Section 3

Comprehensive Needs Assessment

medicare local

Connecting health to meet local needs

Medicare Local Comprehensive Needs Assessment Report 2014-15

This template must be used to submit the Medicare Local's (ML's) Comprehensive Needs Assessment (CNA) Report to the Department of Health (the Department) by **16 May 2014 as required under Schedule 21.1 of the ML Deed for Funding with the Commonwealth.**

Name of Medicare Local

Western NSW Medicare Local Ltd

CERTIFICATION
To be signed by CEO or delegate(s)

I/We, the undersigned certify that the appropriate senior oversight has occurred and approval of the process outlined and the outcomes of the CNA process have been obtained.

I/we certify that the information provided in this CNA Report 2014-15 is correct.

I/We acknowledge that it is an offence under Section 137 of the *Criminal Code Act 1995* to provide false or misleading information or documents to the Commonwealth.

Signed:  Date: 14/05/2014

Name: Dr Jennifer Beange Position: Chief Executive Officer

Executive Summary

The Western NSW Medicare Local (WML) has undertaken a Comprehensive Needs Assessment (CNA) to guide our strategic direction and inform our resource allocation. We have consulted and worked in partnership with the community, health professionals and stakeholders to assess the health status of the population, and identify the key health issues/needs and problems of the region.

For the purpose of the CNA, WML drew on extensive epidemiological information that had been collated from the Western NSW Health Needs Assessment 2013. We have also reviewed National, State and Local datasets to capture any new data released focusing on key demographic trends, the influence of the social determinants of health, health inequalities and the demand for health care services in the region.

Based on the previous needs assessment, key priority areas were identified and a number of new strategies and activities were commenced to address these priority areas. It is our intention to retain and expand on these priority areas, identify new primary care needs emerging in our region and assess findings from the CNA to underpin the future allocation of resources in priority areas.

Key Priority Areas

1. Smoking prevention and cessation.
2. Nutrition and physical activity interventions, including obesity prevention.
3. Diabetes prevention and management.
4. Well Child Care, particularly for Aboriginal children – the first 1000 days.
5. Mental Health – strengthening current community services.

The development of the 2014 CNA was overseen by a steering group established to provide support and assist with the priority setting processes. Members of the steering group included executive and senior staff. The WML also worked with key Advisory Groups to ensure it captured a broader network input, and then used their expertise and knowledge when drilling down into priority settings.

A formal project plan was developed outlining governance, project schedule, resources, methodology, outcomes and risks. It was decided to use WML teams to conduct stakeholder and community engagement. The WML employs nine Community Liaison Officers (CLOs) who have crucial role in connecting the WML to stakeholders and the community. The CLOs have established strong connections and are working in partnership with organisations and services locally to address existing and emerging health issues in the community.

The CLO's ongoing working relationships ensure continuity of engagement through their usual work practices. Other WML teams that were involved in the process include the Care Coordination and Supplementary Services (CCSS) team, Closing the Gap (CTG) team, Practice Support team, and the Allied Health services team.

Summary of the quantitative data analysis:

- Population growth overall has been minimal. Towns closer to Sydney have grown, while those beyond Dubbo have declined.
- The largest growth is in the 65+age group.
- Socio-economic indicators show that the Bathurst area is the least deprived, then Orange, Dubbo and with high levels of disadvantage in the North-West, which is significantly disadvantaged compared to NSW overall.
- Aboriginal People continuing to show disadvantage across all social determinants.
- Highest rate of obesity at 79% locally showing eight out of ten adults are overweight or obese.
- High Diabetes rates particularly in the Aboriginal community, compared to NSW average.
- Causes of premature death rates are all higher compared to NSW average.
- Higher numbers of the population with at least one of the four risk factors compared to NSW average.
- Significant barriers for people aged 18 years and over in accessing GP services and purchasing medication.
- Higher ratio of hospitalisations than NSW average, the WML area showing higher rates for females than males.
- Rate of potentially preventable hospitalisations for acute conditions is higher than those for chronic conditions.

Issues and needs identified by stakeholders and communities include:

Integration and Chronic Disease

- High rates of Diabetes and Obesity
- High smoking rates
- Integrating care and coordination of services to improve case management duplication
- Child and Adolescents Mental Health

Aboriginal and Torres Strait Islander Health

- Expansion of Care Coordination and Supplementary Services
- Podiatry services for Aboriginal People
- Expansion of Cultural Awareness training delivery

Issues and Gaps in services in communities

- Lack of general counselling and psychology services
- Increasing number of suicides in rural communities
- Lack of Podiatry services, Speech, OT, Dietetics, Diabetes Education
- Lack of Dental Services
- Lack of Drug & Alcohol Services
- Women's Health services needed

Prevention and Early Intervention

- Increased healthy lifestyle programs needed for the whole community
- Increased focus on early diagnosis
- High prevalence of children requiring early intervention services
- More healthy eating advice for children needed

Health Workforce

- Sustainability, in terms of an ageing GP workforce and more General Practice Support
- General Practice Nurse training in Diabetes and Chronic Disease Management
- More Specialists needed to provide telehealth services
- Improved community knowledge of how to access services
- Increase education opportunities for remote GPs

Determinants barrier/enablers

- Improve Transport options
- All practices to be registered for PIP and CTG
- Lack of community services to assist the elderly
- Health Literacy and Knowledge of Health services and how to access them

The strategic activities that were selected are expected to improve services by transforming existing services into an integrated Western NSW system of care which is tailored to meet the needs of rural and remote communities, and improves access and health outcomes with a particular focus on Aboriginal People.

Section 1 – Planning (Phase 1)

Table 1 - Phase 1 Selected Gate Review Items

Item Title	Complete?
Phase 1	
Governance established (Strategic Leadership Group or similar appointed).	√
Stakeholder mapping has been completed and analysed – appropriate partnering and engagement plans developed.	√
Data sources (secondary and primary) identified including existing reports and relevant background information from partners.	√
Resourcing (with appropriate capacity and capability either internal or external) has been acquired, and are aware of their involvement and commitment.	√
Project Plan (including schedule, resourcing capacity and capability, methodology, measures of success and a risk management strategy) completed and approved.	√
Project Plan is in alignment with the CNA Reporting Template and describes how final outputs are expected to be published and distributed.	√

Section 2 – Assessing Needs Gate Review Items (Phase 2)

Table 2 - Phase 2 Selected Gate Review Items

Item Title	Complete?
Phase 2	
Part A – Compiled and reviewed data on health inequity, key demographic trends and decided on special needs groups (or sub-regions) where issues/needs may exist based on evidence.	√
Part B - Compiled and reviewed data on health outcomes, health status and health utilisation as well as considered available information on patient experience or consumer satisfaction.	√
Part C - Compiled and reviewed data/information on service provision including mapping service capacity and considering gaps in access for vulnerable and marginalised populations.	√
Part D - Findings from the community profile completed in A, B and C informed the scope of and approach to community engagement and health professional and service provider consultations.	√
Part D1 **-** The community has been appropriately consulted (considering the most appropriate engagement methods) including consultations with special needs groups where identified and deemed important.	√
Part D2 **-** Health professionals and service providers have been appropriately consulted (considering the most appropriate engagement methods) including consultations with special needs groups where identified and deemed important.	√
Part E **-** Data and information from Parts A, B, C and D has been compiled and a final population health profile has been completed, including consideration of normative, comparative, expressed and felt needs. The Strategic Leadership Group (or similar) has approved the final population profile.	√
Part E **-** A shortlist of needs, using that profile as a key input, has been generated. The Strategic Leadership Group (or similar) has approved the final shortlist of issues/ needs.	√

Table 4 – Phase 2

Table 4 is available from http://www.wml.org.au/ResourcesandLinks/annual-report-financial-statements

Discussion Box 2

- *Process which was used to triangulate and shortlist the identified issues / needs*

The issues and needs identified through the community and stakeholder engagement were summarised into consistent themes as well as data analysis. All of this information was filtered through the triangulation matrix and cross checked. WML used the triangulation process to confirm findings. The finding were reviewed by program managers and the executive, to consider the result, and whether it was necessary for further review or more information, if there were partnership options, had the WML already identified the issues/need internally and what was the capacity of the organisation to develop a strategy to address the health issues or need within the community.

- *Identified key issues/needs that were considered but not included in the shortlist for Table 4 (even though there was evidence to identify it as an issue/need) and the rationale for their exclusion*

The following issues/needs were not included in the shortlist: Transport, Dental, and Drug and Alcohol due to a lack resources and capacity. Although we are not providing direct services in these areas, it may be a component of individual programs. We have also provided support for these issues through partnerships, such as working with NSW National Council of Social Services, General Practice and the WLHD. There is the potential through collaborative and integrative partnerships to advocate for further funding so that communities are better resourced. This is expanded on in Discussion box 3 using Drug & Alcohol services as an example.

Section 3 – Establish priorities (Phase 3)

Table 5 - Phase 3 Selected Gate Review Items

Item Title	Complete?
Phase 3	
Assessed the impact, evidence, changeability, acceptability and resource feasibility of each issue/need.	√
Considered and assessed strategies to address issues/needs and documented an indicative Scoping Paper for discussion in selecting priorities.	√
Engaged with relevant stakeholders to ensure they have bought into the set of prioritised problems or factors.	√
Validated priority setting criteria and ratings and rankings of each strategy/proposal/initiative.	√
Prepared recommendations and received formal comment from the Strategic Leadership Group (or similar) and other stakeholders identified in *Phase 1* through stakeholder mapping.	√
Validated and agreed the final list of priorities including those that will be progressed by the ML and those that will be progressed by other stakeholders (if applicable).	√

Table 6 - Summary of issues/needs and strategies to address (include all priorities identified in the Excel spreadsheet established as priorities for 2014-15)

Issue/ Need	Strategy	Description of Strategy Activities	Justification	Expected Outcome
INTEGRATION				
Discharge Planning	The WML/LHD Demonstrator Integrated Care	This will be progressed within the broader "Integrated Care Pathways" deliverable under the WML/LHD Integration Service Redesign work stream	WNSW Health Needs Assessment 2013	To transform discharge communication into more of a 'transfer of care' orientation under an integrated Western NSW system of care which improves health outcomes.
Remote GPs Education Access	Ability to utilise RHOF/MOICDP contracted specialists to provide up skilling as part of their visit service in identified areas of specialty if required.	Contracted RHOF/MOICDP Endocrinologist providing education in small rural town. Contracted MOICDP General Physician providing small evening case studies with capacity for videoconference link.	RHOF/MOICDP Funding provision has specialist in a particular town with knowledge of local issues and referral patterns. Priority Issue CNA Matrix 2014	Rural GPs will receive localised up skilling around Diabetes Management in General Practice.
Integrated Primary Care	The WML/LHD Integrated Care Initiative program	Integrated primary care demonstration sites	WNSW Health Needs Assessment 2013 CNA Matrix 2014	To transform existing services into an integrated Western NSW system of care that is tailored to the needs of our rural and remote communities, and improves access to care and health outcomes, with particular focus on closing the Aboriginal health gap.
Health Information Analytics		This will be progressed within the "Proof of Concept sites" deliverable under the WML/LHD Integration Service Redesign work stream and the "E- Plan" and "Health Intelligence Unit" enabler deliverables	WNSW Health Needs Assessment 2013	As above.

Workforce Planning	Allied Health Service Delivery Planning	Develop local Allied Health Assistant workforce and Telehealth Model of Care. Expand Primary Health Care Nurses school of practice to include basic foot care and preventative care e.g. smoking cessation, HEAL	Address service shortfalls and unsustainable models of care e.g. podiatry. Increase efficiencies in service delivery WML CNA Matrix 2014	Increased staff numbers for PHCN and AHA's. Providing services and increase use of telehealth.
Dubbo Diabetes Project – localised CTG project templates	The WML/LHD Integrated Care Initiatives program will progress "Whole of locality action for diabetes (Dubbo)"	This will be progressed alongside the broader "Models of Care" and "Integrated Care Pathways" deliverables under the WML/LHD Integration Service Redesign and Enablers work streams	LHD's Health Needs Analysis (HNA) 2013 LHD's Strategic Health Services Plan 2013-20162 (SHSP)	To transform existing diabetes services in Dubbo, to inform improved access to diabetes care and diabetes related health outcomes, with particular focus on closing the Aboriginal health gap.
Providing communities with Service Directories	WML's current partnership with the LHD has established a Connecting Care directory to provide clarity around CDM service providers	In partnership with the LHD under Connecting Care, WML has made available a CDM directory through our website. WML currently link with the national directory also on the website and provide other PHC directories.	Connecting Care contract & program requirements	CDM directory remains within our website however the national service directory links are to be maintained as a highly visible resource

Issue/ Need	Strategy	Description of Strategy Activities	Justification	Expected Outcome
MENTAL HEALTH				
Whole system review	Collaboratively develop and design an integrated community focused Mental Health service	This may also be progressed within the "Proof of Concept sites" deliverable under the WML/LHD Integration Service Redesign work stream but in large would be informed by the Health Intelligence Unit and Mental Health Review deliverables. WML/LHD Leads and Integration Team appointed to begin work on new model of care.	WNSW Health Needs Assessment 2013 WML CAN Matrix 2014	To transform existing mental health services and drug and alcohol services into an integrated Western NSW system of care that is tailored to the needs of our rural and remote communities, and improves access to care and health outcomes, with particular focus on closing the Aboriginal health gap.
Intake Process	Establishment of central intake for Partners in Recovery	Intake processes established and first clients logged	Part of Program establishment obligation to Commonwealth as Lead Agency	Secure and transparent intake process for PIR
Intake and access	Establishment of intake and referral system for Mental Health Programs including ATAPS.	Centralised intake has been established and Is to be implemented across the region with a staged model.	Ensures a systemic approach to referrals and provides consistency and a clear referral process with access to a central information point.	Improved service and communication for all stakeholders with secure, confidential processes in place.
Service Collaboration	Establishment of Services Accords with cluster agencies Justice Health/system, FACS,AMS orgs, Public Guardian	Accords drawn up and negotiation for finalisation will occur over next 6mths	Sector change initiatives as indicated by Partners in Recovery Program outcome and benchmarked achievements	Implantation of sector change as indicated in Program outcome expectations

Child and Adolescent Services in North Western Sector and Mudgee	Provision of existing ATAPS and MHSRRA services and expansion of existing services.	Child Mental Health Service continuing in Gilgandra and Coonabarabran. Services can be accessed by surrounding towns including Baradine and Gulargambone. Child Liaison Officers to assist with access to services. Providers under MHSRRA program in Mudgee and Gulgong see children, adolescents and adults. ATSI service in Coonamble is accessible for adolescents and adults. Review of Coolah to take place, can access services in Mudgee.	Consolidation of existing services. WML CNA 20104 Matrix	Improved access to Mental Health services in target regions.
Suicide prevention	Establish ATAPS Suicide Prevention Program in headspace Dubbo	ATAPS funding to allow for headspace Dubbo to recruit to a position to provide suicide prevention services	To expand existing suicide prevention service in Bathurst headspace to include Dubbo headspace.	To provide an early intervention suicide prevention service to the youth of Dubbo and surrounds.
Access to Community Mental Health Services	Region wide centralised intake for Mental Health referrals	Staff recruitment, establishment of central intake, establishment of consortia governance, client referrals commenced, sector change processes commenced (service accords and pilot programs), Data warehouse capacity established, sector program presentations and broachers, staff training completed.	Community need Mental Health Review	Increased quality and relevance of services to Program target group within the context of achieving significant sector change.
Headspace Dubbo	Business Plan before hNO	Business plan submitted and awaiting feedback. Consortia formed, with preliminary consultation completed. Managerial integration of Bathurst and Dubbo locations proposed to maximum resources at both locations	Lead agency role provides opportunity to be at the forefront of youth mental health service delivery in the Dubbo community (and surrounds) WML CNA Matrix 2014	Increased services available for young people aged 12-25 years experiencing mental health and associated concerns.
Service Implementation	Implementation of Intake and referral System. Consolidation of ATAPS Tier 2 specialised programs - ATSI and CMH	Centralised Intake has been established and Is to be implemented across the region with a staged model. Existing targeted Tier 2 programs to be strengthened with consolidating partnerships with AMS	Provides a systemic approach to referrals, greater consistency and clear referral pathways. Facilitate access for ATSI and children in the region.	Ensures consumers who are most disadvantaged are able to access the service with more efficient use of funding.

Issue/ Need	Strategy	Description of Strategy Activities	Justification	Expected Outcome
WORKFORCE AND PRACTICE SUPPORT				
Existing Practice and New Practice Support	Continued targeted support will be provided in the following areas: Accreditation; MBS items; Chronic disease data; Practice Management issues including recruitment & orientation and clinical and business support for staff.	Practice visits by the practice support team will offer support to all members of the general practice under an overarching strategy that links to the wider WML/LHD integration program	WML is currently developing a proactive provider support approach to better meet the needs of general practices in order to maximise their impact on health outcomes.	New practices will operate successfully and remain viable in rural/regional settings. Accreditation rates will be maintained. Practice staff will operate at optimal skill levels.
Practice nurses require up skilling in Chronic Disease Management	Looking at developing and supporting practice nurse clinical leadership	WML considering supporting a Practice Nurse clinical network to assist practice nurse workforce development and input into care planning & health assessment pathway development	WNSW Health Needs Assessment 2013 WML CNA Matrix 2014	Improved chronic disease outcomes
Women's Health	Provision of Well Women's training to 5 PNs	Communities with low Cervical screening rates will be prioritised to up skill 5 PNs in Well Women's Screening in 2014 FY. Ongoing provider support will be offered by practice support team to ensure these skills are utilised within each general practice.	low cervical screening rates in WML Cervical Screening Program Pap test register, Cancer Institute NSW	Increased provision of cervical screening within general practice
General Practice Support	Support for practice clinical/business system optimisation	Currently scoping support that can be provided in the area of business modelling data for general practices	WNSW Health Needs Assessment 2013 WML CNA Matrix 2014	New and existing practices will operate successfully and remain viable in rural/regional settings with clinical staff able operate at optimal skill and efficiency levels
Workforce planning & succession planning for GPs including Ageing GP Population and GP Proceduralist	Currently scoping WML support capacity for workforce planning within WML/LHD integration context	Currently scoping support that can be provided in the area of local workforce data for sustainable and top of scope general practice utilisation within planned LHD/ML demonstration sites	WNSW Health Needs Assessment 2013 WML CNA Matrix 2014	New and existing practices will operate successfully and remain viable in rural/regional settings with clinical staff able operate at optimal skill and efficiency levels

Sustainable Primary Care Service delivery	WML and LHD joint commissioning	WML and LHD have agreed to consider how commissioning can be strengthened across the District and at locality level to support integrated care.	Better support for integrated care is needed that encompasses the configuration, capacity, capability, processes and tools dimensions of commissioning	This will multiple link streams of parallel work in order to foster innovative responses to the needs of rural and remote clinicians; focus on improving outcomes for the more vulnerable patient cohorts; and support new workforce and delivery models, and attraction and retention of a sustainable workforce

Issue/ Need	Strategy	Description of Strategy Activities	Justification	Expected Outcome
ABORIGINAL & TORRES STRAIT ISLANDER HEALTH				
Social disadvantage in Aboriginal Youth population	Desert Pea Media Project / Connecting Care	2 media projects to be completed in Coonamble using DPM. A health promotional video is created identifying local health concerns to which a health promotional package is created around to use in the community/PHCN's to accept referrals from the acute sector to assist in complex care health management	Significant social and health concerns in this community/ Non indigenous individuals with high frequency of hospital admissions. WNSW Health Needs Assessment 2013, Priority Issues CNA Matrix 2014	Increased school attendance, 715 assessments and engagement with local community members, including health and human sector service providers.
Culturally aware service providers	Allied Health Position Descriptions modified to identify the KPI of increasing access and services to Aboriginal Populations. Cultural awareness training	All Allied Health Team to complete local cultural awareness training	WML CNA 2014 Matrix	Increased cultural awareness and safety when delivering Allied Health services.
Service alignment with need	Implementation of reviewed Allied Health services delivery and strategic plan	Prioritisation of service delivery to ATSI populations. Locations of service reviewed and modified if needed to increase Aboriginal access.	Burden of disease is greater in ATSI population WML CNA 2014 Matrix	Increased Aboriginal presentations across Allied Health services.
Aboriginal Immunisation Position	Employment of Aboriginal Immunisation Health Worker	Partnership with LHD Aboriginal Immunisation Health Project Officer to improve Aboriginal child immunisation rates	Up to 10% lower immunisation rates for Aboriginal children compared to total children immunised within WML area. National Health Performance Authority data: 2011	That the WML rates will stay above 90% and there will be an increase in our aboriginal rates.

More funding for CCSS	This program has been recently expanded however is again at capacity	In partnership with the State/Commonwealth funding agencies & local partners	Strong program success Capacity as recommended by the AML Alliance is about 30 clients / FTE due to the complexity of the cases. This equals a recommended capacity of 207 clients. Current number of WML program participants (as at end of April) 387 This means program is running at almost double the recommended capacity.	Improved Health Access for Aboriginal People
Strategy to work with practices not registered for CTG	Under national CTG strategy	Working with WML eHealth team to ensure all practices are registered with CTG	79% Practices currently registered	100%
Integrated approach to Aboriginal Health	Affective collaboration with stake holders	Form strategic partnership with Aboriginal Health Services providers and Local Health District	Best use of available resources to tackle health issues	Contribute to Closing the Aboriginal Health Gap

Issue/ Need	Strategy	Description of Strategy Activities	Justification	Expected Outcome
ALLIED HEALTH				
Early Intervention	Short term contract/partnership with the RFW to deliver “Come n See” Program up until Jun 14 in Gilgandra and Gulargambone. Employment of a paediatric OT workforce to deliver services to priority towns	Telehealth and AHA to be delivered employed Gulargambone/Gilgandra. Develop new partnerships with Cudgegong Learning Centre and other Education groups (e.g. DET) to explore potential for supporting them with investing in AHA's in schools. Paediatric OT to deliver services to Coonamble, Gulargambone and Gilgandra	Early Intervention (EI) identified in the Allied Health Strategic Plan 2014 - 2015. use of Allied Health Assistants (AHAs) and Telehealth in the school environment	The use of telehealth will significantly increase both the number and frequency of individuals in therapy. The employment of AHA will build capacity within communities in the areas of health literacy, advocacy, and efficacy resulting in early intervention and improved health outcomes for young children. This addresses one of the key social determinants of health for WML.
Audiology and Speech	Allied Health Assistants (AHAs) and Telehealth in the school environment. Increase pediatric OT workforce.	AHA and Telehealth Model of Care/Service delivery. Employed OT previously contracted under the LHD. Delivery of paediatric OT services to prioritised towns.	Towns prioritised for services using AEDI data Early Intervention (EI) identified in the Allied Health Strategic Plan 2014 - 2015.	Increased occasions of OT services and an improvement in AEDI data relevant to OT discipline.
	Implementation and evaluation of Maxi Kids program in Grenfell	Maxi Kids pilot project was developed in 2014 FY by a private OT. Recruitment of an AHA in Grenfell to deliver this project to 4-7year olds aiming to address all areas of early intervention, including fine and gross motor skills, social skills, speech skills and nutrition health literacy.	Grenfell was identified as a priority community for early interventions services by both the local community as well as AEDI data. This pilot project targets a key social determinant of health within WML	Completed evaluation of pilot project to determine value of wider implementation of project
Private Provider Child & Adolescent Forbes can provide outreach	Continued provision of ATAPS services in Forbes.	Existing ATAPS Tier 1 provider to retire. New provider to be contracted, preferably with scope of practice to include Child and Adolescent mental health experience and skills.	To continue existing service and expand to include children and adolescents if suitable contractor available.	Continue to provide ATAPS service in Forbes in the new financial year.

Lack of Specialists & RHOF program Rheumatology in Orange and Respiratory in Cowra & Canowindra	New Rheumatologist to commence work in Orange. Liaising with CLO in Cowra regarding quantitative need for Respiratory Physician for Cowra	Continued partnership with LHD to recruit to Rheumatologist staff specialist at Orange Base Hospital. Support for current visiting Rheumatologists to Orange. Review of telehealth options for visiting specialists.	Require sufficient referral numbers to justify commencement of new service within funding guidelines. Current funding budget static until June 2016. Cowra ED Presentation 2012/13	Waiting times for new patients requiring review with a Rheumatologists in Orange and surrounding area will reduce. Identified need for Respiratory Physician at Cowra will be quantified.
Knowledge of Services	Implementation of Allied Health Communication Plan	Communication plan incorporates series to deliver health information, including utilisation of local media and Allied Health Team members.	WNSW Health Needs Assessment 2013 Priority Issue CNA Matrix 2014	
Royal Far West as a partner to support our Allied Health Services and Prevention Days.	Implementation "Come n See" Project	Speech Therapy delivered by telehealth in 5 communities across the WML. Target group last year of Preschool and Primary School. Team work towards sustainable service delivery.	Speech Pathology position under WML was vacant. RFW contracted to address immediate and significant need Priority Issues CNA Matrix 2014	Increased speech pathology services
Practice Nurse Diabetes Training	Development of a Diabetes Education training workshop commenced in 2014 FY with planned delivery to PNs into 2015 FY	Up skilling of PNs in Diabetes Education, including workshopping of case studies and follow up support from WML employed and contracted DE.	Increasing demand on DE services and PN to provide these services. WNSW Needs Assessment 2013	Improved health outcomes in diabetes.
Early Intervention	Continue to work in partnership with Royal Far West and LHD to explore opportunities to deliver the Healthy Kids Bus Stop program	Pilot program evaluation still under development. Tri-party level agreement to identify additional towns for service	Early intervention; whole of child screening provides health and developmental safety net for children the year immediately prior to school and provides pathways to care using the knowledge and resources of the RFW, LHD and WML.	Increased identification of needs for referral
Podiatry services	Enhance workforce skills for practice nurses and community health staff.	Diabetes foot care is likely to be progressed within the "Proof of Concept sites" deliverable under the ML/LHD Integration Service Redesign work stream	WNSW Health Needs Assessment 2013 WML CNA matrix 2014	To transform diabetes foot care services under an integrated Western NSW system of care.

Diabetes Education Need to improve access	MOICDP underspend to provide short term program	Partnering with Orange Aboriginal Medical Service to provide a Diabetes Educator to assist the Chronic Disease team to develop a Diabetes Chronic Disease Program	High rates of diabetes within WML and increasing demand on diabetes education services. Workforce shortages of Diabetes Educators resulting in need for succession planning	Improved health outcomes for management of Diabetes
	Appointment of second DE (Feb 2014) under the RTPHCI. Service provided out of GP clinic's	Diabetes Educator using GP clinic and software for service delivery. Currently working towards credentialing as a diabetes educator		Increased number of diabetes education occasions of service and an additional credentialed DE within the area.

Issue/ Need	Strategy	Description of Strategy Activities	Justification	Expected Outcome
AGED CARE				
Deteriorating patient in aged care facility	Implement ISBAR training in ACFS.	Triage training for nurses in aged care facilities	Potentially avoidable hospital presentations	Decreased unnecessary hospital transfers
Podiatry in Aged Care Facilities	PCHN's to conduct Basic Foot Care	Details TBC for service delivery Jul 14	Podiatrists are significantly under resourced through the WML area of those potentially available it is increasing unaffordable to recruit. PHCN's ability to provide basic foot care can and will provide relief in communities where currently no podiatry and or foot care exists	Access to basic foot care services improved efficient use of resources
Single Record	Promote PCEHR across the clinical pathway for each client	Assistance with registration in all aged care facilities	Need for continuity of care	Increased registration and use of the PCEHR

Issue/ Need	Strategy	Description of Strategy Activities	Justification	Expected Outcome
eHealth				
Allied Health Education	Promote eHealth to contracted Allied Health providers	Link Allied Health providers with eHealth team to increase understanding of PCEHR and encourage registration as a provider	Centralised point records irrespective of geography	Increased number of allied health providers registered and uploading patient records.
Secure messaging and E-Health Training	Included in new staff orientation	New staff are orientated with the eHealth team and the use of it. Processes are yet to be formalised.	Staff are aware of the benefits and procedures required to advise and assist pts.	Increase number of registrations. Bottom up pressure to encourage SP's not using eHealth to.
Service Expansion	Develop a model for telehealth with WML Diabetic Educator services	Develop a model for telehealth with WML DE services and pilot at selected sites.	Increasing demand on DE services and increased costs and impracticalities of travel to deliver such services.	Evaluation of piloted service delivery model
Tele health & Allied Health	Develop a model for telehealth with WML early intervention services	Develop and implement a model to utilise telehealth to Occupational Therapy and Speech Pathology and Diabetic Educator services	Increased demand for early intervention services, particularly those that are regular and engage with those children that require it.	Increased use of telehealth with increased service delivery and reduction in auxiliary costs.
Tele Health and ACF	Utilise telehealth to provide remote supervision to Allied Health Assistants working within the RACF setting	AHAs delivering services within prioritised RACFs will be remotely supervised by appropriate clinical supervisors utilising telehealth	Poor access for RACF residents to allied health services	Build the capacity of local community members in an AHA role to increase the provision of allied health aged care services

Issue/ Need	Strategy	Description of Strategy Activities	Justification	Expected Outcome
HEALTH PROMOTION AND POPULATION HEALTH				
Health Promotion addressing - Obesity	The ML/LHD Demonstrator Integrated Care Initiatives program will progress issues such as health promotion for obesity	This will be progressed alongside the broader "Models of Care" and "Integrated Care Pathways" deliverables under the ML/LHD Integration Service Redesign and Enablers work streams	WNSW Health Needs Assessment 2013	Expected to have more strategic coordination as outlined within the LHD/ML integration program plan especially with regards to the opportunities that will come from the wider Health Promotion Review
Obesity	Identify appropriate models of care	Utilise evidence based practice to develop a plan for delivering weight loss programs within WML	High overweight and obesity rates within WML	WML Community Health Reports show lower levels of obesity
Health Promotion addressing - smoking	The ML/LHD Demonstrator Integrated Care Initiatives program will progress issues such as health promotion for smoking	This will be progressed alongside the broader "Models of Care" and "Integrated Care Pathways" deliverables under the ML/LHD Integration Service Redesign and Enablers work streams	WNSW Health Needs Assessment 2013 WML CNA 2014 Matrix	Reduced smoking rates
Smoking cessation	Increase Primary Health Care Nurse (PHCN) workforce	PHCN s to be up skilled in smoking cessation	WNSW Health Needs Assessment 2013	Increased provision of individual and group smoking cessation sessions.
Healthy Lifestyle Groups	Increase PHCN workforce	PHCNs scope of practice to include large component of preventative health care, including delivery of healthy lifestyle programs. Healthy literacy and heal coaching	High burden of disease related to chronic diseases that are largely preventable via lifestyle changes. Lack of preventative health programs in communities. WNSW Health Needs Assessment 2013 Priority Issue CNA Matrix 2014	Increased number of preventative health care occasions of service with long term outcomes of reduced rates of chronic disease

Health Literacy	The ML/LHD Demonstrator Integrated Care Initiatives program will progress issues such as health promotion for health literacy	Health Literacy will be progressed within the "Models of Care" and "Integrated Care Pathways" deliverables and within the ML/LHD Integration Service Redesign and Enablers work streams	WNSW Health Needs Assessment 2013 Priority Issue CNA Matrix 2014	Expected to have more strategic coordination of health literacy support as outlined within the LHD/ML integration program areas especially with regards to the opportunities that will come from the wider Health Promotion Review

Discussion Box 3

For the key shortlisted issues/needs which will not be implemented, please provide:

- *A rationale for their exclusion, including whether it requires more information or resourcing and should be considered in future CNA updates.*

The increasing complexity of unmet needs in the community has seen a number of key areas identified where either increased provision is required, or where service models require better coordination and sophistication. Whilst the WML has both an interest in quality service outcomes and support to key provider populations such as GPs, a fundamental strength has been developed in the role of systemic coordination. This role is evident within the myriad of partnerships and work on service integration with bodies such as the LHD and Aboriginal Medical Services. This work has not excluded establishing some level of service provision capacity across those domains prominent in unmet needs. Rather, an active space has been created where the role of service coordination offers the capacity for innovation.

An example of this would be where drug and alcohol services are often identified by local communities as an area with service gaps and perceived unmet need. The WML is able to support a range of service provision interventions through staff who work in local medical practices, and in advisory roles such as Community Liaison and Closing the Gap. However, the unfilled role in the present service delivery domain for D/A services is in the progressive coordination and innovation of contemporary service models. As a non-provider in this space, WML is well placed to have a wide ranging and evidence based dialogue across the community, derive best practice models, and coordinate partnerships and implementation.

In this respect, integration partnerships lend a ready made methodology to perform this type of coordination role. Within the current integration partnership with the LHD, a number of possibilities for service restructure and innovative practice models become possible. Co-morbid treatment and therapy models will directly affect the way in which community D/A services are delivered, and the type of workforce training required to implement a changed model. The WML is unencumbered by restraining factors which may be experienced in the wider service delivery system, and can coordinate and create more efficiently, with more community partners, and within a shorter timeframe, than direct service providers.

Section 4 – Confirm priorities for action (Phase 4)

Table 7 - Phase 4 Selected Gate Review Items

Item Title	Complete?
Phase 4	
Presented the recommendation to the ML Board and gained endorsement.	√
Developed action plans for each initiative and implemented a stakeholder communication. strategy	√
Set up the post-CNA evaluation review process.	√

Discussion Box 4

Briefly describe:

- *The deliberations undertaken by the Strategic Leadership Group (or similar) / ML Board in confirming the priorities to be funded*
- *Next steps of the CNA process, including how the ML has communicated plans to implement the outcomes of the CNA process to the ML community*
- *How the ML proposes to evaluate the CNA process which was adopted*
- *How the ML will evaluate the success of the implemented strategies*

A collaborative approach was taken to confirming the priorities for action considering the triangulation matrix, previous needs assessments, and other relevant internal and external documents. The WML also held strategic and planning meetings to review program areas and develop strategic ideas considering issues, need and other critical factors such as data comparison, geographical inequalities, special needs groups and socio economic factors and social determinants of health, qualitative information, government priorities and budget. Other groups involved in this collaborative process were the steering group, executive, relevant Advisory Groups, and senior staff. Updates were provided at a Board level prior to the final draft being presented and endorsed.

The CNA outcomes will be available on our website and a summary report will be available for stakeholders and the community.

The CNA process will be evaluated through the original project plan reviewing both the successes and identifying areas for improvement. The WML would like to incorporate the CNA evaluation framework currently being developed by the Population Health Planning Group through the Alliance.

The success of the implemented strategies will be measured through individual program evaluation including KPIs, feedback on service satisfaction and usage from the community and our project partners.