community-wide leadership for the Latrobe Health Innovation Zone while maintaining a focus on strategic outcomes and systemic change.*
Palliative care	*Palliative care and pain management were identified as themes in stakeholder feedback and pain management was identified as a service gap. Community input note palliative care as a service gap, including pain management, grief and bereavement.* *Recent changes to Victorian legislation is having an impact on the service landscape.*	• *A national report on palliative care notes that:*[53] ○ *There was a 28.2% increase in palliative care-related hospitalisations between 2011–12 and 2015–16, compared to a 14.6% increase in hospitalisations for all reasons over the same period* ○ *50.5% of all hospitalisations in which the patient died, the patient had received palliative care in 2015–16* ○ *48.3% of palliative care hospitalisations involved cancer as the principal diagnosis in 2015–16* ○ *In 2015–16, about 1 in 1,000 GP encounters reported for the BEACH collection was palliative care-related* ○ *GPs' understanding of what constitutes palliative care and end of life care varies widely* • *The total number of deaths in Gippsland has increased and was 2,556 in 2016;*[29] ○ *Bass Coast 326* ○ *Baw Baw 375* ○ *East Gippsland 494* ○ *Latrobe 725* ○ *South Gippsland 253* ○ *Wellington 384* • *There were a total of 1,126 admissions to hospital with a recorded palliative care diagnosis for Gippsland residents in 2016-17;*[54]

Outcomes of the health needs analysis		
		○ *Bass Coast 123* ○ *Baw Baw 160* ○ *East Gippsland 236* ○ *Latrobe 242* ○ *South Gippsland 163* ○ *Wellington 202* *24.5% of admissions were to a hospital outside Gippsland.* • *The Aged Care Funding Instrument estimates that 1 in 50 aged care residents need palliative care.*[55] • *Palliative care was identified as a theme in stakeholder feedback.* [78] • *Pain management was identified as a service gap in stakeholder analysis as well as by the Gippsland PHN Clinical Council.*[77] • *Grief and bereavement was mentioned as an issue in the community survey.* [79] • *Palliative care was mentioned in both the community survey and interviews as an issue and as a service gap,* [79] *and has been identified as a priority by the Latrobe Health Advocate (personal communication).* "Demand outstrips the capacity of community services associated with palliative care … respite …" • *Comments provided in the 'Have your say' web survey included a need for a hospice in Gippsland.*[79] • *The Medical Treatment Planning and Decision Act 2016 was enacted in Victoria in March 2018. This legislation recognises the importance of advance care planning, and the need for people to plan for their future, and have these plans respected and followed, in the setting of life limiting illness.* • *The Voluntary Assisted Dying legislation will apply from 1 July 2019. Health Services will be developing policies procedures and guidelines related to the introduction of this legislation* • *Statewide and regional projects reinforce the Victorian Government's* End of life and palliative care framework, 2016*, with an emphasis on early referral to palliative care, and strengthening specialist palliative care capacity (personal communication GRPCC). They enable identification of opportunities for quality improvement / or change and will inform future palliative care policy;* ○ *The palliative care consortiums in Victoria are undertaking a quality improvement project to achieve consistent pathways for referral to palliative care services across the rural regions.* ○ *The '*Gippsland Palliative Care Skills matrix project' *is addressing workforce capacity of district and palliative care nurses with an aim to achieve a consistent level of palliative care skill across the region.* ○ *Community Palliative Care services work closely with the Gippsland Palliative Care*

Outcomes of the health needs analysis		
		Consultancy Service who provide advice and consultancy for complex palliative care symptoms.
Reproductive / sexual health	*The birth rate among girls aged 18 years or younger is high in Gippsland. Smoking during pregnancy is common and low birth weight babies are also more common in large parts of Gippsland.* *Chlamydia notifications are high for people under 25 years of age, especially females.* *Sexual and reproductive health services are a health need identified by community members and other stakeholders, especially among youth. Service gaps and access issues exist for reproductive and sexual health services in general with affordable and confidential access to emergency contraception and terminations of pregnancy a specific need.*	• *The fertility rate is high in most of Gippsland (2.2 children per 1,000 women in Bass Coast, Baw Baw, East Gippsland and South Gippsland) compared to Victoria (1.9).[7]* • *Gippsland has a high proportion of girls aged less than 19 years becoming mothers (14.0 live birth per 1,000) compared to Victoria (9.5) and even higher in Bass Coast (15.4) and Latrobe (21.5).[7] These 2015 rates are lower than in 2012 (20.8 births per 1,000).* • *Chlamydia notifications in Gippsland have reduced over recent years, except in Baw Baw were the rates have increased; in 2017 there were 336 notifications per 100,000 people, higher than Victoria (322).[56]* ○ *Chlamydia notification rates for females under 25 years are higher than Victoria across Gippsland (2013 – 2014 data request).* • *Low birthweight babies (<2,500 grams) were more common than in Victoria (6.3%) in parts of Gippsland; East Gippsland (8.6%), Latrobe (7.2%) and Wellington (6.8%).[25]* • *20.0% of mothers in Gippsland smoke during pregnancy compared to 11.0% in Australia, with Latrobe especially high at 25.6% and East Gippsland 21.7%.[26]* • *The number of registered births to Gippsland women was (2016):[7]* ○ *Bass Coast – 340* ○ *Baw Baw – 651* ○ *East Gippsland – 492* ○ *Latrobe – 962* ○ *South Gippsland – 309* ○ *Wellington – 508* • *53% of women in Gippsland attended at least one antenatal visit in the first trimester compared to 65% in Australia. Baw Baw and Wellington had rates over 70% with only 25% in East Gippsland.[26]* • *'Family planning support' and 'STD and safe sex' were the 4th and 5th most commonly reported service gaps in a Gippsland wide survey by Gippsland Women's Health; 'IVF' was also noted as a service gap.[32]* • *Reproductive and sexual health was a theme in consumer input and other stakeholder input, especially in relation to youth.[79]* • *Service gaps were identified for pregnancy termination, access to specialist obstetricians and gynecologists and accessible sexual health clinics.[79]* • *The Gippsland PHN Clinical Councils identify reproductive and sexual health as a priority. There are recent concerns about access to appropriate terminations of pregnancy services in Gippsland.*

Outcomes of the health needs analysis		
		• *Sexual health and family planning was rated as having relatively low importance by survey respondents, but young people rated it as more important.* [79] *Some comments were also made;* "GP was uncomfortable discussing sexual health/family planning; it made me feel uncomfortable to discuss anything with her again." "Women need improved access to comprehensive sexual and reproductive health services." "Teen pregnancy … because its someone to love" • *A service gap identified in interviews was sexual assault and rape services.* [78] • *A Latrobe practice nurse reported being "*very concerned about the increase in repeated risky sexual behaviour of people in the Valley*" (information from regular practice visit by practice support officer).* • *5.5% of South Gippsland Dairy Expo survey respondents reported having a sexual and reproductive health issue in the past 12 months; results also suggest more support for sexual or reproductive health are needed for people aged 60 or over.*[35] • *A survey of pharmacies in Gippsland in 2018 found (68 pharmacies, response rate 71%);*[57] ○ *Good access to long acting reversible contraception* ○ *Emergency contraception pills were dispensed by 97% of pharmacies, however age restrictions were reported by up to a third with varying criteria* ○ *Medical terminations of pregnancy medications were supplied by 42% of pharmacies; many did not keep these medications in stock* ○ *Potential delays of 1-3 days of pharmacy items not in stock* • *A survey of general practices in Gippsland in 2018 found (75 clinics, response rate 48%);*[57] ○ *Screening and treatment for Sexually Transmitted Diseases were provided by close to 100% of practices* ○ *Long acting contraceptives were provided by all practices* ○ *Intra uterine devices could be provided by 73% of practices* ○ *Medical terminations of pregnancy were provided by 48% of practices;* ▪ *the majority of non-providers stated lack of training as the main reason; small numbers reported conscientious objection to termination, concern about the practice being identified as a termination clinic and one noted the long distance to a hospital* ▪ *48% of referrals were to Melbourne, 17% to a local hospital; 35% did not specify* ○ *61% of practices provided surgical terminations of pregnancy or a referral;* ▪ *44% of referrals were to Melbourne, 30% to a local service/hospital, 26% did not specify*

Outcomes of the health needs analysis		
		○ *The majority of practices did not bulk bill these services, except for pregnancy testing and screening for sexually transmitted diseases or for health care card holders or pensioners* ○ *Fertility services were offered by 47% of practices* • *Comments provided in the 'Have your say' web survey included a need for;* [79] "Indigenous Women's Health Clinic" "Easier access to medical and surgical termination of pregnancy" • *Hysterectomy hospitalisations were common in Latrobe and Baw Baw (481 and 409 per 100,000 women, 15 years and over); compared to Victoria (281), 2014–15.* [31] • *Endometrial ablation hospitalisations were common in Latrobe (234 per 100,000 women, 15 years and over) – the highest rate for a Victorian SA3; compared to Victoria (98), 2014–15.* [31] • *Caesarean section hospitalisations were less common in Baw Baw (142 per 100,000 women, 15 years and over) – the lowest rate for a Victorian SA3; compared to Victoria (262), 2014–15.* [31]

Primary Mental Health Care (including Suicide Prevention)

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Regional planning aligned to a stepped care mental health model	*A high proportion of the Gippsland population experience mental health issues with 29% of the population reporting anxiety and depression. The burden of disease is high and especially significant among people aged under 50 years. High or very high psychological distress is experienced by up to 1 in 5 people.* *Stakeholder consultation identified mental health as a top priority across age groups and in all areas of Gippsland. The overlap between mental health and AOD issues were prominent and social determinants such as poverty, community connectedness and stigma were key themes in the community.* *Difficulty accessing services is most pronounced in more remote parts of Gippsland and leads to a great reliance on GPs.*	• *Mental health is the leading cause of disability (based on Disability Adjusted Life Years-DALY) in Baw Baw, Latrobe, South Gippsland and Wellington LGAs and the second cause in Bass Coast and East Gippsland.[28]* • *For the nation, mental and substance use disorders was the third highest cause of burden of disease (as DALY) at 12%.[27]* • *Mental and substance use disorders is the leading cause of non-fatal burden for males and females.[27]* • *Mental and substance use disorders and injuries were the largest disease groups in terms of DALY in the younger age groups (from childhood through to age 49 years).[27]* • *The proportion of persons experiencing high or very high psychological distress was high in Gippsland (14.3%), compared to 12.6% in Victoria in 2014; especially in South Gippsland (20.5%), Latrobe (17.0%) and Bass Coast (15.4%).[73]* • *28.7% of the population in Gippsland reported depression and anxiety, compared to 24.2% in Victoria.[73]* • *National data estimates that perinatal depression affects around 10% of new mothers and is more common among mothers who were; younger (aged under 25), smokers, came from lower income households or were overweight or obese.[58]* • *People with a disability are two to three times more likely to have a mental health illness but are less likely to receive treatment.[71]* • *People with a mental illness are more likely to die early due to poor management of their physical health. Many common chronic diseases such as cardiovascular disease, respiratory disease and diabetes are twice as common among people with mental illness.[71]* • *The rate of registered mental health clients in Gippsland are high (15.1 clients per 1.000 population) compared to Victoria (11.9). The highest rates were in Latrobe, Bass Coast and East Gippsland.[8]* • *There were 110 overnight hospital admissions per 10,000 people (age-standardised) for mental health in Gippsland in 2015-16; higher than national rates at 102. Overnight hospital admission rates involving bipolar and mood disorders and anxiety and stress were among the highest in the nation.[26] Latrobe had the highest rates of hospitlisation due to mental health in Gippsland.* • *According to national data for 2015–16 (BEACH), 12.4% of all GP encounters were mental health related.[59]* ○ *Depression was the most commonly managed problem at mental health related encounters (32%).*

Outcomes of the health needs analysis		
		○ *Management of mental health problems were most commonly managed by medication (62%).* • *GP data from Gippsland practices indicate that of people with an activity in 2017-18;[3]* ○ *21.7% recorded a mental health diagnosis* ○ *6.0% of 0-14-year olds recorded a mental health diagnosis* ○ *18.7% of 12-25-year olds recorded a mental health diagnosis* ○ *22.5% of people 65 years and over recorded a mental health diagnosis* ○ *Depression was the most common mental health diagnosis (9.8%)* ▪ *Attention deficit hyperactivity disorder was the most common mental health diagnosis among 0-14-year olds (1.5%)* ▪ *Depression the most common mental health diagnosis among 12-25-year olds (5.0%)* ▪ *Depression was the most common mental health diagnosis among people 65 years and over (11.1%)* • *Engagement with mental health and AOD consumers in Gippsland highlighted underlying factors related to mental health and AOD issues;[60]* ○ *Homelessness* ○ *Lack of community spaces and social activities* ○ *Poverty* ○ *Shame and stigma* ○ *Family violence* ○ *Family breakdown* ○ *Lack of affordable housing*
Low Intensity Mental Health Services	*Additional work is required to learn what consumers would like and if there is knowledge among professionals and the public about available low intensity mental health options.* *Further planning work at local level, including through applying the National Mental Health Service Planning Framework to understand demographics of at-risk groups across Gippsland is required.*	• *Estimated total number of people in Gippsland at risk of mental illness is 62,661 (23.1% of total Gippsland population 271,261, based on National Mental Health Commission stepped care model.[71]* • *A pilot program is underway in Wellington LGA to address local needs associated with changes to employment and business opportunities likely to lead to increased distress. For the period January to June 2018, 617 occasions of service delivered, with the main presenting issues being grief and bereavement, workplace issues and stress.[61] A lack of referral options has been identified, especially for children/young people.* • *A pilot program (Calm Kids Central) is underway in Gippsland to provide free online services to children, their parents and carers, and health professionals. Data for the first two months (July to August 2018) showed strong interest and uptake with 45 parent/caregivers and 27 professionals joining and accessing the program.[62]* • *Consideration of population groups with specialised needs and/or high risk (e.g. LGBTIQ, men,*

Outcomes of the health needs analysis		
		Aboriginal, trauma impacted) is required.[79] • *An estimated 2.7% of the adult population in Gippsland has been trained in Mental Health First Aid compared to 3.4% nationally.*[63]
Children and Young People	*High rates of prescription of antidepressants, antipsychotic and ADHD medications for young people aged under 17 is a feature in Gippsland, possibly linked to gaps in alternative interventions such as therapeutic treatment options.* *Community input confirms mental health as a top health issue for children and young people in Gippsland. There was concern about over-reliance on medication to address mental health issues and a lack of affordable support unless you are in crisis.*	• *Modelled estimates of 12-month prevalence of mental disorders among 4-17-year olds in Gippsland shows rates comparable to the Australian average. Modelled estimates by SA3 level indicate East Gippsland has the highest prevalence at 17.1%, compared with Gippsland average of 14.3%. By age group, East Gippsland also has the highest modelled prevalence estimate for 12-17-year olds at 19% compared with Gippsland average of 14.4%. Latrobe Valley has the highest modelled prevalence estimate for 4-11-year olds at 16.2% versus 14.3% Gippsland average.*[64] • *Gippsland headspace data for the 2017-18 period showed:*[65] o *13.6% of Gippsland headspace participants reported tenuous housing situations, compared to a national Centre average of 9.8%* o *71.9% of Gippsland headspace participants are aged 12-17 years, compared with the national headspace center average of 54.1%* o *There was a considerably lower average of young people from CALD backgrounds attending Gippsland headspace centers (3.6%), compared to the national headspace center average (9.9%)* o *The proportion of young people attending Gippsland headspace centers identifying as LGBTQI (22.6%) was similar to the national headspace center average (22.2%)* o *Mental health was the primary issue for 77.7% young people, comparable with the national headspace center average of 76.9%.* • *Young people presenting for care to the four local Youth Access Clinics in Gippsland:*[66] o *Are young, with a mean age of 16 years* o *Present with high levels of self-harm, mental ill-health, suicidal ideation, family conflict, exposure to trauma, and alcohol and substance misuse* o *engage in sexual behaviours at a young age* o *Are witness to, or experience, interpersonal violence* o *Are experiencing or are part of families that are experiencing, financial struggles* o *Come from a variety of living situations with a large number of single parent families* o *And that males are less likely to access care than females* • *The proportion of children with emotional or behavioral problems at school entry is high in Gippsland (7.4%), compared to 4.6% in Victoria. The highest proportions are in Latrobe (8.5%), South Gippsland (7.8%) and East Gippsland (7.7%).* [67] • *Mental health was rated as the most important health issue in community interviews. There was specific mention of postnatal depression, anxiety, youth and sexual assault services.*[79] "..there are a lot of dysfunctional families…this has led to a dramatic increase in anxiety (of both

Outcomes of the health needs analysis		
		children and parents)"
Hard to Reach Populations	*The level of socioeconomic disadvantage in Gippsland is high and is a recognised risk factor in mental health.* *Local pressure on Gippsland communities affected by job loss and financial pressures due to drought are noted.* *Further planning work at local level, including by applying the National Mental Health Service Planning Framework to understand demographics of mild and moderate mental illness across Gippsland is required.*	• *Estimated total number of people in Gippsland experiencing mild mental illness is 24,413 (9% of total Gippsland population 271,261, based on National Mental Health Commission stepped care model).* [71] • *Estimated total number of people in Gippsland experiencing moderate mental illness is 12,478 (4.6% of total Gippsland population 271,261, based on National Mental Health Commission stepped care model).* [71] • *Data from 2017-18 Gippsland PHN funded Primary Mental Health Care services (Psychological Therapies and Severe and Complex) showed:*[68] ○ *35.1% of clients identified as holding a Health Care Card* ○ *55.2% of clients identified as not currently employed* ○ *64.7% of clients identified as female* ○ *54.3% of clients were aged 25-64 years* • *Mental health was rated as the second most important health issue in the community interviews and rated highly in every LGA; in East Gippsland mental health was the top health issue. Specific population groups such as farmers are also at risk.*[79] "Mental Health - would be the no 1 shortfall in this area - we fill the gaps that paid services can't provide" [Community House] "Farming people have Mental Health problems due to what is happening in the dairy industry" • *Mental health was rated as the most important health issue by people with financial worries in the community survey,*[79] *in line with national data*[71]*. The cost of accessing mental health services was a key barrier across respondents and more remote locations were more likely to report long waiting times and access issues for services generally due to transport issues and fewer local options.* "Mental Health - probably ½ the people who come here… [Centrelink]" • *Drought conditions are becoming more severe in East Gippsland and Wellington, leading to added pressure on farmers in these areas. The entire communities are affected.* [127]
Severe Mental Illness	*Hospital admissions for mental health related conditions are variable and warrant further investigation in Gippsland. The variation may be related in part to limited capacity of regional mental health beds.* *Further planning work at local level including through applying the National Mental Health Service Planning Framework to understand*	• *Estimated total number of people in Gippsland experiencing severe mental illness is 8,409 (3.1% of total Gippsland population 271,261, based on National Mental Health Commission stepped care model).* [71] • *There were 110 overnight hospital admissions per 10,000 people (age-standardised) for mental health in Gippsland in 2015-16; higher than national rates at 102. Overnight hospital admission rates involving bipolar and mood disorders and anxiety and stress were among the highest in the nation.*[26] *Latrobe had the highest rates of hospitlisation due to mental health in Gippsland.* • *Demographic data for Gippsland Partners in Recovery participants (2013-18):*[69] ○ *59% identified as female*

Outcomes of the health needs analysis		
	demographics of severe mental illness across Gippsland is required.	○ *80% of clients between 25 and 54 years of age* ○ *45% of clients lived alone* ○ *47% of clients had been living in their place of residence for less than one year* ○ *31% of clients identified as having a formal or informal carer* ○ *Top three principal diagnoses were mood disorders (44%), schizophrenia (16%) and personality disorders (8%)* ○ *10% of clients' mental health legal status was identified as involuntary* ○ *55% of clients identified as not in the labour force* ○ *52% of clients identified the Disability Support Pension as primary source of income* • *PIR providers report community issues including;[127]* ○ *A need for education* "Understanding a person's depression and mental illness when you are close to them" ○ *Exclusion due to stigma in the community and by family and friends* "Advising friends you have a mental illness and being seen differently to other community members, and that your opinions do not matter" ○ *Social issues;* "Men and mental health" "Young people who disengage from learning, peers and employment" • *The top five areas of unmet need for PIR participants during 2013-18 were psychological distress, daytime activities, company/social life, physical health, and employment/volunteering.[69]* • *Approximately 32% of Mental Health Community Support Services (MHCSS) clients reside in Latrobe, 17% East Gippsland, 16% in Wellington, 14% in Baw Baw, 12% in Bass Coast and 10% in South Gippsland.[70]*
Suicide Prevention	*The suicide rate in Gippsland is high, especially for males. The rate of intentional injuries is also high.*	• *Suicide accounts for 1.5% of all deaths in Gippsland and 2.5% of male deaths.[29]* • *Suicide is the 10th cause of death for males in Gippsland (Australia 9th), while it is not among the top 20 for females.[29]* • *The suicide rate for Gippsland is 14.1 deaths per 100,000 people, high compared to Victoria (10.0).[29]* • *Male suicide rates are higher than female rates in rural and remote regions generally.[71] The suicide rate for males in Gippsland is high (23.9 per 100,07900 males) compared with Victoria (15.3). The highest is in East Gippsland (32.9).[29]* • *The rate of intentional injuries treated in hospital is high in Gippsland at 4.4 per 1,000 people, compared to 3.0 for Victoria. Rates are particularly high in Wellington (6.7), Latrobe (5.1) and East Gippsland (4.5).[17]* • *Emergency Department presentations in Gippsland involving a suicide attempt / ideation are most common for 15 to 54-year olds, accounting for 87% of presentations.[17]* • *It is estimated that for every death by suicide, as many as 30 people attempt to end their lives (Lifeline*

Outcomes of the health needs analysis		
		Australia).
Aboriginal and Torres Strait Islander people	*A high proportion of Aboriginal and Torres Strait Islander people are impacted by mental health issues.* *A higher proportion of the Indigenous population were admitted to hospital for mental health issues compared with non-Indigenous people.*	• *Mental health and substance use disorders are leading contributors to burden of disease, causing 19% of total disease burden among Aboriginal and Torres Strait Islander people.*[27] • *Suicide rates are twice as high for Aboriginal and Torres Strait Islander people.* [71] • *The Bairnsdale headspace center reported a higher number of Aboriginal and Torres Strait Islander people receiving services at 9.8%, compared with the Morwell center at 7.5% and the national average of 8.4%.*[65] • *Referrals to Partners in Recovery (PIR) show that Indigenous clients made up 4% from the commencement of program in 2013 to 30 September 2018.*[69] • *In 2017-18, 3.4% of clients accessing Gippsland PHN funded Primary Mental Health Care services (Psychological Therapies and Severe and Complex) identified as Aboriginal and/or Torres Strait Islander.*[68] • *The rate of hospitalisations for mental and behavioral disorders was six times higher for Aboriginal clients compared to non-Aboriginal clients.*[28] • *22% of Aboriginal adults report 'high or very high' levels of psychological distress nationally compared with 11% for non-Aboriginal people.*[94] • *Admissions for mental health conditions for Aboriginal people 15 years and over was 2,942 per 100,000 people (East Gippsland/Wellington) and 1,729 in Latrobe compared with 1,608 (Victoria) and 3570 (Australia).*[95] • *A much higher proportion of Indigenous children aged less than 15 years are in jobless families compared to non-Indigenous children (17%); Latrobe (49%), East Gippsland / Wellington (43%), Baw Baw (40%) and Bass Coast / South Gippsland (33%).*[94] • *Evidence indicates that Aboriginal clients are more likely to have first contact with the mental health system at the acute end.* [71]

Alcohol and Other Drug Treatment Needs

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Alcohol and Other Drugs (AOD) – general	*A high proportion of the Gippsland population consume alcohol at risky levels, likely to cause long term harm and injury. Alcohol sales are high and crime rates linked to illicit drug use are also high, especially in Latrobe. This includes family violence.* *Service use for alcohol and illicit drugs is high as is the alcohol related death rate. Cannabis is common among young people while amphetamine use is increasing, especially among 20-44-year olds.* *Stakeholder input clearly identifies alcohol and other drugs as an important health issue with numerous service gaps. Community input confirmed AOD as an important health issue.*	• *Alcohol sales (wholesale) are high in Gippsland at 12.6 liters per person 18 years or older, compared to Victoria (10.0).[72] The highest sales are in Latrobe (15.7), Bass Coast (15.2), East Gippsland (14.0) and Wellington (10.9).* • *Alcohol-consumption at levels likely to cause long term harm (>2 standard drinks per day) among adults is higher than Victoria (59%) in Bass Coast (63%), East Gippsland (61%), Latrobe (61%) and Wellington (76%).[73]* • *45.1% of adults consumed alcohol at levels likely to increase the risk of alcohol-related injury (>4 standard drinks) is higher than Victoria (42.5%); especially in Wellington (52.5%).[73]* • *The crime rate for drug offences is high in Latrobe (960 offences per 100,000), East Gippsland (550), Baw Baw (485) and Wellington (524).[74]* • *Alcohol-related family violence rates in four of six Gippsland Local Government Areas (LGAs) is well above the Victorian rate; Bass Coast, East Gippsland, Latrobe and Wellington.[75] The highest rate was seen in the 25-39-year age group and the rate for women was twice as high as for men.* • *The rate of ambulance attendances involving alcohol-intoxication was higher than Victoria (351 per 100,000 people) in Bass Coast (381), East Gippsland (484), Latrobe (451) and Wellington (384).[75]* • *The rate of alcohol related emergency department presentations was higher than the Victorian rate (13.8 per 100,000 people) in East Gippsland (18.5) and Wellington (21.8).[75]* • *For males, the alcohol related hospital admission rate was among the top 25% in Victoria for three Gippsland LGAs; Bass Coast, East Gippsland and Wellington. [75]* • *For females, the alcohol related hospital admission rate was among the top 25% of rates for four Gippsland LGAs; Bass Coast, East Gippsland, Latrobe and South Gippsland. [75]* • *The alcohol related death rate was higher than the Victorian rate (1.7 per 10,000 people) across Gippsland's six LGAs, especially in Baw Baw (4.8), Latrobe (3.3) and South Gippsland (3.9).[74] The rates for men were more than twice the rate for women.* • *The rate of ambulance attendances for illicit drug use were higher than the State rate (180 per 100,000 people) for Latrobe (252) and Wellington (175).[75]* • *The highest rates of hospital admissions for illicit drug use were seen in East Gippsland (25.3 admissions per 10,000 people), Latrobe (21.0) and Wellington (24.9), compared to Victoria (25.3). [75]*

Outcomes of the health needs analysis		
		Hospital admission rates in Gippsland are likely affected by limited local capacity of detox beds. • *Average annual rate of overdose death 2009-2016 for Victorian LGAs show that Latrobe has the second highest rate of regional LGAs in the State at 10.2 average annual deaths per year per 100,000 people; Bass Coast, East Gippsland and Baw Baw also had a higher rate than Victoria.*[76] • *Alcohol and other drugs was a key theme across both consumer and other stakeholder feedback in existing reports.*[77] • *Interviews with key stakeholders identified;*[78] ○ *alcohol and other drug addiction as a key health issue, and* ○ *the importance of mental health and alcohol and other drug comorbidity.* • *Alcohol and Other Drugs were rated as the least important health issue in the community survey.*[79] *However, this is likely to be due to many people in the community not directly affected. One respondent with a health issue that they felt had not been managed well noted that:* "Alcoholism [was not managed well] because there are only services in the city e.g. detox and rehabs, which compounds the stress on yourself and family." • *Alcohol and Other Drugs was identified as the 4th most common health issue in community interviews, especially among young people, Indigenous people and for families.*[79] • *Priorities identified in the 2019 Catchment Based Plan are:*[80] ○ *Increasing the awareness of AOD services and how to access them; both for community and professionals* "Frontline services are not familiar enough with referral pathways and local services" "Consumers often do not know 'where to start' when seeking help" ○ *Improved collaboration between AOD services providers* ▪ general fragmentation between services ▪ lack of step-down supports ▪ long wait times ▪ perpetual cycle of referrals ▪ access difficulty relating to size of region and geographic isolation of smaller communities ○ *Co-design with consumers* • *State funded services for AOD treatment episodes of care in 2015-16;* [87] ○ *71% were for clients aged between 20 and 44 years* ○ *67% were for males* ○ *33% of episodes of care were for clients with alcohol as the principal drug of concern,*

Outcomes of the health needs analysis		
		followed by 22% cannabinoids, 18% amphetamines, 3% heroin and 20% miscellaneous drugs of principal concern ○ *Some differences in principal drug of concern by age group were noted;* *10-19-year olds 53% cannabinoids* *20-44-year olds 27% alcohol, 22% amphetamines, 21% cannabinoids* *45+ years 64% alcohol* ○ *53% of episodes of care were for clients who had never injected drugs* ○ *30% of episodes of care were for self-referred clients, with 25% for clients on a court diversion and 23% for clients referred by correctional services (also referred to as forensic clients)* ○ *The main treatment type was counselling for 64% of episodes of care, 19% assessment; support / case management 16%, withdrawal 15% and rehabilitation 1.5%.* ○ *LGA of clients shows that 38% of episodes of care were for clients in Latrobe, followed by 21% for clients in East Gippsland* ○ *The rate per 1,000 population was highest in Latrobe (22.2 episodes of care per 1,000 people), East Gippsland (19.7), Bass Coast (14.2), Wellington (11.6), Baw Baw (8.9) and South Gippsland (8.6). Compared to State rate of 11.3.* • *The primary drug of choice for Gippsland clients accessing State funded AOD services remain alcohol at 41% (Jul-Dec 2017), followed by amphetamines (27%) and cannabis (21%).[80] An increasing proportion of clients reporting amphetamines over times is apparent (2015-2017).* • *The Alcohol and Other Drug Treatment Services National Minimum Data Set incorporates data from seven publicly funded AOD service providers in Gippsland; in 2016-17 there were 4,533 episodes of care (differences in State reporting to be noted):[81]* ○ *68.9% were for males (66.2% in Australia)* ○ *11.0% were for Indigenous people (14.8% in Australia))* ○ *Age distribution (Australia);* ▪ *8.0% were 10-19 years (12.7%)* ▪ *30.4% 20-29 years (27.8%)* ▪ *30.7% 30-39 years (27.1%)* ▪ *19.5% 40-49 years (19.2%)* ▪ *8.3% 50-59 years and (8.9%)* ▪ *3.1% were 60 years or older (4.3%)*

Outcomes of the health needs analysis		
		○ *Setting (Australia);* ▪ *67.1% were in non-residential facility (66.6%)* ▪ *9.9% outreach (13.0%)* ▪ *6.2% residential (12.2%)* ▪ *1.0% home (1.0%) and (15.8% other; 7.2% Australia)* ○ *Treatment type;* ▪ *47.6% were counselling (40.0%)* ▪ *32.8% were support and case management (14.1%)* ▪ *15.1% were withdrawal management (11.9%)* ▪ *0.2% information and education only (8.4%)* ▪ *1.4% rehabilitation (5.6%) and (2.0% other; 4.4% Australia)* ○ *Principal drug of concern in Gippsland (Australia):* ▪ *29.0% alcohol (32.3%) – downward trend* ▪ *25.3% amphetamines (25.7%) – upward trend* ▪ *22.8% cannabis (21.7%) - steady* ▪ *17.9% other (heroin 5.2%)* • *National data based on interviews with drug users highlight some changes over time;*[82] ○ *Consistent high use of cannabis, alcohol and tobacco* ○ *Heroin use was stable* ○ *Increase in the use of crystal methamphetamine (reduced use of powder)* ○ *Use of both a stimulant and depressant was common* ○ *Around one quarter reported a non-fatal overdose* ○ *Almost half self-reported experiencing a mental health problem in the past six months* ○ *Awareness of Naloxone among over half of injecting drug users*
Aboriginal and Torres Strait Islander people	*Indigenous Australians have higher rates of drug and alcohol use compared to non-Indigenous Australians, but a lack of available data on AOD service use and AOD needs for Indigenous Australians hinders efforts in describing their specific needs.* *In addition to a shortage of AOD treatment services, there are a range of other barriers*	• *5% of Gippsland clients of State funded AOD services identified as Aboriginal or Torres Strait Islander.*[91] • *11% of Gippsland clients identified as Indigenous in 2016-17.*[81] • *The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) provided the following points about AOD issues among Aboriginal people:*[83] ○ *Data gaps exist.* ○ *Aboriginal people in remote areas were less likely to have used an illicit substance in the previous year (23% compared with 19% in less remote areas).* ○ *63% of Aboriginal and Torres Strait Islander people in remote areas said they had never used an illicit substance, compared with 49% of those in non-remote areas*

Outcomes of the health needs analysis		
	to accessing services relating to social and /or cultural factors including geographic isolation, lack of transport and affordability of services, cultural beliefs around AOD use, shame and fear of the justice and child protection system. *AOD services need to advertise their services more to the Indigenous community; and promote referral pathways to their services to medical staff.*	○ *Rates for both alcohol use and drug use are higher for Aboriginal and Torres Strait Islander people compared to the general population.* ○ *Aboriginal people drink at riskier levels than the general population.* ○ *Alcohol is reported as a principal drug of concern, followed by marijuana (97% of organisations), tobacco (64%), multiple drug use (54%) and amphetamines (43%).* ○ *New HIV diagnoses attributable to injecting drug use was higher among Aboriginal Australians compared with the general population, at 16% versus 3%.* ○ *Rates of HIV and hepatitis C virus notifications were higher among Aboriginal compared with non-Aboriginal persons at 5.9 versus 3.7 per 100,000 and 164 versus 35 per 100,000 respectively.* • *Mental disorders are more common among Aboriginal people than for non-Aboriginal people of all ages, except for women aged over 75 years. The major causes of admission for mental disorders are schizophrenia, mood disorders, alcohol and drugs and neurotic disorders. The Aboriginal rates of admission for alcohol and drugs, schizophrenia and neurotic disorders are more than twice the non-Aboriginal rates.*[84] • *AOD was identified as the top ranked health issue, including tobacco use.*[79] "Closing the gap has focused on 0-5-year olds and 21-year olds and older - there are big issues with 6-24-year olds - early intervention, AOD use, smoking are all big issues."
Young People	*Drug and Alcohol use is a significant issue for young people and their parents, but it needs to be seen in the context of other mental health and family issues.* *There is a lack of awareness by young people of the potential harm of illicit drug use.*	• *AOD treatment episodes delivered by State funded services show that 53% of 10-19-year olds were treated for cannabinoids as the main drug of concern.*[70] *Alcohol and amphetamines became more prevalent with age.* • *A youth survey in Baw Baw in 2015 indicated that drug and alcohol was ranked second (after mental health) as the issue of most importance to young people.*[85] • *25% of parents in Baw Baw did not think young people were safe in the community, and suggested drug issues are normalised.*[85] "…drug and alcohol use among our youth is almost 'normal' in the eyes of a lot of youth and their families…" "I believe people have become complacent about the long-term impact drugs and alcohol have on our youth." (parent) • *In Bass Coast, more than half of youth rated 'other drugs' as the top issue affecting young people and 4 in 5 parents/carers rated 'other drugs' as an issue of concern for young people.*[86] • *Young people in Gippsland identified AOD as a health issue.*[79] "Drugs – it's one of the major things that affects health and wellbeing"

Outcomes of the health needs analysis		
		• *The State consultation notes that:*[123] "Young people who use drugs are ill-informed about the potential harms associated with illicit drug use" • *Analysis of AOD treatment episodes delivered by State funded services in 2015-16 show that cannabinoids was the drug of principal concern among people 24 years or younger, especially for people 19 years or younger. Amphetamines became more of a concern for the 20-24-year age group.*[87] • *The Communities That Care program*[88] *is in place in Baw Baw and East Gippsland LGAs with a focus on addressing AOD and underlying issues among young people in the community.*
Families and carers	*There is a need for greater collaboration between AOD and other agencies working with families. The needs of carers is an important consideration in AOD work as they can provide important support if equipped to do so.*	• *The Gippsland Integrated Family Violence Service Reform Steering Committee identified that;* "Stronger links need to be made between MBCP, AOD, mental health agencies and GCASA"[89] • *Carers have reported having difficulty obtaining information about both AOD and MHCSSs. One carer stated that they;* "...have had to tell the story seven or eight times. This includes speaking to the GP, psychiatrist and other health services". [90] • *Carers want access to carer support groups.*[90] • *19% of clients accessing State funded AOD services in Gippsland lived with dependent children (Jan-Jun 2017).*[91]
Hard to Reach Populations	*There are a range of populations that may be at particularly high risk and/or have high treatment needs. These include Indigenous people, geographically isolated people, CALD people, vulnerable children and families, clients of the justice system, homeless people, people with comorbid mental health problems and/ or cognitive impairments and poly drug users. Funding models do not factor in the additional support needs of hard to reach population and vulnerable groups.*	• *Specific populations with additional needs include;* [123] - *People in regional and rural settings* - *People from other cultures such as Aboriginal people, CALD communities* - *Brief interventions for early onset* - *recently released from prison are at high risk of drug related overdose* - *alienated from healthcare and distrustful of mainstream services* - *from CALD backgrounds* - *poly drug users who use a cocktail of different drugs in an opportunistic manner* "...whatever is available or on offer at the time." • *State funded service data shows that;* ○ *5% of clients had an acquired brain injury*[121] ○ *3% of clients were homeless or at risk of homelessness* • *The service mapping and brief survey conducted in 2016 highlighted the following in relation to hard to reach populations:*[90] - *absence of youth AOD services in remote East Gippsland* - *absence of Indigenous specific AOD services in remote East Gippsland*

Outcomes of the health needs analysis		
		- *models of AOD service delivery do not fund the true costs of AOD outreach so it is not occurring in remote areas of Gippsland* - *remoteness of parts for the Gippsland catchment excludes access to the one-day rehabilitation program in the region*
Dual Diagnosis - mental health and alcohol and other drugs	*Consumers and carers see a need for more widespread knowledge among clinicians about dual diagnosis and coordination of treatment services.*	• *Consultation with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) indicated that dual diagnosis is common and advocate for a more holistic approach.*[123] • *Harm Reduction Victoria (HRV) highlights people with a dual diagnosis as a high-risk group.* [123] • *In Gippsland, 43% of clients accessing State funded AOD services were recorded as having a psychiatric diagnosis (Jan-Jun 2017).*[91] • *Gippsland PHN Partners in Recovery data to the end of September 2018 shows that of the 737 accepted referrals, 2% were from AOD services; 10% had unmet needs in relation to alcohol and 11% in relation to prescribed drugs.* • *Dual diagnosis clients can be challenging for the service system, especially in the child, youth and family sectors due to limited dual diagnosis awareness and capacity.*[90]

Indigenous Health (including Indigenous chronic disease)

Outcomes of the health needs analysis		
Identified Need	Key Issue	Description of Evidence
Indigenous health – health and wellbeing	*Gippsland has a high Aboriginal and Torres Strait Islander population and health service use is significantly higher compared to non-Indigenous people for many health conditions, including end-stage renal disease, diabetes, mental and behavioral issues, cardiovascular diseases, dental conditions and respiratory diseases.* *There is a high rate of low birth weight babies and low participation in maternal and child health for children under 12 months. Indigenous children are more likely to be developmentally vulnerable, especially in some LGAs.* *Community consultation revealed work and study opportunities as a top-rated health issue among Indigenous people. Mental health, dental services and AOD were commonly mentioned as issues. Barriers to service access include cost and wait times (as for all respondents), but transport and 'feeling comfortable to access the service' were more common for Indigenous people.*	• *Estimates of the Aboriginal and Torres Strait Islander population in Gippsland was a total of 5,207 people in 2016. The proportion of the total population identifying as Aboriginal of Torres Strait Islander is 4.2% in East Gippsland, 2.0% in Latrobe, 1.9% in Wellington, 1.3% in Baw Baw and 1.0% in South Gippsland and Bass Coast.* [10] • *Approximately 10% of Victoria's Indigenous population live in Gippsland.* [10] • *Hospital admissions are twice as common for Aboriginal people compared to non-Aboriginal people.*[28] • *The participation rate for young Aboriginal children in maternal and child health is lower than for non-Aboriginal children; 90% compared to 97% at 2 weeks and 71% compared to 79% at 12 months.*[92] • *Aboriginal and Torres Strait Islander women in Gippsland have a high rate of low birth weight babies (13.2%), compared to Australia (10.6%).*[26] • *Concerns documented for Victoria are likely to also be relevant for Gippsland.* [93] ○ *Indigenous women are three times more likely to smoke during pregnancy – an estimated 52% in Gippsland* [26] ○ *Low birth weight babies were more than twice as likely from Indigenous mothers* ○ *Indigenous women have low rate of access to antenatal care in the first trimester* ○ *End-stage kidney disease is increasing and 4.5 times more common among Indigenous Australians* ○ *Indigenous Australians are almost five times as likely to be hospitalised for injury due to assault* ○ *Unemployment among Indigenous Australians is much higher than among non-Indigenous Australians* • *In a national analysis, it is highlighted that the death rate for diabetes (underlying and/or associated cause) was more than 4 times as high among Indigenous Australians as non-Indigenous Australians.*[40] *This report also highlights many other indicators for diabetes among Indigenous Australians.* • *Indigenous health was not ranked highly in stakeholder analyses, but was identified in relation to chronic disease management, mental health and socio economic determinants of health such as employment and housing.*[77, 78] • *Aboriginal unemployment was high across Gippsland; 26.7% in Latrobe, 21.0% in Baw Baw, 17.7% in East Gippsland / Wellington and 14.9% in Gippsland South-West, compared to 14.0% in Victoria.*[94]

Outcomes of the health needs analysis		
		• *The proportion of Aboriginal children who are developmentally vulnerable on two or more domains is much higher than for all children (11.5% Gippsland) in Latrobe (46.7%), Bass Coast – South Gippsland (18.8%) and East Gippsland –Wellington (36.1%).*[94] • *The proportion of children aged less than 15 years in jobless families is much higher than for all children (13.8% Gippsland) in Latrobe (51.8%), East Gippsland –Wellington (37.6%), Baw Baw (38.8%) and Bass Coast – South Gippsland (34.8%).*[94] • *Aboriginal participation in full-time secondary schooling is lower than Victorian levels (75%) in Baw Baw (63%) and East Gippsland/Wellington (70%), but higher in Latrobe (94.4%) and Gippsland South-West (100%).*[94] • *Immunisation rates for Aboriginal children (fully immunized 2016-17);* ○ *1-year olds - 87.4% (94.9% of all children)* ○ *2-year olds – 87.0% (93.6%)* ○ *5-year olds – 96.4% (95.7%).*[26] • *The health issue rated as most important for Indigenous people was work and study opportunities, mental health and heart and lung health as identified in the community survey.*[79] • *44% of Indigenous survey respondents reported that nothing stopped them from getting health care they needed in the past 12 months, compared to 48% for all respondents. Main barriers were:* [79] ○ *Cost 44%* ○ *Long wait for appointments 41%* ○ *Didn't feel comfortable accessing the service 18%* ○ *Couldn't get there 15%* ○ *Didn't understand how to access the service 8%* • *18% of Indigenous survey respondents reported that they did not think they could get the help they needed if they had a health problem (compared to 10% of respondents overall).* [79] • *Overall, survey respondents did not rate Work and Study Opportunities among the most important issues for health, but for young people and Indigenous people it was in the top three.* [79] • *Alcohol and other drugs was the top ranked health issue identified in interviews, including tobacco use, and noted as a specific issue for youth.* [79] *Other issues of note include obesity / overeating, heart disease, diabetes and respiratory issues.* • *A national study found that Indigenous Australians experience a burden of disease that is 2.3 times the rate of non-Indigenous Australians.*[27] • *A national survey of Aboriginal and Torres Strait Islanders found that in Victoria;*[93] ○ *37% felt that they had been unfairly treated at least once in the previous 12 months because*

Outcomes of the health needs analysis		
		they were ATSI ○ *57% identified with a clan, tribal or language group* ○ *51% were employed* ○ *21% had experienced or been threatened with physical violence in the past 12 months* • *The national 2017 Bringing Them Home report identifies a need to do a comprehensive assessment of the contemporary and emerging needs of Stolen Generations members and to better understand intergenerational trauma to allow change for young Aboriginal and Torres Strait Islander people in the future.*[95] • *Community engagement by the State government in Gippsland in 2018 noted;*[96] ○ *Community needs a direct voice to set priorities and plan, not through ACCHOs* ○ *It is the Government's role to provide resources for capacity and meeting targets* ○ *Government and representatives need stronger cultural competency, respect and understanding of Aboriginal culture and protocols* ○ *A need for improved access to affordable, culturally appropriate health services* ○ *Lack of non-Aboriginal understanding of intergeneration trauma* ○ *Importance of housing for good health (overcrowding)* ○ *Recognition of racism affecting health* ○ *Address drug and alcohol use, including fetal spectrum disorder* ○ *Education needs to include Aboriginal ways of learning* ○ *Community based prevention of crime, including strong Aboriginal role models* ○ *Importance of cultural land recognition by all who visit Gippsland*
Indigenous health – chronic disease	*Chronic disease including diabetes, cardiovascular disease and mental health issues are all more common among Indigenous people. It is important to consider the whole person and family experiences including trauma to help address these issues.*	• *Conditions where hospitalisations for Aboriginal people are much more common than for non-Aboriginal people;* ○ *Renal dialysis – 26 times* ○ *Diabetes – 7 times* ○ *Mental and behavioral disorders – 6 times* ○ *Cardiovascular diseases – 4 times* ○ *Hospitalisations attributable to alcohol or tobacco – 3.4 times* ○ *Hospitalisations attributable to tobacco – 2.7 times.* [28] • *The top Ambulatory Care Sensitive Conditions leading to a hospital admission in Gippsland are:* ○ *Diabetes (28%)* ○ *Dental conditions (17%)* ○ *COPD (12%)*

Outcomes of the health needs analysis		
		○ *Convulsions / epilepsy (9%)* ○ *Asthma (9%)* ○ *Angina (8%)* [28] • *Hospitalisation rates for Aboriginal people (15 years or older) were high in East Gippsland-Wellington (81,904 hospital admissions per 100,000 population, age standardised rate 2012-13) and Latrobe (68,838) compared to Victoria (49,020);* [94] ○ *Digestive and circulatory system diseases were high compared to Victoria* • *Chronic diseases as a group accounted for almost two-thirds (64%) of the total disease burden for Indigenous Australians. Disease groups causing the most burden was mental & substance use disorders (19% of the total), followed by injuries (including suicide) (15%), cardiovascular diseases (12%), cancer (9%), respiratory diseases (8%) and musculoskeletal conditions (7%).*[27] • *The biggest difference to non-Indigenous was for cardiovascular diseases (19% of the gap), mental & substance use disorders (14%) and cancer (9%).*[27]
Indigenous health – mental health		*See Primary Mental Health and Suicide prevention*
Indigenous health – Alcohol and Other Drugs		*See Alcohol and Other Drug Treatment Services section*

Section 3 – Outcomes of the service needs analysis

This section summarises the findings of the service needs analysis in the table below. For more information refer to Table 2 in '5. Summarising the Findings' in the Needs Assessment Guide on www.health.gov.au/PHN.

Additional rows may be added as required.

General Population Health

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Access to services	*Accessing health services can be a challenge in a regional and remote area due to the vast distances and challenging terrain. Transport was mentioned as an issue for many people even in the least remote parts of Gippsland due to few public transport options.* *Economic factors are an important consideration for many people in accessing services, especially for people with low socio-economic status.* *Access to specialists is an issue and private hospitals are very few.* *Community input shows that access to health services is most difficult for people with social or financial worries, parents and people with a disability. Main barriers are cost, long wait times and transport, while not feeling comfortable accessing a service*	• *The ABS remoteness category is Inner regional for much of Gippsland, but Outer regional for Wellington and East Gippsland.[8]* • *The population density ranges between a low of 2.2 persons per km² in East Gippsland to 52.1 in Latrobe (average for Victoria 27.2).[10]* • *34.0% of the Gippsland population are within 400 m of tram/bus or 800 m of train, compared to 73.9% of Victorians; even lower proportions in South Gippsland (8.5%), East Gippsland (19.5%), Baw Baw (20.9%) and Wellington (26.6%).[8]* • *1.5% of journeys to work in Gippsland are by public transport compared to 12.6% across Victoria. [10]* • *16.1% of families are one parent families (Victoria 15.3%); the highest proportion is in Latrobe with 19.9%.[10]* • *16.4% of people in Gippsland needed to see a GP but did not according to a national survey (Australia 14.1%).[26]* • *37.0% of people in Gippsland could not access their preferred GP in the preceding 12 months, antenatal as estimated by a national survey (Australia 28.5%).[26]* • *The average number of GP attendances varies across Gippsland; it is high in Latrobe and Baw Baw (6.5 per person per year) but low in East Gippsland (4.5) compared to Australia (6.1).[26]* • *The proportion of people who did not claim a GP attendance in 2016-17 was 9.8% in Gippsland, compared to 12.5% nationally; highest proportions were in Wellington (13.2%) and East Gippsland (11.9%).[26]* • *The average number of specialist attendances varies across Gippsland; it is low in East Gippsland with 0.71 per year per person and highest in Latrobe with 1.11 compared to 0.95 for Australia. [26]*

Outcomes of the service needs analysis		
	and lack of information about available services are also relevant, especially for some groups. Access to GPs was the top health issue in interviews but access to medical specialists, dental services and mental health service were also common. Variation between groups and geographical areas is noted.	• *The proportion of bulk billed attendances at GPs in Gippsland is high at 86.7% compared to Australia (85.1%), especially in Latrobe (90.1%), except in East Gippsland (80.3%) and Wellington (82.6%).[26]* • *Hospital admissions rates are high in Gippsland (409 per 1,000 people), especially for East Gippsland residents (508) and Latrobe residents (443), compared to Victoria (305);[54] Baw Baw had the lowest rate at 308.* • *77% of hospital admissions for Gippsland residents are in public hospitals, compared to 61% for Victoria.[8]* • *Emergency department presentation rates in Gippsland are high (398 presentations per 1,000 people), compared to 286 for Victoria.[17] South Gippsland rates are low as there is no funded ED.* • *Primary care type presentations to ED (category 4-5) are high across Gippsland (238 per 1,000 people), compared to Victoria (148) except for South Gippsland residents.[17]* • *Population groups more likely to experience access issues include;* ○ *Persons with low socio-economic status (see separate priority area).* ○ *Persons with low English proficiency – 0.4% in Gippsland, but 0.7 % in Latrobe and 0.5% in Bass Coast (Vic 2.9%).[25]* ○ *Homeless persons, estimated to be 692 persons in Gippsland.[97]* ○ *Persons with a profound or severe disability, more than 17,000 in Gippsland (see separate priority area).[10]* ○ *Same sex and gender diverse population – we don't know the size of this population.* • *Service gaps were identified as the top theme in existing reports with consumer and other stakeholder feedback as well as in stakeholder interviews.[77] Specific issues related to accessing services included:* ○ *Transport which is an issue both due to lack of public transport options in many parts of Gippsland and also due to the sheer distance to access many services even if they exist within Gippsland.* ○ *The cost of accessing services is a major factor leading to disadvantaged groups unable to access existing services (including people with low socio-economic status, Aboriginal and Torres Strait Islanders, and the aged)* ○ *There is a general lack of access to specialists across the region, but the difficulty in accessing becomes greater with increased remoteness.* • *Service access by community survey respondents showed some variation across the region, [79]* ○ *Bass Coast residents reported higher use of GPs, ED, ambulance, allied health and dentists.* ○ *Baw Baw residents reported higher use of ambulance and nursing in the home.* ○ *East Gippsland residents reported lower use of GPs and allied health, while ambulance,*

Outcomes of the service needs analysis		
		community health and nursing in the home use was higher. ○ *Latrobe residents reported higher use of GPs, ED, community health services, and pharmacists.* ○ *South Gippsland residents reported higher use of GPs, pharmacists, allied health and dentists, while use of ED and community health was low.* ○ *Wellington residents reported lower use of community health and nursing in the home, while use was not high for any service.* • *Overall, 48% of survey respondents reported that nothing stopped them from getting health care they needed in the past 12 months.* [79] ○ *Variation by sub-group shows that only around 30% of people with low SES, parents and people with a disability had nothing stopping them from accessing health care they needed.* • *The most commonly reported barriers to accessing health care were;* [79] ○ *Cost – overall 32% of respondents reported this as a barrier, with even higher proportions reported by people with low SES (55%), people with a disability (48%) and Indigenous people (44%).* "There is a huge difference in affordable services for those that do and do not have a health care or pension card … middle income earners are falling through the cracks" "I now ask if they do bulk billing and if they don't I'll go elsewhere, but you are ending up with scenarios of people not going to the Drs" ○ *A too long wait for an appointment was reported by 24% of respondents, with up to 40% of Indigenous people, parents and people with a disability reporting this a barrier.* "GP services are very limited in this area which prevents anything but urgent care being attended." ○ *10% of all respondents reported that they couldn't get to the health care they needed. For people with a disability, as many as 23% had problems getting there, while around 15% of carers and people with low SES reported this as an issue.* ○ *6% of all respondents reported that they did not feel comfortable accessing the service they needed, while 17% of Indigenous people and 14% of young people reported this as an issue.* ○ *4% of all respondents reported that they did not know how to access the service, while over 8% of Indigenous people and young people reported this as a barrier.* ○ *Some regional differences were also noted with the most significant being a high proportion of East Gippsland residents reporting a long wait for appointments and issues with getting to their service.*

Outcomes of the service needs analysis		
		• *In 2018, 38% of survey respondents reported travelling more than an hour to access health services at least once in the past year.*[35] • *Overall, 10% of survey respondents reported that they did not think they could get the help they needed if they had a health problem.* [79] ○ *People with a disability (26%), Indigenous people (18%) and people with low SES (15%) were more likely to report that they could not get help when needed. Results by LGA show that East Gippsland residents are least confident about getting the help they need if they have a health problem.* • *In 2018, 83% of survey respondents knew how to access the health care they needed.*[35] • *43% of all survey respondents reported problems getting an appointment with a GP during business hours. For parents of children aged 0-14 years and carers, around 55% reported problems accessing a GP within business hours.* [79] *Differences by LGA show that residents of Bass Coast and East Gippsland were more likely to report problems accessing a GP, while Baw Baw residents were less likely to report problems accessing a GP during business s hours (26%)* "No continuity in GP practices, always see a different doctor and differing opinions in the end my illness side effects were missed and I had 5 weeks off work" • *The most common health issue identified in community interviews was access to GPs.* [79] *Other common issues were;* ○ *transport, often mentioned as "*transport to access health care*" and in association with affordability* ○ *access to medical specialists* ○ *access to health care (general).* • *The most common service gaps identified in community interviews was GPs and this was commonly mentioned in association with continuity of care, bulk billing and after-hours access.* [79] *Other service gaps were;* ○ *medical specialists, including cardiologist, rheumatologist and ophthalmologist* ○ dental services, especially affordable dental ○ *transport, often mentioned as "*transport to access health care*" and in association with affordability* ○ *mental health services, including child mental health, counselling (affordable) and youth services* ○ *specialist health care, including early assessment and intervention for children, diagnostic services, chemotherapy, maternity, dialysis, rehabilitation and youth health services*

Outcomes of the service needs analysis		
		○ *allied health services, especially pediatric allied health, audiology, speech and podiatry (affordable)* • *Access to specialist services was rated as a top service gap identified in feedback provided via the Gippsland PHN web site. There was specific mention of; mental health services, including youth specific, cancer treatment, orthopedics, ophthalmologists and pediatricians;* [79] "Mental health services - complex to access" • *Access to GPs was rated as a top service gap identified in feedback provided via the Gippsland PHN web site.* [79] • *A local community engagement project was undertaken in Mallacoota to learn more about the community's health needs.*[98] *Key themes included;* ○ *the community were supportive and appreciative of current service providers* ○ *GP access is limited due to a sole practitioner* ○ *aged care services are largely not available (a high proportion of residents are 55+)* ○ *community palliative care services are needed* ○ *face-to-face mental health services are needed* ○ *ambulance services are limited due to limited staffing* ○ *health service provision is limited by reliable transport, power and telecommunications, especially in emergencies* ○ *lack of coordination between existing service providers is a significant barrier; "*all of these services should be under one umbrella*"* ○ *tourism leads to much greater demand for services in peak season* • *A project to inform the Gippsland South Coast Primary Health Plan (Bass Coast and South Gippsland LGAs) was undertaken in 2018 and included engagement with local general practices.*[99] *Themes included;* ○ *Long waits for public allied health and mental health services* ○ *Limited space and lack of infrastructure funding is a barrier to expansion of services at general practices* ○ *After-hours access is limited and costs to consumers and remuneration of GPs are barriers, leading to increased pressure on ED services where available. South Gippsland does not have a funded ED, but three Urgent Care Centers.* ○ *POLAR can be used more effectively within the practices to identify patients' needs* ○ *The area has a large population increase over the summer holiday period without increase in capacity to meet demand for primary care*

Outcomes of the service needs analysis		
		○ *Improvement in connectivity and referral processes between GPs, hospitals and private providers are needed*
Access to services – After-hours	*Community engagement reveal after-hours service access as a community concern in many parts of Gippsland, especially in more remote locations with no access to an emergency department.* *GPs are responsible for around half of all after-hours medical activity in Gippsland, either through a general practice or urgent care centre.* *Cost is a barrier to people accessing GP practices after-hours due to lack of bulk billing. At the same time, providers find it challenging to attract staff after hours due to lack of financial incentives.* *Awareness of after-hours options is generally low.*	• *The after-hours period is defined as:* ○ *Before 8.00am and after 6.00pm weekdays* ○ *Before 8.00am and after 12.00pm Saturdays* ○ *All day Sundays and public holidays* • *The after-hours period is further categorised into the following periods:* ○ *The sociable after-hours period, between 6.00pm and 11.00pm, and 7.00 am until 8.00 am* ○ *The unsociable after-hours period, between 11.00pm and 7.00am* • *An after-hours practice incentive payment (PIP) is available and PHNs are funded by the Department of Health to increase the efficiency and effectiveness of after-hours primary care in their catchments.* • *Emergency Departments funded by DHHS are available in five locations across Gippsland; Bairnsdale, Sale, Traralgon, Warragul and Wonthaggi.* • *GP operated urgent care centres in six locations; Omeo, Orbost, Leongatha, Korumburra, Foster and Yarram.* • *Support by Gippsland PHN for GP practices to operate in the after-hours period is provided in Cowes, Leongatha, Moe, Omeo and Orbost.* • *40 GP practices in Gippsland received the level 5 after-hours incentive payment for the November quarter 2017.*[42] • *Additional GP practices operate in the after-hours period through use of PIP and/or MBS funding support.* • *After-hours service options in remote communities include an urgent care type service in Mallacoota, supported by the Ambulance service, and bush nursing services in Cann Valley, Ensay, Gelantipy, Buchan, Swifts Creek and Dargo.* • *The average number of after-hours GP attendances is low across Gippsland with 0.18 visits per year per person compared to 0.49 for Australia.* [26] • *Workforce issues are an important consideration influencing after-hours medical service provision. GPs willing to accept the responsibility of 24 hours coverage can be hard to find, leading to recruitment issues in rural areas.*[100] • *Approximately half of after-hours activity in Gippsland is provided by GPs (at a general practice or via urgent care centers) with the other half accounted for by emergency departments.*[100] *Variation by LGA highlight South Gippsland as very GP reliant due to lack of funded ED.* • *After-hours ED presentations are high in Gippsland compared to the rest of Victoria (except in South*

Outcomes of the service needs analysis		
		Gippsland where there is no ED).[100] • *ED presentations for category 4-5 (semi-urgent and non-urgent) account for 54% of after-hours activity.*[100] • *MBS items are available for urgent and non-urgent after-hours attendances. Data for 2015-16 shows the distribution of the type of claims;* [100] ○ *9.6% were a consultation in an aged care facility* ○ *1.6% were home visits (or a consultation at an institution other than hospital)* ○ *14.4% were urgent after-hours attendances* • *Based on regional de-identified GP practice data, after-hours activity provided in 2016, 50.3% occurred in the 6 pm to 8 pm period on week-days, when there is no after-hours MBS item available.* [100] • *Access to after-hours emergency care on Philip Island has been an on-going community concern. A project to identify a suitable model to address this gap has been undertaken, including literature review, data analysis of current activity and community focus groups. Findings include:*[101] ○ *The community is not aware of all existing options* ○ *Any model needs to cater for the strong fluctuation in demand due to tourism* ○ *The needs of people with mental illness, drug and alcohol and domestic violence issues need to be considered* ○ *Transport needs are an important service consideration* • *Gippsland PHN Clinical Councils have expressed some concerns about the sustainability of GPs providing after-hours care due to the impact on work / life balance for rural and regional GPs. Poor remuneration is an additional concern.* • *The Gippsland PHN Clinical Councils have identified that access to after-hours medical care for residents of aged care facilities is an issue contributing to deteriorating conditions for residents who are then more likely to present to the emergency department.* • *Access to medical services after-hours was identified as a need in community interviews across Gippsland; a need is access to ED in South Gippsland.*[79] • *Survey results show that respondents are most likely to access the ED after hours if they had a health problem (86%). The proportion reporting they were likely to seek help from other services;* [79] ○ *Ambulance 76%* ○ *Family / friends 69%* ○ *Nurse on call / GP help line 59%* ○ *Their doctor / GP 31%* • *After-hours access of own doctor / GP was reported as not likely by 53% and 17% did not know how to*

Outcomes of the service needs analysis		
		contact. South Gippsland and Baw Baw residents were more likely to seek help from own doctor / GP after-hours (around 40%), while East Gippsland residents were less likely (22%).[79] • *After-hours access of Nurse on call / GP help line was reported as not likely by 33% and 8% did not know how to contact. Parents, Carers and people with a disability were more likely to contact help lines (around 70%), while males were less likely (47%).*[79] • *Barriers and enablers to access after-hours services were identified;* [79] ○ *GPs are often not available* ○ *GPs are too expensive* "It's too expensive to go to the GP on any normal visit time, let alone an after-hours fee. Forget it. I'd go the emergency dept instead" ○ *GP would refer to ED* "I end up at emergency with doctor's letter" ○ *Nurse on call had mixed reviews* ○ *ED was seen as a good options but wait times were a barrier* ○ *Ambulance is the only option in some areas; concern about response time was noted* ○ *A lack of knowledge about after-hours options* "More info should be provided to people about what to do when mental health problems occur after hours" • *Service providers have identified some specific challenges;* [127] ○ *Making it financially attractive for GPs to provide an after-hours service without increasing the cost for consumers. Potential use of a nurse practitioner model.* ○ *Increased demand for mental health services.* ○ *Increased demand for chronic disease management.* ○ *High proportion of patients with low socio-economic status leading to high demand for bulk billing.* ○ *Workforce challenges in outer regional areas could be addressed by additional incentives for international graduates and funding for locum cover.* ○ *Tourism activities can lo added injuries which add to after-hours service pressure.* ○ *After-hours medical issues include heart related issues, injuries, mental health issues, family violence issues and exacerbation of asthma.*
Digital health	*Stakeholder feedback indicated that there is awareness and some optimism that digital health initiatives such as telehealth and e-*	• *77.7% of households in Gippsland have broadband internet connection compared to 83.7% in Victoria; East Gippsland has the lowest proportion (74.7%).*[10] • *Of 82 GP practices in Gippsland;*

Outcomes of the service needs analysis		
	referrals can improve communication between providers. Access to an adequate internet connection is a barrier for the roll out of digital health initiatives. *Recent My Health Record engagement has improved awareness of the tool and many providers are looking forward to seeing its full benefits. Community awareness is improving.* *The Gippsland PHN Digital Health Strategy identifies enablers and barriers for improved use of technology for health in Gippsland.*	○ *57 practices (70%) have POLAR installed; 3 practices (4%) are awaiting install and 14 practices (17%) are unable to have POLAR installed while 8 practices (10%) are not willing to have POLAR installed.*[102] ○ *64 practices use My Health Record* [102] • *A total of 135 providers in Gippsland have registered with My Health Record (up from 91 in 2017), 64 of these were GP, 52 pharmacies (17), 1 aged care provider, 6 hospitals and 12 others.* [103] • *There are 49,994 people registered with My Health Record in Gippsland, 18.4% of the Gippsland population (up from 13.6% in 2017).* [103] • *67% of general practices use one or more secure messaging solution, most commonly Argus.*[107] • *Digital health was a key theme in stakeholder interviews and identified as an opportunity to improve communication between service providers.*[79] • *MBS data show that claims for telehealth have more than tripled between 2012-13 and 2016-17, especially in Wellington.*[104] • *93% of people responding to a survey in 2018 reported using the internet for any purpose.*[35] • *4% of people responding to a survey in 2018 reported having used telehealth.*[35] • *Stakeholder input identified lack of adequate internet connection as a barrier to accessing some services such as telehealth.* [78] • *There was one mention of digital health in the community survey;* [79] "Stop talking about video conferencing/consulting and do it!" • *A survey of allied health stakeholders in Gippsland identified that a lack of electronic health record was an issue.*[35] • *Engagement with community about My Health Record at events and community groups indicate that many started off with a negative and un-informed view;*[105] "I've already opted out; my information is my business" "What's this all about" "Isn't it going to make more work for the doctors" "What about hackers, who knows what they'll do with my information" "I don't use a computer, what good is it to me" *Following engagement, many became more positive:* "It just makes sense to me to have my information there, I don't have to remember everything myself'

Outcomes of the service needs analysis		
		"I get tired of telling my story over and over again to different health providers." "I don't use computers or smart phones but if my doctor can see the information and add to it, those who need to see it can, even if I don't ever plan to look at it myself" • *My Health Record engagement with clinicians has raised awareness of its potential benefits, both among GPs, specialists and allied health providers. While not everyone uses the tool yet, there is growing awareness;*[105] o "We are not using the My Health Record system yet, but I can see great benefit of the system. For example, I see a lot of out of home care patients and it like solving a mystery. I have to find out who has seen the child before, what previous investigations or treatment have been done etc. It is like re-inventing the wheel." (specialist) o "My Health Record has been very helpful to have access to information uploaded from other healthcare providers. My Health Record has been most useful for us for patients who have been in hospital." (pharmacist) o "My Health Record compliments what I think about a good quality Health Record in General Practice, especially in a multi person practice and especially in a practice where registrars and students are coming and going so the quality of your medical record is really important otherwise things are forgotten about or ignored or not acted upon." (GP) o "I think My Health Record will be fantastic once it gets up and going and patients know more about it and what it means to opt-out. I would like to see more advertisement for patients about it. I had not really heard of it before and only became aware of My Health Record through networking conversations." (podiatrist) o "I guess the biggest benefit of My Health Record is that the patient does not need to carry their own (paper) records with them, wherever they go, interstate or within a state, especially in an emergency where there is no one to give information about (an individual's) health history, the doctor in ED of a hospital can login to My Health Record and retrieve the information, so whether it is allergies, any medications they might be taking, any conditions they might have, they will be well aware of when treating the patient in ED." (GP) • *48 GP practices in Gippsland received the eHealth incentive payment for the November quarter 2017.*[42] • *A Digital Health Strategy has been developed for Gippsland PHN with a focus on engaging and empowering patients, activating caregiver networks to drive improved engagement, accessibility, quality, safety, efficiency and sustainability into all corners of the health system.*[107] *The Strategy identifies some enablers and barriers;* o *Mobile devices with access to mobile data are common across socio-economic groups and*

Outcomes of the service needs analysis		
		among young people ○ *Use of desktop PCs and broadband internet is less common among people with low socio-economic status* ○ *Technology such as mobile applications and wearables have the potential to support patients in lower socio-economic, rural and remote areas to manage chronic disease and medication* ○ *Digital health communities can help improve health literacy and provide support* ○ *New technology can empower patients to become engaged consumers and carers to be more informed and better equipped to assist* ○ *Web portals are most likely to be used by people with higher socio-economic status who already have better health outcomes* ○ *Innovative models such as Health Care Homes provides a funding model which can facilitate innovative approaches to healthcare delivery* ○ *The referral landscape involves many stakeholders, different technology and different incentives and workflows posing some distinct challenges, fax is still widely used* ○ *The National Health Service Directory has significant limitations* ○ *Most general practices, hospitals and community services have access to some type of telehealth solution with several versions available for different purposes* ○ *Evidence of consumer need for telehealth options* ○ *Evidence of a siloed approach and a lack of coordination across stakeholders* ○ *General practices are focused on the current service model with limited incentives to change*
Service coordination	*Stakeholder input identified service coordination as a priority to improve health outcomes. It is especially important for conditions where many service providers are involved in the care, including. chronic diseases and for patients with complex care requirements.* *Information about local service providers and where to access the service is needed. There is relatively low health literacy across Gippsland which further compounds service coordination needs and integrated care*	• *It is estimated that of people in Gippsland over 45 years;[26]* ○ *78.1% have a usual GP (Australia 87.4%)* ○ *92.4% have a usual place of care (90.5%)* • *21.2% of people saw three or more health professionals for the same condition according to a national survey (Australia 16.7%).[26]* • *Postcard surveys in Gippsland in 2018 suggest that 40% of people had seen three or more health professionals for the same condition in the past year.[35]* • *Coordination of services (as a broad theme) was raised as a priority among consumer and stakeholders. The theme included statements about service models, integration, collaboration and communication formats.[77, 78]* • *Service coordination was also identified as a key issue for certain disease types, such as chronic diseases (e.g. diabetes) and cancer, and for persons with co-morbidities where complex care plans require the involvement of numerous providers. [78]*

Outcomes of the service needs analysis		
	challenges. *Community input confirms that service coordination is a common problem impacting on the quality of care provided. Key aspects include poor communication between providers and members of the community being unaware of service options.*	• *The coordination of care between the primary care setting and the acute setting was identified as challenging, e.g. discharge planning from the hospital setting.* [78] • *A lack of information about existing services and how to access them, both tailored for primary care providers and consumers, is an issue raised in general terms and for specific service types;* [78] ○ *Alcohol and Other Drug treatment services* ○ *Mental health services* ○ *After-hours medical services* • *The Gippsland PHN Clinical Council identified low health literacy among a high proportion of Gippsland's population as an important factor affecting health (2016).* • *A lack of information about health services was the 8th most common theme identified in community interviews.*[79] *There is confusion about what is available, how it can be accessed and costs.* "It's too confusing who does what - people get confused about what is available" "Rural Health Claiming for $ for visits to specialists for … what you can get with a HCC" "More information that comes to the school about what's available - for lots of families school is their first port of call and we need information to tap them into what services are around" "A consultant who people could go to and say this is my problem - who could answer their questions" • *Poor communication between health service providers, and to consumers was identified in community interviews.* [79] "[Wish for] …health practitioners (all disciplines) that can understand and has the time to understand the needs of the clients …" • *Community survey responses revealed that difficulties in accessing a preferred GP, especially in a timely manner was a top-rated concern. Respondents were concerned about having to repeat their history every time a new GP or other service provider was seen, even within the same GP practice.* [79] "Drs keep changing and you have to keep explaining yourself in the end I think why am I here - I'm just wasting my time - it should all be on the computer" • *Health issues that were not managed well were identified in the community survey.* [79] *A common issue across health issues was lack of effective communication;* "… in the end all comes down to communication" "The consumer and carer/family need time to be listened to, to understand …" • *A survey of allied health stakeholders in Gippsland identified that issues around aged care was a top concern, especially coordination between providers.*[35] • *A Gippsland PHN referral analysis project was undertaken in 2016 and the findings included;*[106]

Outcomes of the service needs analysis		
		○ *the bulk of health information communication between services and providers in Gippsland are not through secure electronic messaging and include phone, fax, unencrypted emails, posted mail, and patient-presented paper referrals* ○ *there are pockets of significant electronic referral use* ○ *hospitals in Gippsland mostly use the S2S electronic referral system internally* ○ *Argus secure messaging transfer allows encrypted, electronic messages from GPs to be received in S2S, but this functionality has not been implemented in the hospitals resulting in continued significant use of phone, unencrypted email, posted letters, and patient-presented referrals* ○ *stakeholders identified significant barriers to using electronic referrals, including lack of capability, infrastructure and compatibility between hospitals, specialists, general practice and other service providers* ○ *hospitals identified a lack of timely, good quality, standardised information from both internal and external sources as the biggest challenge* A Digital Health Strategy[107] has since been developed – see Digital health. • *A Gippsland PHN project about advance care planning (ACP) in the community found that;*[108] ○ *82% of interviewed consumers had no working understanding of advance care planning, but 40% had had a poor experience with a death* ○ *78% of consumers would welcome a discussion about ACP at their next GP appointment* ○ *GPs were supportive of ACPs, but 82% were concerned about a lack of consistent approach* ○ *ACP activity is initiated in an ad hoc manner and there is generally poor coordination between hospitals and the primary care setting* ○ *Enablers for ACP were identified and included; passionate clinicians, inclusion in checklist for 75 year health assessment, funding and high level organisational support, a clear process and coordination between providers and community events* • *A follow up project explored Advance Care Planning from a hospital perspective;*[109] ○ *Health services in Gippsland are preparing for the new Medical Treatment Planning and Decisions Act 2016 (Vic) with specific reference to Advance Care Directive and the appointment of the Medical Treatment Decision Maker.* ○ *Victorian Health Services currently report quarterly via their patient management system to provide the number of patients 75 years and over admitted with an Advance Care Directive. Admission processes include check for the existence of an Advance Care Directive.* ○ *Hospital activity is primarily focused on internal processes to ensure staff are trained and*

Outcomes of the service needs analysis		
		Advance Care Directives are acted on. ○ *Hospitals also initiate Advance care planning discussions.* ○ *A gap between hospital and primary care remains and hospitals were supportive of greater activity in the primary care space to bridge the gap and greater engagement with GPs.* ○ *Lack of My Health Record interoperability with hospital systems.* ○ *Hospitals identified primary and aged care personnel as best placed to facilitate Advance Care Plans.* ○ *Hospitals identified the consumer and/or the Medical Treatment Decision Maker as best placed to carry the Directives and ensure they are communicated to the hospital.* • *In 2018, 10% of survey respondents in reported having an Advance Care Plan.*[35] • *Place-based planning of primary health service need has highlighted the need for service integration as a key component.*[99]
Service quality	*Variation in prescribing rates for medications and choice of procedures were identified and can be an indication of unwanted variation rather than an underlying disease pattern. Barriers to the provision of evidence-based care were identified as difficulties in planning for services due to short term funding cycles and lack of awareness and skills in certain areas.* *Community input revealed that some people experience issues with attitudes of service providers and lack of effective communication, both main factors leading to health problems not being managed well. There was variation between population groups and geographical areas.*	• *Variation in prescribing, procedures and investigations were identified;*[31] ○ *Opioid prescribing rates are high across the region, especially in Latrobe and East Gippsland* ○ *Rates of hysterectomy and endometrial ablation are high* ○ *Rates of mental health treatment plans vary by LGA, being high in Bass Coast, South Gippsland and Baw Baw and low in Latrobe* ○ *Antidepressant prescribing rates are high for 0-17-year olds but vary by LGA and age* ○ *Prescribing of anxiolytics and antipsychotics vary by age and LGA* ○ *Prescribing of ADHD medications for those aged 17 or younger are high across Gippsland* ○ *Fibre optic colonoscopy rates are high in some a low in other LGAs* ○ *CT imaging of the lumbar spine vary across Gippsland's LGAs* ○ *Antimicrobial prescribing rates vary by type and LGA* ○ *Asthma medication prescribing rates are high for most age groups and LGAs* ○ *Anticholinesterase medicine prescribing rates are low in Gippsland* • *PBS data show that Gippsland residents had the highest number of prescriptions per person of any PHN in 2016-17 at 16.6 per person, compared to 12.8 per person for Australia (range 14.9 in Baw Baw to 18.3 in East Gippsland).*[110]*The patient contribution made up 17% of the cost of prescriptions in Gippsland compared to 19% nationally (range 16% in East Gippsland to 18% in Bass Coast/South Gippsland).* • *Health service planning and associated funding models were identified as a barrier to service quality. Continuity of funding would improve service quality.*[77] *Furthermore, service availability can be lost as currently most service providers report loss of clinicians due to delays in funding announcements.*[78]

Outcomes of the service needs analysis		
		• *Education needs were identified;* [78] ○ *Family violence for primary care providers* ○ *Radiology for GPs* ○ *Motivational interviewing* ○ *Refugee health* ○ *Interpreter service access* • *Attitudes among services providers as a barrier to good quality health care was identified as a theme in consumer and stakeholder input to existing reports.*[77] • *Service provision to refugees and other migrants is not common in Gippsland but therefore poses challenges, for example in knowing how to access interpreters, diagnosing and treating diseases not usually seen and cultural differences.*[78] • *SSAGD people have poorer health outcomes because of systemic stigma and discrimination. SSAGD people suffer from higher rates of violence, social isolation and alienation which are associated with reduced physical and mental health.*[23] • *SSAGD people under-utilise health services and delay seeking treatment due to actual or anticipated bias from service providers.* [23] • *22% of all survey respondents reported that they had a health problem they did not think had been managed properly, groups where this was more likely; 44% of people with a disability,31% of carers and people with low SES. Differences by LGA showed that Latrobe had the highest proportion (27%) and South Gippsland the lowest (16%) proportion of respondents reporting a health problem they did not think had been managed properly. The most common health issue that was not managed well was mental health issues.*[79] • *Issues with attitudes of some service providers were noted in community interviews in 2016.* [79] "Drs don't explain things well and you've still got no idea and you just sit there nodding like a bloody idiot." "… they treat you like you're a bloody idiot, like they don't have to tell you anything and you wouldn't understand anyway" • *Health issues that were not managed well were identified in the community survey in 2016* [79] *A common issue across health issues was lack of effective communication;* "… in the end all comes down to communication" "The consumer and carer / family need time to be listened to, to understand …" • *The importance of good quality interactions with health professionals was a key message from research by the Health issues Centre in 2018;*[20]

Outcomes of the service needs analysis		
		"Ageing consumers expressed emphatically that they do not want to be viewed by health service providers simply as an 'elderly person'. For those who attend consultations with a GP who fails to listen, express empathy towards their situation, or validate them as a witness to their own experiences, this results in withdrawal from that particular doctor and in some cases from clinical services in general." "This can be achieved by providers actively listening to consumers, communicating effectively and demonstrating empathy." • *65% of survey respondents thought that health professionals communicate well with each other to support their care.*[35] • *75.6% of people across Gippsland received a prescription; high compared to 71.1% for Victoria (especially in Latrobe 78.2%).*[31] • *A theme among comments provided in the 'Have your say' web survey was the great skill and commitment by local clinicians. It also included suggestions for improvements*;[79] "Ensure all GPs are all competent regarding mental health issues and pathways to support" • 61 of 81 GP practices in Gippsland received the rural loading payment in the November 2017 quarter.[42]
Workforce	*The proportion of the Gippsland population with a higher education is low and the rate of participation in higher education among young people is also low. Gippsland has a lower than expected number of registered professionals in the health area compared to Victoria, especially for medical specialists and allied health. The number of registered GPs is similar. Many service gaps identified in stakeholder consultations are likely to be affected by workforce limitations.* *There is a great deal of complexity relating to a comprehensive workforce analysis. Gippsland PHN has initiated place-based and broader initiatives to better understand workforce issues with other stakeholders.*	• *Higher education qualifications are held by 27% of Gippsland residents compared to 46% of Victorians.*[10] • *School leaver participation in higher education in Gippsland is 20.7% compared to 39.3% in Victoria.* [10] • *There are 82 general practice locations in Gippsland;* ○ *Bass Coast – 8* ○ *Baw Baw – 15* ○ *East Gippsland – 15* ○ *Latrobe – 26* ○ *South Gippsland – 8* ○ *Wellington - 10* • *Gippsland has 123 FTE GPs (including registrars) per 100,000 people, compared to 117 across Victoria. The range for LGAs is from 99 in Wellington to 157 in South Gippsland.*[111] • *Gippsland had an estimated 144 FTE registered medical professionals (other than GPs) per 100,000 people compared to 292 in Victoria as a whole.*[111] *All LGAs except Latrobe has an even lower rate (Latrobe 264).* [111] • *There are 1,177 FTE nurses (enrolled and registered) Gippsland compared to 1,273 in Victoria.* [111] • *Allied health professional FTE in Gippsland (compared to Victoria);* [111]

Outcomes of the service needs analysis		
		○ *Psychologists – 50 (Vic 102)* ○ *Occupational therapists – 48 (Vic 62)* ○ *Pharmacists – 84 (Vic 100)* ○ *Physiotherapists – 60 (Vic 99)* ○ *Podiatrists – 17 (Vic 23)* • *Workforce shortages related to disability were reported in pediatric speech therapy, pediatric care, and in child and adult mental health.[78]* • *Service and workforce gaps including Indigenous health workers and culturally specific services were identified by stakeholders. [78]* • *Service gaps for numerous specific population groups, geographical areas and health conditions were identified (see under other identified needs). Many of these are affected by workforce issues.* • *Data about GPs from RWAV (2013-17) show that;[112]* ○ *The number of GPs (excluding registrars) in Gippsland has increased from 292 in 2013 to 338 in 2017. The increase is evident in all LGAs except South Gippsland and Wellington.* ○ *The number of registrars in Gippsland has declined slightly from 76 in 2013 to 65 in 2017.* ○ *The proportion of female GPs ranges between 37% in Wellington to 52% in Baw Baw.* ○ *The proportion of GPs aged 55 years or older ranges between 28% in Baw Baw to 48% in Wellington with a high proportion also found in South Gippsland (41%) and Bass Coast (40%).* ○ *The average weekly hours worked for full time GPs ranges from 44.9 hours in Baw Baw to 51.0 hours in East Gippsland.* ○ *International Medical Graduates make up 11% of GPs in Bass Coast to 23% in Latrobe, with a high proportion also in Wellington (20%), east Gippsland (18%) and Baw Baw (16%).* ○ *115 GPs with procedural skills work in Gippsland with the most common being;* ▪ *Anaesthetics - 44* ▪ *Emergency Care - 36* ▪ *Obstetrics – 25* ○ *GPs intending to stay in the profession for 10 years or more varies from 35% in East Gippsland to 81% in Bass Coast; with a low proportion also in South Gippsland (47%), Wellington (50%) and Latrobe (58%).* • *RWAV have identified Gippsland priority areas for attention in 2018-19;[113]* ○ *Yarram* ○ *Longford – Loch Sport* ○ *Churchill*

Outcomes of the service needs analysis		
		○ *Wonthaggi - Inverloch* ○ *Drouin* ○ *Orbost (added since publication – personal communication)* • *A survey of allied health stakeholders in Gippsland identified workforce issues within the allied health profession as an issue generally, with podiatry and orthotics mentioned as a specific need.[78]* • *The most commonly identified health issue in community interviews was access to GP services, encompassing a range of issues including waiting times, compromised continuity of care due to lack of GPs, availability of bulk billing GPs, after-hours access to GPs, and access to GPs who do home visits;[79]* "we need more Doctors - we have an elderly one here who wants to retire but he can't" "doctors keep changing and you have to keep explaining" • *Access to specialist doctors was the 5th most common theme in community interviews; [79]* "Everything is in Melbourne or if they come here they can be very hard to get into" "Ophthalmologists - it's harder for older people to have to travel to Melbourne so they don't go ahead with what needs to be done. It costs a fortune to travel" • *The most common service gap identified in community interviews was for GPs followed by medical specialists. Service gaps for allied health were also rated highly. [79]* "Need permanent physio in this town" "…mental health and dental services are a scarecity and hard to access in this area." • *The community survey results show that having to wait too long for an appointment was a key barrier to accessing health care, reported by 24% of all respondents. [79] See under Access to services for more information.* • *Accessing a GP during business hours can be problematic according to 43% of survey respondents; [79]* "…not enough doctors" "Too heavily booked" "Need to know you are going to be sick so you can make an appointment ahead." "I try to see the same GP as my presentation and history is complex. Seeing her each time cuts out the lengthy discussion of my medical history which occurs even with unrelated medical issues. Unfortunately she's not always available". "I stopped attending an allergy specialist in Melbourne due to the problems with travel distance and cost." • *Gippsland PHN are working with Monash University Department of Rural Health (MUDRH) and State Department of Health and Human Services Workforce Unit, RWAV and two other regional Victorian PHNs to better understand and advocate for rural and regional workforce issues. Planned work*

Outcomes of the service needs analysis		
		includes: ○ *Understanding current workforce levels and determine workforce needs in the short, medium and long term through modelling* ○ *Using available data and information to assist with this* ○ *Market analysis and predictive modelling, including impacts of the NDIS and other health reforms on health workforce supply and distribution in Gippsland* ○ *Evidence based workforce recruitment and retention strategies* • *33 GP practices in Gippsland received the teaching incentive payment for the November quarter 2017 (down from 38 in August).* [42] • *Increased costs of human resources impacts service provision if not taken into account when renewing contracts.*[127]

Primary Mental Health Care (including Suicide Prevention)

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Regional planning aligned to a stepped care mental health model	*Stakeholder consultation identified numerous service gaps, some of which relate to workforce shortages and affordable access to services.* *There are service gaps for children and youth and for psychiatry and counselling services, especially in more remote parts of the region* *There is concern that current management of mental health issues is not effective and that issues with stigma are still common.* *Service access generally becomes more challenging in more remote areas of Gippsland and GP data confirms these issues and the challenges to find suitable referral options.*	• *The rate of completed mental health treatment plans by GPs is high in Bass Coast / South Gippsland (57 per 1,000 people) and low in East Gippsland (40), with Latrobe (51) and Wellington (52) similar to the Victorian rate (48).*[31] • *Prescribing rates for anti-depressant medications are high for 18-64-year olds across Gippsland; especially in East Gippsland and Latrobe.* [31] • *Prescribing rates for anti-depressant medications are high for people 65-years and older in Latrobe.* [31] • *Prescribing rates for anxiolytic medications are high for 18-64-year olds in Latrobe.* [31] • *Prescribing rates for anxiolytic medications are low for people 65-years and older in Bass Coast / South Gippsland and East Gippsland.* [31] • *Prescribing rates for antipsychotic medications are high in Baw Baw, East Gippsland, Latrobe and Wellington for people aged 18-64.* [31] • *Prescribing rates for antipsychotic medications are low in Bass Coast / South Gippsland, Baw Baw, East Gippsland and Wellington for people aged 65+.*[31] • *Mental health specific PBS data confirm that the Gippsland population has a high use of antidepressants (15.2% of the population), anxiolytics (5%), hypnotics and sedatives (4.0%) and antipsychotics (2.4%).*[114] • *The registered workforce of psychologists shows that Gippsland has only about half the expected number compared to Victoria.*[111] *South Gippsland and East Gippsland have especially low numbers.* • *MBS data for mental health service provision in Gippsland shows that;* [115] ○ *East Gippsland has the lowest proportion of its population claiming a mental health item (7.3%), while Baw Baw has the highest proportion claiming (11.1%).* ○ *Gippsland service provision was provided primarily by allied health professionals (38% compared to 28% for Australia)) and GPs (34% compared to 30%), with less services provided by psychiatrists (14% compared to 24%) and clinical psychologists (14% compare to 18%).* ○ *East Gippsland and Wellington residents have an especially low usage of psychiatrists and clinical psychologists compared to other LGAs.* ○ *East Gippsland has a low usage of GPs for mental health items.* • *16% of Gippsland Dairy Expo attendees reported that they or someone in their household had an experience of a mental health issue in the previous 12 months. Of these 25% were dissatisfied with the support they received, most reporting that they would have liked more support.*[35] • *Consumer and carer views about mental health and AOD services in Gippsland were explored in a*

Outcomes of the service needs analysis		
		series of consultation activities.[116] Key themes identified a need to; ○ *Address stigma and discrimination among the health workforce to assist individuals with mental health and AOD issues as well as their family members.* "Normalising it, and it needs to actually come from the people with the illness … it doesn't just need to come from them, but they need to contribute." ○ *Improve how emergency departments manage mental health and AOD presentations.* ○ *Reliable and local information about available services.* ○ *Prepare for local implementation of the NDIS* ○ *For service providers to meet the needs of families and carers of those affected by mental health and AOD issues.* ○ *Primary care providers need to be better equipped to manage mental health and AOD diagnoses, especially GPs.* "Some GP's are excellent, but if a person with a psychiatric illness goes to a GP who has predetermined ideas about mental health and who just doesn't get it, they're going to cause more harm…" "A lot of the doctors don't know where to send people to…" "… the very first doctor we went to said, oh, here's some medication, go home take that." "I believe there needs to be a lot more talking, and a bit less medication, they need to find out the root of the problem by talking to the patient." ○ *Coordination of services needs improvement to ensure individuals receive the care they need when ready to address their issues, regardless of where they present.* "There's been a culture in these services, they don't want to share and then, … they have to tell their story, again." • *Consumers and carers of mental health and AOD services in Gippsland report a range of experiences, with overall sense that needs were not effectively being met:[116]* ○ *Complexity of dual diagnosis was not effectively addressed* ○ *Changes since NDIS introduction had affected service availability* "…the personal helpers and mentors program … has been closed because of the NDIS, which has meant that you can't get that type of support service anymore, and that was the thing that has kept me healthy for a long time." ○ *Needs in terms of service improvements: availability of services including acute and post-acute care and support, better access to support services for those not funded under NDIS, better pathways through services, improved quality of care offered by health professionals and sufficient training in dual diagnosis*

Outcomes of the service needs analysis		
		"…when you're not well, you don't know, and that's the whole stupid part about it, I'm fabulous when I'm well, I can tell you the whole system, but when I'm ill, forget it, I can't focus." "It would be good for like a central place to go, so people can go there and get the information where it's streamlined, where you can say, 'this is my concern' and then they can say, 'ok, this is the avenue you need to go down', this is the steps you need to take." • *In another consumer engagement activity in 2018, many themes were re-iterated;*[60] ○ *Stigma and lack of understanding of mental health and AOD issues in the community and among service providers are exacerbated in the regions.* ○ *Privacy and confidentiality are a concern* ○ *Frontline services, especially GPs have inadequate knowledge of referral pathways and available services* ○ *Fragmentation of services and lack of step-up / step-down support* ○ *The size of the area creating issues with travel times* ○ *Support for peer workers as part of the service system* ○ *A general lack of resources for mental health and AOD services* • *The Mental Health Police Response program in Morwell was recommended for other areas.*[60] • *The lack of after-hours / crisis services was a gap.*[60] *"…*mental health issues don't work on a 9 to 5 schedule.*"* • *Suggested solutions to service issues identified by consumers include;*[60] ○ *A living database (web page / phone app) with service information for a region as a central point of information for both consumers and providers, especially GPs.* ○ *Continued community consultation to gain insights and to build on the momentum; strong community support in Gippsland was noted* ○ *Utilise people with lived experience in mental health and AOD to boost the regional workforce through support for peer workers. Evidence suggests this as a model with good outcomes for consumers and the community more broadly.*
Low Intensity Mental Health Services	*Current funding models and workforce issues impact on the ability to provide affordable low intensity mental health services.*	• *Uneven service provision and distribution across the Gippsland region.*[117] • *Lack of digital service coordination and integration.*[117] • *Low numbers compared to State average of allied health and specialist workforce to work with cohort.*[111] • *Lack of service provision scope by providers leading to inappropriate referrals and service utilisation.* [117]
Children and Young People	*Integrated, multi-disciplinary services across sectors (e.g. health, education, employment,*	• *Mental health prescribing for children is most commonly done by non-psychiatric specialists.*[114] • *Gippsland headspace data for the 2017-18 period showed:*[65]

Outcomes of the service needs analysis		
	welfare, justice, etc.) is needed to provide best practice, accessible care for young people. *Inequitable or limited access to expertise in primary care for young people experiencing serious mental illness.* *Affordable and timely support for children, young people and families was noted as a service gap in community input.*	○ *There was a 74% increase in number of young people accessing headspace services from 835 people in 2016-17 to 1,457 in 2017-18, and a 78% increase in occasions of service from 3,003 in 2016-17 to 5,373 in 2017-18* ○ *Wait-times for services are shorter than National Centre averages, 27.6% of young people attending Gippsland headspace centers in 2017-18 waited less than three days for their first appointment, compared to 15.3% for headspace centers nationally* ○ *8.7% of young people in Morwell and 4.3% of young people in Bairnsdale felt that they waited too long for their first appointment (less than the National Centre average of 13.6%)* ○ *16.5% of Gippsland headspace occasions of service resulted in referrals out to community/welfare services, compared with the national headspace average of 12.7%* ○ *6.4% of Gippsland headspace occasions of service resulted in referrals out to alcohol or other drug services, compared with the national headspace average of 3.6%* ○ *Most referrals out were to community based mental health services or specialist health care (psychiatrist, pediatrician or inpatient), similar to the National Centre data* • *Analysis of consumer and stakeholder input into existing reports highlighted a mental health workforce shortage in infant mental health and child mental health across the catchment; particularly significant in geographically isolated areas.*[77] • *For youth mental health services to be successful there is a need for them to have developed with the input and support of the community, to be a part of the community and supporting a bottom-up approach – growing instead of arriving, actively seeking to find ways to overcome stigma, promote availability and openness of the service and at the same time ensure confidentiality.*[118] *The main themes reported to be important to delivery of local youth health services were:* ○ *Barriers: limited transportation, parent consent, restricted access to services; limited doctors and counsellors; negative social proximity/stigma; staff recruitment and retention issues; non-youth friendly spaces; limited funding.* ○ *Enablers: positive social proximity; community support; bulk-billing drop in services; creation of the consortium; multi-skilled youth friendly staff; mature minor status; funding from Gippsland PHN.* ○ *Recommendations: additional mental health professionals; funded psychologist/mental health nurse; youth friendly spaces with access to mental health first aid courses; increased advertising.* ○ *Headspace: Consult with four local Youth Access Clinics to gain community knowledge and program delivery expertise; provide additional services and funding through hub and spoke model; provide increased outreach services.* • *GPs identified referral options for mental health support for children and adolescents as a service gap.* [117] • *Mental health was the third most commonly reported service gap in community interviews, including*

Outcomes of the service needs analysis		
		specific mention of child mental health, youth services, counselling and anger management.[79] "There is nothing for children with mental health issues – counsellors that can relate to children- get to the children before they reach high school" "Access to mental health services for parents who can't afford to pay – the waitlist is enormous" "School supports children with specific issues that they do not receive funding for e.g., they have a school counsellor who works with resilience/mental health and dealing with conflict – this is funded through the Parents and Friend s at the school" "…had to wait for youth mental health and 6 months for CASA [Centre Against Sexual Assault]"
Hard to Reach Populations	*A range of factors impact on service delivery for hard to reach populations, with geographic isolation, lack of access to transport, service costs, and workforce shortages in more remote areas.* *Telehealth solutions to these challenges are limited by lack of internet access and/or poor broadband speeds.*	• *GPs do more than 90% of mental health prescribing for people aged 65 years or older.*[114] • *Data from 2017-18 Gippsland PHN funded Primary Mental Health Care services (Psychological Therapies and Severe and Complex) showed:*[68] ○ *87% of referrals came from GPs* ○ *69% of referrals were accompanied by a Mental Health Treatment Plan* ○ *Services were delivered by mental health nurses (39.6%), generalist psychologists (18.1%) and social workers (16.4%)* • *Difficulties in recruiting and retaining skilled and qualified mental health staff is an issue across Gippsland, but especially in the more remote areas.*[68] • *There are few specialised mental health positions in Gippsland, leading to a greater importance of the availability of secondary consultations.*[111] • *Insufficient mental health support for people over 65 has been identified.* [117] • *Mental health was rated as the second most important health issue in the community interviews and also rated highly in every LGA; in East Gippsland mental health was the top health issue. Specific population groups such as farmers are also at risk.*[79] "Should have a Mental Health inpatients here; it's hard for families to travel" [East Gippsland] "Dr accessible but follow through with Mental Health plan is hard as how do they get to appointments in [central area] with no transport" • *Providers of psychological services have identified a need for co-locating services in locations such as community houses, schools and medical centers to improve access.*[127]
Severe Mental Illness	*Improved care coordination for this group is a priority, especially where there are multiple providers.* *Access to mental health services for people in remote areas is a gap.* *After hours support is lacking across the*	• *Data for Gippsland Partners in Recovery participants (2013-18):*[69] ○ *57% of referrals came from public clinical mental health, community mental health support, or community health services* ○ *50% of clients identified a GP as being their principal clinical mental health service provider* • *PIR providers report consumer needs including;*[127] ○ *Service system challenges to find the right service provider* ○ *Lack of support from emergency service personnel* ○ *A need for community to understand a person's depression and mental illness when you are*

Outcomes of the service needs analysis		
	region. *Concern expressed in the community regarding unknown impact of NDIS for people living with serious mental illness.* *A need for service coordination and a regional model for severe mental illness has been confirmed and is an opportunity to improve the outcomes for clients.*	*close to them* ○ *Social issues "*men and mental health*"* • *Access to Mental Health Community Support Services (MHCSS) in smaller, remote communities was identified as a need by stakeholders.* [117] *Latrobe Regional Hospital operates the Gippsland Area Mental Health Service providing inpatient, residential and community services.* • *Mental Health Nurse in Practice support is provided in South Gippsland, Wellington, Bass Coast and Latrobe. The service is mainly face to face but phone support and coordination with specialist mental health services is also offered. Feedback indicates;*[127] ○ *A need for social work support including for administration around NDIS applications* ○ *Professional development and networking opportunities* • *Key service gaps include:* [117]` ○ *lack of service provision scope by service providers leading to inappropriate referrals and service utilization,* ○ *lack of digital service coordination and integration,* ○ *treatment and care pathways not formalized, and* ○ *poor coordination of existing service provision.* • *Community members and providers report the following psychosocial supports as an unmet need for people with severe mental illness:*[119, 116] ○ *Case worker or support worker to help finding pathways through the system.* "I wanted someone to navigate me, I wanted them to steer me in the right direction, because I'd go to one, no no, this one, no no no, this one." ○ *Community engagement, including assistance with recreational activities, and other existential needs related to workplace skills and social connectedness.* ○ *Living skills – domestic, cooking, cleaning, shopping.* ○ *Support groups for both Carers and Consumers* ○ *Peer support/peer led service model, rather than clinical* "…just pure drop in places, run by peer workers, like trained peer workers and skilled peer workers, and it's just for people to come and be, and learn these processes, …where to access services." "…not be met by the clinical model … and they have a Warm line, not a crisis line." ○ *A place-based service where people could go to find out about what programs and services were available – a specific facility. Could operate as both a drop-in service and as a location for living skills courses and training, and as a central hub where they could gain advice about and access to providers of other psychosocial needs.* "[Need to avoid] Having expectations for outcomes … allowing people to process and

Outcomes of the service needs analysis		
		go through, walk in and walk out in their own time…" "…the difference between medical and social intervention … the fact that an agency has that link is important, because for example … I haven't seen a psychiatrist for two to three years… it is important that that's part of your mental health program…" ○ *Would also need to be mobile to meet needs in remote locations* "…isolated people, that are right out … like travel isn't accounted for…" "On the transport and that, that's been one of the problems all the way through with workers … the time to travel to where they've got to go, the agencies have never allowed travel time, or the government funding has never allowed travel time." ○ *Someone to find pathways through the system, this is especially important at acute times when people are least able to navigate the system themselves* ○ *Promote existing services/supports and encourage people to link in with other supports.* • *Community members and providers report following solutions to respond to psychosocial support needs;*[119, 116] ○ *Capacity building and support independent living, including practical issues like insurance, finance, cooking, cleaning* ○ *Delivery format: 3 sub-regions, adult focus 18-64 (however not excluding other ages)* ○ *Address common barriers to access: social anxiety, remoteness, stigma etc.* ○ *Focus on the consumer experience; community connectedness* ○ *Socialising + doing + learning (e.g. ecotherapy, men's shed type models, craft groups and selling products, men's digeridoo, learning to develop trust and safety in social environments) activities to be overseen by a clinician and include an education component: MH and coping* ○ *Address stigma – it doesn't need to be advertised as a mental health service however must raise awareness of mental health* ○ *Build on existing infrastructure e.g. neighbourhood houses, community mental health; current services under-resourced* "They're just stretched … so understaffed, that you hear all the time" • *Service provider reports of gaps in services for people displaying hoarding and squalor behaviours, people with eating disorders, people with moderate to severe personality disorders, and lack of access to local treatment for personality disorders (e.g., Dialectical Behaviour Therapy).*[120] • *Insufficient acute services, such as hospital beds, for people in crisis situations was a consumer and carer identified need.*[116] *Transition after an acute episode can also be a vulnerable time without sufficient support;* "When a person has been in a psych unit and comes out, they really need a lot of

Outcomes of the service needs analysis		
		support in the community …"
Suicide Prevention	*Suicide prevention treatment services are at capacity, and additional treatment services following acute episodes are required.* *Increased integration between existing suicide prevention services is required.* *Use of technology (e.g., telehealth and online resource tools) could increase efficacy of suicide prevention services.* *Postvention services need to be accessible, evidence-based and community friendly.* *A need for a regional model and training to ensure effective support across the region is noted.* *Community input emphasise the need for a system well equipped to respond to and provide on-going support for the client and families.*	• *Current services include the Latrobe Regional Hospital (LRH) Area Mental Health Service, including Child and Youth Mental Health Service and mental health triage. Lifeline, headspace, apprentice and school support program, police, ambulance and other telephone counselling and websites.* • *Place-based suicide prevention projects in partnership with DHHS are underway in Latrobe and Bass Coast, using the Lifespan Model. Detailed audit reports and community partnerships will inform local actions.* • *Key service gaps related to suicide prevention have been identified:*[117] ○ *Formal suicide prevention partnerships are limited.* ○ *No consistent/regional model of best practice aftercare.* ○ *Lack of consistency and confidence in suicide risk assessment and screening.* ○ *Communications and integration between hospitals and primary care can be challenging* ○ *Varied process for forwarding discharge summaries.* ○ *Peer workforce not as strong in suicide prevention as for mental health service.* ○ *Disjointed State and Commonwealth funding initiatives that need to be managed in the region – regional leadership is required.* ○ *Evaluation and understanding of impact of current services is limited.* ○ *Low numbers compared to State average of allied health and specialist workforce to work with cohort.* ○ *Consideration of population groups with specialised needs and/or high risk (e.g. SSAGD, men, Aboriginal, trauma impacted) is required.* ○ *Lack of consistency in the use of referral pathways and tools/resources.* ○ *Need for regional guidelines on the use of medication with individuals experiencing suicidality.* ○ *Lack of strategies to address specific barriers to suicide prevention programs in rural and remote parts of Gippsland (e.g. transport, available workforce, cost of treatment).* ○ *Need for consistent and available education, training and support for GPs working with people experiencing suicidal symptoms.* ○ *Lack of specific, routine or consistent inclusion of stories from people with lived experience to help guide improvements in practice.* ○ *Suicide prevention training for frontline staff (gatekeepers) is ad-hoc – would benefit from a centralised system to identify gatekeepers, train and ensure updates to training.* • *Lack of inpatient capacity and follow up after suicide attempts;*[116] "… because the ward is so full, my daughter couldn't even get in there so if I had a child that was attempting suicide, she's out on the street, … and then no one follows it up with me."

Outcomes of the service needs analysis		
Aboriginal and Torres Strait Islander people	*A more integrated, holistic approach is sought by Indigenous consumers to improve their engagement with mainstream health services.* *Access to mental health services for Indigenous people is limited across the region, both due to barriers such as transport and distance, and funding and service models that are inflexible and culturally inappropriate.*	• *Key gaps in mental health services for Aboriginal and Torres Strait Islander people include:* [117] ○ *No specific specialist suicide prevention referral pathways for Aboriginal and Torres Strait Islander people currently exists* ○ *Specific mental health promotion campaigns which consider the unique needs of communities with high-risk populations such as Aboriginal and Torres Strait Islander people do not exist* ○ *Lack of knowledge of what local expertise exists in region in relation to mental health of Aboriginal and Torres Strait Islander people* ○ *No formalised or region wide postvention process in relation to suicide clusters in Aboriginal community exists* • *A key barrier to access mental health services was long waiting lists to access affordable services;* [79] "…end up stuck on waiting lists, often more than 6 months, but what choice do you have when private health care is so expensive." • *Providers of ITC service in Gippsland have identified a need for a mental health nurse in Latrobe as it is "…*a daily issues with all our clients*."* [127]

Alcohol and Other Drug Treatment Needs

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Alcohol and Other Drugs (AOD) – general information	*Service use for alcohol and illicit drugs is high and there is a high rate of alcohol related family violence. While the rates of clients receiving services are high, stakeholder input clearly identifies alcohol and other drugs as an area with numerous service gaps.* *Funding for new residential rehabilitation facilities have been announced by the State government and this will meet an identified need once opened. The effects of this on the broader service system need to be considered, including the capacity of withdrawal and community support services.*	• *A map of current AOD services in Gippsland is being kept up to date with assistance of the DHHS funded Catchment Based Planner AOD. See Appendix.* • *Intake and referral to Gippsland's AOD services is provided by ACSO, while assessment is provided by the service providers. Direct intake is also offered by service providers for youth and Indigenous clients.* • *Latrobe Community Health Service (LCHS) is the lead agency for AOD service provision funded by DHHS. Partners are Gippsland Lakes Community Health Service (GLCH), Bass Coast Health (BCH) and Gippsland Southern Health Service (GSHS).* • *Emergency Department AOD nurses are available in three of five emergency departments; Bairnsdale, Sale and Traralgon.* • *Withdrawal beds (total of four beds) are available in Bairnsdale, Sale and Leongatha.* • *A peer led community-based SMART Recovery support service, funded by Gippsland PHN, is intended as a post withdrawal and rehab support to help people integrate back into community settings. This service now operates in Sale, Bairnsdale and Leongatha, linked with hospital-based withdrawal providers.* • *7% of Gippsland GP patients (aged 15 years or older) have a high alcohol consumption recorded (>14 standard drinks per week), (67% of patients did not have alcohol consumption recorded).* [3] • *The rate of clients receiving alcohol and drug treatment service were higher than the Victorian rate (5.0 per 1,000 people) in Bass Coast (7.1), East Gippsland (10.0), Latrobe (10.5) and Wellington (6.8).*[8] • *The following service gaps have been identified across Gippsland;*[78, 121] ○ *lack of capacity of residential withdrawal facilities* ○ *lack of residential rehabilitation facilities – State funding has been announced for a residential rehabilitation service in Bairnsdale (Hope Restart - to be delivered by Odyssey House Victoria) and for youth in Latrobe* ○ *significant loss of clients between referral and comprehensive assessment* ○ *gap in community education and early intervention programs* ○ *opportunities for improvement in care coordination* • *AOD service delivery that embeds principles of collaboration with the child, youth and family service sectors and the mental health sector are needed.*

Outcomes of the service needs analysis		
		• *There is a funding gap for the delivery of community education/early intervention programs for all ages, including the possibility of an online platform.* • *Alcohol and Other Drugs was identified as a service gap in the community with specific mention of the lack of local AOD rehabilitation services and detox beds.*[79] "Alcoholism [was not managed well] because there are only services in the city e.g. detox and rehabs, which compounds the stress on yourself and family." "There is no support for family/carers of people with MH, AOD issues or are grief stricken – it's not just the person but it's the families and carers" • *The need for information for workers and consumers about what services are available and how to access them.*[79] "I think there are some things working for Mental Health and AOD but I don't know exactly what's available" • *Workforce shortages in the AOD sector impact service providers ability to deliver a service.*[123] • *Funding models that account for capacity building, workforce training and development and flexible service delivery options to suit geographically isolated areas and vulnerable populations such as Indigenous and youth clients are needed.* [123] • *The regional Pharmacotherapy Program is administered by Latrobe Community Health Service. Pharmacotherapy service delivery in Gippsland (2017 figures);*[122] o *There are 45 GP prescribers (up from 38 in 2016) after additional training provided; Bass Coast (4), Baw Baw (8), East Gippsland (12), Latrobe (11), South Gippsland (3) and Wellington (7)* o *66% of pharmacies dispense pharmacotherapy; Bass Coast (100%), Baw Baw (50%), East Gippsland (85%), Latrobe (47%), South Gippsland (89%) and Wellington (50%)* o *A total of 632 clients;* ▪ *12% identified as Aboriginal and/or Torres Strait Islander* ▪ *78% had a permit for Methadone, 46% for Suboxone and 11% Subutex* ▪ *Proportion of Methadone permits by LGA (Suboxone); Bass Coast 8% (11%), Baw Baw 11% (11%), East Gippsland 13% (12%), Latrobe 25% (33%), South Gippsland 3% (17%) and Wellington 41% (16%)* • *During 2017, 187 patients received an in-patient withdrawal service at a Gippsland Hospital with an average stay of around 6 days;*[121] o *1 in 4 were forensic patients* o *The principal drug of concern was alcohol*

Outcomes of the service needs analysis		
		○ *Residential LGA of patients (Jan-Jun) were Wellington (35%), East Gippsland (25%), and Latrobe (20%) with very low numbers from Bass Coast, South Gippsland and Baw Baw. A few patients from outside Gippsland also accessed the service.* • *Non-residential withdrawal was provided to 690 clients during 2017;*[121] ○ *40% were from Latrobe, 20% Bass Coast, 14% East Gippsland, 12% Wellington, 8% South Gippsland, 6% Baw Baw (excludes day program), (Jan-Jun)* ○ *People aged 31-45 years accounted for about half of the clients*
Aboriginal and Torres Strait Islander people	*There are significant service gaps in the provision of AOD services to Aboriginal people because of funding shortfalls, workforce shortages, lack of AOD skills and knowledge base in the workforce.*	• *Intake and assessment for Indigenous clients is offered directly by the service providers (through ACCHOs).* • *There are no Indigenous specific services provided in Bass Coast, South Gippsland or Wellington.* • *There is a lack of good data about service provision for Indigenous clients.* • *Services that have a more "holistic" service model appropriate for Indigenous people is needed.*[78] • *The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) provided the following points in 2016:*[123] ○ *Information and education (98%), counselling (95%), and support and case management (94%) were the most common treatment types.* ○ *Depression/hopelessness (86%), family/relationship issues (78%) and grief and loss issues (73%) were key social and emotional wellbeing issues reported in terms of staff time and organisational resources.* ○ *Lack of accessible and appropriate rehabilitation and detoxification services for 'ice' and poly drug use.* ○ *Psychiatric services lacking the capacity to respond to drug-related mental health problems.* ○ *Lack of systematic alcohol and drug awareness education in schools.* ○ *Many AOD related emergency presentations are also mental health related.* ○ *There is a need for more holistic and comprehensive approach to AOD treatment and support for dual diagnosis.* ○ *Aboriginal people with AOD and mental health diagnoses often need treatment and support upon release to the community and this is a continuing challenge for all service providers.* ○ *Access to services are often impacted by geography (e.g. physical distance to health services, availability of transport and quality of roads); the cultural competency of services; affordability (e.g. of services, pharmaceuticals, and travel costs); and availability of services and health professionals.* ○ *Additional barriers include cultural beliefs and attitudes concerning alcohol and drug use,*

Outcomes of the service needs analysis		
		such as shame associated with seeking treatment, concern about getting into trouble with the law and fear of losing their children. • *Regional stakeholder consultation in Gippsland in 2016 identified additional regional issues:*[90] ○ *Detox beds for Indigenous consumers are very limited and most Indigenous consumers impacted by alcohol and drugs are referred back to their GP. There is limited capacity for opportunistic health screening and working with AOD affected people.* ○ *Few ACCHOs employ staff in roles incorporating AOD treatment. Often, generalist staff end up supporting AOD issues.* ○ *Staff at ACCHOs were in many cases unaware of the referral pathway for AOD services at their own organisation and to other services.* ○ *Gaps in clinical staff to provide medical advice and information were identified, and GP support was taken up by meeting physical disease presentations.* ○ *Limited AOD training for staff was identified as a workforce issue and as a barrier to service access.* ○ *A holistic services and opportunistic interventions would assist in addressing access to services:* "‥ need for holistic services that can assist with general issues (like mental health, AOD, and family violence) without being referred to several people as a lot of presentations at the clinics have several needs." ○ *Additional barriers identified:* ▪ *An absence of (public) transport* ▪ *Limited finances* ▪ *Waiting lists* ▪ "…referrals not being followed up". ▪ *A feeling it is* "…too hard for people to make change". ▪ *Privacy issues in small communities* ▪ *Caring commitments* ▪ *Lack of awareness of what services are available* ○ *People are more likely to access the AOD service if is recommended to them or if they know the worker.* • *Data from State funded AOD services in Gippsland show that 14% of episodes of care were for Indigenous clients (2015-16).*[87] • *Cannabinoids was the drug of principal concern for 40%, alcohol for 34% and amphetamines 18%.*[87]

Outcomes of the service needs analysis		
Young people	*A youth specific service is lacking in East Gippsland.*	• *Intake and assessment for youth clients is offered directly by the service providers; Youth Support and Advocacy Service (YSAS) and LCHS (Breaking the Cycle and Youth outreach service).* • *Youth support was identified as a key service gap in 2016, with inclusion of youth outreach and a dual diagnosis understanding.* [119] *There is a need for better models of AOD service delivery that embed principles of collaboration with the youth service sector.* [90] • *A youth specific service is now delivered across Gippsland, except in East Gippsland, offering an assertive youth outreach model providing direct care, support and AOD treatment.* ○ *The service has been successful in its promotion and is experiencing increased referrals, mainly self-referrals and soft referrals through the youth justice team.*[127] ○ *While no waitlist exist for this service, wait lists at services such as residential withdrawal, rehabilitation and supported accommodation services are noted and this has led to a need for outreach support for affected youth.*[127] ○ *Challenges with recruitment of suitably qualified staff were noted.*[127]
Families and carers	*A family and carer support service is now available across the region.*	• *VAADA identified families as a specific service need.* [123] • *Stakeholders reported an absence of services for children and families affected by AOD in 2016, including group, individual and peer support. This would include upskilling, advice and referrals.* [119] • *AOD service delivery collaboration with the child and family service sector is needed.* [91] • *There is a need for information on what AOD services are available and how to access them.* [91] • *A family and carer support service is now available across Gippsland, funded by Gippsland PHN, providing individual/family single sessions, group education, and community education sessions to families and carers of people experiencing alcohol and other drug issues and peer support.* ○ *Most referrals into the program are self-referrals, especially after a media campaign which has seen an increase in overall referrals to the program*[127] ○ *Facebook support groups and an outreach presence in general practice rooms have been successful, both in supporting client sand raising awareness among GPs*[127] ○ *Community event presence and education of services providers to address stigma*[127] ○ *An increase in clients with family violence issues has been identified, in particular elder abuse. Increased links with service providers in these areas have been formed.* [127] ○ *A need for an Indigenous specific service has been identified.*[127] ○ *A need for specific men's support groups has been identified.*[127]
Hard to reach	*There is an on-going challenge to ensure AOD service provision is available in less*	• *People in regional and rural settings have specific service needs.* [123] • *People from other cultures including Aboriginal people, CALD communities have specific service needs.*

Outcomes of the service needs analysis		
populations	*accessible geographical areas and in a for appropriate to vulnerable groups. Funding models need to take this into consideration and coordination of provider resources becomes even more essential.*	*[123]* • *A post withdrawal / relapse prevention support (e.g. day rehabilitation 'popup' model, peer support) could be a valuable service model. [119]* • *Stakeholders identified that the existing service system could be improved, especially for rural and remote people, by increased; [119]* ○ *Clearer pathways developed and improved integration (e.g. stepped care and a flow of movement rather than disjointed, particularly for child first/vulnerable families/CP/schools)* ○ *Allowance for transition planning (e.g. between detox/rehab/prison)* ○ *Flexibility of funding (e.g. not just sessions based, considerations for other outcomes)* ○ *Increasing capacity of existing services* ○ *Better coordination of existing services* ○ *Pooling of resources* ○ *Ensure appropriate brokerage (e.g. transport, housing)* ○ *Allow for a rurality loading and other variables*
Dual diagnosis	*There is one regional dual diagnosis service in Gippsland with limited capacity.* *Consumers and carers see a need for more widespread knowledge among clinicians about dual diagnosis and a need for improved coordination of treatment services. Mental health and AOD issues are commonly co-occurring and service provision needs to reflect this.*	• *In Gippsland, the dual diagnosis service is delivered by the LRH Dual Diagnosis service.* ○ *Service providers report a positive community response to the new dual diagnosis service for Indigenous clients[127]* • *A key theme for rural consumers of AOD and mental health services across regional and rural areas of the State was a feeling of* "… sitting on the outside looking in*"- a feeling of disengagement from what was going on at a higher state level.[60]* • *Specific service needs requiring additional support or funding considerations were identified for the most complex people, which is not factored into the funding model. This includes, but is not limited to, people with cognitive disabilities including Acquired Brain Injury, personality disorders, comorbidity and forensic clients. [123]* • *Stakeholders identified that the existing service system could be improved, especially for people with a dual diagnosis by increased capacity building within the existing system to improve understanding of this client group. [119]* • *Consumer and carers noted that there are insufficient services specific to dual diagnosis in the Gippsland area. Most general health practitioners do not sufficiently understand the complexity of dual diagnosis, and there is a lack of workers sufficiently skilled in dual diagnosis issues.[116]* "… dual diagnosis has been a problem, not being understood, that the two things work together, alcoholism and the drugs with mental illness, that's been a bit of a problem, we've had a lot of suicides…"

Indigenous Health (including Indigenous chronic disease)

Outcomes of the service needs analysis		
Identified Need	Key Issue	Description of Evidence
Indigenous health	*Indigenous people need a holistic, culturally appropriate service that recognizes the whole person and their background and environment.* *Local Aboriginal health workers can improve trust and community connection.* *The main barrier to service access was cost including for transport and to pay for services.* *Training is needed to allow all health care providers to offer access to culturally appropriate services.* *Service providers note the time-consuming nature of holistic care and a need of Aboriginal health workers to provide the link to community and practical support such as transport.*	• *Presentations to the emergency department are more than twice as common for Aboriginal people compared to non-Aboriginal people (difference increasing).* [28] • *Bairnsdale Regional Health Service and Latrobe Regional Hospital are among the top 10 Victorian hospitals admitting Aboriginal people.*[124] • *Consumers identified barriers relevant for Indigenous people's access to health services, such as cost of services, cost of transport, racism and culturally inappropriate service models.* [77] • *Service and workforce gaps including Indigenous health workers and culturally specific services were identified by stakeholders;* ○ *"Holistic / multidisciplinary services are preferred for ATSI"* [78] • *Top service gaps identified in interviews were AOD, dental services, transport to get to health services and access to affordable medical specialists.* [79] • *Key findings from the evaluation of the Victorian Koolin Balit investment, Strategic Directions for Aboriginal health;*[125] ○ *Connections to Place and Culture are crucial for health and wellbeing, reinforcing the need for a holistic approach to health and wellbeing to help Aboriginal clients and for services to be culturally responsive and culturally safe* ○ *Government should be more active in some specific areas, including monitoring Aboriginal people's experiences of healthcare and ensuring accountability for improving cultural safety* ○ *The Aboriginal workforce experiences dangerous levels of racism and trauma and support networks are needed* ○ *There are opportunities for greater coordination and sharing of good practice through networks* • *10 GP practices in Gippsland received the Indigenous Health incentive patient registrations payment for the November quarter 2017 (down from 12 in August).* [42] • *MBS data for Indigenous health checks (item 715) show that in Gippsland the number of patients checked was 704 (2015-16) or an estimated 13.3% of the Indigenous population – the 8th lowest rate among PHNs.*[126] • *2.6% of all patients with GP activity (4,424) identified as Indigenous; 16.0% had a 715 health check in 2017-18 (note: the number of patients will include double counting of patients attending more than*

Outcomes of the service needs analysis		
		one practice, and 29.9% of all patients did not have Indigenous status data).[3] • *Services commissioned to provide Integrated Team Care and other services for Aboriginal clients in Gippsland noted;*[127] ○ *Workforce challenges to fill advertised positions and retain staff, leading to fragmentation and difficulty in building relationships.* ○ *Current staffing not sufficient to meet demand; risk of burn out of existing staff due to high demand for the service and lack of admin support to enable data capture.* ○ *A need for staff education to support evidence based chronic disease management.* ○ *Suggestion for Aboriginal Liaison officer / health worker to support care coordinator* "The majority of my Chronic Disease clients need quite a bit of assistance and if we were able to employ someone connected to the Aboriginal community … this would improve trust and client outcomes." ○ *A need to raise awareness of the service both internal and external to ensure referral criteria are clear and to enable the service to better meet needs.* ○ *Transport needs of clients are affecting time for care coordination; increased capacity for transport services is needed.* ○ *Reliance on written feedback forms is a barrier for people who are unable to write;* "Most of these clients aren't at the stage of self-managing due to inability or unable to read or write." ○ *Resources for health promotion and prevention are needed, including young people's health checks.* • *Indigenous people identified several things that are working well in terms of health, including educational community activities and praise for staff at local services.* [79] "Family Violence activities e.g. Koori Family Fun day, men's groups, woman specific program" "Access to supplementary services to appointments which would otherwise be difficult to get to" "Dr can lead them in the right direction if they have a mental health problem" "Access to bulk billing GPs" "Nurses at [local health service]" • *They also identified the following things to improve health;* [79] "Need a doctor of choice" "Closing the Gap has focused on 0-5-year olds and 21+; big issues with 6-24 early intervention,

Outcomes of the service needs analysis		
		AOD use, smoking and sexual health are all big issues” “GP shortage puts pressure on everything” “More employment opportunities” “Need backfill capacity …”

Appendix I – AOD service mapping table - November 2018

Bass Coast	ACSO	Wonthaggi	●			●																																	◊			
	BCH	Bass Coast Shire catchment with delivery in Wonthaggi, Cowes, San Remo, Grantville and Corinella		●			●	●	●	●	●		●						●																					◊	●		
	YSAS	Outreach in Wonthaggi, Cowes, San Remo. Grantville & Corinella (12-25 years)																															◊	●	●	●	●	●				◊			
Baw Baw	ACSO	Warragul	●			●			●																															◊			
	LCHS	Warragul		●			●12+	●12+		●	●		●					●16+	●12 +															●<21				●<25yo		●			●		●
	GEGAC	Outreach to Drouin and Warragul										◊							●	●	●	●	●			●	●			●	●	●								●					
	YSAS	Outreach Drouin, Warragul , Neerim, Ripplebrook, Rawson, Erica, Willow Grove, Narracan (12-22 years)																																●	●	●	●	●				●			
East Gippsland	ACSO	Lakes Entrance, Orbost, Bairnsdale	●			●			●																															◊			
	GLCH	Bairnsdale		●		●	●	●					●						●							●	●															◊	●		
		Lakes Entrance		●		●	●	●		●	●		●													●	●													●		◊	●		
		Orbost				●	●	●					●																													◊	●		
	GEGAC	Bairnsdale										◊							●	●	●	●	●	●		●	●			●	●	●								●					
	BRHS	Bairnsdale												●		●≥16yo																										◊	●	●	
Latrobe	ACSO	Morwell, Traralgon	●		●				●																															◊			
	LCHS	Morwell		●			●12+	●12+		●	●		●					●16+	●12+															●<21				●	●<26	●<26	●18+		●		●12+
		Moe		●			●12+	●12+					●	●				●16+	●12+															●<21				●	●<26	●<26			●		●12+
		Traralgon		●			●12+	●12+					●	●				●16+	●12+															●<21				●	●<26	●<26	●18+		●		●12+
		Churchill					●12+	●12+					●	●				●16+	●12+															●<21				●	●<26	●<26			●		●12+
	Ramahyuck	Morwell																							◊									◊											
	GEGAC	Outreach to Morwell, Trafalgar, Churchill and Moe										◊								●	●	●	●			●	●			●	●	●								●					
	LRH	Traralgon												● 18-64yo																															
	YSAS	Outreach (12-22 years)																															◊	●	●	●	●	●				◊			
South Gippsland	ACSO		●						●																																				
	GSHS	Leongatha and Korumburra sites, Foster and Mirboo nth-room rentals if available		●		◊	●	●			`		●	●		●			●																			◊					●	●	
	YSAS	Outreach Leongatha, Korrumburra, Foster, Inverloch, Mirboo North (12-25 years)																															◊	◊	◊	◊	◊	◊				◊			
Wellington	ACSO	Sale	●		●	●			●																															◊			
	CGHS	Sale												●		●																											●	●	●
	LCHS			●			●	●		●			●						●																										
	Ramahyuck	Sale					◊12+	◊12+					◊12+						◊12+																										
	YSAS	Outreach; Sale, Maffra, Heyfield, Darnam, Rosedale, Stratford, Loch Sport, Golden Beach (12-25 years)																															◊	●	●	●	●	●				◊			
Regional Service	LCHS	Traralgon, Sale, Bairnsdale, Yarram, Orbost, Warragul, Korumburra, Leongatha, Wonthaggi										●18-64		●18-64					Day Hab																							◊			●

◊ provider indicates that this is provided, but is not a funded activity

Additional Comments: Family counselling provided through ACSO is single session work

Latest update: November 2018

Please refer directly to providers for any updates

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