



Queensland
Commonwealth
Partnership

Implementation Toolkit

A toolkit to support the
implementation of the
Joint Regional Needs
Assessment Framework



Version control

Version	Date	Comments
Version 1.0	27 March 2024	Living document.

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Introduction

This implementation toolkit has been developed to support the implementation of the joint regional needs assessment framework and should be read in conjunction with the main framework document. The toolkit provides guidance, with practical examples, to support regions to undertake joint needs assessments.

The toolkit will remain a living document and evolve over time as new examples are added to support regions in completion of their needs assessment. The intention is to evolve the toolkit from a document to an interactive web-based tool with clickable links to further information and examples.

Framework phases

As outlined in the framework, there are four phases involved in undertaking a needs assessment, outlined in Figure 1. The implementation toolkit will provide implementation support for each phase of the process.

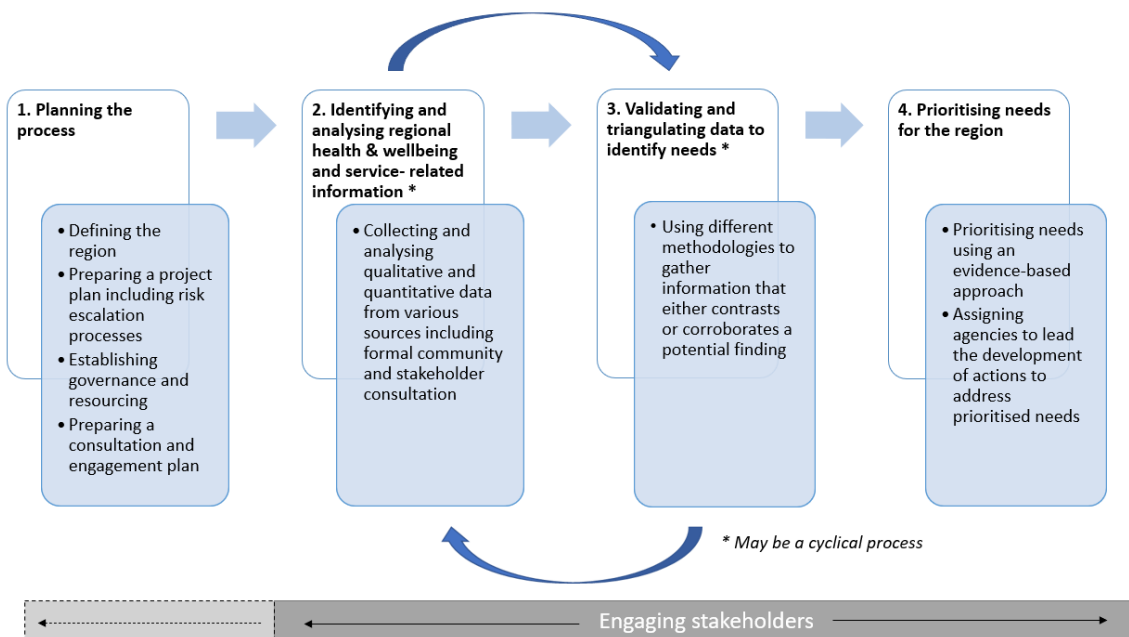


Figure 1 Needs assessment phases

Phase 1: Planning the process

As outlined in the framework, planning the process is the initial step in preparing for a collaborative approach to joint regional needs assessments.

Once the region is defined for which the needs assessment applies, the relevant partnered agencies can be determined. Agencies that may be part of the partnership may include, but are not limited to, PHNs, HHS, Aboriginal and Torres Strait Islander Community Controlled

Health Organisations (ATSI CCHOs), Queensland Ambulance Service (QAS), Health Consumers Queensland (HCQ), and/or consumer/s.

Establishing governance and resourcing

The process of joint regional needs assessments must be supported by strong governance arrangements, as outlined in the framework.

Each region is responsible for establishing a steering committee and project team. The steering committee provides leadership and oversight of the joint needs assessment processes within each region. Suggested steering committee membership includes senior representatives from the Hospital and Health Service, Primary Health Network, Aboriginal Community Controlled Health Organisations, senior leaders in health service planning, and clinical leaders/champions, as well as consumer representatives. Other members, including representatives from non-government organisations, may be added as appropriate for the region.

In addition to the steering committee, a dedicated project team should be established to conduct the joint regional needs assessment process under the direction of the steering committee. The project team should also have representation from partnered agencies to promote a collaborative approach. An example governance structure is shown in Figure 2, showing the structure for a single HHS region. In regions where there are multiple HHSs within the boundary of a single PHN, the structure below should be replicated in each HHS region. The PHN will then participate in multiple steering committees and project teams as they work with each HHS region.

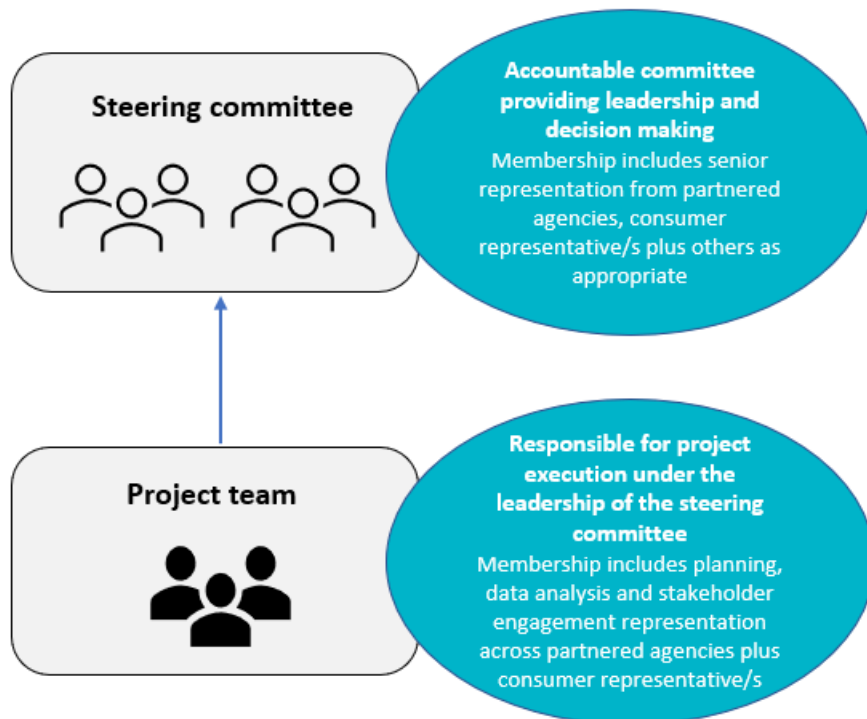


Figure 2 Governance diagram for the steering committee and project team

While regions determine their own structures and organisational processes to tailor the approach to the unique context of its region, it is expected that the region collaborates to ensure:

- adequate resources and skills are available to undertake the joint regional needs assessment,
- governance structures, including a dedicated group, are established to oversee and lead the process,
- formal processes and timeframes (e.g. a project plan) are in place for undertaking the joint regional needs assessment
- there are mechanisms to evaluate the joint regional needs assessment process and ensure continuous improvement,
- all parties are clear about the purpose of the joint regional needs assessment, including its use in informing the PHN Activity Work Plans, the HHS, the Australian Department of Health and Aged Care, and Queensland's Department of Health's program planning and policy development,
- further evidence can be provided to the Commonwealth DoHAC and Queensland's Department of Health, if requested, to demonstrate how a region has addressed the completion requirements of the joint regional needs assessment.

Phase 2: Identifying and analysing regional health and wellbeing-related and service-related information

The joint regional needs assessment must be informed by an appropriate mix of evidence, both qualitative and quantitative. This information may include quantitative data from various sources (see Appendix 1 – Reference data sources), qualitative information from engaging with stakeholders, as well as existing documents, previous needs assessment reports, and other relevant documentation. Processes regarding quantitative data collection and analysis and stakeholder engagement and collaboration are further described below.

Quantitative data

The joint regional needs assessment will be prepared based on critical data domains. The purpose of this approach is to support consistency and rigor when undertaking data collection and analysis as part of the needs assessment process. Data domains include:

- population data
- social determinants of health
- lifestyle factors
- preventative health
- mortality
- managing health conditions

- service mapping and utilisation
- workforce.

Additional consideration should be made to specifically assess health needs and service needs as they relate to the health associated Closing the Gap targets:

- Close the Gap in life expectancy within a generation, by 2031.
- By 2031, increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91 per cent.
- Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero.

Regions are expected, at a minimum, to obtain relevant and reliable data and undertake data analysis, using appropriate techniques and statistical methods, to inform each data domain. Moreover, all statistics and claims must be appropriately cited. When collecting and analysing First Nations peoples' data, partnered agencies must incorporate a consideration for the principles of Indigenous Data Sovereignty and Indigenous Data Governance. Further guidance on this process is in development and will be included in this toolkit once complete. An example list of data items for each domain are listed in Appendix 1. An associated data source for each item has also been recommended and should be considered its source of truth when including an item within your analysis. The list of data items is not exhaustive, nor is it a minimum dataset. Rather, data sources have been recommended to support statewide consistency, transparency, and efficiency in the collection and analysis of data. Additional local data may be considered, where appropriate, to inform a more granular local picture.

As the joint needs assessment process matures, and barriers to sharing data are removed, it is the objective to develop a centralised data portal. In the interim, joint regional needs assessments should share existing data across all relevant agencies working in partnership, to enhance transparency and a shared understanding of needs and avoid duplication of effort. Information from the monitoring and evaluation processes of commissioned activities should also be used where appropriate. Furthermore, analysis of data should leverage capability and capacity across partner agencies.

Where feasible and useful the most granular level of data (SA2) should be used for demographic analysis as part of the needs assessment; however, using SA2s for data analysis may have limitations, especially for smaller areas. Some regions regularly use different geographical structures in their local planning and analysis. It is important to investigate and identify issues and agree with relevant stakeholders which level will be used as part of the joint regional needs assessment, noting that this should be clearly communicated in the report.

Qualitative data from stakeholder engagement and collaboration

The stakeholder engagement and collaboration process, outlined in Figure 3 and covered in this section of the implementation toolkit, has been adapted from the Commonwealth Department of Health and Aged Care (2015) Stakeholder Engagement Framework and the AA1000 AccountAbility Stakeholder Engagement Standard (2015). This approach may be used as a guide to support planning and execution of stakeholder engagement throughout the joint regional needs assessment process.

The structured five-step process is designed to facilitate meticulous planning, thorough preparation, decisive action, and thoughtful evaluation of every engagement activity. Underpinned by the joint needs assessment engagement principles, outlined in this section, this dynamic and continuous cycle fosters a comprehensive approach to engagement, gradually constructing an evidence-based platform that serves as a foundation for continuous improvement over time. Joint stakeholder engagement and collaboration plans may be developed in accordance with this process; however, this is not a prescribed approach.

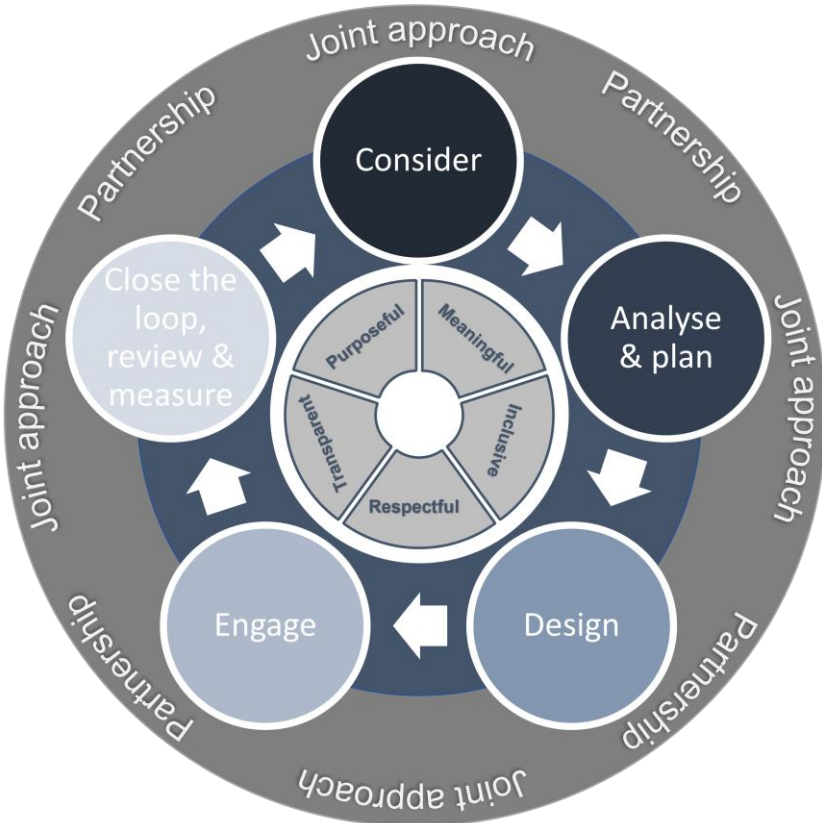


Figure 3 A joint stakeholder engagement process

Consider

At this stage of the process, partnered agencies should strategically consider their joint approach to qualitative data collection as part of their joint needs assessment process. Some areas for consideration should include:

Identifying existing qualitative datasets that may be leveraged in lieu of new engagement activities.

Stakeholder mapping; identifying critical stakeholders and stakeholder groups.

Defining critical success factors for the joint regional needs assessment engagement plan.

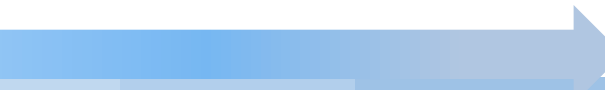
Analyse and plan

During the analysis and planning stage of the process, it is essential to profile relevant stakeholders. This process entails analysing mapped stakeholders to designate each a specific engagement level and method, or methods, of engagement. While there are various frameworks available to assist with this step, it's important to note that, due to its subjective nature, there is no one-size-fits-all approach. One such framework that can guide the stakeholder profiling process is the IAP2 Public Participation Spectrum (Table 1).

Stakeholder groups for mapping may include:

- consumers, parents, families, and carers
- healthcare providers and clinicians
- health professional networks
- healthcare workers
- relevant non-government organisations (NGOs)
- relevant peak bodies
- government departments
- consumer advocacy groups
- organisations and services

Table 1 Adapted IAP2 (2018) Public Participation Spectrum for needs assessment stakeholder engagement and collaboration*

INCREASING IMPACT ON DECISION 					
	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
Stakeholder participation goal	<i>To ensure stakeholders remain informed through the balanced and objective information provided.</i>	<i>To obtain stakeholder feedback on analysis, alternatives and/or decisions.</i>	<i>To work directly with stakeholders throughout the process to ensure concerns and aspirations are consistently understood and considered.</i>	<i>To partner with stakeholder / stakeholder group, in each aspect of the decision including the development of alternatives and the identification of the preferred solution.</i>	<i>To place final decision making in the hands of the stakeholder / stakeholder group.</i>

Commitment to stakeholder	<i>Partnered agencies will keep stakeholders informed at key milestones in the needs assessment process through informal communications.</i>	<i>Partnered agencies will acknowledge stakeholder input and provide feedback on how input influenced the decision.</i>	<i>Partnered agencies will ensure stakeholder concerns and aspirations are consistently understood and considered.</i>	<i>Partnered agencies will regularly communicate and partner with this group to formulate solutions and incorporate advice to the maximum extent possible</i>	<i>Partnered agencies will await final decision for this group before proceeding with planned activity. E.g. governance steering committee and executives leadership</i>
Example Engagement Methods	<ul style="list-style-type: none"> • Fact sheets • Websites and social media • Published needs assessment reports • Media releases 	<ul style="list-style-type: none"> • Surveys • Focus groups • One-on-one interviews • Observations • yarning circles 	<ul style="list-style-type: none"> • multi-stakeholder forums • advisory panels (e.g. clinical and consumer) • workshops 	<ul style="list-style-type: none"> • Partnerships • advisory panels (e.g. clinical and consumer) • Collaboratives • Communities of practice 	<ul style="list-style-type: none"> • Governance group meetings • Direct email communication

**Permission granted from IAP2 to adapt resource for the purpose of this implementation toolkit*

During stakeholder profiling, partnered agencies should systematically seek to understand each stakeholder / stakeholder group's:

- knowledge of the needs assessment process and the purpose and scope of the engagement,
- existing relationship with partnered agencies (close or distant; formal or informal; positive or negative),
- dependence on the organisation,
- willingness to engage,
- level of influence,
- type (NGO, government, consumer, etc.),
- cultural context,
- requirements to enable meaningful participation, for example, accessible documents and venues for consumers with disabilities. Clear and upfront communication about support that will be offered such as reimbursement or remuneration.
- geographical scale of operation,
- capacity to engage (e.g., language barriers, IT literacy, disability),
- legitimacy and representation, and
- relationships with other stakeholders.

Stakeholder profiling complements the analysis of partnered agencies' resources and organisational constraints, a practice highly encouraged at this stage of the process. Moreover, having a deeper understanding of specific stakeholders' representatives is beneficial. This insight aids in identifying whether additional efforts are required to build trust and strengthen relationships with these specific stakeholders.

Design

Prior to the execution of engagement, a detailed joint stakeholder engagement and collaboration plan should be developed.

Joint engagement and collaboration plans should, at minimum, contain the elements outlined in Figure 4:

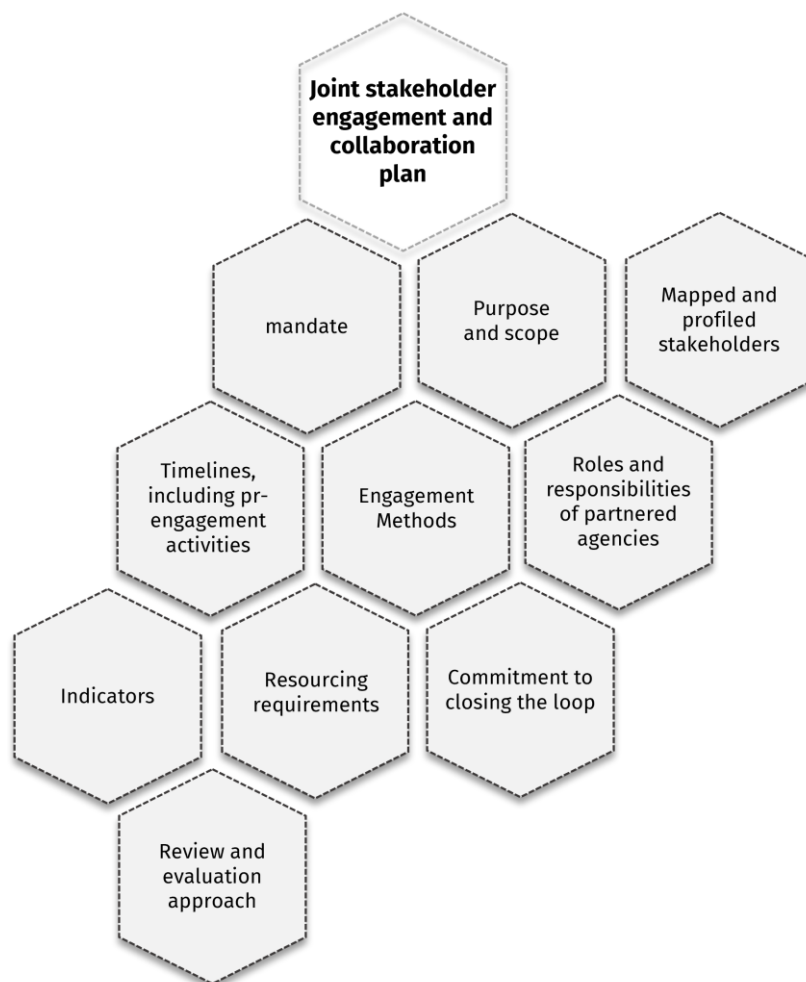


Figure 4 Recommended minimum constituents of a joint stakeholder engagement and collaboration plan (Adapted from AccountAbility (2015, p. 23))

Some potential engagement methods include:

- **Focus groups:** Getting a small group of people together to talk about their experiences and opinions.
- **Surveys:** Asking people to answer questions about their health and experiences.
- **Forums:** Organising events where people can openly discuss healthcare topics.
- **Workshops:** Holding interactive sessions to learn from people's insights and experiences.
- **Observation:** Watching and learning from how people interact with healthcare services.
- **Interviews:** Talking to individuals one-on-one to understand their personal

experiences and thoughts.

- **Yarning circles:** a culturally grounded and inclusive method of communication and collaboration, particularly within First Nations communities. This approach emphasises equal participation, open dialogue, and shared decision-making.

Engage

Implementation of the stakeholder collaboration and engagement plan will likely take place over several phases of the joint needs assessment process. It is critical to adequately brief stakeholders prior to any engagement activity to ensure they are fully prepared to participate. Engagement facilitators must ensure they seek informed consent from participants to share and use their feedback as part of the needs assessment process and wider health system planning. This entails the facilitator explaining the needs assessment process and how participants' input will inform it, providing all the pertinent information and allowing the potential participant ample opportunity to ask questions, voice concerns, or withdraw from participation. Facilitators must provide clear instructions to stakeholders about sharing or exchanging information and feedback, particularly if information is confidential and not for wider distribution. Partnered agencies should conduct all engagement in accordance with the joint needs assessment principles outlined in Figure 5, which have been developed in consultation with partnered agencies.

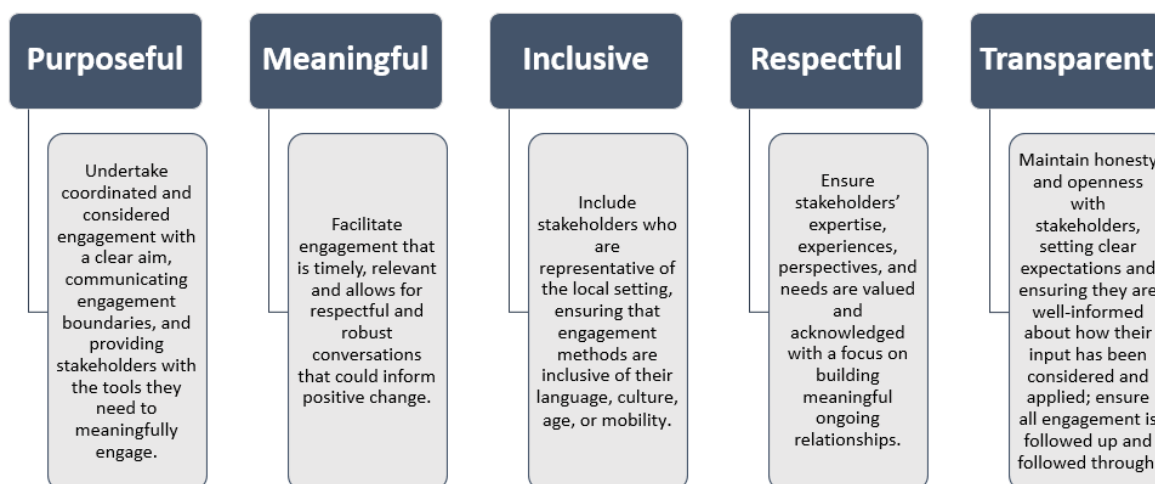


Figure 5 Engagement principles to guide consultation as part of joint needs assessments.

Inclusive and equitable participation

Inclusiveness is a fundamental principle among the five stakeholder engagement principles outlined in the joint regional needs assessment framework. Equitable engagement provides mutually beneficial opportunities for people to contribute to the joint regional needs assessment process and is mindful of power and privilege within engagement processes, institutions, and broader systems. Our dedication lies in collaborating with stakeholders who might experience barriers to participation due to factors such as language, culture, age, discrimination, or mobility.

Consider the following when planning to inclusive engagement:

Is this a "table" that everyone can access?

Can everyone at the “table” participate in meaningful discussion?

Do participants feel at ease at the “table”?

How will participants be assured they are being listened to and heard?

Will participants want to re-engage in the future?

Some stakeholder groups who may experience barriers include:

Note: the groups below are examples and not a comprehensive list. Be guided by your population and burden of disease data to identify groups or communities within the population who experience poorer health outcomes. Also note that there can be as much “in group” diversity amongst communities as there are differences across groups and cultures.

Aboriginal and Torres Strait Islander communities

First Nations First is a guiding principle underpinning all work carried out by the Queensland – Commonwealth Partnership, including the implementation of the joint regional needs assessment framework. Agencies involved in the joint regional needs assessment process should share power and decision-making with Aboriginal and Torres Strait Islander peoples and peak bodies. Governments are committed to the National Agreement on Closing the Gap, emphasising joint decision-making, support for community-controlled organisations, enhancement of mainstream institutions, data leadership by First Nations peoples, and improvement of socio-economic outcomes (Commonwealth of Australia 2020). Fostering Aboriginal and Torres Strait Islander community involvement is crucial throughout the joint regional needs assessment process, ensuring a genuine partnership and transparency. Respect for cultural governance and leveraging existing consultation and data are essential to enhance the quality of engagement. Regional needs assessment steering committees should include First Nations representatives, aligning with the principles of the 2020 National Closing the Gap Agreement (Commonwealth of Australia 2020).

Culturally and linguistically diverse communities

The integration of and cooperation with CALD groups can play a pivotal role in the joint regional needs assessment process. Collaborating agencies should capitalise on established partnerships and adopt best practice frameworks to connect with CALD communities. This includes the consideration of supplementary resources like interpreters or translators when necessary. It is imperative to develop and employ culturally sensitive and easily accessible engagement materials, incorporating plain English information in written, audio, or video formats to cater to diverse literacy levels and facilitate accurate translation (Queensland Health 2022). Additionally, agencies should explore culturally appropriate distribution channels to ensure adequate dissemination of information to these communities. Agencies should further collaborate with advocacy groups, CALD-specific organizations, and NGOs to leverage existing data and partnerships.

People from refugee and asylum seeker backgrounds

People from refugee backgrounds can be people seeking asylum or arriving as humanitarian migrants, as well as family members arriving on other visas, and children born in Australia to parents from a refugee background. People from refugee backgrounds are likely to be CALD and more likely to face physical, mental, emotional, social, cultural, and spiritual challenges because of their experiences (Queensland Health 2022). Almost 50 percent of humanitarian migrants are children, and many have complex health issues resulting from trauma, poverty, and immigration detention (Queensland Health 2022). When jointly assessing regional needs, partnered agencies should recognise barriers that these communities may face in accessing health service information and commit to high quality engagement strategies that are culturally appropriate and accessible to CALD communities. This would include supporting the use of plain English and culturally appropriate

information distribution or, ideally, the use of interpreters when consulting with CALD groups. Partnered agencies should also seek to collaborate and partner with advocacy groups, settlement services, refugee specific organisations, and NGOs to leverage existing data and collaborations (Queensland Health 2022).

People with disabilities

People with disability have diverse, unique, and individual regional needs and experiences. Overall, people with disability report poorer general health and higher levels of psychological distress than people without disability (Australian Institute of Health and Welfare 2022). They also have higher rates of some modifiable health risk factors and behaviours, such as poor diet and tobacco smoking, than people without disability (Australian Institute of Health and Welfare 2022). People with disability have the right to equitable access to healthcare services in their region, whether that is to meet their general healthcare needs, or any additional health needs they may have as a result of disability.

When jointly assessing these regional needs, partnered agencies should make health information available in easy-to-follow formats; for example, including plain language with images, audio captioning, and accessible print formats to make material accessible for people with hearing, vision, and cognitive impairments (Queensland Health 2023). Inclusive and respectful engagement with consumers, peak bodies, and the disability sector will provide a comprehensive understanding of the regional needs of the disability community.

Supporting people experiencing homelessness or at risk of homelessness

The impacts of homelessness and disadvantage on health outcomes is substantial. Individuals experiencing homelessness and disadvantage are more likely to have co-morbidities and experience mental illness. Individuals experiencing homelessness and disadvantage are also less likely to access health services that are available. Studies have identified an association between at least one episode of homelessness with premature mortality (Seastres et al. 2020). Unstable housing situations further can inhibit access to effective health care leading to an increased level of unmet health need (Australian Institute of Health and Welfare 2021). This lack of accessible health care can have an exacerbating effect on existing health conditions and increase the chronic disease burden of the community.

Partnered agencies should consider engagement with peak bodies, NGOs, and local advocacy groups to accurately capture the needs of homeless and disadvantaged groups in their communities. Collaboration with dedicated homeless health services should be pursued, to leverage existing data related to health experience. The utilisation of tools such as the Homeless Health Access to Care Tool (Currie et al. 2022) could also be considered as a guide for and to inform the joint regional assessment of the needs and experiences of this vulnerable group.

People living with mental illness

Meaningful, inclusive, and respectful engagement with carers and mental health service consumers with different levels of regional need should be pursued, with a genuine commitment to the co-production of the joint regional needs assessment that can successfully measure the needs and identify outcomes in a mental health context (National Mental Health Commission n.d.). Deliberate engagement with people with lived experience of suicide, community managed organisations, ATSI CCHOs, National Disability Insurance Scheme (NDIS) providers, Local Area Coordinators, private providers, and social service agencies can provide a comprehensive assessment of the regional needs. Consideration must be made to unmet regional needs in a mental health context, as those suffering from severe or complex mental illness can be classified as vulnerable and hard to reach (Rens et

al. 2020).

The inclusion of consumers, carers, or people with lived experience as partners and in working groups, with shared responsibility in the co-design process, can ensure regional mental health needs and expectations are addressed (National Mental Health Commission n.d.).

People experiencing domestic and family violence

Domestic and family violence refers to any violent behaviour between family members, partners, or carers. Violence can include physical, sexual, emotional, social, verbal, spiritual, and economic abuse (Mission Australia n.d.). There is evidence that a lack of coordination between services, particularly between services such as health and police, contributed to the death of victims of domestic homicide (Special Taskforce on Domestic and Family Violence in Queensland 2015a).

When engaging with people who have or are experiencing domestic and family violence, it is important to listen and believe them, so they feel validated and heard. This can be an empowering experience for a person affected by violence. Consider that gender differences in terms of awareness, attitudes, and behaviours may be evident, so structure any focus groups or engagement strategies with this in mind, e.g. female only groups and male only groups, with facilitators reflecting the same gender (Special Taskforce on Domestic and Family Violence in Queensland 2015b). Other considerations include ensuring that:

The emotional and physical safety of participants is protected before, during, and after their involvement in any engagement.

Safety concerns raised during the focus group are adequately responded to (e.g. through appropriate counselling support or referral to services).

Engagement is carefully conducted by trained facilitators who are able to address any safety concerns that arise during the group discussions.

People who identify as LGBTIQ+

There is evidence that LGBTIQ+ people face disparities in terms of their mental health, sexual health, and rates of substance abuse (Australian Institute of Health and Welfare 2018). LGBTIQ+ people also experience higher rates of discrimination, stigma, and rejection because of their identity or sexual orientation (Patel and Kazi 2022). There is rich diversity of experiences within the LGBTIQ+ community, even within groups who share the same identity. It is important to understand these diverse experiences by being an active listener, respecting the privacy of individuals, avoiding assumptions, and using correct pronouns (IDAHOBIT 2023). For example, it is important to not ask LGBTIQ+ people about their bodies, surgical status, or sex lives, unless you have explicit permission to do so.

Close the loop, review and measure

Partnered agencies should include a commitment to ‘closing the loop’ with stakeholders who have been engaged as part of the joint needs assessment process. Following up with stakeholders on the outputs of engagement supports the development of deeper and ongoing relationships with stakeholders by building trust and demonstrating the value of their input. When ‘closing the loop’, there may be an opportunity to provide an evaluation survey encouraging feedback that supports reviewing and measuring joint engagement and collaboration activities.

Monitoring and evaluating is essential for enhancing performance and achieving results, and aims to improve the current and future management of engagement outputs, outcomes, and impact. It involves assessing each engagement individually, followed by aggregating

and evaluating information included as part of the qualitative data collection process. The evaluation of outputs (action plans, activity results) and outcomes (decisions, actions, results) should seamlessly integrate with overall sustainability and performance monitoring, providing valuable feedback for the joint needs assessment process.

Lack of a thorough review and evaluation of a stakeholder engagement activity makes it challenging to assess the effectiveness of the approach and identify necessary changes. Neglecting the review process diminishes the opportunity to learn from and enhance engagement. The joint stakeholder engagement and collaboration plan should incorporate periodic review checkpoints during engagement processes, allowing flexibility for adjustments when required.

Identification and analysis of health and wellbeing-related and service-related information

Health and wellbeing-related information

Each region will undertake a health needs identification and analysis process to understand information relating to the health of individuals and communities within their region. This process makes use of a range of demographic, epidemiological, and consultative data sources, as well as analysis of needs previously identified through other processes, including any previous joint regional needs assessments. The focus of the regional health needs analysis moves progressively from the overall community health status, characteristics of specific populations or conditions, and narrows towards an identification of needs for the region. When identifying health needs it is helpful to consider the level of detail obtained about a health need; for example “mental health” versus a specific mental health condition such as “anxiety”. Sometimes this may be further drilled down by age or population if the need is specifically relevant to a population subgroup or age cohort; for example, the health need may be “anxiety in people over 65 years”.

Elements that form part of the identification of health and wellbeing-related information include (but are not limited to) the following, noting that these elements may be tailored to the context of the region:

1. Demographics

A variety of demographic data should be used in order to understand the region’s population profile and project changes over time. Population trends can be significant indicators of current or future regional health needs (e.g. an ageing population).

2. Determinants of health

Health determinants are factors that impact the health of individuals and communities including their social, economic, and physical environments, and the person’s individual characteristics (including health literacy). Essential indicators related to the region’s determinants of health are listed in the minimum dataset.

3. Health status

A range of data sets should be examined, alongside the outcomes of stakeholder consultation, to identify the overall health status of the community. Consideration should also be given to the burden of communicable disease and injury, with techniques for either disaggregation or synthetic estimates at a granular level. Essential indicators related to the region’s health status are listed in the minimum dataset.

4. Population groups with different needs

The joint regional needs assessment should involve an explicit consideration of populations with non-disease related needs to identify issues or inequities specific to the region that may have been less evident in the preceding analyses. These population groups may include people with a disability, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, people in prison, and refugees. Note that this is not an exhaustive list and consideration should be given to specific populations and their characteristics within the region.

Service-related information

Service issues identification and analysis promotes understanding of a region's existing services and health infrastructure across the care continuum, with a focus on efficiency, effectiveness, and coordination. A service issues analysis includes the distribution of the workforce and services across the region, characteristics of specific locations, and service types. It can narrow in on specific locations, service types, or relationships between services that are likely to be important for the region. The elements that may be included should be identified using a mixed methods approach.

Elements of the regional service needs assessment include (but are not limited to) the following, noting that these elements may be tailored to the context of the region.

1. Service mapping

Service mapping involves identifying and documenting the range of services available within the region, across the care continuum, and the kinds of relationships that exist between services. Service mapping can also include consideration of the system's ability to deal with public health emergencies (such as an influenza pandemic) and issues around regional coordination that may impact on emergency preparedness.

In undertaking service mapping, regions should consider service:

- Location – physical location and opening hours of primary and secondary services including any services provided outside the region which are accessed by people from within the region. For rural areas this would also include outreach services.
- Utilisation – including data from the Medicare Benefits Schedule, Pharmaceutical Benefits Schedule, Queensland Hospital Admitted Patient Data Collection (QHAPDC) as well as inpatient, emergency department, and outpatient activity data. This should include consideration of under-utilisation, duplication, and waste.
- Accessibility – including financial, cultural, and disability barriers, access to primary care and specialist services, and access to services after hours.
- Capability – including the Clinical Services Capability Framework for hospitals in the region as well as the skills and competence of service providers across the care continuum.
- Acceptability – such as culturally safe care, or a patient's experience and satisfaction.
- Quality – including markers of quality and safety within the hospital environment and practice accreditation and PIP enrolment within the primary care environment.

2. Distribution of services

In analysing service needs, regions should consider how ATSI, PHN, and HHS boundaries impact their region's health system capacity and performance. This can include issues such as cross-border utilisation, distribution of services, referrals in and out of centralised services (such as large teaching hospitals, specialist, and allied health services), and the location of specialist imaging or diagnostic services. Variations in services provided by different local government authorities within a region may also be relevant.

3. Workforce mapping

Regions should analyse the health workforce data for their region. This could include the:

- size and distribution of workforce by type of service,
- workforce characteristics (e.g. full or part time, reliance on locums, public versus private, qualified but not working in health care etc.),
- formal relationships and communication channels between professional groups.

4. Market analysis

The region should be alert to how the health market operates in their region, as well as how it has changed since the previous needs assessment process. This includes considering elements of the market not currently active in health care but where there are potential opportunities for engagement, such as informatics or business models from other sectors.

5. Efficiency and effectiveness of health services

These should be measured through how well a service's outputs achieve its objectives, and at what cost. Components to investigate include access, quality, appropriateness, and cultural competency for First Nations or CALD communities.

6. Coordination and integration of services

Regions should analyse the level of coordination and integration of health care services in the region, where there are opportunities for improvement, and the presence or absence of services that seek to directly address coordination. Evidence could include:

- shared health records and other e-health initiatives,
- examples of integrated service delivery,
- models such as the Patient Centred Medical Home,
- transitions between acute care and primary care,
- coordination between general practice and allied health,
- linkages between health and social services (aged care, disability services, youth, child and family services, housing),
- referral patterns and use of HealthPathways and [Clinical Prioritisation Criteria](#).

7. Strengths and weaknesses

This final step combines the evidence gathered to reflect on the strengths and weaknesses of the region's services and health infrastructure. This synthesis further builds on the PHN and HHS's understanding of their region and informs the next step of the needs assessment process, being assessment and prioritisation.

Phase 3: Validation and triangulation

As part of the joint regional needs assessment process, information from stakeholder consultations, quantitative analyses, and existing documentation should be triangulated to better understand the issues impacting on a region. Triangulation enables validation of data through cross verification from three or more sources to test the consistency of findings. Triangulation should include checking these issues against those identified in previous needs assessment processes undertaken locally. As part of the validation process, identified health and wellbeing-related and service-related information that has been corroborated through a triangulation process will enable the identification of health needs and service needs for the region.

Triangulation and validation processes

Bradshaw's taxonomy of need

As part of the joint regional needs assessment process, a variety of health and wellbeing-related and service-related information will be identified. These needs can be conceptualised using Bradshaw's taxonomy to support the identification, validation, and understanding of health needs and service needs (Bradshaw, 1972). Bradshaw conceptualises need into four types, which are outlined in Figure 6:

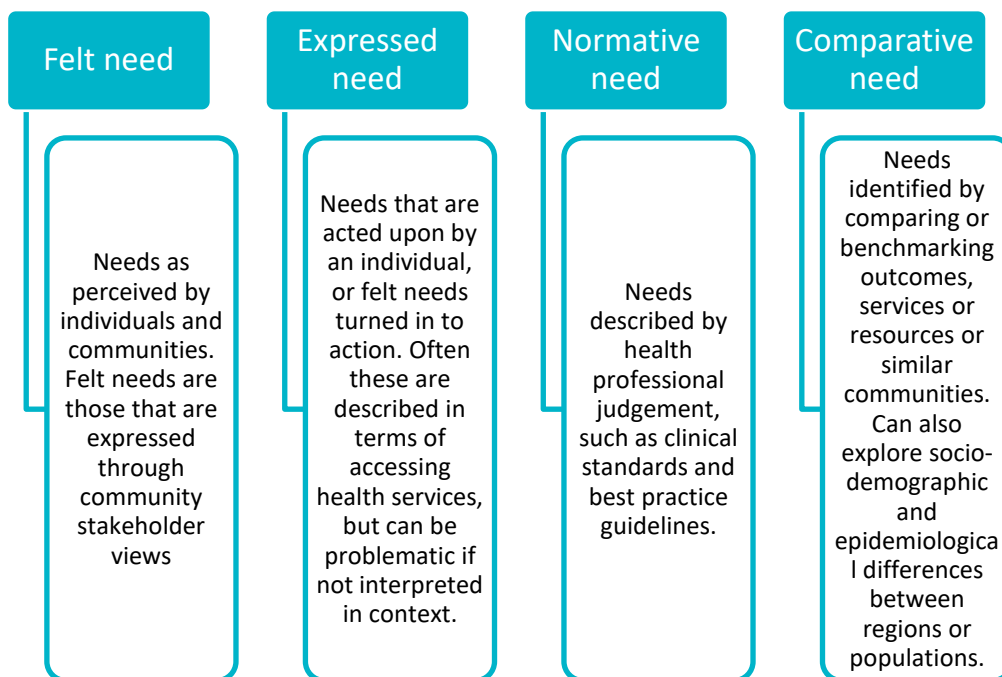


Figure 6 Bradshaw's taxonomy of need

Triangulation

Triangulation should be undertaken to develop a rich understanding of how the health and wellbeing-related and service-related information interrelate. Triangulation involves using different methodologies to gather information that either contrasts or corroborates a potential finding. It involves considering the different kinds need outlined in Bradshaw's taxonomy to describe needs and view them from different perspectives to see how these perspectives intersect. This process improves consistency and supports the verification and validation of results (Quinn, 1999); for example, if specific health and wellbeing-related and service-related information is identified through quantitative data, reports, interviews, or engagement methods, triangulation can be used to cross-validate and establish the authenticity of the identified need. This approach ensures that conclusions are made with a strong basis in reliable and comprehensive information. An example of the steps involved in triangulation are shown in Figure 7.

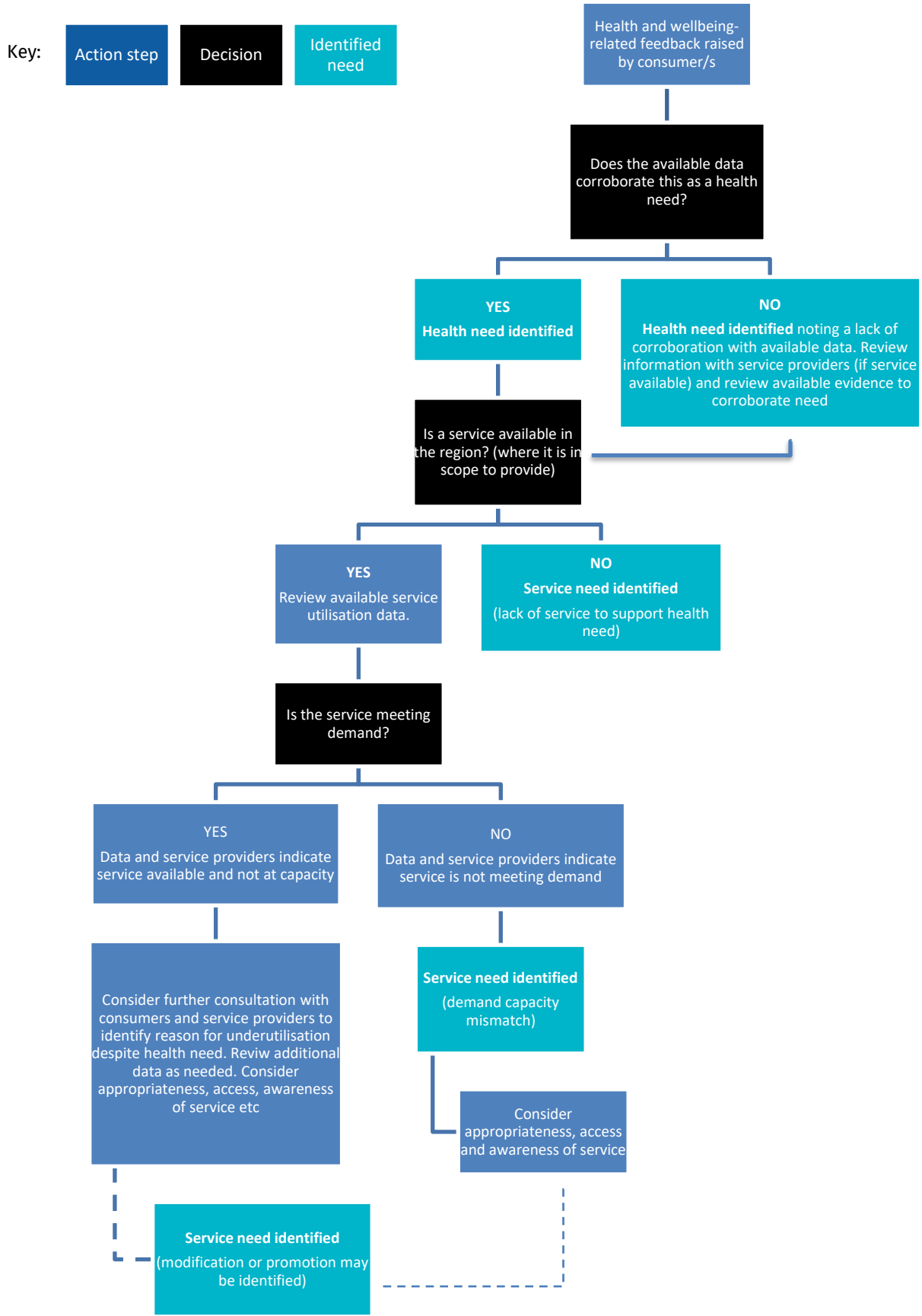


Figure 7 Example of triangulation process

Given the complexity involved in triangulating information from multiple sources, a matrix can be used to systematically review the identified health and wellbeing-related and service-related information. The triangulation matrix method shown here is one method that can be used to confirm major themes, patterns, and key issues identified through the needs assessment process. Here, triangulation can be used to verify the issues identified through community and stakeholder consultations with the findings of the analyses of data or service utilisation patterns.

The matrix shown in Table 2 below is an example of how various sources of information can be cross-checked with feedback, health-related data, or service usage information.

Table 2 Example of a triangulation matrix

Health and wellbeing-related and service-related information	Community / consumer feedback	Service provider feedback	Health-related data analysis	Service-related data analysis	Triangulation result: Health or service need identified?

Preparing for priority setting

Once the regional needs are themed, the project team and steering committee should develop a list of regional health needs and regional service needs, based on the joint regional needs assessment and validation process, to focus on during priority setting.

Phase 4: Prioritising needs for the region

Following the identification, analysis, and validation of regional health needs and service needs the steering committee and project team should, collectively, prioritise these needs by developing a single list of prioritised needs for the region, where possible. While the project team provides subject matter and process expertise, the steering committee provides governance and decision making authority over the assessment and prioritisation of needs.

To ensure fairness and credibility, the process of prioritisation must be based on transparent criteria, grounded in evidence, informed by strategic priorities, comprehensible, and available for everyone to see. There should be a diverse group of people from across stakeholder groups involved in these decisions, so everyone's voice is heard, noting, it is essential to be aware of any potential biases that might influence the decision-making process, and these should be mitigated where possible.

Prioritising needs for the region builds upon the validation and triangulation of need. Any method utilised should be discussed and supported by the steering committee, prior to its execution. An option to prioritising needs for the region is to use explicit prioritisation criteria detailed below to inform the development of a prioritisation matrix.

Prioritisation matrix

The project team, supported by the steering committee, may choose to develop and use a prioritisation matrix to prioritise needs for the region. Developing a prioritisation matrix allows for the evaluation of needs against a number of prioritisation criteria.

A matrix should list 'needs' vertically down the y-axis and 'prioritisation criteria' horizontally across the x-axis. This means that each row in the matrix represents an identified need and each column represents a prioritisation criterion.




The main advantage of using a prioritisation matrix is that it provides an objective method for prioritising need that works well with explicit prioritisation criteria. It can also be used as evidence for addressing challenges with stakeholders when needs are prioritised differently to what they may be expecting. The method is also compatible with the use of data analysis and other information obtained from 'Phase 2: Identifying and assessing regional health and wellbeing-related and service-related information phase'. Finally, the prioritisation matrix accounts for criteria with varying degree of importance, although, selecting and agreeing on weighting of criteria can be a challenge.

One of the disadvantages of the prioritisation matrix is that it can be difficult to use when there are a large number of needs to prioritise. However, this can be mitigated by agreeing on an initial shorter list of needs for inclusion in the prioritisation matrix. Also, establishing rankings that are based on the prioritisation matrix scores alone (i.e. without further deliberation) can result in unintended consequences. Therefore, adopting a combination of techniques with the prioritisation matrix (such as consensus voting) offers a more effective approach.

Developing prioritisation criteria

To assist with prioritising needs for the region, one method is to develop prioritisation criteria, prior to the generation of a matrix. An example of prioritisation criteria used by the Brisbane South PHN is shown below and may be adapted for local use.

Table 3 Example of prioritisation criteria – adapted from Brisbane South PHN Needs assessment report

<p>Criteria 1. Scale/magnitude of the issue</p>	
 <p>This criterion aims to understand the scale and magnitude of the issue. This can be observed through the incidence or prevalence of an issue across the population of interest.</p>	<p><i>How many people does this issue affect?</i></p> <p><i>How widespread is the issue?</i></p>
<p>Criteria 2. Impact of the issue</p>	
 <p>This criterion aims to understand the size and nature of the impact that the issue has on people affected by it. This can be thought of as the potential implications, costs or risks of inaction.</p> <p>For a health need, this impact might relate to the burden on health and wellbeing. For a service need, this might relate to the impact on the ability of the service system to effectively respond to the health needs of the population.</p> <p>In addition to the size of the impact of the issue, it is also important to consider equity. That is, how equitably (or not) the impact is felt or experienced across the population, particularly when considering portions of the community experiencing greater levels of vulnerability.</p>	<p><i>How much of an impact does this issue have?</i></p> <p><i>Does the issue have an inequitable impact on more vulnerable groups in the community?</i></p> <p><i>What is the impact of not taking action?</i></p>
<p>Criteria 3. Level of endorsement</p>	
 <p>This criterion aims to validate that the issue is genuinely an issue through the subjective endorsement (or dis-endorsement) of it, based on the professional expertise and wisdom of participants in the prioritisation process.</p> <p>It should be noted that this criterion is intentionally subjective. There will be limitations in the data and information that is available on any issue. For this reason, validating each issue using the subjective opinion of informed and</p>	<p><i>How much do you agree that this is a valid issue from your perspective?</i></p> <p><i>How well do the findings that support the issue align</i></p>

knowledgeable stakeholders against the triangulated findings is reasonable. *with your own expertise and experience?*



Criteria 4. Scope

This criterion aims to prioritise issues that relate to, or are likely to have, a response that falls within the remit of the partnering agencies.

This criterion also considers 'feasibility' to some extent in the context of how the

issue can be addressed through a regional approach.

Does the issue fall into the remit of one or more of the partnering agencies?



Criteria 5. Effectiveness of system response

This criterion aims to prioritise issues that are not likely to be adequately or effectively addressed through the current system response.

This helps to identify issues that are lower relative priorities if there are adequate existing resources and responses.

Likewise, it helps to identify issues as higher relative priorities when there is no, or a highly ineffective, system response to the issue at present.

How well can the issue be addressed at a regional level?

How appropriate or effective is the current system response to this issue?

Rating needs against prioritisation criteria

After developing the suite of criteria, each need is rated against each criterion by a predetermined rating scale, such as:

- 1 = criteria not met,
- 2 = criteria slightly met,
- 3 = criteria met,
- 4 = criteria met well,
- 5 = criteria met exceptionally well.

Weighting criteria

In addition, some criteria may be deemed more important than others and, therefore, may be more heavily weighted.

For example, a weight of 0.5 is assigned to 'Risk of unmet need' and a weight of 0.25 is

assigned to 'Balancing need and benefit', meaning that the 'Risk of unmet need' criteria is twice as important as 'Balancing need and benefit'.

Determining priority score

The next step is determining the overall 'priority score' for each need, by adding together the result from each of the criteria (ie. rating x weight).

A sample prioritisation matrix is provided below in Table 4, noting that the weightings are an example only and each region should determine weightings and criteria appropriate to their region.

Table 4 Sample prioritisation matrix

	Criteria 1 (Rating x Weight)	Criteria 2 (Rating x Weight)	Criteria 3 (Rating x Weight)	Criteria 4 (Rating x Weight)	Criteria 5 (Rating x Weight)	Priority Score
Weighting	1.0	0.5	0.2	0.1	0.1	
Need A	2 x 1.0 = 2.0	1 x 0.5 = 0.5	3 x 0.2 = 0.6	3 x 0.1 = 0.3	4 x 0.1 = 0.4	3.8
Need B	3 x 1.0 = 3.0	2 x 0.5 = 1.0	2 x 0.2 = 0.4	2 x 0.1 = 0.2	5 x 0.1 = 0.5	5.1
Need C	1 x 1.0 = 1.0	1 x 0.5 = 0.5	1 x 0.2 = 0.2	1 x 0.1 = 0.1	1 x 0.1 = 0.1	1.9

Prioritising needs for the region – a practical example

Note that this example shows the use of the five criteria outlined in the above example.

Step 1: Identifying need

Phase 2 and 3 identified the following as needs:

Need A – access to sleep testing services for people with signs of obstructive sleep apnoea

Need B – access to podiatry services for people with diabetes

Step 2: Identifying criteria

Criteria will have been identified as part of the prioritisation process for the region. In this case, five criteria will be used

Criteria 1: Scale/magnitude of the issue

Criteria 2: Impact of the issue

Criteria 3: Level of endorsement

Criteria 4: Scope

Criteria 5: Effectiveness of system response

Step 3: Weighting criteria

Criteria should then be weighted based on their overall importance to the community's health and the partnering organisations.

Criteria 1: Scale/magnitude of the issue (score = 1.0)

Criteria 2: Impact of the issue (score = 0.5)

Criteria 3: Level of endorsement (score = 0.2)

Criteria 4: Scope (score = 0.1)

Criteria 5: Effectiveness of system response (score = 0.1)

Step 4: Rating of need against criteria

Based on the collated evidence, each need should be rated against each criteria.

1 = criteria not met

2 = criteria slightly met

3 = criteria met

4 = criteria met well

5 = criteria met exceptionally well

WORKINGS –

The below examples show the workings of two criteria of the five for simplicity

For sleep testing:

- **Rating against criteria 1 Scale/magnitude of the issue = 2 (slightly met)**

Sleep apnea only affects around 5 per cent of people. It was decided to rate this as 'met'.

- **Rating against criteria 2 Impact of the issue = 4 (well met)**

Health conditions related to sleep apnea include insomnia, depression, cardiovascular disease, cerebrovascular disease, obesity and asthma. These conditions are quite serious and widespread. It was decided to rate this as 'met well'.

Need	Scale/magnitude of the issue (Weight x Rating)	Impact of the issue (Weight x Rating)	Priority Score
sleep testing	1.0 x 2 = 2.0	0.5 x 4 = 2.0	4.0

For podiatry:

- **Rating against criteria 1 Scale/magnitude of the issue = 3 (met)**

Access to podiatry is especially important for people with diabetes, which is a widespread condition in the community.

- **Rating against criteria 2 Impact of the issue = 5 (exceptionally well met)**

A diabetic foot ulcer occurs in approximately 15 percent of patients with diabetes. Health conditions related to lack of podiatry services include high levels of amputations, which is a very severe outcome. It was decided to rate this as 'met exceptionally well'.

Need	Scale/magnitude of the issue (Weight x Rating)	Impact of the issue (Weight x Rating)	Priority Score
podiatry	1 x 3 = 3	0.5 x 5 = 2.5	5.5

Step 5: Priority ranking

Sleep testing total priority score was 4, while podiatry total priority score was 5.5. Therefore, podiatry scored higher and as a result, is deemed a high priority need than sleep testing.

Priority rank	Need	Scale/magnitude of the issue (Weight x Rating)	Impact of the issue (Weight x Rating)	Priority Score
1	podiatry	1 x 3 = 3	0.5 x 5 = 2.5	5.5
2	sleep testing	1 x 2 = 2	0.5 x 4 = 2	4

Note: If two needs obtain the same priority core, it is at the discretion of the project team, supported by the steering committee, to decide which need is a higher priority.

Conclusion and next steps

The framework describes the process for finalising the Joint regional needs assessment paper and using this as the basis for reports for each partnered agency.

It is intended that this implementation toolkit will continue to evolve as regions use the framework to undertake joint regional needs assessments resulting in examples of processes that can be shared with others, with permission of the relevant region.

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Appendix 1 – Reference data sources

This framework outlines critical data domains to be included when undertaking joint regional needs assessments. The purpose of this approach is to support consistency and rigor when undertaking data identification and analysis as part of the needs assessment process. Data domains include:

- population data
- social determinants of health
- lifestyle factors
- preventative health
- mortality
- managing health conditions
- service mapping and utilisation
- workforce.

Additional consideration should be made to specifically assess health and service needs as they relate to the health-associated Closing the Gap targets:

- Close the Gap in life expectancy within a generation, by 2031.
- By 2031, increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91 per cent.
- Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero.

A list of example quantitative data items to inform each domain are provided within this appendix. An associated data source for each item has also been recommended and should be considered its source of truth when including an item within your analysis. The list of data items is not exhaustive, nor is it a minimum dataset. Rather, data sources have been recommended to support statewide consistency and transparency in the collection and analysis of data. Data sources for each item have been selected with consideration for trustworthiness, reliability, contemporariness, and granularity. Furthermore, having a prevailing source of truth for population-level data provides a baseline for the amalgamating of needs assessments across geographical and jurisdictional boundaries. Additional local data may be considered for collection and analysis by partnered agencies to inform a richer local picture; with the inclusion of qualitative data, this will inform a robust understanding of a region's health needs and service needs.

The approach of this framework provides a scaffold that supports the in-depth collection, analysis, and triangulation of data to inform the prioritisation of local health needs and service needs. By adequately collecting data for each domain prescribed within this framework, partnered agencies may undertake analysis through a wide range of lenses. For example, by applying a life-stage lens to the data, partnered agencies may analyse regional health needs and service needs as they pertain to the first 2000 days of life. Moreover, by taking this consistent statewide approach to data collection, it will support the future objective to have a centralised, shared data portal, with needs assessment data presented and accessible to all partnered agencies within Queensland.

Example data sources

Source	Link
Australian Bureau of Statistics (ABS)	https://www.abs.gov.au/
Australian Institute of Health and Welfare (AIHW) data collections	https://www.aihw.gov.au/about-our-data/our-data-collections
Queensland Health Planning Portal	https://qheps.health.qld.gov.au/cps/spb/html/planning_portal
Public Health Information Development Unit (PHIDU)	https://phidu.torrens.edu.au
Queensland Government Statistician's Office (QGSO)	https://www.qgso.qld.gov.au/
Australian Early Development Census	https://www.aedc.gov.au/resources/detail/public-table-by-statistical-area-level-(sa3)-2009-2021
GEN aged care	https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Home_care_report/Home-Care-Data-Report-3rd-Qtr-2021-22.pdf
Heads Up	https://hwd.health.gov.au/headsupp/
Other population health data and statistics	https://www.health.qld.gov.au/research-reports/population-health
NDIS Registrants	https://data.ndis.gov.au/datasets/participant-datasets

Example data items

Data item	Recommended data source
Population data	

Geographic area	QGSO
Remoteness score	QGSO
Total Population ERP	QGSO
Community/sub regions population	QGSO
Population growth previous 5 years and next 5 years	QGSO
Population projections	QGSO
Population by Age – child, youth, adult, older	QGSO
Populations by sex	QGSO
Indigenous population % and number	QGSO
Language other than English at home	QGSO
Country of birth	QGSO
Resident in Australia for five years or more and born in NES countries	PHIDU
Annual Births	ABS
NDIS Registrants	NDIS
Fertility rate	QGSO
Social determinants of health	
Reported Offences	PHIDU
SEIFA score	ABS
Education – highest level of schooling	ABS
Total family income	QGSO
Unemployment rates	ABS / Jobs and Skills Australia, Small Area Labour Markets (QGSO)
Financial hardship	PHIDU
Access to housing	QGSO

Overcrowding	PHIDU
Household composition	QGSO
% children developmentally vulnerable	PHIDU
Percentage of population living in need of assistance with a profound or severe disability	QGSO
Non-medicare card holders	AIHW
Lifestyle factors	
Obesity rates (adult)	QPHS
Adult adequate Fruit intake	QPHS
Adult adequate Vegetable intake	QPHS
Physical activity (adult)	QPHS
Smoking rates (adult)	QPHS
Alcohol consumption (adult)	QPHS
Average unhealthy days (adult)	QPHS
Self-assessed health	PHIDU
Obese mothers	Perinatal data collection
Smoking during pregnancy	Perinatal data collection
Preventative health	
Premature births	Perinatal data collection
Low birthweight	Perinatal data collection
Cancer screening rates: Breast Bowel Cervical	AIHW
Immunisation rates	PHIDU
Vaccine Preventable Diseases	Commonwealth Department of Health
Mortality	

Life expectancy	PHIDU
Years of life lost	PHIDU
Premature mortality rates	PHIDU
Infant mortality rate	PHIDU
Leading causes of Death	QLD Death Registry
Avoidable deaths	QLD Death Registry
Managing health conditions	
Incidence/Prevalence rates of selected diseases and conditions	ABS/AIHW/QGSO
Chronic disease plans (MBS, 2013–14 to 2018–19)	AIHW
Mental and psychological distress	PHIDU
Rates of suicide	PHIDU
Service mapping and utilisation	
Service mapping - capacity of supply to meet demand, incl market analysis	HHS, Health Contact Centre, PHN
QAS – Health Contact Centre activity	Health Contact Centre
Mental health care plans (MBS, 2013–14 to 2018–19)	AIHW
Aboriginal and Torres Strait Islander health checks (MBS item 715 and 228, 2018-19)	AIHW
Number of Aboriginal Community Controlled Health Services	NACCHO
Average number of GP attendances per person	AIHW
Services delivered by GPs (MBS, 2013–14 to 2018–19)	AIHW
Services delivered by Allied Health Professionals (MBS, 2013–14 to 2018–19)	AIHW
Barriers accessing healthcare	PHIDU

Bulk billing rates	Medicare/AIHW
Frequent GP attenders	AIHW
After hours GP usage rates	AIHW
GP attendances to residential aged care	AIHW
Percentage of population that did not see a GP	AIHW
NDIS participants	NDIS
Lowest service-related groups by total relative utilisation	QHAPDC
Activity by GPOHS clinic	Office of Chief Dental Officer
Activity by CAOHS	Office of Chief Dental Officer
Residential aged care places	ABS/QGSO
Number of antenatal visits	Perinatal data collection
Oral Health activity - OOS by service provision catchment versus patient resident catchment	Office of Chief Dental Officer
Potentially preventable hospitalisations	QHAPDC
Aged standardised rates of PPH	QHAPDC
Total admitted separations for PPH dental related conditions (primary diagnosis)	DSS
Average number of attendances per person	Medicare
Hospitalisations - Total admitted patient hospital episodes for all conditions and overnight and same day	QHAPDC
Relative utilisation of private and public hospital services	QHAPDC
Mental health hospitalisations per 100,000 people	AIHW/QH
Local hospital self-sufficiency rates – secondary & tertiary	QHAPDC
ED presentations	EDIS
Emergency department statistics - arrival by ambulance - admission rate	SPR, EDIS

Potentially unnecessary ED presentations	EDIS
Estimates of unmet need for assistance for 1-4 activities	ABS & Department of Social Services
Hospital beds per capita	AIHW
Elective surgery wait times	SPR
Elective procedure wait times	SPR
Outpatient wait times	SPR
Number of outpatient service events	QHNAPDC
Service events	QHNAPDC
Virtual Bed Separations	QH
Service performance analysis - capability of supply to meet demand (efficiency (cost), effectiveness (outcomes), integration)	HHS
Workforce	
Number of GP clinics by sub region and hospital catchment	PHN
Registered health workforce by Profession	Commonwealth Department of Health
Workforce FTE per 1000 population by Profession	AIHW
GP FTE per 1000 people	AIHW
Medical FTE per 1000	AIHW
Nursing FTE per 1000	AIHW
Allied Health FTE per 1000	AIHW
Indigenous health workers FTE per 1000 population	AIHW
Mental health practitioners per 1000 population	AIHW
District of workforce shortage for GPs	Doctor Connect website, Commonwealth
Percentage of workforce identifying as First Nations	Commonwealth Department

of Health

Workforce mapping - capacity and capability of supply to meet demand

HHS and PHN