



Australian Government

Department of Health



An Australian Government Initiative

Primary Health Networks Program

Needs Assessment Template

This template may be used to submit the Primary Health Network's (PHN's) Needs Assessment to the Department of Health by **15 November 2021**.

Name of Primary Health Network

Western Queensland

Section 1 – Narrative

Needs assessment process and issues

WQPHN's 2022/23 – 2024/25 Needs Analysis builds on the previous Needs Assessments and draws on data captured and maintained by the WQPHN Health Intelligence Unit, recently released public data, consultation through established internal governance mechanisms and with WQPHN staff, key partner organisations, commissioned service providers and local government and aged care stakeholders.

Since its establishment in 2015, the WQPHN has been intent on building the capacity and sustainability of general practice providers (including private, Aboriginal Community Controlled and more recently those operated by the Hospital and Health Services (HHSs) so that people living in Western Queensland have access to an agreed set of essential primary health care services close to home. This has been a key focus of the Western Queensland Health Care Home. Retaining and attracting key clinical and management personnel presents an ongoing challenge impacting on the viability of services, continuity of care for patients and maximisation of potential benefits of the model. Service mapping highlights the array of health services and programs operating in the WQPHN geographic footprint funded through various Commonwealth, state and HHS sources in addition to those commissioned by the PHN. While their purpose is to improve access to health care for the residents of the region, the wicked problem of fragmentation of services and subsequent challenges of service system navigation for patients arises. These issues are well understood by the WQPHN and its partner organisations and with the maturation of relationships recognise opportunities to progress co-commissioning, place-based planning and inter-agency workforce development and employment strategies as essential for a sound platform for local primary health care.

The Opportunities and Priorities identified through the consultative processes of this HNA are framed around the draft Recommendations from the Primary Health Reform Steering Group to inform the Australian Government's Primary Health Care 10 Year Plan.

Methodology

The methodology for the health needs assessment included:

- Desktop audit of previous health needs assessment(s) and workforce needs assessments, program evaluation reports, service activity reports
- Analysis of local population characteristics and data trends drawing on WQPHN health intelligence portal, LGA profiles, aggregated general practice data, publicly available health data, health service data and workforce data
- Detailed service mapping of five case study sites drawing on the WQPHN online commissioning maps and commissioned services contracts, websites for the North West HHS, Central West HHS, South West HHS, HealthDirect, CheckUp service activity report, and My Community Directory
- Three online surveys to enable broad consultation and input from:
 - WQPHN staff (n=26 complete responses)
 - Community members (n= 166 complete responses across 16 of the 20 LGAs in WQPHN), seeking to identify priority issues from a life-course perspective
 - Clinicians and service provider organisations (n=90 complete responses with representation across the seven Commissioning Localities)
- Broad consultation with key stakeholder groups (via online meetings due to the uncertainty of the COVID situation at the time)
- Analysis of data including triangulation of population health data, service mapping and information gathered through the online surveys and stakeholder consultations. Key themes and issues were identified as were opportunities identified through the consultations and desktop audit
- Identified priorities and opportunities tested with the WQPHN Executive Management Team
- Review of the HNA and priorities with the WQPHN Board prior to submission to the Department.

Key Stakeholder Consultations

Consultations occurred in August and September 2021 and included:

- The North West, Central West and South West Clinical Chapters and Community Advisory Councils

- Executive staff of the Central West and South West HHSs
- WQPHN staff Deep Dive Workshop and written submissions
- Nukal Murra Alliance (representing the four Aboriginal Community Controlled Health Organisations in the PHN)
- Health Workforce Queensland
- RHealth
- Royal Flying Doctor Service
- CheckUp
- Centre for Rural and Remote Health, James Cook University
- Mornington Island Health Council
- Private general practitioners
- Commissioned service providers (individually and in Clinical Chapter meetings)
- Local government through RAPAD (Central West), the South West Regional Organisation of Councils and the North West Regional Organisation of Council
- Aged care providers (private, Aboriginal Community Controlled and multi-purpose health service representation)

Additional Data Needs and Gaps

There are a number of caveats to the data reported in Section 2. It should be noted that:

General Practice data

- All RFDS data is reported as either Charleville or Mt Isa
- Residence is unknown and therefore tourists and FIFO workers may be included as active patients
- Practice data is a snapshot of the month, and may be susceptible to seasonal variations
- Gidgee Healing data is reported at a block level rather than a practice level and therefore is accurate at the HHS level but not a commissioning level
- Duplicate patients cannot be filtered from PATCAT, resulting in an overestimation of active patients (particularly in the North West). To obtain more reliable prevalence rates, ABS populations were used as the denominator for the 15-24 and 25-64 year age groups, and PATBI active patients were used as the denominator in the 65+ age group.

MBS data

- MBS data is commonly used to report service activity. However, services provided by Royal Flying Doctor Service (RFDS) and other non-Government organisations that are in receipt of Commonwealth grants are unable to bill Medicare hence these services are not captured in MBS data. In addition, all of the hospitals in the small towns have Section 19(2) exemption, and there is variability in the rigor of systems to utilise the MBS in these facilities. Therefore, MBS data is not a good reflection of the full extent of service activity nor is it an accurate reflection of general practice capacity and provision of enhanced primary care.

Queensland preventative health survey

Whilst the Queensland preventative health survey can be useful for planning purposes to drill down on particular locations of health inequality, one must be mindful that estimates derived from small sample sizes are more unreliable than estimates from large samples. To manage this limitation:

- Uncertainty around estimates has been quantified by reporting 95% confidence intervals where possible.
- Estimates have been aggregated to a HHS, age-group or gender level to maintain an adequate sample size

Workforce Data to Inform gap analysis and service planning

The need for comprehensive, high quality data on the health workforce in rural and remote environments such as Western Queensland is essential for workforce planning, service planning, training plans and to inform health policy. This is highlighted in Section 3. In Western Queensland, developing an accurate picture of the health workforce working in primary care is complex and limited by:

- Conflation with the hospital workforce, particularly where HHS employed Senior Medical Officers (SMOs) and Other Medical Practitioners (OMPs) work across the hospital and HHS managed general practice, and the quantum of work in primary care is difficult to determine
- The Section 19(2) exemptions operating in most locations in the WQPHN resulting in provider numbers issued for locums, junior doctors, SMOs, OMPs that work only or predominantly in rural hospitals providing an inaccurate and over-estimated measure of medical workforce capacity in primary care
- Using MBS billing generated through the Section 19(2) exemption is an inaccurate assessment of the provision of comprehensive primary care (and general practice capacity) as MBS billing under Section 19(2) is for non-referred ED presentations
- The limited number of allied health professions registered with AHPRA further complicated by the relationship of their registered address and where they may work (i.e., resident or visiting basis from outside the region)
- The visiting service models operating in the region particularly for allied health, challenging the development of an estimate of the quantum of work undertaken in the region, a town, in the primary care setting or hospital setting
- Turnover and delays in recruitment hindering assessment of capacity for all workforces.

COVID 19

The impact of the COVID-19 pandemic must also be considered in activity data for 2020 and 2021. 2019 data has been reported for service data that may have been skewed by COVID.

The COVID outbreaks that occurred in June and July 2021 in Queensland and NSW impacted on the capacity of the consulting team to travel throughout Western Queensland as planned, resulting in all meetings and interviews being conducted online or by telephone. COVID was also a competing priority for health services and Executive staff, limiting the opportunity to engage with the Chief Executives of the CWHHS and NWHHS.

Survey data

The online community survey was generated on a web-based platform and the link was disseminated through the WQPHN website, newsletter and social media. As such, the participants were drawn from random convenience sampling and cannot be considered statistically representative of the population.

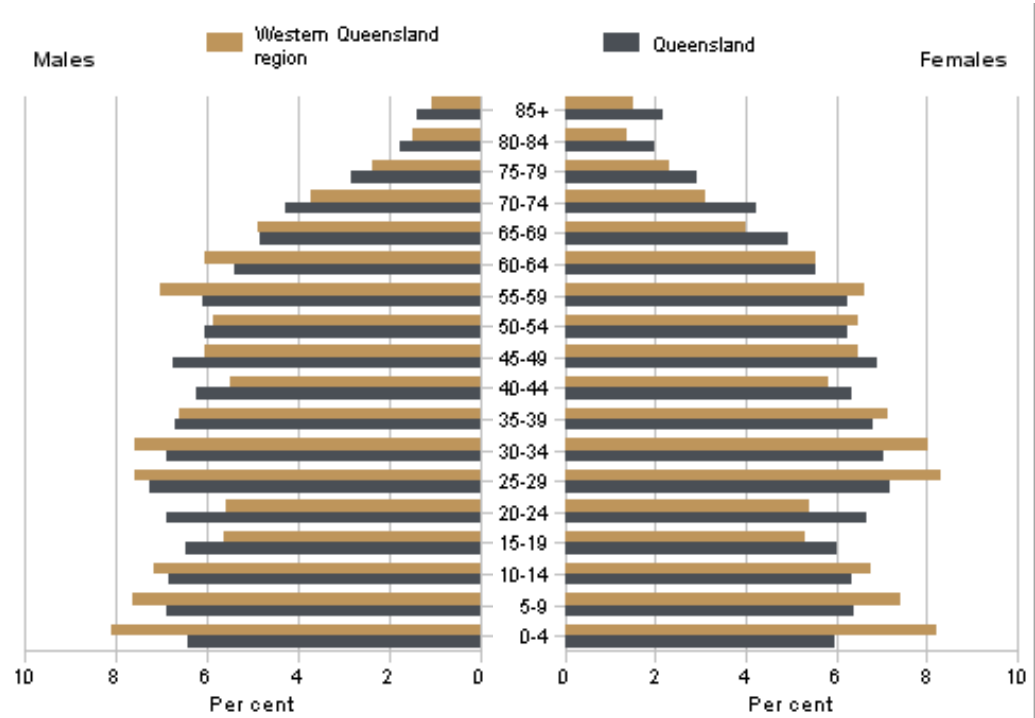
The Clinician and Service Provider survey was generated on a web-based platform. The WQPHN identified stakeholders through their stakeholder and commissioning service provider databases and distributed the link accordingly.

Evaluation of the Needs Assessment Process

WQPHN commissioned KBC Australia to undertake this needs assessment. The key consultants have detailed knowledge of the Western Queensland communities and health service system, however, they are not embedded in the PHN and as such are not across the detail of all contracts and programs in place or in development, or breadth of available data. The consultants undertook various activities to engage with the PHN staff to seek input into the HNA through online surveys, written submissions and online workshops. As a follow up to the HNA process, it will be important to seek feedback from the staff, Clinical Chapters and Consumer Advisory Council and key partners about the HNA process (including consideration of the online consultation strategy and surveys) and consider the pros and cons of undertaking this work in-house or contracting to an external party.

Section 2 – Outcomes of the health needs analysis

Identified Need	Key Issue	Description of Evidence
Population		
Living in remote areas is itself an independent health risk factor due to multiple factors including geographic isolation, cultural diversity, socioeconomic inequality, health inequality, resource inequity, and a full range of climatic conditions.	Majority of the WQPHN population live in remote areas	<p>Approximately 88% (n=54,031) of Western Queensland residents live in remote and very remote locations (MM 6 & 7) and the remaining 12% (n=7,541) live in medium and small rural towns (MM 4 & 5).</p> <p>At a commissioning locality (CL) level:</p> <ul style="list-style-type: none"> • 4 CLs have people living entirely in very remote areas (MM 7) • 2 CLs have people living in mostly remote areas (MM 6 & 7) • 1 CL has half the people living in a medium rural town (MM 4), with other half living in remote and very remote areas (MM 6 & 7).
The demand for services is seasonal and not reflected in official population estimates.	Transient population may not be included in population estimates	Large numbers of tourists (particularly 'grey nomads' – retired older persons) seek help from health services each winter whilst mining developments can add significant pressure. In 2019, visitors to the outback region of Queensland numbered 1,076,000 people.
The negative population growth across 16 of the 20 LGAs in Western Queensland will further decrease the population density of Western Queensland and impact on the feasibility and viability of local service delivery.	Negative population growth over the next 20 years	From 2016 to 2041, the population of Western QLD PHN is projected to decrease from 63,719 persons to 57,516 persons. This equates to a decrease of 0.4% per year. In comparison, Queensland's population is expected to increase 1.6% per year over the next 20 years. The Lower Gulf is the sole CL within Western Queensland to have positive population growth of 445 persons by 2041.
The region has a high Aboriginal and Torres Strait Islander population with notable sub-regional variations.	Large Aboriginal and Torres Strait Islander population	<p>The region's Aboriginal and Torres Strait Islander population is far higher than for Queensland. The proportion of the total population in WQPHN that are Aboriginal and Torres Strait Islander is 17.2%, compared to the Queensland average of 4.0%. The Lower Gulf CL has a substantially higher percentage of Aboriginal and Torres Strait Islander people compared to the rest of the WQPHN, at 66.9%. The Central West and Maranoa CLs are considerably less than the WQPHN average, and much closer to the Queensland average, at 6% and 7.2% respectively.</p> <p>LGAs that differ greatly from other LGAs in their CLs are Winton LGA in the Central West CL (9.5% compared to the CL average of 6%), Boulia (LGA split) LGA compared to Barcoo and Diamantina LGAs in the Western Corridor CL (27% compared to 12.4% and 14.8%), Doomadgee and Mornington LGAs compared to the Burke and Carpentaria LGAs in the Lower Gulf CL (93.4% and 86% compared to 40.5% and 41.3%), McKinlay and</p>

Identified Need	Key Issue	Description of Evidence
Population		
		<p>Boulia (LGA split) LGAs in the Mt Isa and Surrounds CL (4.9% and 27% compared to the CL average of 17.4%), and the Paroo LGA in the Far South West CL (27.9% compared to the CL average of 15.9%)</p> <p><i>Source: (QGSO), Queensland Regional Profiles (2021)</i></p>
The region has a younger population profile with noteworthy sub-regional variations.	Younger population profile	<p>WQPHN has 22.7% of its population aged between 0-14 years compared to state average of 19.4%, and 13.0% aged 65 years and over compared to the state average of 15.7%, demonstrating a noticeably younger population profile. However, this younger population profile is largely due to the influence of the north-west part of the WQPHN and its large Aboriginal and Torres Strait Islander population.</p>  <p><i>Source: ABS Population by Age and Sex, Regions of Australia (2020)</i></p>

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		<p>The Lower Gulf CL has a considerably younger population profile compared to other WQPHN CLs, with 28.6% of the population aged less than 15 years, and 7.9% aged 65 years and over. The Central West and Western Corridor CLs have older population profiles than the WQPHN average, with 19.1% and 16.5% aged less than 15 years and 19.3% and 14.1% aged 65 years and over, respectively.</p> <table><tr><th>Commissioning Locality</th><th>0-14 n (%)</th><th>15-24 n (%)</th><th>25-44 n (%)</th><th>45-64 n (%)</th><th>65+ n (%)</th></tr><tr><td>Central West</td><td>1,788 (19.1%)</td><td>926 (9.9%)</td><td>2,194 (23.5%)</td><td>2,628 (28.1%)</td><td>1,804 (19.3%)</td></tr><tr><td>Western Corridor</td><td>162 (16.5%)</td><td>94 (9.6%)</td><td>299 (30.5%)</td><td>287 (29.3%)</td><td>138 (14.1%)</td></tr><tr><td>Lower Gulf</td><td>1,454 (28.6%)</td><td>685 (13.5%)</td><td>1,450 (28.5%)</td><td>1,097 (21.6%)</td><td>401 (7.9%)</td></tr><tr><td>Mt Isa and surrounds</td><td>5,429 (23.7%)</td><td>2,707 (11.8%)</td><td>7,468 (32.6%)</td><td>5,338 (23.3%)</td><td>1,941 (8.5%)</td></tr><tr><td>Far South West</td><td>1,481 (21.3%)</td><td>660 (9.5%)</td><td>1,736 (24.9%)</td><td>1,945 (27.9%)</td><td>1,138 (16.4%)</td></tr><tr><td>Balonne</td><td>922 (22.8%)</td><td>465 (10.7%)</td><td>1,026 (23.5%)</td><td>1,172 (26.9%)</td><td>705 (16.2%)</td></tr><tr><td>Maranoa</td><td>2,814 (22.2%)</td><td>1,308 (10.3%)</td><td>3,444 (27.2%)</td><td>3,157 (24.9%)</td><td>1,942 (15.3%)</td></tr><tr><td>Western Queensland</td><td>14,033 (22.7%)</td><td>6,804 (11.0%)</td><td>17,491 (28.3%)</td><td>15,507 (25.1%)</td><td>8,017 (13.0%)</td></tr><tr><td>Queensland</td><td>19.4%</td><td>13.0%</td><td>27.3%</td><td>24.6%</td><td>15.7%</td></tr></table> <p>Source: QGOS, Queensland Regional Profiles (2021)</p>	Commissioning Locality	0-14 n (%)	15-24 n (%)	25-44 n (%)	45-64 n (%)	65+ n (%)	Central West	1,788 (19.1%)	926 (9.9%)	2,194 (23.5%)	2,628 (28.1%)	1,804 (19.3%)	Western Corridor	162 (16.5%)	94 (9.6%)	299 (30.5%)	287 (29.3%)	138 (14.1%)	Lower Gulf	1,454 (28.6%)	685 (13.5%)	1,450 (28.5%)	1,097 (21.6%)	401 (7.9%)	Mt Isa and surrounds	5,429 (23.7%)	2,707 (11.8%)	7,468 (32.6%)	5,338 (23.3%)	1,941 (8.5%)	Far South West	1,481 (21.3%)	660 (9.5%)	1,736 (24.9%)	1,945 (27.9%)	1,138 (16.4%)	Balonne	922 (22.8%)	465 (10.7%)	1,026 (23.5%)	1,172 (26.9%)	705 (16.2%)	Maranoa	2,814 (22.2%)	1,308 (10.3%)	3,444 (27.2%)	3,157 (24.9%)	1,942 (15.3%)	Western Queensland	14,033 (22.7%)	6,804 (11.0%)	17,491 (28.3%)	15,507 (25.1%)	8,017 (13.0%)	Queensland	19.4%	13.0%	27.3%	24.6%	15.7%
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	Overall there are less elderly people living in Western Queensland but sub-regional differences exist	13% of the Western Queensland population is aged 65+, less than the 15.7% for Queensland. However, differences in the proportion of older people exist between commissioning localities with the Central West having 19.3%, while the Lower Gulf and Mt Isa and Surrounds regions have 7.9% and 8.5% respectively.																																																												

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WQPHN generally experiences high socio-economic disadvantage, but the socio-economic vulnerability is relatively worse in those CLs that have the greater proportion of Aboriginal and Torres Strait Islander people.	High socio-economic disadvantage generally but considerably worse in areas with larger Aboriginal and Torres Strait Islander populations	<p>53% of the WQPHN population are in the two most disadvantaged SEIFA quintiles.</p> <p>At a Commissioning Locality level:</p> <ul style="list-style-type: none">100% of Lower Gulf CL population are in the two most disadvantaged SEIFA quintiles70% of Western Corridor CL and Far South West CL population are in the two most disadvantaged SEIFA quintiles <p>At a LGA locality level</p> <ul style="list-style-type: none">100% of the population from the Boulia, Doomadgee and Mornington, Carpentaria, Burke and Barcoo LGAs are in the two most disadvantaged quintiles. <table><tr><th>Commissioning Locality</th><th>Quintile 1 (most disadvantaged)</th><th>Quintile 2</th><th>Quintile 3</th><th>Quintile 4</th><th>Quintile 5 (least disadvantaged)</th></tr><tr><td>Central West</td><td>15.6%</td><td>35.5%</td><td>31.9%</td><td>11.5%</td><td>5.5%</td></tr><tr><td>Western Corridor</td><td>43.6%</td><td>27.3%</td><td>29.2%</td><td>0%</td><td>0%</td></tr><tr><td>Lower Gulf</td><td>83.8%</td><td>16.2%</td><td>0%</td><td>0%</td><td>0%</td></tr><tr><td>Mt Isa and surrounds</td><td>17.4%</td><td>22.8%</td><td>33.6%</td><td>17.8%</td><td>8.4%</td></tr><tr><td>Far South West</td><td>44.4%</td><td>33.0%</td><td>8.6%</td><td>14.0%</td><td>0.0%</td></tr><tr><td>Balonne</td><td>26.3%</td><td>35.4%</td><td>16.9%</td><td>21.3%</td><td>0%</td></tr><tr><td>Maranoa</td><td>21.2%</td><td>23.0%</td><td>15.6%</td><td>36.9%</td><td>3.3%</td></tr><tr><td>Western Queensland</td><td>26.6%</td><td>26.6%</td><td>23.2%</td><td>19.0%</td><td>4.6%</td></tr><tr><td>Queensland</td><td>20%</td><td>20%</td><td>20%</td><td>20%</td><td>20%</td></tr></table> <p>Source: ABS, Index of Relative Socio-Economic Disadvantage (2016)</p>	Commissioning Locality	Quintile 1 (most disadvantaged)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (least disadvantaged)	Central West	15.6%	35.5%	31.9%	11.5%	5.5%	Western Corridor	43.6%	27.3%	29.2%	0%	0%	Lower Gulf	83.8%	16.2%	0%	0%	0%	Mt Isa and surrounds	17.4%	22.8%	33.6%	17.8%	8.4%	Far South West	44.4%	33.0%	8.6%	14.0%	0.0%	Balonne	26.3%	35.4%	16.9%	21.3%	0%	Maranoa	21.2%	23.0%	15.6%	36.9%	3.3%	Western Queensland	26.6%	26.6%	23.2%	19.0%	4.6%	Queensland	20%	20%	20%	20%	20%
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Identified Need	Key Issue	Description of Evidence
Health determinants		
Poorer access to the Internet in much of Western Queensland, and in particular the Lower Gulf region, impedes access to telehealth services and online supports, as well as many government and community service sites e.g., MyAged Care, Centrelink, NDIA.	Poor internet access	22.9% of the occupied private dwellings in Western Queensland had no internet access, compared to 13.6% in Queensland. Within Western Queensland the Lower Gulf region had the largest percentage of dwellings without Internet access (38.0%).
While unemployment rates in Western Queensland are similar to the rest of the State, there are sub-regional variations, with higher unemployment rates in CLs with larger Aboriginal and Torres Strait Islander populations.	Increased unemployment in the Aboriginal and Torres Strait Islander population	<p>Over the past five years the unemployment rate in Western Queensland has been on par with Queensland's unemployment rate. Prior to the COVID-19 pandemic the unemployment rate was around 6%. Since March 2020, the unemployment rate in Western Queensland has risen to 7.4%.</p> <p>At a Commissioning Locality level</p> <ul style="list-style-type: none"> • Central West, Western Corridor and Maranoa CLs had the lowest unemployment rates of between 3.4% and 3.7% • The Lower Gulf CL had the highest unemployment rate of 27.8% • Mt Isa and Surrounds CL has had the sharpest increase in unemployment over the COVID-19 pandemic from 6.5% in June 2020 to 8.3% in March 2020 <p style="text-align: right;"><i>Source: QGSO, Queensland Regional Profiles (2021)</i></p>

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Overcrowding and poor housing conditions, and homelessness, leads to poorer health outcomes.	Overcrowded households and homelessness in the Aboriginal and Torres Strait Islander population	<p>14.3% of Western Queensland households with Aboriginal and Torres Strait Islander persons were overcrowded compared to 2.1% of non-Indigenous households. Across Queensland 10.5% of households with Aboriginal and Torres Strait Islander persons were overcrowded compared to 2.7% of non-Indigenous households.</p> <p style="text-align: right;"><i>Source: ABS 2016 Census</i></p> <p>Rates of homelessness were also higher in communities with a high proportion of Aboriginal Torres Strait Islander people. In the Lower Gulf CL, there were 612.9 homeless persons (per 10,000 people), compared to 119.7 across Western Queensland and 45.6 across Queensland.</p> <table border="1"> <thead> <tr> <th rowspan="2">Commissioning Locality</th><th colspan="2">Homeless persons</th></tr> <tr> <th>number</th><th>rate</th></tr> </thead> <tbody> <tr> <td>Central West</td><td>31</td><td>27.1</td></tr> <tr> <td>Western Corridor</td><td><10</td><td>22.0</td></tr> <tr> <td>Lower Gulf</td><td>397</td><td>612.9</td></tr> <tr> <td>Mt Isa and surrounds</td><td>305</td><td>117.6</td></tr> <tr> <td>Far South West</td><td>29</td><td>36.9</td></tr> <tr> <td>Balonne</td><td>18</td><td>40.1</td></tr> <tr> <td>Maranoa</td><td>66</td><td>47.5</td></tr> <tr> <td>Western Queensland</td><td>849</td><td>119.7</td></tr> <tr> <td>Queensland</td><td>27,715</td><td>45.6</td></tr> </tbody> </table> <p style="text-align: right;"><i>Source: ABS 2016 Census</i></p>	Commissioning Locality	Homeless persons		number	rate	Central West	31	27.1	Western Corridor	<10	22.0	Lower Gulf	397	612.9	Mt Isa and surrounds	305	117.6	Far South West	29	36.9	Balonne	18	40.1	Maranoa	66	47.5	Western Queensland	849	119.7	Queensland	27,715	45.6
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Health determinants		
There is a strong association between some social determinants, such as lower levels of education and socioeconomic status, older age, and being from a culturally and linguistically diverse background, and low health literacy. As such it is not surprising the region would have more people with lower levels of individual health literacy. People with low health literacy are more likely to have worse health outcomes overall and adverse health behaviours.	Low levels of individual health literacy	<p>Survey findings and stakeholder consultations identified poorer health behaviours that respondents believed were in part attributable to lower levels of health literacy including:</p> <ul style="list-style-type: none"> • lower engagement with health services, particularly for preventive services • higher hospital readmission rates • poorer understanding of medication instructions • lower ability to self-manage their own care
Distance and travel times between communities are considerable, making it challenging for residents to attend services and health care professionals to deliver services.	Poor access to health care due to remoteness	<p>1.2% of the state's population is geographically distributed across 51% of the total land mass of Queensland.</p> <p>Survey findings and stakeholder consultations identified a number of barriers to accessing health care including:</p> <ul style="list-style-type: none"> • poor public transport throughout most of the region • limited patient and family accommodation • telecommunication constraints • higher financial and time costs borne by patients • higher costs to deliver services on the ground • difficulties in attracting and retaining local health care staff • long waiting time to access appointments

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While living in remote areas is itself an independent health risk factor, because Aboriginal and Torres Strait Islander people make up a substantial proportion of remote area populations, the overall poorer health status is more likely due to be a reflection of Indigenous health issues and their determinants.	Considerably large numbers of Aboriginal and Torres Strait Islander peoples	17% of the WQPHN population are Aboriginal and Torres Strait Islander, which is higher than the State average of 4%.																																																																																	
		The Lower Gulf CL (66.9%) has the highest proportion of Aboriginal and Torres Strait Islander peoples in WQPHN, followed by Mount Isa and Surrounds CL (17.4%), Western Corridor CL (19.4%), Far South West CL (16.6%), Balonne CL (15.9%), Maranoa CL (7.2%) and Central West CL (6%).																																																																																	
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		<p>and Torres Strait Islander peoples in NWHHS (53 years) but slightly higher in SWHHS (60 years) and CWHHS (65 years).</p> <p><i>Source: WQPHN Health Needs Assessment (2016)</i></p>
	Higher rates of potentially avoidable deaths	<p>There were 188 age-standardised potentially avoidable deaths per 100,000 people in Western Queensland in 2014-2018 compared with 106 per 100,000 nationally.</p> <p><i>Source: AIHW Australia Health Performance (2019)</i></p>
	Higher rates of potentially preventable hospitalisations	<p>In 2016, the Grattan Institute published a report that examined selected PPHs (nine high-volume Ambulatory Care Sensitive Conditions (ACSCs) and a tenth combined measure of Chronic ACSCs) over a decade for SA2 areas of Queensland with a population of at least 1000 people, and listed what they termed 'priority places': areas with rates at least 50% above the state average, for one or more ACSCs, in every year for a decade.</p> <p>The report identified 7 of the 11 SA2 areas in the WQPHN as 'priority places':</p> <ul style="list-style-type: none"> • Mt Isa Region had a rate at least 50% above the state average in every year for a decade for all ten ACSCs analysed • Carpentaria had seven of the ten ACSCs including the combined Chronic ACSCs • Far South West had six of the ten ACSCs including the combined Chronic ACSCs • Charleville had three of the ten ACSCs including the combined Chronic ACSCs • Balonne had three of the ten ACSCs including the combined Chronic ACSCs • Barcaldine-Blackall had two of the ten ACSCs (Cellulitis and ENT) • Roma had one of the ten ACSCs (ENT) <p><i>Source: Duckett and Griffiths (2016)</i></p>

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People living in rural and remote Australia don't have the same opportunities to access disability support services as people living in big cities. There simply isn't the population base to support the range of specialist services that some people with disabilities need to access.	The number of people accessing the NDIS appears to be below those reporting living with a profound or severe disability	<p>While low numbers preclude reporting in some LGAs, the available data shown in the table below suggests lower participation in the NDIS in Western Queensland than census data would predict.</p> <table> <tr> <th>Commissioning Locality and LGA</th><th>Number of NDIS participants 2021*</th><th>0-64 year olds with a profound or severe disability**</th></tr> <tr> <td>Lower Gulf</td><td>93</td><td>74</td></tr> <tr> <td>Carpentaria</td><td>33</td><td>33</td></tr> <tr> <td>Doomadgee</td><td>39</td><td>16</td></tr> <tr> <td>Mornington</td><td>21</td><td>18</td></tr> <tr> <td>Burke</td><td>-</td><td><10</td></tr> <tr> <td>Mount Isa and surrounds</td><td>290</td><td>334</td></tr> <tr> <td>Mount Isa</td><td>266</td><td>291</td></tr> <tr> <td>Cloncurry</td><td>24</td><td>29</td></tr> <tr> <td>McKinley</td><td>-</td><td>14</td></tr> <tr> <td>Central West</td><td>76</td><td>155</td></tr> <tr> <td>Barcaldine</td><td>29</td><td>39</td></tr> <tr> <td>Longreach</td><td>47</td><td>68</td></tr> <tr> <td>Blackall Tambo</td><td>-</td><td>34</td></tr> <tr> <td>Winton</td><td>-</td><td>14</td></tr> <tr> <td>Western Corridor</td><td>0</td><td>11</td></tr> <tr> <td>Barcoo</td><td>-</td><td><10</td></tr> <tr> <td>Boulia</td><td>-</td><td><10</td></tr> <tr> <td>Diamantina</td><td>-</td><td><10</td></tr> <tr> <td>Maranoa</td><td>170</td><td>240</td></tr> <tr> <td>Balonne</td><td>45</td><td>73</td></tr> <tr> <td>Far South West</td><td>101</td><td>157</td></tr> </table>	Commissioning Locality and LGA	Number of NDIS participants 2021*	0-64 year olds with a profound or severe disability**	Lower Gulf	93	74	Carpentaria	33	33	Doomadgee	39	16	Mornington	21	18	Burke	-	<10	Mount Isa and surrounds	290	334	Mount Isa	266	291	Cloncurry	24	29	McKinley	-	14	Central West	76	155	Barcaldine	29	39	Longreach	47	68	Blackall Tambo	-	34	Winton	-	14	Western Corridor	0	11	Barcoo	-	<10	Boulia	-	<10	Diamantina	-	<10	Maranoa	170	240	Balonne	45	73	Far South West	101	157
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Barcaldine	29	39																																																																		
Longreach	47	68																																																																		
Blackall Tambo	-	34																																																																		
Winton	-	14																																																																		
Western Corridor	0	11																																																																		
Barcoo	-	<10																																																																		
Boulia	-	<10																																																																		
Diamantina	-	<10																																																																		
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People with a disability																	
		<table> <tr> <td>Murweh</td><td>80</td><td>89</td></tr> <tr> <td>Paroo</td><td>21</td><td>45</td></tr> <tr> <td>Bulloo</td><td>-</td><td><10</td></tr> <tr> <td>Quilpie</td><td>-</td><td>20</td></tr> <tr> <td>Western Queensland</td><td>775</td><td>1055</td></tr> </table> <p>Source: *NDIS; **PHIDU. (2021. Derived from 2016 ABS census data</p> <p>Survey findings and stakeholder consultations identified a number of barriers to accessing the NDIS including:</p> <ul style="list-style-type: none"> • timely access to specialists for assessment and/or diagnosis to support applications • a lack of service providers to provide the supports participants are funded for in their plans • a limited number of planners, or those with expertise in particular disability types, in some locations • a lack of funding for travel and accommodation • the higher prices for some support in remote areas resulting in insufficient funding for a plan • system requirements, access and navigation for consumers, carers and referrers <p>Suggested solutions provided during the consultations included:</p> <ul style="list-style-type: none"> • delivering therapy services in-part or in-whole via remote telecommunication • using qualified allied health assistants to implement interventions under the guidance, remotely or in-person, of an allied health professional • using FIFO allied health practitioners who specialise in disability and have the potential to empower Western Queensland communities, and build capacity amongst generalist allied health practitioners, educators and allied health assistants • develop service delivery models that are designed for families in remote and rural areas • trial some place-based solutions and build off these successes - one stop shop navigator 	Murweh	80	89	Paroo	21	45	Bulloo	-	<10	Quilpie	-	20	Western Queensland	775	1055
Murweh	80	89															
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Identified Need	Key Issue	Description of Evidence																																
Populations with special needs																																		
Mothers and Babies																																		
Research shows the health, wellbeing and nutrition of the mother prior to conception and during pregnancy not only can have an impact on the birth-weight, growth and health of the newborn, but also has a major impact on the lifelong health of the child. A person's susceptibility to many chronic diseases in adult life is determined during pregnancy and are a response to maternal risk factors and behaviours. The primary risk factors include poor maternal nutrition and substance use in pregnancy. For Aboriginal and Torres Strait Islander women timely access to antenatal care is particularly important as they are at higher risk of giving birth to babies of low birthweight and have greater exposure to other risk factors such as anaemia, poor nutrition, hypertension, diabetes, genital and urinary tract infections and smoking.	Higher fertility rates, especially in the Aboriginal and Torres Strait Islander population	<p>WQPHN have higher fertility rates (2.49) compared to Queensland (1.76). In 2019 the Mt Isa and Surrounds CL had the highest rate of births within Western Queensland (21.0 per 1,000 persons), followed by the Lower Gulf CL (18.9 per 1,000 persons).</p> <p>Source: PHIDU (2021)</p> <table><tr><th rowspan="2">Commissioning Locality</th><th colspan="2">Births</th></tr><tr><th>number</th><th>Rate (crude per 1,000)</th></tr><tr><td>Central West</td><td>95</td><td>10.2</td></tr><tr><td>Western Corridor</td><td>14</td><td>14.3</td></tr><tr><td>Lower Gulf</td><td>96</td><td>18.9</td></tr><tr><td>Mt Isa and surrounds</td><td>480</td><td>21.0</td></tr><tr><td>Far South West</td><td>102</td><td>14.7</td></tr><tr><td>Balonne</td><td>64</td><td>14.7</td></tr><tr><td>Maranoa</td><td>218</td><td>17.2</td></tr><tr><td>Western Queensland</td><td>1,062</td><td>17.2</td></tr><tr><td>Queensland</td><td>61,735</td><td>12.1</td></tr></table> <p>Source: QGSO, Queensland Regional Profiles (2021)</p>	Commissioning Locality	Births		number	Rate (crude per 1,000)	Central West	95	10.2	Western Corridor	14	14.3	Lower Gulf	96	18.9	Mt Isa and surrounds	480	21.0	Far South West	102	14.7	Balonne	64	14.7	Maranoa	218	17.2	Western Queensland	1,062	17.2	Queensland	61,735	12.1
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	Younger maternal age profile, especially in the Aboriginal and Torres Strait Islander population	<p>Approximately 57% of Western Queensland mothers who gave birth in 2019 were under the age of 30 years compared to 45% of mothers in Queensland.</p> <p>Within Western Queensland 15% of births by Aboriginal and Torres Strait Islander mothers occur in the under 20 age group compared to 3% of non-Aboriginal and Torres Strait Islander mothers.</p> <p>Source: QGSO, Queensland Regional Profiles (2021)</p>																																
	Improving infant mortality	<p>In WQPHN, infant mortality is higher (3.8 deaths per 1,000 live births) compared with national rates (3.3 death per 1,000 live births) but below Queensland rates (4.1 deaths per 1,000 live births). Infant mortality in WQPHN has been trending down since 2011 when the crude rate was 10.8 per 1,000 live births.</p>																																

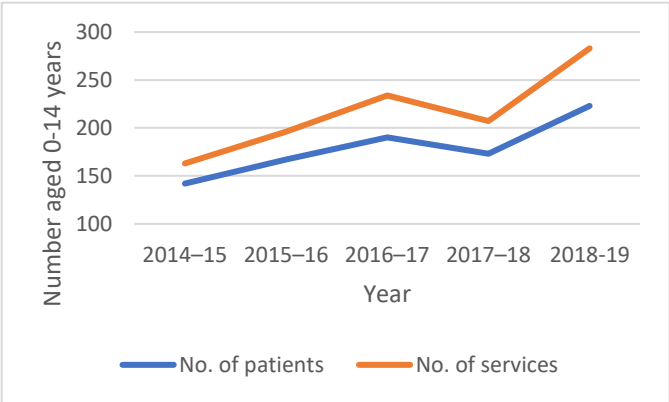
Identified Need	Key Issue	Description of Evidence
Populations with special needs		
Mothers and Babies		
		<i>Source: AIHW Australia Health Performance (2019)</i>
	Higher smoking rates during pregnancy amongst Aboriginal and Torres Strait Islander mothers	<p>Amongst non-Indigenous mothers, the proportion of low birth weight babies and mothers who smoked during pregnancy in the Western Queensland HHSs was similar to Queensland rates (9.1%).</p> <p>Aboriginal and Torres Strait Islander mothers had much higher rates of smoking during pregnancy in both Queensland (42.7%) and Western Queensland PHN (49.5%). In Balonne and the Lower Gulf smoking rates during pregnancy exceeded 60%. The proportion of low birth weight babies was 13.4% in WQPHN compared with 10.7% of Aboriginal and Torres Strait Islander births in Queensland overall.</p> <p><i>Source: PHIDU ATSI Social Health Atlas of Australia (2021)</i></p> <p>In 2018, females having an antenatal visit during the first trimester was lower for WQPHN compared to Australia (61.4% v 74.3%) and has remained unchanged since 2012</p> <p><i>Source: AIHW Australia Health Performance (2019)</i></p>

Identified Need	Key Issue	Description of Evidence			
Populations with special needs					
Children					
The importance of the early years is now well known. These years are a time when the brain develops and much of its 'wiring' is laid down. The experiences and relationships a child has, plus nutrition and health, can actually affect this enormously. Positive experiences help the brain to develop in healthy ways. Seriously negative experiences such as neglect and abuse, on the other hand, affect brain development in more harmful ways, and contribute to emotional and behavioural problems later in life. So, the experiences a child has in the early years can either support learning or interfere with it.	Higher rates of developmentally vulnerable children	The proportion of children in their first year of full time school who were developmentally vulnerable in one or more of the five Australian Early Development Census (AEDC) domains was higher for Western Queensland children compared with Queensland and Australian children. Carpentaria, Far Central West/ Far South West and Charleville statistical areas showed the worst results across the the five domains.			
		Source: AEDC (2018)			
		Indicator	WQ PHN n (%)	QLD (%)	SA2 groups with highest proportions developmentally vulnerable (%)
		Developmentally vulnerable on 1 or more domains	326 (33.7%)	(25.9%)	Carpentaria (48.7%); Far Central West/ Far South West (44.0%); Charleville (39.3%)
		Developmentally vulnerable on 2 or more domains	179 (18.4%)	(13.9%)	Carpentaria (31.6%); Far Central West/ Far South West (26.3%); Charleville (22.8%)
		Physical health and wellbeing – developmentally vulnerable	180 (18.4%)	(12.3%)	Far Central West/ Far South West (28.8%); Charleville (22.8%); Carpentaria (22.4%); Roma (21.0%)
		Social competence – developmentally vulnerable	129 (13.2%)	(11.9%)	Carpentaria (28.9%); Far Central West/ Far South West (21.3%)
		Emotional maturity – developmentally vulnerable	132 (13.7%)	(10.5%)	Far Central West/ Far South West (22.7%) Carpentaria 22.7%
Language and cognitive skills – developmentally vulnerable	138 (14.1%)	(8.0%)	Carpentaria (32.9%); Far Central West/ Far South West (17.5%); Northern Highlands (17.9%)		
Communication skills and general knowledge- developmentally vulnerable	149 (15.3%)	(10.1%)	Charleville (28.1%); Balonne (21.7%); Carpentaria (19.7%)		

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	Lower rates of preschool enrolment	<p>In 2018, 78.0% of children aged four years were enrolled in a preschool program compared to 89.4% of four year olds in Queensland.</p> <table><tr><th rowspan="2">Region</th><th colspan="2">Preschool enrolments- children aged 4 years old</th></tr><tr><th>number</th><th>%</th></tr><tr><td>Western Queensland</td><td>806</td><td>78.0%</td></tr><tr><td>Queensland</td><td>58432</td><td>89.4%</td></tr></table> <p>Source: PHIDU (2021)</p>	Region	Preschool enrolments- children aged 4 years old		number	%	Western Queensland	806	78.0%	Queensland	58432	89.4%
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Western Queensland	806	78.0%											
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	High rates of Aboriginal and Torres Strait Islander children living away from home	<p>Children and young people living away from home are a highly vulnerable group with increased physical, mental and social health needs. Living away from home refers to children in out-of-home care (foster care, approved kinship care, provisionally approved care and residential care services) and other locations such as hospitals, Queensland youth detention centres, and those in independent living.</p> <p>In Queensland, the rate of Aboriginal and Torres Strait Islander children living out of home is disproportionality high. The rate of Aboriginal and Torres Strait Islander children living away from home is ten times higher compared to non-Aboriginal and Torres Strait Islander children (51.4 per 1,000 children vs 5.9).</p> <p>In 2019-20, there were 2,044 Northern Queensland (extends from the Northern Territory border to Townsville in the east); 2,192 South West (includes Toowoomba and Ipswich) and 1,984 Central Queensland (extends from the Northern Territory border to Rockhampton in east) children living away from home. Of Queensland children living away from home 44% (n=4,964) identified as Aboriginal and Torres Strait Islander.</p> <p>Regions are reported by the Department of Children, Youth Justice and Multicultural Affairs and do not align with PHN or HHS boundaries. In addition, Indigenous status and age group is not reported at a more granular level. Data at a PHN or SA3 level is required to better understand the extent of this issue across areas of Western Queensland.</p>											

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Hearing loss in childhood can lead to a lifetime of disadvantage, initially through a detrimental impact on a child's learning and language development, which may lead to behavioural problems, early school leaving and limited job options.	High prevalence of ear conditions amongst Aboriginal and Torres Strait Islander children	<p>Data from Queensland Deadly Ears Program estimates that the minimum prevalence of ear conditions in the Carpentaria- Burke-Mornington Indigenous Area to be 24% for 0-4 year olds and 37% for 5-9 year olds. These prevalence rates are some of the highest of all Deadly Ear Program locations.</p> <table><tr><th>Indigenous Area</th><th>0-4 years</th><th>5-9 years</th><th>10-14 years</th></tr><tr><td>Carpentaria- Burke- Mornington</td><td>24%</td><td>37%</td><td>16%</td></tr><tr><td>Mount Isa</td><td>6%</td><td>14%</td><td>9%</td></tr><tr><td>All Deadly Ear Program locations</td><td>11%</td><td>20%</td><td>8%</td></tr></table> <p>In 2021 an evaluation of the Queensland Deadly Ears Program by the AIHW reported 68% (n=541) of children from North West Queensland (which includes Mornington Island, Normanton, Doomadgee and Mount Isa) between 2015 to 2019 had at least 1 ear condition at their first service, among which 59% (n=317) had conductive hearing loss.</p> <p>Furthermore, 2016/17 hospitalisation data shows that ear, nose and throat conditions were the most common potentially preventable hospitalisation for children aged 0-4 years in all three Western Queensland HHSs. Potentially preventable ear, nose and throat admissions accounted for 10% (n=111) of the total hospital admissions in Western Queensland children aged 0 to 4 years.</p> <p>In 2020/21, 771 children in the WQPHN presented at emergency departments for otitis externa or otitis media reasons, with 56.6% aged 0-4 years. The highest number of presentations were in the North West HHS (498 children).</p> <p>Source: EDIS, Queensland Health</p> <table><tr><th>HHS</th><th>0-4 years</th><th>5-9 years</th><th>10-14 years</th></tr><tr><td>North West HHS</td><td>310</td><td>122</td><td>66</td></tr><tr><td>South West HHS</td><td>98</td><td>64</td><td>38</td></tr><tr><td>Central West HHS</td><td>29</td><td>32</td><td>12</td></tr></table>	Indigenous Area	0-4 years	5-9 years	10-14 years	Carpentaria- Burke- Mornington	24%	37%	16%	Mount Isa	6%	14%	9%	All Deadly Ear Program locations	11%	20%	8%	HHS	0-4 years	5-9 years	10-14 years	North West HHS	310	122	66	South West HHS	98	64	38	Central West HHS	29	32	12
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Populations with special needs		
Children		
Poor oral hygiene as well as limited access to dental services contributes to poor oral health.	High rates of dental hospitalisations	<p>In 2019/20 dental conditions were the most common potentially preventable hospitalisation for Western Queensland children aged 5-9 years (n=119 separations) and 10 - 14 years (n=23 separations). Overall, potentially preventable dental admissions accounted for 32% (n=195) of the total hospital admissions in Western Queensland children aged 0 to 14 years.</p> <p style="text-align: right;"><i>Source: QHAPDC (2021)</i></p> <p>According to EDIS Queensland Health, there were 74 ED presentations for disorders of the teeth and supporting structures in 20/21 (mostly in NWHHS).</p>
Childhood obesity is associated with a higher chance of premature death and disability in adulthood. Worldwide the prevalence of overweight and obesity amongst children has dramatically risen.	Queensland data shows higher percentages of overweight and obese in Western Queensland	Queensland Preventative Health Survey estimates for children (aged 5-17 years) show the percentage of overweight and obese children is higher in Western Queensland compared to Queensland (38% - all WQ children vs 26% - all QLD children).
Youth mental health problems are increasing. The teens and early 20s are the most common time for the onset of mental illness and as young people grow up the prevalence continues to rise. There's also evidence that for 50% of people the first episode occurs before the age of 14 years.	Substantial mental health issues & illnesses in children	<p>17% of 4-11 year olds and 16.6% of 12-17 year old's in the Western Queensland PHN experienced a mental health disorder. Males had a higher prevalence of a mental health disorder than females (19.2% vs 14.3%).</p> <p>4-11 year olds in Outback-North SA3 (which aligns with the Lower Gulf and Mt Isa & Surrounds CLs) had a noticeably higher prevalence of mental health disorders, 19.9% compared to the other regions average of 14.5%.</p> <p style="text-align: right;"><i>Source: Young Minds Matter 2017 Survey (unpublished)</i></p> <p>In 2018/2019, 283 GP mental health services were provided to 223 Western Queensland children aged 0-14 years. In the past five years the number of GP mental health services provided increased 74%, whilst the number of patients increased 57%.</p>

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		<p>GP mental health services provided to Western Queensland young people (0-14 years) 2014/15 to 2018/19</p>  <table border="1"> <caption>GP mental health services provided to Western Queensland young people (0-14 years) 2014/15 to 2018/19</caption> <thead> <tr> <th>Year</th> <th>No. of patients</th> <th>No. of services</th> </tr> </thead> <tbody> <tr> <td>2014-15</td> <td>145</td> <td>165</td> </tr> <tr> <td>2015-16</td> <td>165</td> <td>195</td> </tr> <tr> <td>2016-17</td> <td>190</td> <td>235</td> </tr> <tr> <td>2017-18</td> <td>175</td> <td>210</td> </tr> <tr> <td>2018-19</td> <td>225</td> <td>285</td> </tr> </tbody> </table> <p>Source: AIHW MBS Data 2020</p> <p>Survey findings and stakeholder consultations noted difficulties in referring children to specialist developmental & behavioural paediatricians and child & adolescent psychiatry services.</p> <p>The occasions of service being delivered by Headspace in Mt Isa continues to increase (excepting during COVID). Just over 1 in 4 attendees were in the 12-14 years age group in 20/21 (29% n=68).</p> <p>Source: Headspace Activity Report (unpublished)</p> <table border="1"> <thead> <tr> <th>Financial year</th><th>Occasions of service</th><th>Serviced young people</th></tr> </thead> <tbody> <tr> <td>2018</td><td>1,301</td><td>250</td></tr> <tr> <td>2019</td><td>1,467</td><td>289</td></tr> <tr> <td>2020</td><td>1,559</td><td>276</td></tr> <tr> <td>2021</td><td>1,398</td><td>235</td></tr> </tbody> </table> <p>There are increasing number of children (0-14yrs) receiving commissioned Primary Mental Health Care (PMHC) services – 443 in 2019/20 and 582 in 2020/21</p>	Year	No. of patients	No. of services	2014-15	145	165	2015-16	165	195	2016-17	190	235	2017-18	175	210	2018-19	225	285	Financial year	Occasions of service	Serviced young people	2018	1,301	250	2019	1,467	289	2020	1,559	276	2021	1,398	235
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Employment, education and training opportunities will help young people to gain the skills and knowledge to enable them to gain employment, reach their full potential, lead healthier lives and make positive contributions to their communities.	The percentage of youth 'earning or learning' in Western Queensland is comparable to Queensland with the exception of the Lower Gulf CL.	<p>The percentage of youth 'earning or learning' in commissioning localities of Western Queensland is comparable to Queensland, except for the Lower Gulf CL. Approximately 44% of 15-24 year olds in the Lower Gulf CL are 'earning or learning' compared to 74% in Western Queensland and 82% in Queensland.</p> <table> <tr> <th rowspan="2">Commissioning Locality</th><th colspan="2">Earning or learning at ages 15 to 24</th></tr> <tr> <th>number</th><th>%</th></tr> <tr> <td>Central West</td><td>827</td><td>82%</td></tr> <tr> <td>Western Corridor</td><td>110</td><td>70%</td></tr> <tr> <td>Lower Gulf</td><td>312</td><td>44%</td></tr> <tr> <td>Mt Isa and surrounds</td><td>2151</td><td>73%</td></tr> <tr> <td>Far South West</td><td>580</td><td>77%</td></tr> <tr> <td>Balonne</td><td>362</td><td>77%</td></tr> <tr> <td>Maranoa</td><td>1156</td><td>81%</td></tr> <tr> <td>Western Queensland</td><td>5516</td><td>74%</td></tr> <tr> <td>Queensland</td><td>501,780</td><td>82%</td></tr> </table>	Commissioning Locality	Earning or learning at ages 15 to 24		number	%	Central West	827	82%	Western Corridor	110	70%	Lower Gulf	312	44%	Mt Isa and surrounds	2151	73%	Far South West	580	77%	Balonne	362	77%	Maranoa	1156	81%	Western Queensland	5516	74%	Queensland	501,780	82%
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Youth		
Rheumatic heart disease is preventable and occurs as a result of damage to the heart following acute rheumatic fever. Healthy housing, sanitation, reduced household crowding, cultural safety, access to quality education and employment and access to health services are some measures known to reduce the rates of acute rheumatic fever and rheumatic heart disease.	Higher rates of rheumatic heart disease particularly in the north-west CLs.	<p>In 2017, the prevalence of rheumatic heart disease amongst Queensland Aboriginal and Torres Strait Islander people was 531.0 per 100,000 compared to 7.0 amongst non-Indigenous Queenslanders. The highest prevalence rates are amongst 15-24 year olds (rate 76.4 per 100,000 compared to 44.9 all ages) and females (rate 58.4 per 100,000 vs males 31.2 - all ages). The North West HHS has the highest rate of rheumatic heart disease in Queensland (rate 145.6 per 100,000)</p> <p style="text-align: right;"><i>Source: AIHW (2019)</i></p>
Mental health problems are on the rise among adolescents and young adults. As many as one quarter of young Australians feel disengaged and are at risk of missing out on living healthy, productive lives. When experienced early in life, poor mental health can seriously derail pathways into adulthood through poor academic performance, higher levels of school drop-out and absenteeism, unemployment, interpersonal problems, increased risk of substance	Substantial mental health issues & illnesses in adolescents and young adults	<p>16.6% of 12-17 year olds in Western Queensland PHN experienced a mental health disorder. Males had a higher prevalence of mental disorder than females (19.2% vs 14.3%).</p> <p>21% of 15-24 year olds living in Western Queensland are diagnosed with a mental health and behavioural disorder. The South West HHS had a higher prevalence of mental health and behavioural disorders compared to the Central HHS and North West HHS.</p> <p style="text-align: right;"><i>Source: Young Minds Matter 2017 Survey</i></p> <p>Nearly 1 in 5, 15-24 year olds in WQPHN were admitted to hospital for mental health and behavioural disorders in 2019-2020.</p> <p style="text-align: right;"><i>Source: QHAPDC (2021)</i></p> <p>Based on GP data (PATCAT), 1 in 5 (21%) 15-24 year olds residing in Western Queensland have a mental health and behavioural disorder diagnosis. The South West HHS had a higher prevalence of mental health and behavioural disorders compared to the Central and North West HHS. Anxiety and depression were the most common mental health diagnoses recorded.</p>

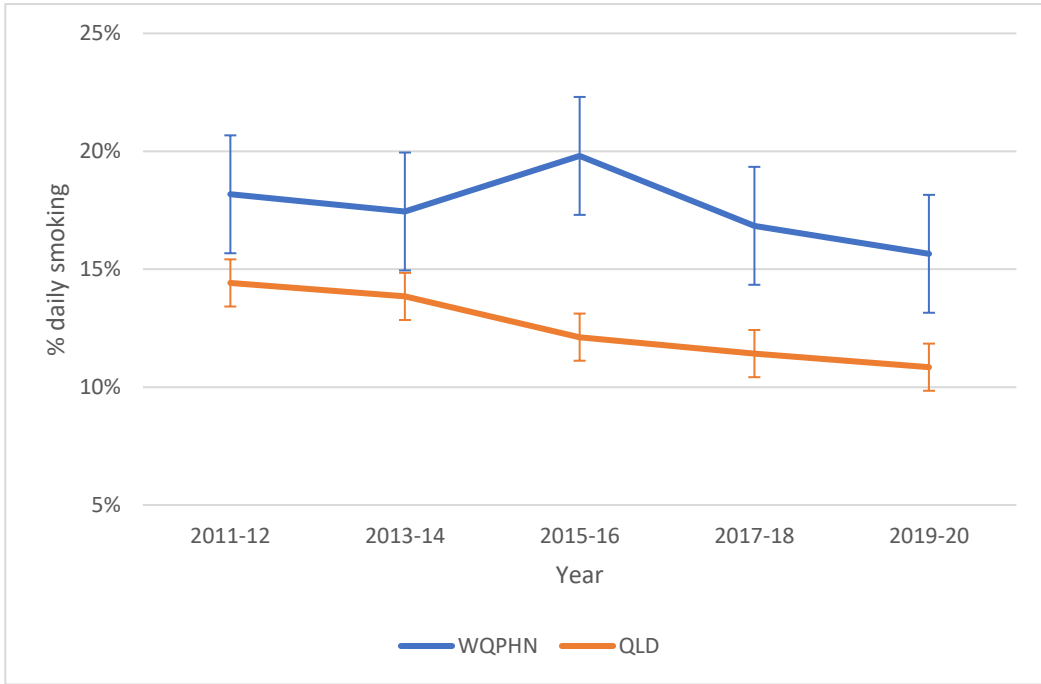
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abuse and increased likelihood of self-harm and suicide.		<table><tr><th></th><th>Central West</th><th>North West</th><th>South West</th><th>WQPHN</th></tr><tr><td>2020 ERP (denominator)</td><td>1020</td><td>3392</td><td>2433</td><td>6804</td></tr><tr><td>Anxiety</td><td>70 (7%)</td><td>213 (6%)</td><td>264 (11%)</td><td>547 (9%)</td></tr><tr><td>Depression</td><td>88 (9%)</td><td>204 (6%)</td><td>285 (11%)</td><td>577 (8%)</td></tr><tr><td>Schizophrenia</td><td><10</td><td>15</td><td><10</td><td>22</td></tr><tr><td>Bipolar</td><td><10</td><td>14</td><td>18</td><td>34</td></tr><tr><td>ADHD</td><td>16</td><td>44</td><td>101</td><td>161</td></tr><tr><td>Autism</td><td><10</td><td>30</td><td>34</td><td>69</td></tr><tr><td>All MH and behavioural disorders</td><td>184 (18%)</td><td>520 (15%)</td><td>706 (29%)</td><td>1410 (21%)</td></tr></table> <p>Source: WQPHN PATCAT (2021)</p> <p>In 2018/2019 1,015 GP Mental Health services were provided to 593 Western Queensland young people (15-24 years). In the past five years the number of GP mental health services provided increased 70%, whilst the number of patients increased 48%.</p>		Central West	North West	South West	WQPHN	2020 ERP (denominator)	1020	3392	2433	6804	Anxiety	70 (7%)	213 (6%)	264 (11%)	547 (9%)	Depression	88 (9%)	204 (6%)	285 (11%)	577 (8%)	Schizophrenia	<10	15	<10	22	Bipolar	<10	14	18	34	ADHD	16	44	101	161	Autism	<10	30	34	69	All MH and behavioural disorders	184 (18%)	520 (15%)	706 (29%)	1410 (21%)
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		<p>The occasions of service being delivered by Headspace in Mt Isa continues to increase (excepting during COVID). The majority of the attendees were in the 15-24 years age group in 20/21 (71% n=167).</p> <p style="text-align: right;"><i>Source: Headspace Activity Report (2021)</i></p> <table border="1"> <thead> <tr> <th>Financial year</th><th>Occasions of service</th><th>Serviced young people</th></tr> </thead> <tbody> <tr> <td>2018</td><td>1,301</td><td>250</td></tr> <tr> <td>2019</td><td>1,467</td><td>289</td></tr> <tr> <td>2020</td><td>1,559</td><td>276</td></tr> <tr> <td>2021</td><td>1,398</td><td>235</td></tr> </tbody> </table> <p>There are increasing number of young people (15-24yrs) receiving commissioned PMHC services – 401 in 19/20 and 426 in 20/21.</p>	Financial year	Occasions of service	Serviced young people	2018	1,301	250	2019	1,467	289	2020	1,559	276	2021	1,398	235
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Long-term adult smokers often begin smoking as young people – 80% begin before the age of 20 years.	Smoking rates in adolescents and young adults appear to be decreasing	Over the last decade, the percentage of 18-29 year olds that smoke daily in Western Queensland appears to be decreasing (21% to 11%). In 2019-20 the rate of daily smoking amongst this cohort was on par with Queensland rates of daily smoking (11% vs 12%). While this is a promising trend it is based on state-wide survey data with wide confidence intervals.															

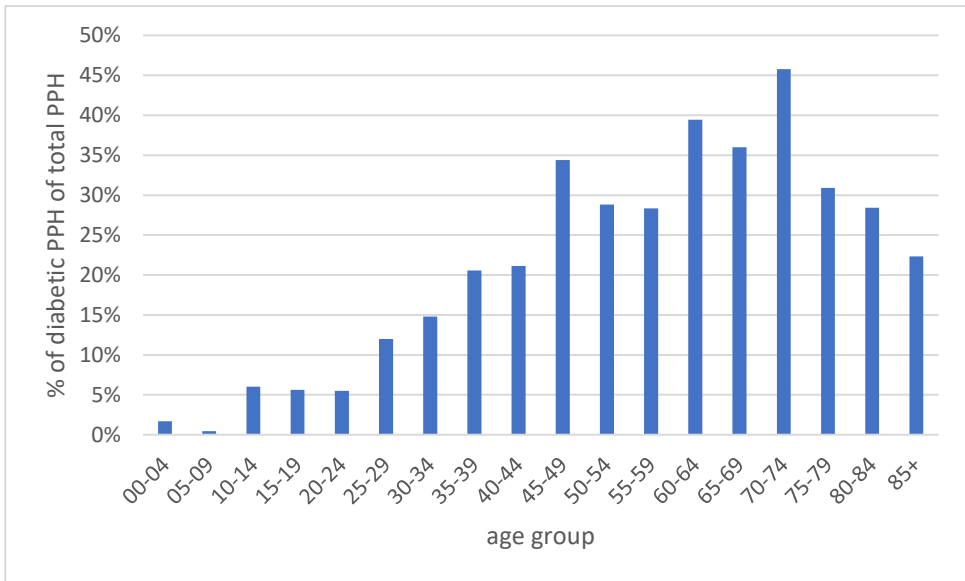
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Disproportionately high rates of blood borne viruses and sexually transmissible infections in remote and rural Aboriginal and Torres Strait Islander communities	Ongoing outbreak of infectious syphilis affecting young Aboriginal and Torres Islander people predominantly aged between 15 and 29 years	<p>Increased notifications associated with the syphilis outbreak that has spread through the country over last 10 years. This was first reported in January 2011 in northwest Queensland, followed by Northern Territory, Western Australia and South Australia since then.</p> <p>In the NWHHS the number of notifications of infectious syphilis has been trending down in the five year period 2016 to 2020 (from 44 in 2016 to 22 in 2020), as has chlamydia, while gonorrhoea notifications increased (83 notifications in 2016 to 111 in 2020). Low numbers of notifications for syphilis and gonorrhoea (usually <4 per year) have been reported in the SWHHS and CWHHS in each year of the five year period.</p> <p>Source: Queensland Health, Notifiable Conditions Report (2021)</p>																		

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Our lifestyle choices, including the amount of exercise we undertake and food we eat, along with the extent to which we smoke, all impact on our health. These modifiable risk factors can increase the likelihood of developing chronic diseases and impact on the management of existing chronic conditions.	High rates of lifestyle-related risk factors	Western Queensland PHN has the highest proportion of overweight and obese adults among all Queensland PHNs. The North West HHS and South West HHS had the two highest percentages compared to all Queensland HHHs, with the Central West HHS ranking 7 th .													
		<table><tr><th></th><th>18+ years (95% CI)</th></tr><tr><td>North West</td><td>71%</td></tr><tr><td>South West</td><td>69%</td></tr><tr><td>Central West</td><td>66%</td></tr><tr><td>Western Queensland</td><td>69%</td></tr><tr><td>Queensland</td><td>60%</td></tr></table>		18+ years (95% CI)	North West	71%	South West	69%	Central West	66%	Western Queensland	69%	Queensland	60%	
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Overall smoking rates across Western Queensland have decreased to some extent. In 2011-12, 18% of Western Queensland adults smoked compared to 16% in 2019-20, although confidence intervals are wide. The percentage of smokers in the youngest cohort (18-29 years) has decreased the most of all age groups (10% in the past 10 years). Analysis of smoking rates over time through health assessment will be a better determination of change.															

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		<p>Percentage of daily smokers in Western Queensland aged 18 years and above, 2011-12 to 2019-20</p>  <table border="1"> <thead> <tr> <th>Year</th> <th>WQPHN (%)</th> <th>QLD (%)</th> </tr> </thead> <tbody> <tr> <td>2011-12</td> <td>18.5</td> <td>14.5</td> </tr> <tr> <td>2013-14</td> <td>17.5</td> <td>14.0</td> </tr> <tr> <td>2015-16</td> <td>19.5</td> <td>12.5</td> </tr> <tr> <td>2017-18</td> <td>17.0</td> <td>11.5</td> </tr> <tr> <td>2019-20</td> <td>15.5</td> <td>11.0</td> </tr> </tbody> </table> <p>Rates of daily smoking are highest in the North West HHS compared to other HHSs of Western Queensland (19% North West vs 12% Central West and 13% South West). It was estimated 17% of North West HHS females are daily smokers compared to 10% across the state. Rates of males smoking are higher across all three Western Queensland HHSs, compared to Queensland. One-fifth of males in the North West HHS smoke compared to 12% in Queensland.</p>	Year	WQPHN (%)	QLD (%)	2011-12	18.5	14.5	2013-14	17.5	14.0	2015-16	19.5	12.5	2017-18	17.0	11.5	2019-20	15.5	11.0
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Chronic diseases are the leading cause of illness, disability and death in Australia and are defined as any condition which is long lasting and with persistent effects. The chronic diseases which affect the greatest proportion of the population and have the greatest impacts on quality of life are the ones most often considered high priorities for monitoring and intervention in the general practice and primary care settings.	High rates of lifestyle-related chronic diseases	<p>In 2018, Western Queensland PHN had the highest age standardised mortality rate of all PHNs in Australia (712.3 per 100,00 vs the lowest - Northern Sydney 398.3 per 100,000). Forty-seven percent of all deaths were classified as premature (aged under 75, n=199) and 55.5% of these premature deaths (n=111) were potentially avoidable. Between 2014 and 2018 the age standardised mortality rate for Western Queensland males was 767.4 per 100,000 compared 584.2 per 100,000 for females.</p> <p>Source: AIHW, MORT (2020)</p> <p>Between 2014 and 2018, coronary heart disease was the leading cause of death in Western Queensland with an age-standardised rate of 89.2 per 100,000. This equates to 13.2% of all deaths (273 deaths). Coronary heart disease was the leading cause of death for WQPHN males and females, but the age-standardised rate amongst males was much higher compared to females (M=112.9 per 100,000 vs F=63.2 per 100,000).</p> <p>Source: AIHW, MORT (2020)</p> <p>Hypertension and hyperlipidaemia are biological risk factors to chronic vascular disease. General Practice data (PATCAT) reports one in five (20%) Western Queensland adults (25-64 years) are diagnosed with hypertension and/or hyperlipidaemia. Within WQPHN there were similar rates of hypertension and hyperlipidaemia across HHSs.</p>																								

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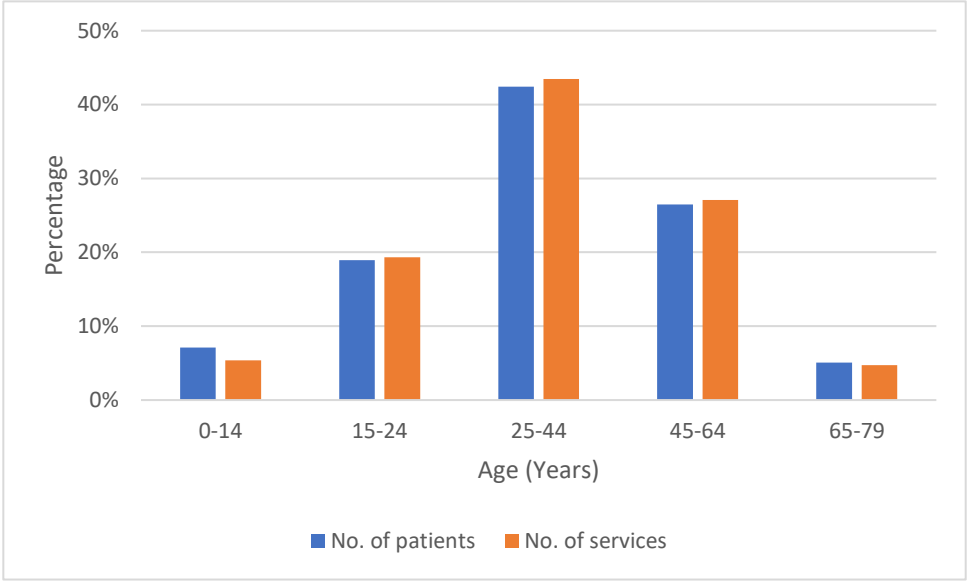
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		<p>Chronic Obstructive Pulmonary Disease (COPD) was the second leading cause of death amongst WQPHN males and 5th amongst females, with 141 deaths recorded between 2014 and 2018. Relative to Australia, Western Queensland had 1.93 times the COPD deaths (all persons age standardised rate 47.0 per 100,000 vs Australia 24.3). The rate of COPD in WQPHN in the 65+ population is about double that for Australia.</p> <p style="text-align: right;"><i>Source: WQPHN PATBI (2021)</i></p> <table><tr><th></th><th>Central West</th><th>North West</th><th>South West</th><th>WQPHN</th><th>National</th></tr><tr><td>Asthma</td><td>150 (8%)</td><td>228 (10%)</td><td>421 (12%)</td><td>799 (10%)</td><td>12.0%</td></tr><tr><td>COPD</td><td>192 (11%)</td><td>331 (15%)</td><td>517 (14%)</td><td>1040 (14%)</td><td>7.0%</td></tr></table> <p style="text-align: right;"><i>Source: *WQPHN PATBI 2021; **ABS National Health Survey (2018)</i></p> <p>Lung cancer was the leading cancer death in Western Queensland and the 3rd leading cause of all deaths. Between 2014 and 2018, there were 123 lung cancer deaths in Western Queensland, of which 83 were in males. This equates to a lung cancer age-standardised mortality rate of 48.8 for males and 28.5 per 100,000 for females. Behind Northern Territory PHN, Western Queensland PHN has the second highest mortality rate from lung cancer (1.33 times the rate of Australia overall).</p> <table><tr><th>Rank- cancer mortality</th><th>Deaths</th><th>ASR (per 100,000)</th><th>Rate ratio relative to Australia</th></tr><tr><td>1.Lung cancer</td><td>123</td><td>39.2</td><td>1.33</td></tr><tr><td>2.Colorectal cancer</td><td>60</td><td>19.8</td><td>1.07</td></tr><tr><td>3.Unknown or ill-defined primary site</td><td>41</td><td>13.2</td><td>1.36</td></tr><tr><td>4.Prostate cancer</td><td>40</td><td>13.9</td><td>1.29</td></tr><tr><td>5.Breast cancer</td><td>30</td><td>9.4</td><td>0.89</td></tr></table> <p style="text-align: right;"><i>Source: AIHW, MORT (2020)</i></p>		Central West	North West	South West	WQPHN	National	Asthma	150 (8%)	228 (10%)	421 (12%)	799 (10%)	12.0%	COPD	192 (11%)	331 (15%)	517 (14%)	1040 (14%)	7.0%	Rank- cancer mortality	Deaths	ASR (per 100,000)	Rate ratio relative to Australia	1.Lung cancer	123	39.2	1.33	2.Colorectal cancer	60	19.8	1.07	3.Unknown or ill-defined primary site	41	13.2	1.36	4.Prostate cancer	40	13.9	1.29	5.Breast cancer	30	9.4	0.89
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		<p>Survey findings and stakeholder consultations noted the considerably higher cancer mortality was in due in part to the limited access to services in WQPHN for timely screening, diagnosis and treatment.</p> <p>South West and Central West have higher percentages of chronic disease-related potentially preventable hospitalisations compared to the North West.</p> <table><tr><th colspan="2"></th><th>Vaccine preventable</th><th>Acute PPH</th><th>Chronic PPH</th><th>Total PPH</th></tr><tr><td rowspan="2">Central West</td><td>Indigenous</td><td>-</td><td>15</td><td>32</td><td>47</td></tr><tr><td>non-Indigenous</td><td>20</td><td>164</td><td>227</td><td>408</td></tr><tr><td rowspan="2">North West</td><td>Indigenous</td><td>110</td><td>587</td><td>527</td><td>1199</td></tr><tr><td>non-Indigenous</td><td>48</td><td>340</td><td>366</td><td>745</td></tr><tr><td rowspan="2">South West</td><td>Indigenous</td><td>12</td><td>119</td><td>171</td><td>298</td></tr><tr><td>non-Indigenous</td><td>58</td><td>336</td><td>519</td><td>905</td></tr></table> <p>Diabetes is the largest contributor to chronic disease-related potentially preventable hospitalisations in the WQPHN's Aboriginal and Torres Strait Islander population (NW 47.4%, CW 52.4%, South West 59.1%). There appears to be significantly lower rates of cardiovascular-related chronic disease potentially preventable hospitalisations in the South West Aboriginal and Torres Strait Islander population compared to other Western Queensland regions (9.8% SW, 19.0% CW, 19.9% NW). There appears to be significantly lower COPD-related chronic disease potentially preventable hospitalisations in the Central West Aboriginal and Torres Strait Islander population (9.5% CW, 15.0% NW, 23.2% SW).</p>			Vaccine preventable	Acute PPH	Chronic PPH	Total PPH	Central West	Indigenous	-	15	32	47	non-Indigenous	20	164	227	408	North West	Indigenous	110	587	527	1199	non-Indigenous	48	340	366	745	South West	Indigenous	12	119	171	298	non-Indigenous	58	336	519	905
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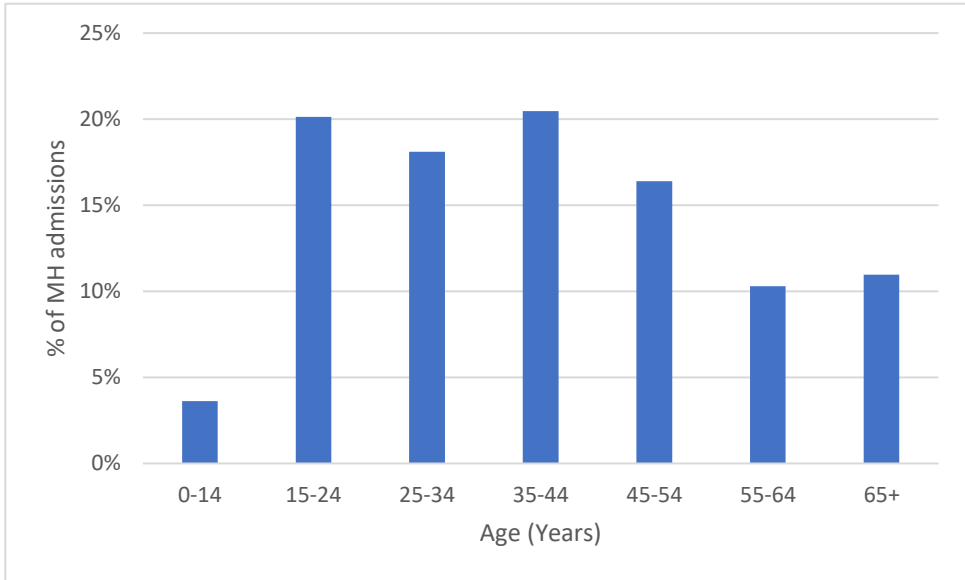
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		<p>Significantly higher co-morbidity rates in 65+ year olds exist in the South West region compared to other Western Queensland regions.</p> <table><tr><th></th><th>Central West</th><th>North West</th><th>South West</th><th>WQPHN</th></tr><tr><td>≥ 1 chronic conditions</td><td>1415 (78%)</td><td>1671 (74%)</td><td>3133 (86%)</td><td>6219 (81%)</td></tr><tr><td>≥ 2 chronic conditions</td><td>940 (52%)</td><td>1159 (51%)</td><td>2228 (62%)</td><td>4327 (56%)</td></tr></table> <p>Source: WQPHN PATBI (2021)</p> <p>Musculoskeletal prevalence rates in 65+ adults were on par with the national rates, but the North West had significantly lower rates of Osteoporosis and Osteoarthritis (12% and 21% respectively compared to national rates of 15.6% and 32.7%), while the South West had higher rates of both diseases compared to the national rate (19% and 37% respectively).</p> <table><tr><th></th><th>Central West</th><th>North West</th><th>South West</th><th>WQPHN</th><th>National</th></tr><tr><td>Osteoporosis</td><td>235 (13%)</td><td>281 (12%)</td><td>688 (19%)</td><td>1204 (16%)</td><td>15.6%</td></tr><tr><td>Osteoarthritis</td><td>488 (27%)</td><td>476 (21%)</td><td>1332 (37%)</td><td>2296 (30%)</td><td>32.7%</td></tr></table> <p>Source: WQPHN PATBI (2021)</p>		Central West	North West	South West	WQPHN	≥ 1 chronic conditions	1415 (78%)	1671 (74%)	3133 (86%)	6219 (81%)	≥ 2 chronic conditions	940 (52%)	1159 (51%)	2228 (62%)	4327 (56%)		Central West	North West	South West	WQPHN	National	Osteoporosis	235 (13%)	281 (12%)	688 (19%)	1204 (16%)	15.6%	Osteoarthritis	488 (27%)	476 (21%)	1332 (37%)	2296 (30%)	32.7%
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We know, one of five adult Australians experiences a mental health disorder every year and almost half of all Australians will experience a mental health disorder at some point during their lifetime. Although people living in rural areas score better on indicators of life satisfaction and feelings of wellbeing, and report higher levels of civic participation, social cohesion, social capital, volunteering and informal support from friends, neighbours and the community, they experience unique circumstances that may impact on their wellbeing, including, for example, flood, fire, drought and economic variability, and these increase with increasing remoteness. Furthermore, we know Aboriginal and Torres Strait Islander peoples are almost three times as likely as non-Indigenous people to report high levels of psychological distress.	Substantial mental health issues & illnesses in adults	<p>One in four 25-64 year olds in Western Queensland have been diagnosed with a mental health and/or behavioural disorder. Depression, followed by anxiety are the most common mental health and behavioural disorders diagnosed (15% and 9% respectively). In the South West HHS one in three 25-64 year olds have been diagnosed with a mental health and/or behavioural disorder.</p> <table><tr><th></th><th>Central West</th><th>North West</th><th>South West</th><th>WQPHN</th></tr><tr><td>2020 ERP (denominator)</td><td>5408</td><td>15353</td><td>12480</td><td>32998</td></tr><tr><td>Anxiety</td><td>363 (7%)</td><td>1329 (9%)</td><td>1418 (11%)</td><td>3110 (9%)</td></tr><tr><td>Depression</td><td>750 (14%)</td><td>1723 (11%)</td><td>2330 (19%)</td><td>4803 (15%)</td></tr><tr><td>Schizophrenia</td><td>56</td><td>140</td><td>89</td><td>285</td></tr><tr><td>Bipolar</td><td>45</td><td>97</td><td>141</td><td>283</td></tr><tr><td>ADHD</td><td>19</td><td>34</td><td>79</td><td>132</td></tr><tr><td>Autism</td><td>10</td><td><10</td><td>18</td><td>36</td></tr><tr><td>Total MH problems and disorders</td><td>1243 (23%)</td><td>3331 (22%)</td><td>4075 (33%)</td><td>8649 (26%)</td></tr></table> <p>Source: WQPHN PATCAT (2021)</p> <p>For 25-64 year olds, mental health and behavioural disorders (26%) are the predominant long term health diagnosis made by general practitioners in Western Queensland. Hyperlipidaemia (20%), followed by hypertension (20%), diabetes (12%) and asthma (9%) are the next most common long term health conditions diagnosed by general practitioners.</p> <p>MBS data shows over two thirds of general practitioner mental health services in Western Queensland are provided to people aged between 25-64 years.</p>		Central West	North West	South West	WQPHN	2020 ERP (denominator)	5408	15353	12480	32998	Anxiety	363 (7%)	1329 (9%)	1418 (11%)	3110 (9%)	Depression	750 (14%)	1723 (11%)	2330 (19%)	4803 (15%)	Schizophrenia	56	140	89	285	Bipolar	45	97	141	283	ADHD	19	34	79	132	Autism	10	<10	18	36	Total MH problems and disorders	1243 (23%)	3331 (22%)	4075 (33%)	8649 (26%)
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		<p>In 2019-20, Western Queensland general practitioners provided on average 1.7 mental health services to every one patient and psychiatrists provided 4.8 services to every one patient. The reduction in the psychiatrist ratio between 2015-16 and 2019-20 is reflective of the higher number of patients rather than a reduction in psychiatry services (15/16 to 19/20: psychiatry services increased 33% and patients increased 47%). Comparatively Brisbane North and Brisbane South PHN had a psychiatrist to patient ratio of 7.0 and 6.8 (respectively) in the same reporting period.</p> <p>Mental health services provided to Western Queensland all people 2014/15 to 2018/19</p> <table><caption>Estimated data from the line graph: Services provided to patient ratio</caption><thead><tr><th>Year</th><th>Psychiatrists</th><th>Clinical psychologists</th><th>Other allied health providers</th><th>Other psychologists</th><th>General practitioners</th></tr></thead><tbody><tr><td>2015-16</td><td>5.2</td><td>3.7</td><td>3.0</td><td>3.3</td><td>1.6</td></tr><tr><td>2016-17</td><td>5.7</td><td>4.1</td><td>3.2</td><td>3.2</td><td>1.6</td></tr><tr><td>2017-18</td><td>5.7</td><td>3.6</td><td>3.0</td><td>2.9</td><td>1.7</td></tr><tr><td>2018-19</td><td>5.3</td><td>4.3</td><td>3.7</td><td>3.3</td><td>1.7</td></tr><tr><td>2019-20</td><td>4.8</td><td>4.3</td><td>3.4</td><td>3.4</td><td>1.7</td></tr></tbody></table>	Year	Psychiatrists	Clinical psychologists	Other allied health providers	Other psychologists	General practitioners	2015-16	5.2	3.7	3.0	3.3	1.6	2016-17	5.7	4.1	3.2	3.2	1.6	2017-18	5.7	3.6	3.0	2.9	1.7	2018-19	5.3	4.3	3.7	3.3	1.7	2019-20	4.8	4.3	3.4	3.4	1.7
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		<p>North West HHS had a higher rate of mental health emergency department presentations compared to the Central HHS and South West HHS (64.1 vs 18.2 and 25.0 per 1000 population) in 2020-21.</p> <table> <tr> <th></th><th>MH ED presentations</th><th>Crude rate per 1000 population</th></tr> <tr> <td>Central West</td><td>185</td><td>18.2</td></tr> <tr> <td>North West</td><td>1,762</td><td>64.1</td></tr> <tr> <td>South West</td><td>598</td><td>25.0</td></tr> <tr> <td>Western Queensland</td><td>2,545</td><td>41.3</td></tr> </table> <p style="text-align: right;"><i>Source: EDIS, Queensland Health (2021)</i></p> <p>In 2019-2020, there were 1,046 mental and behavioural disorder admissions across Western Queensland, with the majority of admissions in North West HHS residents (675).</p> <table> <tr> <th></th><th>MH admissions</th><th>*Rate per 1000 pop</th></tr> <tr> <td>Central West</td><td>98</td><td>9.6</td></tr> <tr> <td>North West</td><td>675</td><td>24.6</td></tr> <tr> <td>South West</td><td>273</td><td>11.4</td></tr> <tr> <td>Western Queensland</td><td>1046</td><td>17.0</td></tr> </table> <p style="text-align: right;"><i>Source: QHAPDC (2021)</i></p>		MH ED presentations	Crude rate per 1000 population	Central West	185	18.2	North West	1,762	64.1	South West	598	25.0	Western Queensland	2,545	41.3		MH admissions	*Rate per 1000 pop	Central West	98	9.6	North West	675	24.6	South West	273	11.4	Western Queensland	1046	17.0
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		<p>The bulk of mental and behavioural disorder admissions in Western Queensland occur between the ages of 15 to 54 years.</p>  <table><caption>% of MH admissions by Age (Years)</caption><thead><tr><th>Age (Years)</th><th>% of MH admissions</th></tr></thead><tbody><tr><td>0-14</td><td>3.5%</td></tr><tr><td>15-24</td><td>20%</td></tr><tr><td>25-34</td><td>18%</td></tr><tr><td>35-44</td><td>20.5%</td></tr><tr><td>45-54</td><td>16.5%</td></tr><tr><td>55-64</td><td>10.5%</td></tr><tr><td>65+</td><td>11%</td></tr></tbody></table> <p>Source: WQPHN Mental Health Data Overview (unpublished)</p> <p>In 2016/17 there were 884 mental and behavioural disorder admissions to Western Queensland hospitals. Half of these admissions were Aboriginal and Torres Strait Islander people. Between the ages of 15 to 54 years Aboriginal and Torres Strait Islander patients far outweighed non-Indigenous patients.</p> <p>Source: WQ-profile priority area/Mental Health (unpublished)</p> <p>In the 30-39 year age group, 11% of indigenous hospital admissions in Western Queensland are for mental and behavioural disorders. For the other age groups above 20 years, mental and behavioural admissions constitute around 6% of hospital admissions</p>	Age (Years)	% of MH admissions	0-14	3.5%	15-24	20%	25-34	18%	35-44	20.5%	45-54	16.5%	55-64	10.5%	65+	11%
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<p>While the prevalence of people experiencing mental illness is similar across Australia: around 20%, rates of suicide and self-harm are higher in remote and rural areas, and increase with increasing remoteness. Farmers, young men, older people and Aboriginal and Torres Strait Islander peoples in remote and rural areas are at greatest risk of completing suicide. A range of remote and rural circumstances contributes to broad socio-cultural, mental health, economic and service-related barriers which in turn place individuals in these areas at greater risk of self-harm. The increasing rates of suicide with remoteness evince there are significant mental health issues that need to be addressed in these remote and rural areas.</p>	<p>High rates of suicide amongst males</p>	<p>In 2019-20, Western QLD PHN had the highest rate of intentional self-harm hospitalisations (317 per 100,000 population) of all PHNs. By gender, rates were highest for females aged 24 and below (522 per 100,00; 52 hospitalisations) and males aged 25-44 years (335 per 100,000 population; 29 hospitalisations). Outback North had the highest rates of self-harm hospitalisations compared to other SA3s within Western Queensland.</p> <p>Between 2015-2019, the age-standardised suicide rates for Western Queensland SA3s were much higher compared to Queensland and Australia.</p> <p>Both males and females of Queensland- Outback SA4 have higher rates of suicide compared to their respective metropolitan counterparts. But males of Queensland-Outback SA4 have nearly three times the age-standardised suicide rate compared to females residing in Queensland-Outback SA4 (34.7 vs 13.0 per 100,000).</p> <p>This evidence is supported in mortality data (2014-2018) which show suicide as the 4th highest cause of death amongst Western Queensland males (n=66 deaths; age-standardised rate 41.0 per 100,000). Furthermore, Western Queensland males had the highest rate of death from suicide compared to all PHNs (2.18 times the rate compared to Australia-wide). For Western Queensland females, suicide was not listed in the top 20 leading causes of death. Source: AIHW MORT 2020</p> <p>In 2017/18 there were 500 suicide specific presentations to Emergency Departments within Western Queensland. Of these presentations, 60% identified as Aboriginal and Torres Strait Islander. In 20/21 this increased to 640 suicide specific ED presentations, of which 66% identified as Aboriginal and or Torres Strait Islander. NWHHS had the highest number (480) compared to SWHHS (124) and CWHHS (36).</p> <p style="text-align: right;"><i>Source: EDIS, Queensland Health)</i></p>

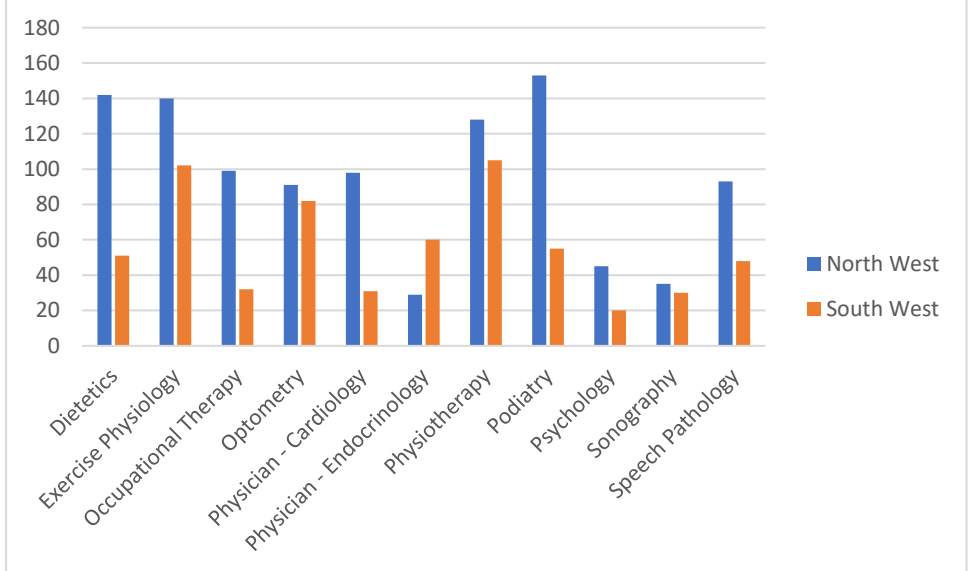
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<p>People living in regional and remote areas are more likely to drink frequently or at levels that are harmful to their health. Various factors contribute to higher alcohol consumption within regional and remote areas including the social acceptability of alcohol and its role in community and social events. Overall use of illicit drugs in regional and remote areas is similar to that in cities, however the type and frequency of drug use varies considerably. For example, people in remote and very remote areas are 2.5 times more likely to use methamphetamines as those in cities. Cannabis use is also more widespread and frequent in remote and very remote settings. Men, FIFO workers, farmers and Aboriginal and Torres Strait Islander peoples in remote and rural areas are at greatest risk of harm from alcohol and other drugs.</p>	Higher rates of risky alcohol consumption, especially amongst males	<p>Significantly higher proportion of males have a risky lifetime alcohol consumption compared to females (WQPHN M-42%; F-13%). And WQPHN, also has a much higher rate of risky alcohol consumption to Queensland overall (28% vs 22%). Within Western Queensland PHN, North West HHS males had the highest rate of risky alcohol consumption (43%) as did young males aged 18-29 years (52%). Data also showed that over the past 10 years there has been minimal change to the rate of risky alcohol consumption among age groups across Western Queensland.</p> <p style="text-align: right;"><i>Source: Queensland Preventative Health Survey</i></p>											
	Increased burden of disease attributable to alcohol and drug use	<p>Presentation to emergency departments for mental and behavioural disorders due to alcohol or drug use in 2020-21 was very high in the North West HHS in comparison to the Central HHS and South West HHS (32.5 per 1,000 in North West vs 4.1 in Central West and 5.9 in South West)</p> <table border="1"> <thead> <tr> <th></th><th>AODTS ED presentations</th><th>Crude rate (per 1,000 pop)</th></tr> </thead> <tbody> <tr> <td>North West</td><td>893</td><td>32.5</td></tr> <tr> <td>Central West</td><td>42</td><td>4.1</td></tr> <tr> <td>South West</td><td>140</td><td>5.9</td></tr> </tbody> </table> <p>WQPHN has nearly double the rate of alcohol-related road traffic deaths compared to Queensland WQPHN has the highest rate of mental health hospitalisations due to alcohol or drug use compared to other PHNs WQPHN has double the rate of alcohol and drug treatment episodes compared to Queensland 1 in 4 people in WQPHN access alcohol and drug treatment services outside the PHN region</p> <p style="text-align: right;"><i>Source: WQPHN, Our People Our Partnerships Our Health 2019</i></p> <p>Alcohol is the greatest reason for Alcohol and Other Drug Treatment Services (AODTS) episodes in NWHHS and CWHHS, however Cannabis type is slightly higher in SWHHS.</p> <p style="text-align: right;"><i>Source: AODTS National Minimum Data Set.</i></p>		AODTS ED presentations	Crude rate (per 1,000 pop)	North West	893	32.5	Central West	42	4.1	South West	140
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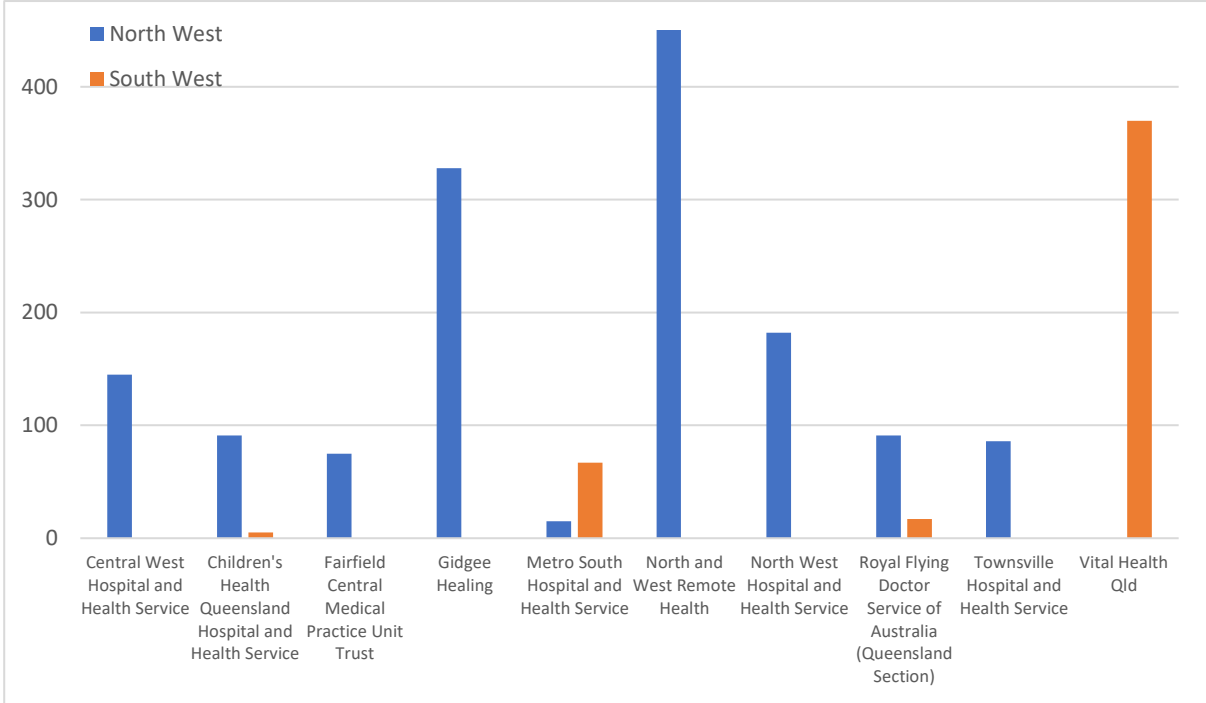
Identified Need	Key Issue	Description of Evidence
Populations with special needs		
Adults		
Those living in remote and rural areas sustain higher non-intentional (e.g. road transport injuries, injuries associated with agricultural production, drownings, poisonings, falls, thermal-related injuries) and intentional injury (e.g. self-harm, assaults) rates than those living in major cities.	Higher rates of non-intentional and intentional injuries	<p>In 2009-10, the age standardised death rate from injuries was higher amongst those living in remote and very remote areas compared with those living in major cities.</p> <p>Similar to injury deaths, hospitalisation for injuries was significantly higher for remote and rural residents compared with people living in major cities in 2012-13 and 2009-10.</p> <p>In 2009-10, the age-standardised death rate for transport injury deaths amongst remote (19.0 per 100,000 population) and very remote (20.4 per 100,000 population) residents was four times higher than the age-standardised death rate for residents of major cities (4.6 per 100,000 population).</p> <p>Age-standardised injury deaths in 2009-10 from self-harm in remote (15.9 per 100,000 population) and very remote areas (16.5 per 100,000 population) of Australia were 1.7 and 1.8 times (respectively) higher than in major cities (9.3 per 100,000 populations).</p> <p>In 2012-13, residents in very remote and remote areas were respectively around 14 and 7 times more likely to be hospitalised for assault than residents in major cities.</p> <p><i>Source: Royal Flying Doctor Service (RFDS) Responding to injuries in remote and rural Australia 2016</i></p> <p>From 2015-2019 WQPHN had an average annual ASR per 100,000 of 10.5 for deaths from road traffic injuries, 0 to 74 years. This was the third highest rate for all PHNs after NT (15.1) and Country WA (14.2). It was over twice as high as the national rate of 4.4.</p> <p>From 2015-2019 WQPHN had an average annual ASR per 100,000 of 25.2 for deaths from suicide and self-inflicted injuries, 0 to 74 years. This was the highest rate for all PHNs and it was over twice as high as the national rate of 12.7.</p> <p><i>Source: PHIDU</i></p>

Section 3 – Outcomes of the service needs analysis

Identified Need	Key Issue	Description of Evidence
Access to services		
Improve access to medical specialist services	Generally poor access to MBS funded specialist services, although some regional variation	<p>GPs and other community-based health professionals provide the majority of care to people with chronic conditions such as respiratory disease, cancer, cardiovascular disease, diabetes, musculoskeletal conditions and stroke.</p> <p>Caring for people with chronic and complex healthcare needs can require:</p> <ul style="list-style-type: none"> • a higher or more specialised level of care • the support of several healthcare professionals, including medical specialists • care for multiple conditions associated with the person's illness. <p>Specialist support in general practice and community settings can provide:</p> <ul style="list-style-type: none"> • access to specialist care, sooner and closer to home • a stronger focus on patients' multidisciplinary health needs for an individual specialism • a stronger focus on a whole of specialism team based clinical governance model • equal or better health outcomes as people spend less time in hospital • healthcare at a lower cost to the health system • fewer avoidable hospital stays. <p>Clinician and community member survey results highlighted that these types of specialist care are not always available in the community, and GPs and primary care providers are not able to easily access specialist advice to support people with chronic conditions. The view was that the number and variety of visiting medical specialist services supporting general practice and community-based care had at the best remained unchanged since the 2016 HNA. In contrast, the Central West was reported to have a better medical specialist support system which had developed through partnerships with private providers and organisations.</p> <p>For the four years from 2013/14 to 2016/17 the WQPHN was consistently ranked 2nd last for specialist attendances compared with other PHNs, with only the Northern Territory below it.</p>

Identified Need	Key Issue	Description of Evidence																									
Access to services																											
		<p>MBS Specialist attendances and MBS expenditure per person by PHN</p> <table><tr><th>Year</th><th>Specialist attendance / person</th><th>Range for PHNs</th><th>MBS expenditure</th><th>Range for PHNs</th></tr><tr><td>2013/14</td><td>0.41</td><td>0.37 – 1.19</td><td>\$33.77</td><td>\$29.39-\$109.15</td></tr><tr><td>2014/15</td><td>0.45</td><td>0.38 – 1.20</td><td>\$36.29</td><td>\$31.14-\$108.56</td></tr><tr><td>2015/16</td><td>0.46</td><td>0.41 – 1.21</td><td>\$38.48</td><td>\$28.50-\$109.41</td></tr><tr><td>2016/17</td><td>0.48</td><td>0.38 – 1.20</td><td>\$40.23</td><td>\$27.74-\$107.99</td></tr></table> <p>Source: AIHW 2021</p> <p>Based on the CheckUp 2021/22 services schedule, the top 10 most frequent CheckUp supported medical specialist visiting services were Cardiology (approximately 129 visits/year), Endocrinology (89), Psychiatry (54), Dermatology (47), Paediatrics (25), Respiratory (22), Ophthalmology (22), General (22), ENT (15) & C&A Psychiatry (11).</p> <p>The CheckUp 2021/22 services schedule indicates that 9 of the 11 most frequent CheckUp supported visiting services, were allied health services with only Cardiology and Endocrinology medical specialist services making the list [see graph below]. This was a surprising finding given the Medical Specialist Outreach Assistance Program, and its various spin-offs, was established in 2000, to primarily improve access to medical specialist led multidisciplinary team based care for people in rural and remote areas of Australia.</p>	Year	Specialist attendance / person	Range for PHNs	MBS expenditure	Range for PHNs	2013/14	0.41	0.37 – 1.19	\$33.77	\$29.39-\$109.15	2014/15	0.45	0.38 – 1.20	\$36.29	\$31.14-\$108.56	2015/16	0.46	0.41 – 1.21	\$38.48	\$28.50-\$109.41	2016/17	0.48	0.38 – 1.20	\$40.23	\$27.74-\$107.99
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Planned models of team based care required to maximise effectiveness and efficiency of health care inputs, provide continuity of care and improve health outcomes	Heavy reliance on a complex array of visiting services from multiple providers and funding programs	<p>From the CheckUp 2021/22 service schedule, CheckUp provides funding to support 47 visiting providers across Western Queensland, through the various streams of the Commonwealth Government's Medical Specialist Outreach Assistance Program, delivering health services to 76 locations, the majority of which are allied health services.</p> <p>70% of the CheckUp supported visits into the region are coordinated and/or delivered by the following services.</p> <ul style="list-style-type: none"> • Central West HHS • Children's Health Queensland • Fairfield Central Medical Practice Unit Trust • Gidgee Healing • Metro South HHS (Indigenous Cardiac Outreach Program, Indigenous Respiratory Outreach Care) • North and West Remote Health • North West HHHS 																																				

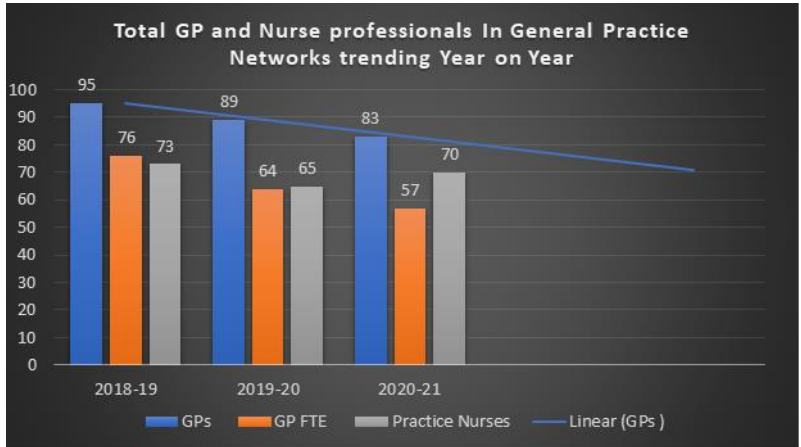
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Identified Need	Key Issue	Description of Evidence
Access to services		
	Complex health care system for patients and providers to navigate	Survey findings and stakeholder consultations identified the need to address system level barriers to make it easier for patients and providers to understand and navigate the Western Queensland health care system. Numerous funding programs supporting multiple service providers under an array of contracts for services with different target groups and eligibility criteria is confusing for community people, referring clinicians and service providers alike, and contribute to poor value, perceived and real duplication, reduced patient engagement and inferior clinical outcomes. Service mapping confirmed issues of duplication, confusing eligibility criteria and lack of up to date and community specific information on publicly available online service directories.
Telehealth as another strategy to improve access to care	Telehealth has an important role in complementing face to face services	The community survey identified that where people had used telehealth the majority (58% - telephone, 62%–video) were satisfied with services accessed by telephone or video. Health professionals surveyed in the HWQ 2021 Health Workforce Needs Assessment for the Western Queensland region reported telehealth had a positive impact on their capacity to provide services e.g., ability to consult while absent from a location, allows extra consults, benefited their clients in various ways (e.g., reduced travel time for clients, easier and more timely access to GPs and specialists, better able to fit in with client's preferred timing). While participants strongly indicated they would like telehealth to be more widely available they did not see it as a substitute for face-to-face consults. Technological issues remained for some (e.g., internet, infrastructure, computer literacy) and it did not work as well for awkward and more complex consults or for some Aboriginal and Torres Strait Islander clients.
Infrastructure and digital readiness support to enable telehealth uptake	Lack of digital infrastructure and workforce and consumer supports for telehealth	Telehealth uptake in primary care increased during the pandemic as new MBS items were added for video conference and telephone consultations if video was not available. Rural and remote primary care service providers were agile in responding to changing service delivery needs, as evident from the overwhelming percentage of WQPHN commissioned service providers who reported they were willing to change (88%) and build skills and capacity to embed telehealth into routine care (73%) (WQPHN Telehealth-Care Stocktake of Commissioned Service Providers, Self-Assessment Survey Outcomes, 2020). However, despite the willingness of providers to change and implement telehealth, the capacity for them to pivot quickly to videoconferencing was challenged during the pandemic by financial sustainability with increased workload and administration burden, reduced income through reduced billable time, workforce capacity issues and lack of technology and infrastructure built into workflows.

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Access to services																																
Improve access to general practitioner services	Poor access to MBS funded general practice services	<p>For the four years from 2013/14 to 2016/17 WQPHN was consistently ranked in the bottom four PHNs for GP attendances compared with other PHNs, along with Country WA, the Northern Territory and the ACT.</p> <p>MBS GP attendances and MBS expenditure per person by PHN</p> <table><tr><th>Year</th><th>GP attendance / person</th><th>Ranking</th><th>Range for PHNs</th><th>MBS expenditure</th><th>Range for PHNs</th></tr><tr><td>2013/14</td><td>4.1</td><td>2nd last</td><td>4 – 7.6</td><td>\$205.42</td><td>\$208.48-\$340.02</td></tr><tr><td>2014/15</td><td>4.4</td><td>3rd last</td><td>4.3 – 7.7</td><td>\$231.44</td><td>\$214.85-\$354.16</td></tr><tr><td>2015/16</td><td>4.6</td><td>2nd last</td><td>4.4 – 7.7</td><td>\$245.15</td><td>\$223.70-\$359.90</td></tr><tr><td>2016/17</td><td>5.1</td><td>equal 4th last</td><td>4 – 7.6</td><td>\$279.62</td><td>\$242.98-\$363.10</td></tr></table> <p>Source: AIHW 2021</p>	Year	GP attendance / person	Ranking	Range for PHNs	MBS expenditure	Range for PHNs	2013/14	4.1	2 nd last	4 – 7.6	\$205.42	\$208.48-\$340.02	2014/15	4.4	3 rd last	4.3 – 7.7	\$231.44	\$214.85-\$354.16	2015/16	4.6	2 nd last	4.4 – 7.7	\$245.15	\$223.70-\$359.90	2016/17	5.1	equal 4 th last	4 – 7.6	\$279.62	\$242.98-\$363.10
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	Current GP workforce is insufficient to meet demand.	<p>Determining the numbers of GPs working in actual general practice in WQPHN is fraught. Because work arrangements have the potential to be more complicated in rural areas, and especially in remote areas, the level of confidence in the official GP numbers decreases as remoteness increases. This is certainly the case in WQPHN.</p> <p>HWQ annually compiles a Minimum Data Set based on a headcount of individual medical practitioners working in primary care in remote, rural and regional Queensland. This data lists individual GPs as working at their primary site on the census date. For those who work across multiple sites their primary site is confirmed through the survey or a ring-around.</p> <p>Over 80% of medical practitioners in the Western Queensland PHN work in either remote or very remote locations. The table below summarises where medical practitioners are primarily employed in remote and very remote Queensland. HWQ doesn't routinely publish PHN specific data as part of the MDS, and so remote and very remote classifications have been used as a proxy for Western Queensland PHN. While the numbers fluctuate there appears to be a trend of increasing employment in the hospitals and decreasing employment in general practice over the six years between 2015 and 2020.</p>																														

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		<p>Medical practitioner employment type by ASGC-RA classification Remote and Very Remote</p> <table><tr><th>ASGS-RA: Remote/Very Remote</th><th>2020</th><th>2019</th><th>2018</th><th>2017</th><th>2016</th><th>2015</th></tr><tr><td>ACCHOs</td><td>11</td><td>9</td><td>12</td><td>18</td><td>7</td><td>2</td></tr><tr><td>HHSs</td><td>81</td><td>62</td><td>51</td><td>57</td><td>61</td><td>56</td></tr><tr><td>General Practice</td><td>55</td><td>64</td><td>55</td><td>70</td><td>76</td><td>73</td></tr><tr><td>RFDS</td><td>19</td><td>16</td><td>11</td><td>13</td><td>13</td><td>7</td></tr><tr><td>Total</td><td>166</td><td>151</td><td>129</td><td>158</td><td>157</td><td>138</td></tr></table> <p>Source: HWQ MDS 2015-2020</p> <p>A more recent bespoke HWQ analysis commissioned by the WQPHN in 2021 has summarised employment type for medical practitioners working in the region by HHSs. The information is sourced from the same HWQ database that informs the MDS. This is presented in the following table. The yearly headcounts for the overall number of medical practitioners in Western Queensland have increased each year. However, the rise has been minimal for those in general practice. In contrast, medical practitioners employed in HHS in 2020 has increased by 20 on the 2019 number and those employed by the RFDS have nearly doubled from 2018 to 2020. There appears to have been a decline in GPs working in the ACCHO sector from 2018 to 2020 but HWQ notes that this may be attributable to inconsistent access to workforce data from this sector.</p>	ASGS-RA: Remote/Very Remote	2020	2019	2018	2017	2016	2015	ACCHOs	11	9	12	18	7	2	HHSs	81	62	51	57	61	56	General Practice	55	64	55	70	76	73	RFDS	19	16	11	13	13	7	Total	166	151	129	158	157	138
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South West	67	28	32	11	<10																																																																											
2019 Total	110	52	33	16	<10																																																																											
Central West	20	13	<10	0	0																																																																											
North West	34	16	<10	<10	<10																																																																											
South West	56	23	18	<10	<10																																																																											
2018 Total	101	51	29	10	11																																																																											
Central West	21	13	<10	0	0																																																																											
North West	30	17	<10	<10	<10																																																																											
South West	50	21	16	<10	<10																																																																											

Identified Need	Key Issue	Description of Evidence
Access to services		
		(headcount) or 76 to 57 GP FTE. This would mean a GP FTE per 1,000 residents in 2020/21 of 0.9. This figure is equal to that of the Northern Territory but less than Western Australia (1.1) and the national average (1.2).
		<p>Number/FTE of general practitioners and practice nurses in General Practice 2018-19 to 2020-2021</p>  <p>Adequacy of GP supply in Western Queensland is a complex notion. As well as needing accurate numbers of general practitioners actually working in general practice, be it headcounts or FTEs, a number of other factors need to be considered. They include:</p> <ul style="list-style-type: none"> • the underlying need for greater quantities of primary care given the poorer health status of the region • the need for remote and rural GPs to have a broader scope of practice • the need for many remote and rural GPs to spend time travelling between different worksites and patients, and therefore having less time to spend with patients • the increased chronic disease complexity and comorbidity in the region means longer consults and fewer patients being seen in a 'standard' work day • the average number of hours worked per week by a GP is declining meaning fewer patients are seen in a 'standard' work day <p>None of the official counts have been adjusted for any of these factors. Such adjustment would result in statistics showing even greater disparity/lesser access in the rural and especially remote areas of WQPHN. The</p>

Identified Need	Key Issue	Description of Evidence
Access to services		
		combination of these factors means that a greater headcount of GPs is required to provide the same FTE workforce, and a larger overall FTE workforce is also needed.
	General practitioners are time poor and consumed by acute and episodic care	While GPs reported benefits of the WQPHN's Health Care Home model to support a more proactive and planned approach, they also noted when workforce shortages occur within practices, which is most of the time, acute episodic care took precedence over chronic disease management, scheduled care, and proactive follow up. They saw these long-entrenched acute care-focused treatment and reimbursement realities as hampering progress in the new model of care.
	Barriers to recruitment and retention of GP Registrars in general practice	Structural and geographical barriers are evident in the current regionalised training program in Western Queensland. There are two GP Registered Training Organisations in Qld – one based in Townsville (JCU General Practice Training) and one located in Toowoomba (General Practice Training Queensland). The geographic boundaries are largely based on PHNs and as such the South West falls under JCU's mandate, in line with the rest of WQPHN. However, it was identified by some South West general practices, attracting GP registrars to St George or Roma may be more accessible, efficient and effective if they were drawing from a pool based in Southern Queensland given travel time to Toowoomba or Brisbane is 3-5 hours, where the GP registrars' families are likely to be based. The South West GPs advocated for the need to improve the alignment of training opportunities with community and workforce natural linkages in order to increase registrar recruitment potential.
	Lower proportion of residents who have a usual treating general practitioner	Based on the 2020 calendar year analysis of HeaDS UPP data HWQ estimated >300 individual GPs billed Medicare in the WQPHN region during 2020. <i>Commonwealth Department of Health HeaDS UPP Tool, Health Needs Assessment WWP, extracted 7 Sept 2021</i> WQPHN has 29 hospitals, multi-purpose services and primary health clinics that have a COAG 19(2) exemption and the above numbers would include a large number of senior medical officers, principal house officers and locums predominantly working in these rural facilities providing non-referred services. While this may add to overall medical workforce stability in the hospitals, specifically around obstetrics, anaesthetics and emergency medicine, it is not necessarily reflective of general practice and primary care capacity or capability and enhanced community-based care. On the contrary the high workforce turnover and substantial use of short-term staff is more likely to result in undesirable effects including concerns about the cost and continuity of care in complex, cross-cultural settings. These adverse impacts from higher rates of staff turnover were highlighted in both the survey findings and stakeholder consultations.
	Decline in the number of private general practices and	In the WQPHN there are currently 4 privately owned general practices in the South West (3 in Roma and 1 in St George), and 3 in the North West (1 in Cloncurry, 2 in Mt Isa) as well as a corporately owned practice in Mt Isa.

Identified Need	Key Issue	Description of Evidence
Access to services		
	a shift to HHS managed practices staffed by rural generalists over the last decade	<p>While there is a private practice management company operating in the Central West (which manages two practices) the GPs are employed by the CWHHS.</p> <p>In the South West there are now nine HHS managed practices (including a jointly run practice with the ACCHO in Cunnamulla) and the GPs are employed as by the HHS. These practices previously operated under the Medical Superintendent/Medical Officer with Right to Private Practice. Cloncurry is the only site where the MSRPP model continues to operate.</p>
	Marginal viability and sustainability of general practice	<p>GP stakeholders identified a range of factors impacting on the viability of private practice in WQPHN locations including: the Medicare freeze with rebates not keeping up with rising wage and operating costs, difficulties recruiting VR GPs, uncertainty of GP registrar placements, and high locum costs. These extra costs limit options to bulk bill.</p> <p>Survey findings and stakeholder consultations acknowledged the substantial efforts by the WQPHN in supporting general practice viability and sustainability, and in particular the few remaining private general practices, through a range of programs and supports such as Health Care Homes, Mental Health Nursing Program (as part of the P4 stream), the locum support program and data management contracts. However, the consensus view was that at the best the general practice environment hadn't changed much since the 2016 HNA and remained fragile, with private practice particularly vulnerable and the emergent HHS practice models not as yet delivering on their ambitions.</p> <p>A number of planning initiatives were identified during the stakeholder consultations that could provide future opportunities to examine existing and upcoming general practice models for WQPHN and future-proof general practice in the region. These included:</p> <ul style="list-style-type: none"> • a review of CWHHS's 'one practice general practice model' • a plan by SWHHS to review general practice delivery in its region • a plan by NWHHS to seek a COAG 19(2) exemption and establish a fast-track general practice in Mt Isa • a suggestion by private general practice to examine the application of the recently announced Rural Health Alliance alternative model, badged as a Rural Area Community Controlled Health Organisations • an aspiration by the RFDS to be further engaged in delivering extended general practice services in the region
	Utilisation of Mt Isa Hospital Emergency Department for low acuity presentations	<p>North West clinician and community survey respondents identified reduced general practice capacity reflected in long waits for appointments, restricted extended hours primary care options, limited bulk billing and the higher cost of diagnostic services as factors that promoted the use of Mt Isa Hospital Emergency Department for</p>

Identified Need	Key Issue	Description of Evidence
Access to services		
		<p>primary care type services. In the 12 month period July 2020-June 2021, there were 55,123 presentations to Mt Isa Hospital ED of which 39,205 were category 4 and 5 (approximately 108 per day).</p> <p>The North West Emergency Department Avoidance Strategy was developed through a partnership between NWHHS, WQPHN representing the 3 private practices in town, Gidgee Healing and the JCU CRRH to address this issue. It commenced in 2018-19 with a research project conducted by the CRRH. At the time NWHHS was advocating for a COAG Section 19.2 Exemption for Mt Isa Hospital ED for Category 4 and 5 presentations. This was not supported by Mt Isa GPs, Gidgee Healing and WQPHN. The ED Avoidance Strategy continued with NWHHS being funded in partnerships with General Practices, WQPHN with CRRH conducting an evaluation. This ED Avoidance Strategy fell over during COVID and was not completed in full. The NWHHS is currently planning to introduce a new GP Clinic in Mt Isa which they would manage.</p> <p>Given the disruption of the project and ongoing concerns of the key service providers, it may be prudent to re-set the Emergency Department avoidance strategy.</p>
Improve access to culturally secure primary care services	Maintain Nukal Murra Health Support Services	<p>Evaluation of the Nukal Murra Health Support Services in 2021 was largely positive with the reviewers noting:</p> <ul style="list-style-type: none"> the 4 ACCHOs are well positioned to deliver the services to suit local needs the NMHSS is making a positive contribution on the uptake of chronic disease management MBS items the contribution the NMHSS is making to improving patient navigation of the health system should not be discounted the NMHSS reduces many of the barriers to accessing services and health aids the NMHSS has fostered ongoing collaboration and learning between the WQPHN and the 4 ACCHOs the NMHSS offers an economic positive return on investment with \$1 invested in the service estimated to save \$3.48 in avoided hospital costs
	Support Gidgee Healing and its partners to undertake a review of the community control pathway and health service model for the Lower Gulf in particular the Aboriginal communities of Mornington Island and Doomadgee	<p>In 2016 the WQPHN commissioned a health service review of the Lower Gulf region (Lower Gulf: Case for Change 2016). It painted this picture:</p> <ul style="list-style-type: none"> a fractured service delivery environment that results in gaps and duplication in care, poor coordination of care, and leads to an adverse impact on patient experiences and care outcomes a poorly developed local primary health care base and the need to build up the capacity of resident services so that people living in the Lower Gulf have close to home access to these essential primary care services

Identified Need	Key Issue	Description of Evidence
Access to services		
		<ul style="list-style-type: none"> • a pathway to community control reflective of a community's aspirations and consistent with ensuring a functioning primary health care system • substantial upfront investment (including infrastructure) will be required to support the primary health care transformation in the region <p>Unfortunately based on feedback from stakeholder consultations it could be argued little has changed on the ground in the last 5 years for communities like Mornington Island and Doomadgee in terms of fragmented and poorly coordinated care, a poorly developed local primary care service and workforce foundation and local Aboriginal and Torres Strait Islander peoples' participation in the design and delivery of health services. While pockets of success were identified, there hasn't been the transformative change that was hopefully anticipated.</p> <p>Of note, the review commented "a key issue to resolve will be which pathway is taken in growing the local primary health care services. Do you expand the community-based primary health care services independent of the hospital-based services or do you integrate the community and hospital-based health services, and grow them as a whole? Clearly there are pros and cons to both strategies, the divided approach will enable the community-based service to better focus on the prevention, early detection and team-based care of chronic and complex conditions and for resources to be less likely absorbed in to the local hospitals. On the other hand, a more integrated approach will be more cost effective and accrue additional benefits from the greater connectivity, alignment and collaboration between the cure and care sectors".</p> <p>In the last 5 years Gidgee Healing has achieved significant growth to become a major provider and partner in the delivery of primary health care to the Aboriginal communities of Mt Isa and the Lower Gulf. However, the challenge in expanding their operations to such a demanding health service environment like the Lower Gulf is immense and not without risk. Feedback from Gidgee Healing is that it is currently reviewing its position regarding what its control of health services in Lower Gulf should best look like at this stage of its own organisational development.</p> <p>There are many similarities between Gidgee Healing in the Lower Gulf and Apunipima's ongoing thirty years transition to community control journey in Cape York. From seeing its core business as coordination, advocacy and a partnership approach to the development of health solutions in the 1990s, by 2003 the organisation was arguing for the 'formation of a regional intergovernmental agreement on primary care' and short- to medium-term expansion of its own advocacy and service delivery role, with the long-term goal of the 'devolution' of responsibilities in health and greater community control services. However, the commitment to full community control has yet to be realised with a hybrid primary health care system operating (with Queensland Health and RFDS) in all communities other than one or two locations.</p>

Identified Need	Key Issue	Description of Evidence
Access to services		
	Continue to increase rates of Aboriginal and Torres Strait Islander annual health checks and follow-ups	<p>Based on 2021 AIHW data, WQPHN had the highest rate in Australia for Aboriginal and Torres Strait Islander annual health checks (715s) in both 2018-2019 (41.2% of population, 5,263 persons) and 2019-2020 (39% of population, 5,041 persons). There has been a steady increase over last 4 years with 3504 health checks conducted in 2015-2016 and 4854 conducted in 2016-2017. WQPHN, like the majority of PHNs, saw a drop in rates of health checks between 2018-19 and 2019-2020, the exceptions being PHNs in NSW and Tasmania.</p> <p>However, in 2018-2019 WQPHN had only the 6th highest rate (51.2% of health checks, 2,697 persons) in Australia of an Aboriginal and Torres Strait Islander follow-up service in the 12 months following the health check. This figure still compared favourably with the national figure of 47%. Research indicates that a broad range of factors can limit the use of follow-up services, such as a practitioner's lack of awareness of item numbers, staffing issues, ineffective use of clinical information systems for patient recall and reminders, and communication and transport challenges for patients.</p>

Identified Need	Key Issue	Description of Evidence
Primary care workforce supply and sustainability		
Improved workforce data to inform service planning and workforce development strategies	Determining the true measure of general practitioner workforce requires investigation given Commonwealth funding decisions are made based on these figures	<p>Currently, three datasets exist, (excluding the WQPHN GP Census data reported above) and rely on a mix of self-reported data through Health Workforce Queensland and Australian Health Practitioner Regulation Agency (AHPRA), and GP data derived from Medicare billing information through HeaDS UPP tool which uses each type of Medicare service to calculate GP data that is also adjusted for remoteness. The HeaDS UPP data is not publicly available and can only be used for internal workforce planning due to the sensitive nature of the data. Without revealing figures, there is over 280% variation between the number of GPs (headcount for GPs working in the region who have provided at least one service in the selected geography during the reporting period) in HeaDS UPP data, when compared to the number of GPs (headcount) in the WQPHN GP Census data. This represents significant variation between datasets, creating data integrity and interpretation issues for number of GPs (headcount) measure. In contrast, the GP FTE measure (full-time work based on MBS services claimed, with GP FTE value of 1 representing the work of one full-time GP - 40 hours a week, 46 weeks of the year) across the various data sources was more consistent. <i>Commonwealth Department of Health HeaDS UPP Tool, Health Needs Assessment WWP, extracted 7 Sept 2021</i></p> <p>Potential explanations for the large difference between the GP headcount and the GP FTE include factors such as a large percentage of GPs on rotation, particularly GP Registrars and movements within QLD Health facilities, and the GPs in HHS services who would not usually be billing Medicare for activities taking place in the hospital. Data estimations also vary as RFDS consults are not billed against Medicare and thus missing from the system, so underestimate the GP headcount and the GP FTE. Currently, the most reliable source of GP workforce data is the WQPHN GP Census data outlined earlier. Whilst limitations exist with all of the data measures, it does highlight the need for review of workforce planning data for rural and remote communities in order to determine the true measure of GP workforce capacity. This will enable more accurate supply and demand projections leading to more equitable distribution of the workforce and student placements.</p>
	Lack an accurate picture of the primary care workforce in Western Queensland	<p>Comprehensive, high-quality data on the health workforce are essential to identifying gaps in health service provision, as well as informing future health workforce and health services planning, and health policy. While many data sources are used in Australia for these purposes, the quality of the data sources with respect to relevance, accessibility and accuracy for Western Queensland is arguable.</p> <p>This picture is further complicated by the outreach service models operating in Western Queensland, where there is a mix of locally domiciled health professionals and others based in regional centres such as Townsville, Toowoomba and Brisbane. While these FIFO providers are an important component of workforce supply, the extent to which they are “counted” as part of the Western Qld workforce is dependent on the data source.</p>
	Continued difficulty in attracting, recruiting and	The HWQ 2021 health workforce needs analysis identified 11 workforce shortages across the WQPN with differences between HHSs. For the North West the top 5 workforce gaps included psychology, sonography,

Identified Need	Key Issue	Description of Evidence
Primary care workforce supply and sustainability		
	retaining suitably skilled health workforce	<p>dentistry, radiology and speech pathology, the Central West it was Aboriginal health worker, audiology, optometry, dentistry and exercise physiology, and the South West it was psychology, podiatry, audiology, general practitioner and social work.</p> <p>General practices and ACCHOs across Western Queensland identified significant challenges in recruiting practice nurses and mental health nurses (as part of the P4 stream with long-term vacancies). HHSs offer higher salaries and conditions which private practices and ACCHOS cannot meet. Where hospital nurses seek to transition to general practice and primary care for lifestyle reasons (e.g., no shift work) they usually have a limited understanding and knowledge of primary care requiring practices to invest in growing their own.</p> <p>Long-term vacancies for Aboriginal and Torres Strait Islander workers exist in the Central West (e.g., currently 5 vacancies in CWHHS).</p> <p>The clinician and service provider survey and stakeholder consultations identified high turnover of health professionals and the reliance on medical locums and agency staff negatively impacts service continuity, continuity of care and frustrates patients having to re-tell their stories.</p>
	Propensity of inexperienced graduates within a characteristically lean health workforce	<p>A HWQ 2021 analysis of the South West Queensland allied health workforce (n=51) found that 66% of resident allied health practitioners had been in the region for less than 2 years and 37% had just one to two years' professional experience.</p> <p>Early career practitioners are a feature of the WQPHN health workforce across most disciplines. Stakeholder consultations identified multiple challenges in providing the necessary professional supervision and support to the graduate positions. For a start, the staffing profile is inherently lean, the skills mix limited, the priority is delivering services and there are few resources to train and mentor students or new graduates. Graduate positions are usually short-term in nature because the contract is temporary or the sea-change short-lived, and local health professionals maybe reluctant to invest over and above their normal workload to train and support staff where they are unlikely to see a return for their efforts. Geographical isolation for the graduate is real and the jobs are often complex and culturally diverse. Turnover of senior clinical and management staff was also identified as a key issue. Overall, the general lack of professional and educational support was felt by stakeholders to negatively impact on rural and recruitment of new graduates in Western Queensland health and aged care services.</p> <p>Of note are two recent HWQ sponsored planning projects (North West Interagency Allied Health Workforce Strategy in June 2020 and South West Queensland Interagency Allied Health Workforce Strategy in June 2021). The rationale behind the projects were largely the same and included:</p> <ul style="list-style-type: none"> noted the current workforce profile was strongly weighted to early career allied health professionals

Identified Need	Key Issue	Description of Evidence
Primary care workforce supply and sustainability		
		<ul style="list-style-type: none"> concerns regarding costs and service impacts associated with high staff turnover and periods of vacancy in critical positions difficulties with allied health professional recruitment, particularly for experienced clinicians and leaders challenges implementing sustainable integrated training in small multi-professional teams value of an inter-agency approach that maximised participation of all local health service providers in collaboratively workplace and service development strategies <p>This planning work provides an opportunity for the WQPHN to support HWQ and other resourcing and participating organisations in progressing the major finding of both reports, that is, the development and implementation of an Allied Health Rural Generalist Pathway program(s) in Western Queensland.</p>
	Opportunities to enhance service capacity through the development of an “assistant” workforce.	<p>Allied health service provider consultations and the clinician survey identified that allied health service frequency and intensity was inadequate to achieve a therapeutic effect for patients. Furthermore, allied health clinicians reported capacity to only treat children with higher acuity needs limiting early intervention services for children with lower needs. There is limited use of an allied health assistant workforce in the WQPHN.</p> <p>Developing the assistant workforce was identified as an opportunity to particularly enhance access to, and local capacity of, child development, chronic disease management, aged care and disability services.</p>
	Lack of availability of a Registered Training Organisation(s) with a focus on health careers impedes development of a local training and employment pathways	<p>In the Central West the absence of a Registered Training Organisation in the region is a barrier to progressing local training and employment opportunities for allied health and nursing assistants, the carer workforce and Aboriginal and Torres Strait Islander Health Practitioners. In the North West, the local TAFE has limited training offerings for health careers. Local government, the HHSs, ACCHOs and aged care stakeholders all identified current job vacancies and potential employment opportunities for VET sector trainees.</p> <p>Developing a training and employment strategy that brings together employing organisations, the UDRHs and HHSs (with clinical educator capability), the Gateway to Industry Schools Program (which is delivered by CheckUP in partnership with Queensland’s Department of Employment Small Business and Training) and a local or visiting level Registered Training Organisation was identified by some stakeholders as a potential model for school students and others seeking to develop a career in health, disability or aged care.</p>

Identified Need	Key Issue	Description of Evidence
General practice support		
Retention of clinical and management staff in general practices is critical to maximising potential of WQ Health Care Home program	Continued building of capacity within general practices through the WQ Health Care Homes program	<p>The Western Queensland Health Care Home (HCH) model provides a structure for proactive patient centred care that is team based and GP led. Twenty sites participate in the WQ HCH model. WQPHN staff and GP stakeholders reported that allied health and nursing expertise and capacity in general practice has developed over the last few years under this program, however, the capacity of practices/sites to provide planned care and maximise impact is challenged by ongoing GP fragility (i.e., having the capacity to proactively manage chronic disease cycles of care rather than only being able to reactively responding due to GP shortages) and continuity of key practice staff (management and nurses) – WQPHN staff and GP stakeholders.</p> <p>Developing mechanisms to provide additional and continued GP capacity to support the WQ HCH model is needed. The Virtual GP model is a promising strategy to provide additional GP capacity. Providing opportunities to support hospital nurses to undertake training conducted by the Australian Practice Nurse Association was identified as strategy to support transition to general practice. Strategies to support and retaining existing practice managers and develop this workforce was identified as critical to the leadership of general practice businesses and the WQ HCH program.</p>

Identified Need	Key Issue	Description of Evidence
Integrated health care reform		
More tangible outcomes from current WQPHN partnership arrangements	Ongoing support and development of existing WQPHN partnership arrangements (e.g., Maranoa Accord 2020; Nukal Murra Health Alliance; Strategic MoUs with CheckUp, HWQ, RFDS & RHealth) to create meaningful opportunities for sharing of resources between key partners (e.g., joint planning, pooled funding, shared workforce, co-commissioning services) to achieve a more integrated and coordinated care system.	<p>The raft of memorandums of understanding, partnership agreements and strategic plans clearly demonstrates the WQPHN over the last 5 years has established a strong foundation in the region and progressed multiple high-level strategic health partnerships. Indeed, by any assessment, WQPHN appears to be punching well above its weight, given its comparative size and budget, in leading and promoting primary health care reform to enable person-centred health and care journey, focusing on one integrated system. The PHN's list of achievements are impressive: supporting regional governance endeavours, engaging with key regional health care providers including the HHSs, brokering Aboriginal-led solutions by supporting ACCHOs to play a stronger role, facilitating clinical and community leadership, utilising and promoting data to enable local and regional analysis, to name a few.</p> <p>However, it was evident from the community and clinician survey findings and stakeholder consultations that many local level benefits are still to materialise in relation to addressing long-standing wicked remote health issues such as general practice vulnerability, hotspots of inequality, global health workforce shortages and challenges in recruiting and retaining health care professionals, closer to home access to medical specialist services, and stronger ACCHO service role in order to close the gap. Some respondents noted that with so many strategic plans, needs assessments, etc now existing in the region, strategy implementation at the local level was becoming more important and is what will make the difference. It was mentioned by one clinician that 'a poor strategy well executed is better than a good strategy poorly executed'. Identifying and agreeing on a small number of common priorities and projects with key partners and maintaining focus on these for a sustained time period may lead to tangible results.</p>
Less competitive, more collaborative service arrangements	Commissioning framework needs to go beyond the simple funding and contracting of services to trialling more collaborative commissioning and co-design of services with key partners to achieve a more integrated and coordinated care system.	<p>Improvements to current commissioning arrangements and contracts were identified by commissioning organisations and commissioned services to address issues of service duplication, service inefficiencies and staff retention. Commissioned services are usually on 12 months funding contracts and activity plans were identified to lack flexibility to respond to changes in demand, emergent need or promote a broader primary health care approach to service provision. This is particularly challenging where organisations are commissioned by WQPHN for service provision under a block funded contract (at a town or CL level) and funded by CheckUp for travel and accommodation which operates under a waitlist/ service utilisation framework that seeks to re-direct services to other locations as needs change.</p> <p>Also, separately reporting to two funding bodies (e.g., WQPHN and CheckUp), maybe more (e.g., HHS) was viewed as resource intensive and inefficient. Finally, commissioned services also identified a lack of visibility of what other services are commissioned to provide within the service footprint.</p> <p>Moving toward more collaborative commissioning, co-commissioning, co-design approaches was acknowledged by the WQPHN in their March 2021 'Call to Action' document, following a South West Health Forum held in</p>

Identified Need	Key Issue	Description of Evidence
Integrated health care reform		
		Roma, and provides the opportunity to accelerate collaborative commissioning and co-design of services with key partners to achieve a more integrated and coordinated care system.
Place-based solutions and partnerships within a geographic area, be it a town or community	Implement place-based approaches that enable flexibility for local solutions and partnerships to tailor service providers, workforce and funding options to achieve a more integrated and coordinated care system.	<p>Health services are organised geographically and our interaction and experience or care is directly informed with how these are configured. In the Gratton Institute's report; 'Perils of Place', geography was highlighted as a seminal factor determining health inequality. Quite literally 'where you live' has serious implications for your health. Having a better understanding of the factors that contribute to poor health outcomes within these geographic regions can lead to finding solutions. Further, a 2019 Kings Fund report also highlighted the critical importance of using geographical approaches as a means of supporting better integration and cooperation across local providers within a 'whole of population' focus in order to reduce risks that contribute to fragmented and poorly coordinated services.</p> <p>Stakeholder consultations identified a number of communities which might benefit from a place-based approach including Boulia, Mornington Island, Doomadgee, Cunnamulla and Thargomindah. This place-based approach aligns with the recommendations from the Primary Health Reform Steering Group on the Australian Government's Primary Health Care 10 Year Plan.</p>
Broker Aboriginal and Torres Strait Islander-led solutions by supporting ACCHOs, both individually and collectively through the Nukal Murra Health Alliance, to play a stronger role in the regional integration of services	Consistent with the new National Agreement on Closing the Gap, appropriately fund and resource ACCHOs as the preferred providers of primary health care services to Aboriginal and Torres Strait Islander peoples so that they are accessible across all of Western Queensland.	<p>Given, a growing Aboriginal and Torres Strait Islander population in the region with worsening health disadvantage, a declining non-Aboriginal population, and market failure in the private, and to a lesser degree the public health system, in Western Queensland, the ACCHO Sector needs to be supported to play a stronger role in the planning, design and delivery of the region's health services to ensure their overall sustainability, accessibility and quality. The ACCHO Sector has an increasingly important part to play.</p> <p>The evidence tells us that greater levels of Aboriginal and Torres Strait Islander communities' participation and control in the planning, development and management of primary health care and community care services brings benefits both to the process of health and family service delivery and to the health of those that are engaged. Benefits include a more responsive health and family services system, improved quality and cultural security of services and improved levels of family and community functioning; all contributing to improved levels of health and wellbeing.</p> <p>The ACCHOs of Western Queensland include Gidgee Healing, Charleville and Western Areas Aboriginal and Torres Strait Islanders Community Health (CWAATSICH), Cunnamulla Aboriginal Corporation for Health (CACH) and Goondir Health Services. In addition, the WQPHN and the four ACCHOs have established the Nukal Murra Alliance to strengthen the ability and access of ACCHOs to play a stronger role in the integration of services using regional procurement and commissioning approaches that best suit communities and need.</p>

Identified Need	Key Issue	Description of Evidence
Integrated health care reform		
		While there is good ACCHO coverage in the SWHHS and NWHHS, there remains no ACCHO presence in CWHHS.
Innovation in virtual integrated care models	Lack of funding and planned approach to supporting expansion of digital health	<p>Digital health inclusive of virtual health care can enable the provision of care that improves clinical effectiveness, increases service efficiency and is more responsive to patient needs. However, for virtual care to offer more equitable access, strategies must mitigate against barriers that impact engagement for vulnerable populations with limited digital literacy and access to technology and barriers faced by health care providers.</p> <p>To scale innovations and realise the full potential of virtual care, will require addressing key challenges including: need for improved data integration and data information flows across the health ecosystem; need for better integration of virtual care activities into clinician workflows to enable hybrid virtual and in-person care delivery and; alignment of incentives for virtual health activities with the broader move toward value and outcomes based care (VOBC) that shifts funding reform towards blended funding models and away from fee-for-service and activity based funding</p>
Interconnected health information so that clinicians and support services can access and share information and data to make timely and informed decisions	Lack of interoperability of patient information systems continues to impede service integration	<p>Lack of interoperability of hospitals systems and different practice management software has impacted functionality issues that inhibit information sharing. This is impacting team-based care and connection of services to improve transitions of care for people. Identified challenges include limitations in the ability for organisations to meet the functional requirements defined by digital health foundations. Multiple processes and methods that support the exchange of information between healthcare providers and organisations also varied. Other challenges included the need to consider existing application and technology environments, whilst considering future requirements with market capabilities. Need for determination and adoption of joint data governance rules/policies, data security, data standardisation, data sovereignty and consent to be agreed to ensure data consistency and quality across the continuum of care. Need to consider timeframes, licensing and funding commitments in documenting requirements and solution implementation, with likelihood that some activities would need to be run in parallel. Interoperability applications would need to be agreed across providers including agreement on method for interoperability.</p>

Identified Need	Key Issue	Description of Evidence
Mental health		
Agree and progress key priorities to refine the stepped care model and improve equity of access to mental health services in communities with small populations	Significant growth and investment in mental health services but the stepped care model requires fine-tuning to better embed within the WQ HCH	<p>The five-year plan (2021-2026) to Improve Mental Health, Suicide Prevention and Alcohol and other drug treatment services in Western Queensland documents the findings of an extensive analysis of data in relation to mental health, alcohol and other drug prevalence, service utilisation and issues impacting on access. The approach to developing the 2021-2026 Plan included three Mental Health Round Tables in Central West, Charleville and Roma in late 2018 and a formal review of 2017-2020 MHSPAOD Plan by the University of Queensland's Substance Use and Mental Health Unit at the Centre for Health Services Research in 2019. The development of the 2021-2026 Plan was overseen by the Western Queensland Health Services Integration Committee in 2020.</p> <p>The Plan identifies nine key focus areas:</p> <ul style="list-style-type: none"> • Build a connected and person-centred care sector • Proactive prevention and early intervention • Promote and protect mental health and wellbeing across the lifespan • Support Aboriginal and Torres Strait Islander social, emotional and cultural wellbeing • Strengthen and integrate Alcohol and Other Drug treatment and harm reduction within a stepped care framework • Make suicide prevention everyone's business • Coordinate treatment and support for people who experience severe and complex mental health • Build workforce capability and grassroots training opportunities • Respond to climatic extremes and other adversities within rural and remote communities <p>For each of these focus areas the Plan describes consultation findings, focus area objectives and focus area priority actions. As such the Plan is its own mini mental health, suicide prevention and AOD HNA. The focus areas and priority actions are designed to improve the quality, integration and coordination of MHSPAOD care and develop workforce capability and capacity. These findings are contemporary (published in February 2021) and still in draft form.</p> <p>The findings of the consultations to inform this overarching HNA align with the 2021-2026 MHSPAOD Plan. However, Focus Area 3, Shared Objective 3 (Strengthen the WQ HCH model of care to support planned and structured care to the adult population) and the stepped care model was highlighted as a specific area of feedback. Stakeholder consultations identified:</p>

Identified Need	Key Issue	Description of Evidence
Mental health		
		<ul style="list-style-type: none"> The need to promote and encourage Commissioned Service Providers to more efficiently utilise P3 funding by making greater use of Better Access (funded under MBS) and/or transitioning clients to a low intensity service where indicated, in order to ensure better access to the P3 stream. Under-utilisation of low intensity services (evidenced by low referrals from GPs) indicating the need to better embed the stepped care model within the WQHCH The need for improved and consistent communication by Commissioned service providers with referring GPs.
	Expand reach of mental health services and social supports to older people in the community	Improving access to mental health services and strategies to support community connection were key issues identified for older people in the community survey and aligns with Focus Area 3, Shared Objective 4 of the 2021-26 Plan.
Improve access to culturally appropriate dementia services in the NW	<p>Limited access to behavioural dementia services in the North West resulting in people having to move away for care</p> <p>Demand for dementia care services is likely to increase in the North West with the introduction of more culturally appropriate screening tools</p>	<p>Aged care providers reported that the absence of behavioural dementia services or a dedicated unit in Mt Isa results in the transfer of people from their community to specialised units on the coast.</p> <p>A 2021 AIHW summary report 'Dementia in Australia 2021' noted rates of dementia and cognitive impairment not dementia (CIND) in older Aboriginal and Torres Strait Islanders are 3-5 times higher than the rest of the population. The report cited small studies that found that rates of dementia for older Aboriginal and Torres Strait Islanders in rural and remote communities are among the highest in the world, and prevalence of dementia for Aboriginal and Torres Strait Islanders aged over 60 living in urban and regional areas was 21% compared with 6.8% for all Australians over 60.</p> <p>In the North West the Aboriginal population comprises between 27% (Mt Isa and Surrounds LGA) and 93% (Doomadgee LGA). Gidgee Healing is participating in the Let's Chat research study led by the University of Melbourne to improve detection of cognitive impairment and dementia as well as dementia care and brain health in the primary care context.</p>

Identified Need	Key Issue	Description of Evidence
Alcohol and other drugs		
Increase AOD screening and brief interventions	Limited capacity and lack of confidence of frontline clinical staff to undertake brief interventions	AOD service providers identified the lack of routine screening for AOD by frontline clinicians often resulted in refusal of referrals by mental health services when AOD issues were identified. Also, a lack of confidence in undertaking brief intervention and/or limited referral options for AOD problems were identified barriers to screening. The 2021-2026 Plan Focus Area 5, Shared Objective 2 recognises this issue and prioritises support for GPs in evidence based assessment, brief and early interventions, and medical management for people with AOD issues, withdrawal support and recovery.
Improved access to addiction treatment and rehabilitation services in the SW	Limited availability of addiction treatment and rehabilitation services.	Access to addiction treatment and rehabilitation services, including opioid prescribing was identified as a key service gap in the South West in the clinician survey and in the consultation with the South West Mayors.

Identified Need	Key Issue	Description of Evidence
Older people and aged care		
Strengthen health and aged care services to better support healthy ageing	Increased focus on services and supports for older people to age in place.	<p>The community survey identified the need for adequate home care and support services to enable people to stay in their home and in their community, as opposed to relocating further east. Key priorities for those aged 65 years and over included: support to navigate My Aged Care; strategies to facilitate community connection; improved mental health support services; strengthening home care services; healthy ageing initiatives and other social supports; community transport options; and better access to home modification assessments and services.</p> <p>At March 2021 there were 19 organisations registered to provide Home Care Packages in Western Qld (7 in the North West, 9 in Central West and 3 in the South West). The number of Home Care Package recipients totalled 286 (117 in NW, 35 in CW, 134 in SW). In the March 2021 quarter, the number of new entries to the Home Care Package Program report was 14, 4 and 11 respectively (Home Care Package Program Data Report: 3rd Quarter 2020-2021, June 2021). Further investigation to unpack the issues older people in the regions encounter in accessing and utilising home care services is required.</p> <p>The Federal Government has indicated a role for PHNs as part of the aged care reform package announced in the 2021-22 Federal Budget response to the Royal Commission into Aged Care Quality and Safety. <i>The Draft White Paper, Supporting Healthy Ageing: The Role of PHNs</i>, prepared by the PHN Cooperative flags the increasing role PHNs will play in aged care and the intersection with primary health care services.</p>
	Promote timely access to geriatric assessments and appropriate care to enable older people to remain living in the community	<p>Various models and arrangements are in place for provision of geriatric assessments and geriatrician care. In the SW, a geriatrician from Metro South HHS provides a visiting service to Roma. In the Central West, a geriatrician based at Princess Alexandra Hospital provides three Telehealth Sessions per week, allowing all CWHHS residents access to this service regardless of location. A Geriatric CN supports the geriatrician, undertaking patient assessments upon referral and prior to the telehealth appointment with the geriatrician. There are no visiting geriatrician services in the North West. Geriatrician services for ACAT assessment, outpatient or inpatient care are delivered by telehealth from Townsville HHS.</p> <p>The Cairns Hinterland HHS in partnership with NQPHN, Brisbane North PHN and the Health Improvement Unit (Qld Health) have developed the Older Persons Enablement And Rehabilitation for Complex Health conditions service (Older persons enablement and rehabilitation for complex health conditions (OPEN ARCH) Improvement Exchange Clinical Excellence Queensland Queensland Health). This model provides a direct pathway from General Practitioners to a community-based geriatrician for comprehensive interdisciplinary assessment and care management. Under the OPEN ARCH model, GPs identify high risk consumers and can refer to the specialist geriatric “hot clinic” for comprehensive assessment. A key feature of the model is the geriatrician’s access to the patient record within the GP Practice patient information system. Following specialist geriatric assessment, the client engages with an enablement officer who co-ordinate recommendations from</p>

Identified Need	Key Issue	Description of Evidence
Older people and aged care		
		assessment via referral to relevant existing primary healthcare services. Outcomes of the intervention have demonstrated increased function and independence, increased utilisation of supports to remain living at home, improved quality of life measures and reduced length of stay for people admitted to hospital. Discussions with Professor Eddy Strivens indicates the model could be adapted for telehealth delivery.
	Recruitment and retention of aged care workers and nurses impacts on quality of care	Based on the clinician survey and consultations with aged care providers the robustness of community aged care services and residential aged care services, including private system, NGO and public system multi-purpose services, is challenged by difficulties in recruiting and retaining carers and nurses, and a skilled workforce with a knowledge and understanding of aged care service standards.
	GP attendances to RACFs is lower than other regions in Qld and nationally	General practice capacity impacts GP attendances to older people living in RACFs. In 2018-2019, GP attendances to RACFs in WQPHN was 13.9 attendances per RACF patient compared with 19.1 for metropolitan and 17.8 nationally (AIHW 2021).
	Sustainable delivery of services to older people in remote communities challenged by low client density and 'thin market' and policy constructs do not recognise the need for flexible assessment, referral and funding arrangements	<p>The 2017 Productivity Commission Study Report noted older people living in remote communities, similar to people with a disability, have difficulty accessing carer and support services in a market-based environment because of the 'thin market'. This situation was confirmed in the aged care provider consultations.</p> <p>Furthermore, national policy constructs are a barrier to developing flexibility in funding and service provision for clients who may have a disability and a chronic condition (or be older). Current rules require providers to only provide a service for the primary referral where a subsequent consultation is required for a second issue. This is impractical for clients living in remote areas (where they may already need to travel for a consultation) and limits opportunities for providers to develop efficiencies (human resources and travel) to provide services in remote communities.</p>

Identified Need	Key Issue	Description of Evidence
Palliative care		
Tailor palliative care services with consideration of the dispersed population, clinical capacity and capability	Palliative care and advanced care planning are emerging service needs.	<p>In Australia, and many other parts of the world, the demand for palliative care services is increasing due to the ageing of the population and the increases in the prevalence of cancer and other chronic diseases that accompany ageing. While Palliative care services were identified as an area for service improvement through the community survey and South West Clinical Chapter consultation, there is limited data to determine demand or capacity to meet demand at local and regional levels. This is also the case at a national level (Palliative care services in Australia, Overview of palliative care in Australia - Australian Institute of Health and Welfare, 2021).</p> <p>Palliative care is now provided in most settings where health care is provided including paediatric units, acute hospitals, community and residential aged care and general practices.</p> <p>While the rates of lung cancer and other cancers mortalities are high in the WQPHN relative to Australia, the absolute numbers are low and dispersed. Determining a service and system response requires tailoring to local and regional demographics, geography, medical specialist, generalist and nursing capability and capacity.</p>

Section 4 – Opportunities and priorities

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
* Reshape the primary health care system to create meaningful sharing of resources and reduced service duplication and fragmentation (Recommendation 1 – One system focus)				
* Deliver funding reform to support integration and a one system focus (Recommendation 3 – Funding reform)				
Provide ongoing support and development of existing WQPHN partnership arrangements to enable flexibility for local solutions to meet community needs and a tangible demonstration of investment and redirection of funding towards primary health care	Population health	System integration	Joint health services planning Collaborative commissioning Funds sharing	WQPHN
Lobby for WQPHN as a whole, or part of the PHN and one of the HHSs, as one of the “10-15 vanguard regionalised initiatives” recommended in the Primary Health Reform Steering Group’s draft recommendations report	Population health	System integration	WQPHN chosen as a national vanguard regionalised initiative	WQPHN

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
<ul style="list-style-type: none"> * Formalise and strengthen the relationship of individuals, families and carers with their chosen primary health care provider and practice (Recommendation 2 – Single primary health care destination) * Enable a culture of innovation to improve care at the individual/population level, build 'systems' thinking and ensure application of cutting edge knowledge and evidence (Recommendation 16 – Care innovation) * Support people and communities with the agency and knowledge to better self-care and manage their wellness and health within a system that allows people to make the choices that matter to them (Recommendation 6 – Empowering individuals, families, carers and communities) * Bolster expanded delivery of comprehensive preventive care through appropriate resourcing and support (Recommendation 7 – Comprehensive preventive care) 				
Provide ongoing support and further development of the WQ HCH program to enable quality patient care and adoption of practice-based systems to support team-based care	Population health	Practice support	Improved patient experience Improved GP provider experience Improved GP viability and sustainability Improved population management of practice cohort Improved health outcomes	WQPHN
Through the WQ HCH identify mature sites and trial patient activation measure ideally using practice staff trained in coaching or motivational interviewing	Population health	Health literacy	Improved health literacy within a practice population Improved health outcomes relevant to the trial focus (e.g., chronic disease management, risk behaviours)	WQPHN
Provide ongoing advice and support to general practices to help enhance their viability and sustainability	Population health	Practice support	Effective practice support (e.g., utilising MBS, preparing for accreditation, participating in the Practice Incentive Program, Health Pathways, My Health Record, becoming telehealth enabled, etc)	WQPHN

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
* Implementation of the National Agreement on Closing the Gap for Aboriginal and Torres Strait Islanders through structural reform of the primary health care system (Recommendation 4 - Aboriginal and Torres Strait Islander Health)				
Provide ongoing support and development of The Nukal Murra Alliance	Aboriginal and Torres Strait Islander Health	Aboriginal and Torres Strait Islander Health	Nukal Murra Alliance maintained and proactively supported Joint regional planning to ensure meaningful sharing of resources and reduced duplication and fragmentation	WQPHN Western Queensland ACCHOs
Continue to invest in the Western Queensland ACCHOs as the preferred providers of primary health care services to Aboriginal and Torres Strait Islanders	Aboriginal and Torres Strait Islander Health	Appropriate care (including cultural safety)	Increased investment in ACCHOs Improved continuity of care and health outcomes for Aboriginal and Torres Strait Islanders	WQPHN
Support Gidgee Healing, NWHHS and other key stakeholders to undertake a review of the community control pathway and health service model for the Lower Gulf including the communities of Mornington Island and Doomadgee, with an aim of developing the most appropriate community control governance option, GP workforce solution and integrated primary care system for the region, particularly those communities	Aboriginal and Torres Strait Islander Health	Appropriate care (including cultural safety)	Review completed Improved continuity of care and health outcomes for Aboriginal and Torres Strait Islanders in Mornington Island and Doomadgee	WQPHN Gidgee Healing NWHHS

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
* Implementation of the National Agreement on Closing the Gap for Aboriginal and Torres Strait Islanders through structural reform of the primary health care system (Recommendation 4 - Aboriginal and Torres Strait Islander Health)				
Maintain support for the Nukal Murra (ITC) Health Support Services	Aboriginal and Torres Strait Islander Health	Access	Nukal Murra Health Support Services continues WQPHN ITC program	WQPHN
Support Nukal Murra Alliance, CWHHS and other key stakeholders to examine the transitioning of government-run Aboriginal health services in the region to community-control where this will better meet the needs of communities and improve outcomes	Aboriginal and Torres Strait Islander Health	Appropriate care (including cultural safety)	Improved continuity of care and health outcomes for Aboriginal and Torres Strait Islanders living in Central West region	WQPHN Nukal Murra Alliance CWHHS
Work with Nukal Murra Alliance and other key stakeholders to develop an Aboriginal and Torres Strait Islander health training and workforce strategy with an aim of developing and supporting Aboriginal and Torres Strait Islander workforce to work to top of scope in delivering primary health, mental health, aged care, disability and family support services.	Aboriginal and Torres Strait Islander Health	Workforce	Strategy developed	WQPHN Nukal Murra Alliance HWQ
Trial the implementation of some place-focused interventions within a geographical area, be it a town or community, to identify likely causes of the health system failures and develop solutions to bring down potentially preventable hospitalisations over time	Aboriginal and Torres Strait Islander Health	Potentially preventable hospitalisations	Place-focused approach(es) identified, designed and implemented	WQPHN

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
* Prioritise structural reform in rural and remote communities (Recommendation 5 – Local approaches to deliver coordinated care)				
Trial the implementation of some place-focused solutions and partnerships within a geographical area, be it a town or community, as a means of supporting better integration and cooperation across local providers within a 'whole-of-population' focus in order to reduce risks that contribute to fragmented and poorly coordinated services	Population health	Care coordination	Place-focused approach(es) identified, designed and implemented	WQPHN
Work with HHSs, GP providers and other key stakeholders to review existing GP service models in Western Queensland and explore new models across the nation with an aim of developing a joint plan that supports a mixture of general practice models in the region in order to support a sustainable and quality supply of GPs in general practice and deliver viable remote and rural general practice services across all the towns in the region	Population health	Access	Review/plan completed	WQPHN GP providers
As part of the general practice review, explore the adaptation of the RACCHO proposed service model to suit local community circumstances and needs, and state jurisdictional health system conditions, in the region. Assuming strong local support in one or more towns for the RACCHO service model lobby Commonwealth and state jurisdictions to trial its development and implementation in the region	Population health	Access	Review suitability of proposed RACCHO to Western Queensland	WQPHN GP providers

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
* Prioritise structural reform in rural and remote communities (Recommendation 5 – Local approaches to deliver coordinated care)				
Continue to support existing local private general practices, including ACCHOs, so as to maintain ongoing community access to these established services	Population health	Access	Number of private general practices maintained	WQPHN GP providers
Continue to support the RFDS as a discernible general practice in Western Queensland and support the development of CDM and business models that builds its general practice capacity	Population health	Access	Increased investment in RFDS general practice services Improved continuity of care and health outcomes for very remote communities	WQPHN RFDS
Support NWHHS and Mt Isa general practice providers to revisit and review the Emergency Department Avoidance Strategy addressing the high number of low acuity presentations to the Mt Isa Hospital Emergency Department	Population Health	Access	Plan developed and implemented	WQPHN NWHHS Mt Isa GP providers

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
* Support people to access equitable, sustainable and coordinated care that meets their needs (Recommendation 8 – Improved access for people with poor access or at risk of poorer health outcomes)				
Work with CheckUp, GP service providers and other key stakeholders to review the Western Queensland CheckUp visiting specialist and allied health schedule with an aim to supporting greater medical specialist led multidisciplinary team base care.	Population health	Access	Review completed	WQPHN CheckUp
Work with CheckUp and other key stakeholders to jointly develop and implement a collaborative commissioning program for Western Queensland that initially focuses on community paediatric and child health services, child and adolescent mental health services, community geriatrician and older persons services	Population health	Access	Collaborative commissioning program developed New services implemented	WQPHN CheckUp

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
* Support people to access equitable, sustainable and coordinated care that meets their needs (Recommendation 8 – Improved access for people with poor access or at risk of poorer health outcomes)				
Work with CheckUp and other key stakeholders to commission more region-wide visiting medical specialist led health services (similar to IROC, ICOP & Deadly Ears) through 'metropolitan-remote medical specialist partnerships' with metropolitan-based institutions such as HHSs, hospitals, hospital departments and universities (relying less on opportunistic ad hoc individual specialist service providers) and integration of service provision with health services research to build an evidence base of what works to deliver improved outcomes, and training opportunities to promote succession planning	Population health	Access	New metropolitan-remote medical specialist partnerships established New services implemented	WQPHN
Undertake a review of services for people living with a disability and their carers, with an aim of developing a more appropriate disability service model for Western Queensland	Population health	Vulnerable population	Review completed	WQPHN

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
* Support people to access equitable, sustainable and coordinated care that meets their needs (Recommendation 8 – Improved access for people with poor access or at risk of poorer health outcomes)				
<p>Review and refine the mental health stepped care model to:</p> <ul style="list-style-type: none"> Promote optimal utilisation of low intensity services and ensure clinical services are directed to those patients with higher care needs Maximise use of available resources including Better Access and PHN funding to improve reach of commissioned services to communities with small populations Embed mental health stepped care into the WQHCH model 	Mental health	Access Care coordination	<p>Increased utilisation low intensity services</p> <p>Increased utilisation of Better Access MBS items</p> <p>Improved access to mental health services for people residing in small communities</p>	WQPHN
Finalise and implement the <i>Five year plan (2021 - 2026) to Improve Mental Health, Suicide Prevention and Alcohol and Other Drug Treatment Services in Western Qld</i>	Mental health Alcohol and Other Drugs	Safety and quality Care coordination System integration Workforce	<p>Implementation of the Five year plan and progress in actioning the nine key focus areas for:</p> <ul style="list-style-type: none"> Improved quality, integration and coordination of MHSPAOD care Improved workforce capability and capacity 	WQPHN, NWHHS, CWHHS. SWHHS leads

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
* Support people to access equitable, sustainable and coordinated care that meets their needs (Recommendation 8 – Improved access for people with poor access or at risk of poorer health outcomes)				
Given the expanding role of PHNs in aged care (flagged in the 2021-2022 Federal Budget in response to the Royal Commission into Aged Care Quality and Safety), the WQPHN works with and support others (e.g., RACFs, HHSs, visiting geriatrician and aged care services, GP providers, allied health providers) to undertake more detailed review of aged care issues including gaps and challenges in system navigation, delivery of coordinated care, and provision of high-quality clinical care to older people in the aged care system and develop a road map that identifies opportunities/priorities to improve Western Queensland aged care system	Aged Care	Vulnerable population	Roadmap to support healthy ageing in the regions	WQPHN

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
* Foster cultural change by supporting ongoing leadership development in primary health care (Recommendation 9 – Leadership)				
Provide ongoing support to the region-wide Clinical Council and HHS level Clinical Chapters	Population health	Primary health care leadership	Clinical Council and Clinical Chapters maintained and proactively supported	WQPHN
Provide ongoing support to the region-wide Consumer Advisory Council	Population health	Primary health care leadership	Consumer Advisory Council maintained and proactively supported	WQPHN

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
<ul style="list-style-type: none"> * Address Australia's population health needs with well-supported and expanding primary health care team that is coordinated locally and nationally for a sustainable future primary health care workforce (Recommendation 10 – Building workforce capability and sustainability) * Support and expand the role of the allied health workforce in a well-integrated and coordinated primary health care system underpinned by continuity of care (Recommendation 11 – Allied health workforce) * Support the role of nursing and midwifery in an integrated Australian primary health care system (Recommendation 12 – Nursing and midwifery workforce) * Support and develop all appropriate workforces in primary health care to better support people, the existing health care workforce and achieve an integrated, coordinated primary health care system (Recommendation 13 – Broader primary health care workforce) * Support, streamline and bolster the role of GPs (which includes Rural Generalists) in leading and coordinating care for people, while building and ensuring a sustainable and well supported medical primary care workforce (Recommendation 14 – Medical primary care workforce) 				
Work with HWQ to develop an accurate annual report card of the health workforce working in the primary care environment (distinct from the hospital environment) in Western Queensland to inform and stimulate health workforce and health services planning	Health workforce	Workforce	Annual report card developed and implemented	HWQ WQPHN
Continue to support existing private general practices to provide sustainable and quality GP services through WQPHN's GP locum support program	Health Workforce	Workforce	General practice service continuity	WQPHN HWQ CheckUp

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
<ul style="list-style-type: none"> * Address Australia's population health needs with well-supported and expanding primary health care team that is coordinated locally and nationally for a sustainable future primary health care workforce (Recommendation 10 – Building workforce capability and sustainability) * Support and expand the role of the allied health workforce in a well-integrated and coordinated primary health care system underpinned by continuity of care (Recommendation 11 – Allied health workforce) * Support the role of nursing and midwifery in an integrated Australian primary health care system (Recommendation 12 – Nursing and midwifery workforce) * Support and develop all appropriate workforces in primary health care to better support people, the existing health care workforce and achieve an integrated, coordinated primary health care system * Support, streamline and bolster the role of GPs (which includes Rural Generalists) in leading and coordinating care for people, while building and ensuring a sustainable and well supported medical primary care workforce (Recommendation 14 – Medical primary care workforce) 				
Support private general practice, including ACCHOs, to create a 'sister remote and rural practice program' that links metropolitan practices and/or individual GPs with Western Queensland practices to employ metropolitan based GPs who would regularly visit providing face to face services, and also virtually connected from their home base between visits providing remote telehealth consultations and other practice support functions, lead and coordinated by the remote and rural practice	Health workforce	Workforce	Improved general practice capacity Improved continuity of care	WQPHN Private general practice ACCHOs HWQ Tertiary sector

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
* Address Australia's population health needs with well-supported and expanding primary health care team that is coordinated locally and nationally for a sustainable future primary health care workforce (Recommendation 10 – Building workforce capability and sustainability) * Support and expand the role of the allied health workforce in a well-integrated and coordinated primary health care system underpinned by continuity of care (Recommendation 11 – Allied health workforce) * Support the role of nursing and midwifery in an integrated Australian primary health care system (Recommendation 12 – Nursing and midwifery workforce) * Support and develop all appropriate workforces in primary health care to better support people, the existing health care workforce and achieve an integrated, coordinated primary health care system * Support, streamline and bolster the role of GPs (which includes Rural Generalists) in leading and coordinating care for people, while building and ensuring a sustainable and well supported medical primary care workforce (Recommendation 14 – Medical primary care workforce)				
Support the efforts of individual GP providers to attract and retain a skilled primary care workforce including: <ul style="list-style-type: none"> Developing strategies to support hospital nurses to undertake APNA training in primary care e.g., accessing HWQ health workforce scholarship program Training and CPD for practice managers HR support 	Health workforce	Workforce	Practice management positions filled Practice Nurse positions filled	WQPHN HWQ GP providers (includes private, HHS and ACCHOs)

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
<ul style="list-style-type: none"> * Address Australia's population health needs with well-supported and expanding primary health care team that is coordinated locally and nationally for a sustainable future primary health care workforce (Recommendation 10 – Building workforce capability and sustainability) * Support and expand the role of the allied health workforce in a well-integrated and coordinated primary health care system underpinned by continuity of care (Recommendation 11 – Allied health workforce) * Support the role of nursing and midwifery in an integrated Australian primary health care system (Recommendation 12 – Nursing and midwifery workforce) * Support and develop all appropriate workforces in primary health care to better support people, the existing health care workforce and achieve an integrated, coordinated primary health care system * Support, streamline and bolster the role of GPs (which includes Rural Generalists) in leading and coordinating care for people, while building and ensuring a sustainable and well supported medical primary care workforce (Recommendation 14 – Medical primary care workforce) 				
Support local and visiting primary health care providers to identify opportunities to trial new or expanded roles to support an integrated multidisciplinary team (e.g., local Allied Health Assistants working under the direct or indirect supervision and delegation of an allied health professional to assist with clinical and program related activities, Nurse Practitioner delivering some of the GP services traditionally provided by a GP)	Health workforce	Workforce	New workforce roles established	WQPHN GP providers Primary health care providers/ commissioned services
Support HWQ, Queensland Health and other key stakeholders to progress the allied health workforce development scoping work done in SWHHS (2021) and NWHHS (2020) and the recommendation to develop and implement a regional, inter-agency, collaborative allied health workforce strategy based on the Allied Health Rural Generalist Pathway	Health workforce	Workforce	Increased number of allied health professionals working in Western Queensland Allied health professional training and career pathway in place Increased length of stay/service of allied health professionals in Western Queensland	HWQ Queensland Health (Allied Health Professions' Office)

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
<ul style="list-style-type: none"> * Address Australia's population health needs with well-supported and expanding primary health care team that is coordinated locally and nationally for a sustainable future primary health care workforce (Recommendation 10 – Building workforce capability and sustainability) * Support and expand the role of the allied health workforce in a well-integrated and coordinated primary health care system underpinned by continuity of care (Recommendation 11 – Allied health workforce) * Support the role of nursing and midwifery in an integrated Australian primary health care system (Recommendation 12 – Nursing and midwifery workforce) * Support and develop all appropriate workforces in primary health care to better support people, the existing health care workforce and achieve an integrated, coordinated primary health care system * Support, streamline and bolster the role of GPs (which includes Rural Generalists) in leading and coordinating care for people, while building and ensuring a sustainable and well supported medical primary care workforce (Recommendation 14 – Medical primary care workforce) 				
Using an inter-agency approach, develop and implement a training and employment pathway for allied health assistants, assistants in nursing, Aboriginal and Torres Strait islander Health Workers, aged care and disability workers. Key agencies include employing organisations (i.e., HHSs, ACCHOs, local government, aged care providers and NGOs), SQRH and CRRH with clinical educator capability, CheckUp (delivering the Gateway to Industry Program) and RTO with capacity and flexibility to deliver training in the regions. Initiate a proof of concept in the Central West where there are identified AHW vacancies	Health Workforce	Workforce	<p>Training and employment pathway established with rolling intakes contributing to sustainability of primary care, aged care and disability services</p> <p>Local school leavers and those seeking a health or community service career undertake vocational training in their region/locale</p> <p>Employment opportunities for local people in the health, aged care and disability services are realised</p>	Leads – WQPHN and CWHHS

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and/or opportunities for collaboration and partnership
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✱ Develop digital infrastructure and clinical systems to better support providers to deliver safe and effective care (Recommendation 15 – Digital infrastructure)				
<p>WQPHN continues to engage with the Rural and Remote Digital Healthcare Committee as the Queensland Digital Strategy for Rural and Remote Health Care roadmap is implemented to progress improvements in sharing patient record data such as EMRs, My Health Record and improved access to The Viewer between multi-speciality and inter-disciplinary teams.</p> <p>The PHN also investigates opportunities to share patient consented health records across the continuum of care drawing on learnings from South West Sydney PHN (Integrated Real-time Active Data) (iRAD) interoperability project.</p>	Digital health	Care Coordination	Secure patient information exchanged between primary, secondary and tertiary settings	WQPHN
Identify and promote opportunities to build workforce and consumer digital readiness to expand telehealth use and confidence to embrace technology and digital modes as an adjunct to face-to-face services	Digital health	Access	Resources and strategies identified and promoted to support appropriate use of telehealth by clinicians and consumers	WQPHN

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Section 5 - Checklist

Requirement	✓
Provide a brief description of the PHN's Needs Assessment development process and the key issues discovered.	✓
Outline the process for utilising techniques for service mapping, triangulation and prioritisation.	✓
Provide specific details on stakeholder consultation processes.	✓
Provide an outline of the mechanisms used for evaluating the Needs Assessment process.	✓
Provide a summary of the PHN region's health needs.	✓
Provide a summary of the PHN region's service needs.	✓
Summarise the priorities arising from Needs Assessment analysis and opportunities for how they will be addressed.	✓
Appropriately cite all statistics and claims using the Australian Government Style Manual author-date system.	✓
Include a comprehensive reference list using the Australian Government Style Manual.	✓
Use terminology that is clearly defined and consistent with broader use.	✓
Ensure that development of the Needs Assessment aligns with information included in the PHN Needs Assessment Policy Guide.	✓