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HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

PRIMARY HEALTH NETWORK

Needs Assessment and Planning

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Hunter New England and Central Coast (HNECC) PHN acknowledges the traditional custodians of the lands we walk, reside and work upon. We pay our respects to First Nations people and value the continued connection to culture, country, waterways and contributions made to the life of our vast region.

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Contents

Abbreviations

DoHAC	Department of Health and Aged Care
GP/GPs	General Practitioner/s
HNECC PHN/PHN	Hunter New England and Central Coast Primary Health Network
IAP2	International association for public participation
LGA	Local Government Area
LHD	Local Health District
NA	Needs Assessment
NGOs	Non-Government Organisations
PPERs	Primary Health Network Program Electronic Reporting System

Definitions

Equity	Equity is the absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. Health equity is achieved when everyone can attain their full potential for health and well-being. [5] Health and health equity are determined by the conditions in which people are born, grow, live, work, play and age, as well as biological determinants. Structural determinants (political, legal, and economic) with social norms and institutional processes shape the distribution of power and resources determined by the conditions in which people are born, grow, live, work, play and age.[5] Equity in healthcare is not about treating everyone the same, but rather acknowledging and addressing the unique challenges and needs of different individuals and communities to ensure that healthcare services are delivered in a just and unbiased manner. [5]
General Practitioners	A General Practitioner (GP) plays a central role in the delivery of health care to the Australian community. In Australia, the GP:[4] - Is most likely the first point on contact in matters of personal health - Coordinates the care of patients and refers patients to other specialists - Cares for patients in a whole of person approach and in the context of their work, family, and community - Cares for patients of ages, sexuality, and disease categories - Cares for patients over a period of their lifetime - Provides advice and education on health care - Performs legal processes such as certification of documents or provision of reports in relation to motor transport or work accidents. [4] General practice is a medical specialty.[4]
Health planning	Is the orderly process of defining health problems, identifying unmet needs, and surveying the resources to meet them, establishing priority goals that are realistic and feasible, and projecting administrative action,

	concerned not only with the adequacy, efficacy and efficiency of health services but also with those factors of ecology and of social and individual behaviour that affect the health of the individual and the community.
International Association for Public Participation (IAP2)	IAP2 Australasia is recognised as an affiliate of the International Associations for Public Participation. As a not-for-profit organisation their aim is to advance the community engagement profession by providing training in, and communicating the principles of, public participation and how to achieve effective community and stakeholder engagement (or public participation). [14] IAP2 Australasia: - Leads the national conversation on authentic community and stakeholder engagement. - Advocates for genuine community and stakeholder engagement in alignment with the IAP2 Quality Assurance Standard for Community and Stakeholder Engagement. - Leads the professionalisation of the engagement sector through education, events, professional development, research and standards.[14] IAP2 definition of engagement Engagement is an intentional process with the specific purpose of working across organisations, stakeholders, and communities to shape the decisions or actions of members of the community, stakeholders, or organisation in relation to a problem, opportunity, or outcome.[14]
Needs Assessment	A Needs Assessment is a method of identifying the health needs of a population. It informs a PHN's understanding of their region by ensuring they undertake a detailed and systematic assessment of the regional population's health needs, the local health care services, and engage in stakeholder and community consultation.[8] This process identifies service gaps, key issues, and sets the regional priorities.[8] The Needs Assessment process consists of both analysis and assessment. Analysis is the examination and documentation of the region's health and service needs. Assessment is where the PHN determines priorities. Conducting a Needs Assessment must involve: · population health planning and an analysis of the health needs of the PHN region · reviewing and identifying market factors and drivers of health services in the PHN region · analysing the relevant local and national health data · identifying service gaps or market failures · stakeholder and community consultation and market analysis · determining priorities for the PHN to address through commissioning.[8]
Primary health care	Primary health care is the entry level to the health system and, as such, is usually a person's first encounter with the health system. It includes a broad range of activities and services, from health promotion and prevention to treatment and management of acute and chronic conditions.[2]
Primary healthcare providers	Primary healthcare is a term used to describe a range of healthcare providers who work in the community. Any healthcare professional who

	is the first point of contact for the health system can be a primary healthcare provider.[1] Most people visit their GP (sometimes referred to as the 'local doctor') as a first step when they have a health problem that is not an emergency. The primary healthcare system also includes allied health professionals, such as dentists and physiotherapists. [1]
Primary healthcare settings	Primary health care services are delivered in settings such as general practices, community health centres, allied health practices, and via communication technologies such as telehealth and video consultations. General practitioners (GPs), nurses, nurse practitioners, allied health professionals, midwives, pharmacists, dentists, and Aboriginal health practitioners are all considered primary health care professionals.[2]
Quintuple aim	The Quintuple AIM approach helps ensure optimal services are delivered to meet local health needs while enhancing consumer experience, improving population health, reducing costs, consideration of overall provider satisfaction and enhancing health equity. The Quintuple AIM approach forms the centre of the HNECC commissioning process. It remains patient-centred to deliver the best health outcomes.[13]
Activity Work Plans (AWP)	Activity Work Plans (AWPs) are one of three deliverables to the Department of Health and Aged Care, the other two are the Needs Assessment and the 12 Month Report, as part of PHN funding agreements. Updates to Activity Work Plans are required every April or four weeks from the execution of a funding variation. The purpose of the AWP is to seek approval by the DoHAC for PHN activities in response to the funding schedule requirements, and in accordance with the appropriate funding guidelines.
Strategic direction	The PHN sets its Strategic Direction each five-years. As part of this process the PHN Board and Executive team review the most recently prioritised needs (usually from the preceding November) and identify the strategic challenges the region is facing in the context of primary care. The strategic direction outlines how the PHN will respond to these challenges and prioritise its work to improve population health and access across the region.

Introduction - Our PHN context

The Primary Health Network (PHN) is a not-for-profit organisation funded by the Commonwealth government to improve the efficiency and effectiveness of the primary health care system. The PHN is not a direct provider of services, instead it commissions and manages a range of service agreements with organisations to deliver primary health care programs in areas of identified need.

Our Primary Health Network works with health care providers across the Hunter, New England and Central Coast deliver a range of primary health care services that meet identified needs and close service gaps for people living in our region. We analyse and integrate information and data to identify needs, support health planning and health service delivery in our region.

Our region is vast in geographical terms and diverse in terms of its communities. Covering 130, 000 square kilometres, it stretches from the QLD border in the north to Gosford in the south, and west past Narrabri and Gunnedah, and incorporates 23 Local Government Areas. The region has a population of 1.2 million people who live in small rural villages, in regional towns and in densely populated urban centres (see figure 1).

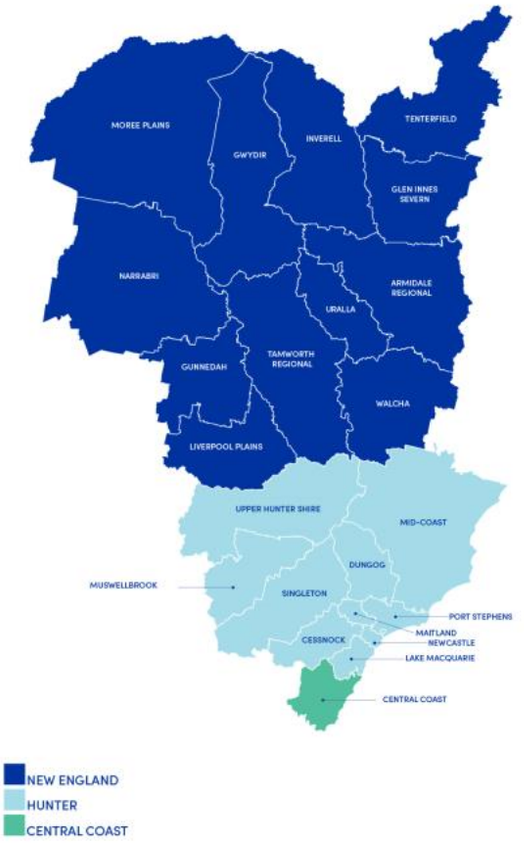


Figure 1: HNECC PHN region map

The Hunter New England and Central Coast Primary Health Network's (PHN) vision is "Healthy People, Healthy Communities".

This Needs Assessment and Planning Framework outlines in two distinct parts a systematic method for identifying and assessing the needs of people living in the Hunter, New England, and Central Coast region and subsequently developing and prioritising activities to address these health needs. Part 1 of the Framework outlines the Needs Assessment (NA) process and Part 2 articulates the subsequent PHN planning processes to ensure need informs strategic planning and activity planning including funding investment, projects, health improvement and service planning, and partnerships.

The NA is a key deliverable to the Department of Health and Aged Care (DoHAC) and is the first stage in the broader PHN commissioning framework. It provides the basis for planning and commissioning of services. The NA is updated in full every three years, with annual reviews and updates when required to respond to emerging needs. Deliverables to DoHAC are demonstrated in figure 2 below.

The PHN undertakes Strategic Planning every five years. The outcomes of the most recent NA are used to identify strategic challenges the PHN can address and respond to.

Activity Work Plans (AWPs) are another DoHAC deliverable, due annually in April. All activities included in AWPs respond to the PHNs strategic challenges and are mapped to individual needs identified through the NA.

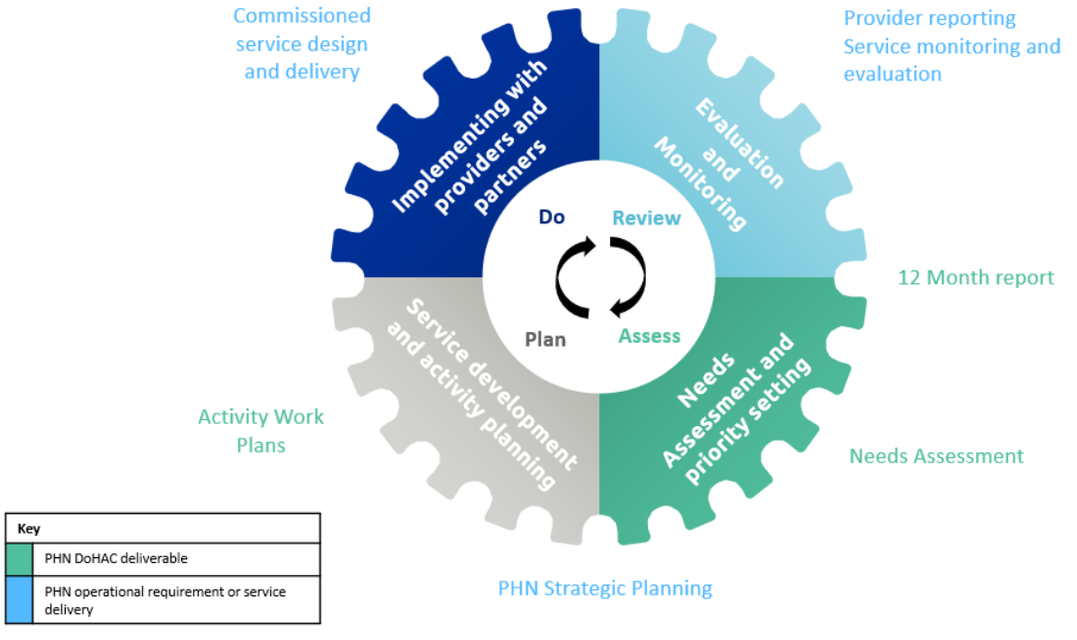


Figure 2: PHN Planning and Activity Development Model

Part 1: PHN Needs Assessment

1.1 Needs Assessment and Planning Purpose

This Framework has been developed to provide the PHN with guidance for a comprehensive and systematic approach to NA and priority setting.

It is designed to assist the PHN to work with their local communities, health professionals, stakeholders, and partners to build a clear picture of critical population health issues/needs and to determine priorities for action.

These priorities and evidence-based interventions can be used to inform PHN investment in activity and funding sources, and to inform shared strategies with local partners.

The Framework (and the supporting *toolkit, Appendix A*) provides the PHN with an indication of best practice when undertaking the NA, guidance, tools, and resources to support the process. For program specific NA, the Framework should be viewed in this light, noting that for some programs there may be better and more tailored methods to address elements of the NA, these approaches can be used so long as they ensure the NA tasks outlined are addressed. It also provides an outline of the PHNs process for using the NA to inform Strategic Planning and Activity Work Plans.

1.2 Needs Assessment objectives and scope

The objective of the NA is to:

- Work in partnership with the community and consumers and primary health care providers;
- Assess the health status of the population and identify the key health issues/needs and problems for the region, including risk factors and burden of disease;
- Identify the population groups or localities most affected and identify the social determinants at play and/or health inequities present;
- Understand the health care needs of PHN communities through analysis of what services are available and help to identify and address service gaps where needed, including rural and remote areas;
- Confirm the priorities and short and medium-term strategies and actions that will have a positive impact on the health of the population and the effectiveness and responsiveness of the primary health care system;
- Consider evidence of the types of interventions available to address the health issue(s)/need(s) or concerns effectively and opportunities for change;
- Review the current capacity of the primary health care system including gaps in the programs and services and opportunities to improve coordination and collaboration and the responsiveness of care and ensure value for money; and
- Consider available financial resources and strategic investment, and disinvestment, of funds to implement and continue strategies and actions.[8]

Figure 3 demonstrates the scope of the NA, its interaction with the PHN's Strategic Planning process and the organisation's goals of commissioning of healthcare services.[16]

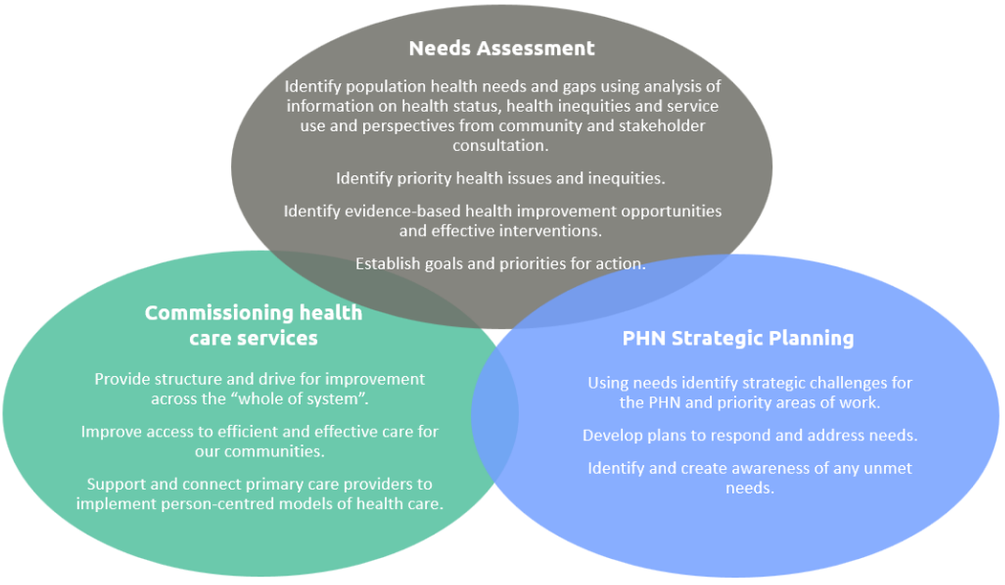


Figure 3: PHN Needs Assessment scope[16]

1.3 Our Guiding principles

Comprehensive – The Framework is comprehensive and covers all facets of primary health care. It considers specific population groups, the social determinants of health and health inequities. It promotes clear objectives and a transparent priority setting process and encourages the adoption of best practice principles to assess population health issues/needs and gaps in primary care services and systems.

Flexible and scalable – The Framework's principles and activities are sufficiently flexible to address the unique circumstances of the PHN. It is scalable so the PHN can use the principles and activities to investigate a specific program area, community, or population group in sufficient depth.

Practical – The Framework is simple and easy to use. At the same time, it provides sufficient guidance and detail to assist the PHN to make informed and robust decisions on opportunities to improve the health of their population and to use resources efficiently and effectively.

Action-focused – The Framework focuses on facilitating the PHN to determine clear strategies for action where implementation and results can be measured over time.

Person-centred - The Needs Assessment provides the basis of the PHN's understanding of the health needs of people living in the region, including differences experienced by population groups, and is used to inform the way it plans and commissions health services through its commissioning processes. The PHN aims to consider the person, rather than a condition to be treated. It involves seeking out and understanding what is important to people, their families, carers, and support people, fostering trust and establishing mutual respect. This approach helps to provide tailored and coordinated primary health services that respect people's individual needs, preferences, and values. Person-centred care helps to achieve better patient outcomes and experiences.

Place-based- During the Needs Assessment process the PHN engages with communities to build its understanding of local communities and their health needs. Through this process the PHN aims to develop a shared understanding of local context, and emerging health issues. An outcome of this

process can be the identification and subsequent recommendation of specific activities, based around shared outcomes, that reflect locally agreed priorities and can be implemented through place-based commissioning or co-designed activities, in partnership with the community. The PHN has a large and diverse footprint ranging from large populations in cities to small regional towns with small populations. Needs and services will vary related to their geographic location and should be adaptable in a place-based context.

Nationally consistent – The Framework ensures national consistency, uses standard terminology and a suite of core approaches. The Framework supports the aggregation and comparison of the information for 'assessing needs' and 'priority setting' provided by PHNs.

The Framework has been informed by the strategic directions and goals set out in the National Health Reform Agreement and in key national primary health care policies and frameworks such as *Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy* [6] and the *Future focused primary health care: Australia's Primary Health Care 10 Year Plan 2022-2023* [7] agreed by the Commonwealth and the State and Territories. These directions and goals describe the shared national vision, priorities and strategic outcomes for primary health care and identify four strategic outcomes:

- Build a consumer-focused integrated primary health care system;
- Improve access and equity;
- Increase the focus on health promotion and prevention, screening, and early detection; and
- Improve quality, safety, performance, and accountability.

The Framework has also been informed by the DoHAC Needs Assessment guidance [6,7,8.]

1.4 Understanding social determinants of health and health equity

It is imperative to apply an equity lens to the broader societal and economic factors that impact population health. This lens involves recognising the profound influence of social determinants, including factors like education, employment status, gender, ethnicity, housing, access to clean water, and nutritious food, as well as living and working conditions, transportation, geographic isolation, and social and community networks, on the health and well-being of the population[4,5]. By considering these determinants, along with individual lifestyle choices and personal attributes, a more comprehensive perspective on health needs and potential obstacles and solutions emerges. This broad perspective is instrumental in addressing persistent health inequities and disparities in health outcomes among various population groups and communities. Figure 4 (below) provides an overview of both the social and biomedical determinants of health.[4,5.]

Figure 4: Influences of health [4]

The connection between social and economic circumstances and disparities in health is widely acknowledged. It is a well-established fact that priority populations generally experience poorer health outcomes and face greater barriers to accessing healthcare services.[4] One of the key challenges lies in ensuring that the NA consistently integrates considerations of health inequity throughout all its stages and the priority setting process. [4] This approach is critical for comprehending the distinct needs of the priority populations and for assessing the relative effectiveness of interventions of strategies aimed at addressing their specific requirements. This can involve, for instance, adapting service models to enhance accessibility and appropriateness or implementing primary healthcare interventions and service strategies proven to be effective for priority populations. To facilitate this approach, the PHN will use health equity assessment tools as part of the NA process. [4]

An equity-focused perspective can also illuminate opportunities to collaborate with other sectors and institute 'whole of government strategies' to address broader determinants of health within certain communities. It encourages the coordinated implementation of health promotion and population health programs to comprehensively address the well-being of the population.[4,5]

This emphasis on understanding and addressing health inequalities and disparities in the NA process plays a pivotal role in informing health planning and shaping the subsequent actions:

- Tailoring services: recognising health inequities allows health planners to tailor services to the unique needs of priority populations. By adopting service models to enhance accessibility and appropriateness, healthcare services can become more effective and responsive.
- Effective strategies: identifying effective strategies for priority population groups is made possible by understanding their distinct requirements.

1.5 Quintuple AIM

The Quintuple AIM (see figure 5) helps ensure optimal services are delivered to meet local health needs while enhancing consumer experience, improving population health, reducing costs, consideration of overall provider satisfaction and enhancing health equity. The Quintuple AIM forms the centre of the HNECC commissioning process. It remains patient-centred to deliver the best health outcomes.

The Quintuple AIM for healthcare improvement

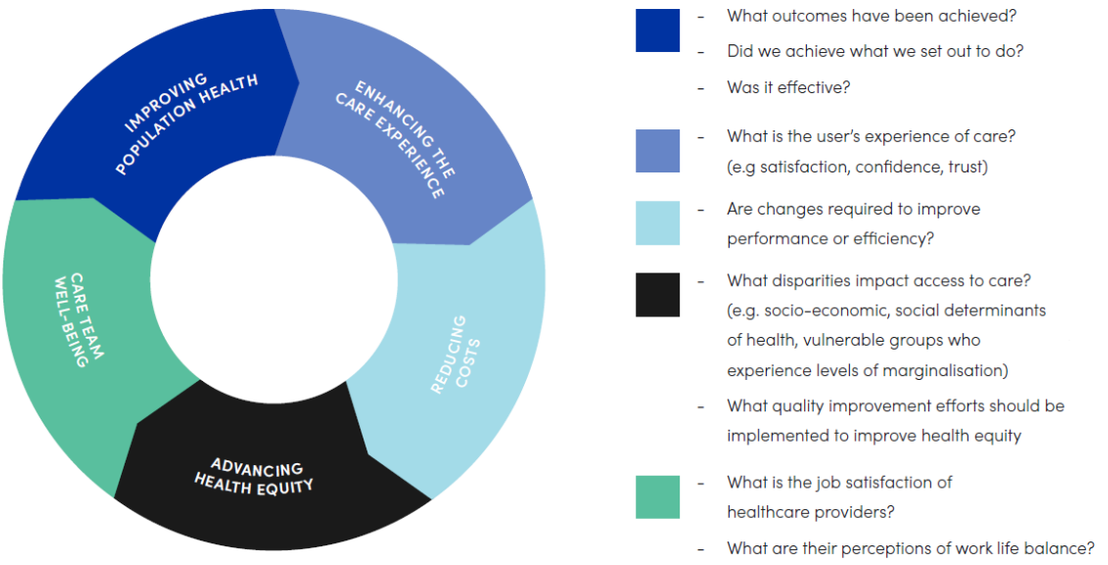


Figure 5: Quintuple AIM

1.6 PHN needs, our approach

The PHN implements a combination of the following methods to inform its NA process and prioritisation of needs:

- Epidemiological-based needs assessment that focuses on disease incidence, service availability and models of care;
- Comparative approaches where the service capacity of one area or region is compared to that of a peer;
- Economic models that assess the cost-effectiveness or cost–benefit of different health care interventions and their relative contributions to health gain;
- Triangulation and synthesis of information on health needs, service availability and community expressed needs; and
- Validation of needs identified which are confirmed through community consultations.

These methods assist to use available evidence to determine the most appropriate health interventions for the Hunter New England and Central Coast regional population, manage current or emerging health conditions and risk factors, and deploy or advise upon measures and or approaches likely to deliver the most effective and efficient outcomes for communities. [10]

1.7 PHN Needs Assessment triennial timeline

To complete the PHN's Needs Assessment successfully and thoroughly and ensure time is taken to understand the needs of the region. The longer NA process is conducted across the three years between the required Department of Health deliverable (see figure 6).

Year 1 is dedicated to the region's needs, focusing on service needs and the health needs of the population of the region's 23 LGAs.

Year 2 utilises the prioritisation from the health and services needs assessment to identify communities and priority populations that would benefit from further investigation and undertakes "deep dives" to ensure the needs of those communities are understood thoroughly and place-based commissioning can be developed as a response if and as appropriate. Information obtained in Year 2 can be used to inform the annual needs assessment to DoHAC but is not a mandatory deliverable.

Year 3 the planning team undertakes further work to understand specific health conditions impacting the region, either within identified populations or more broadly the entire population. This information is either provided into a non-mandatory annual update or, contingent on the findings, will be fed into the next full needs assessment Year 1 process.

Throughout the three-year cycle, the PHN may also undertake funding or program specific needs assessments, which are also reported in the annual update or full needs assessment.

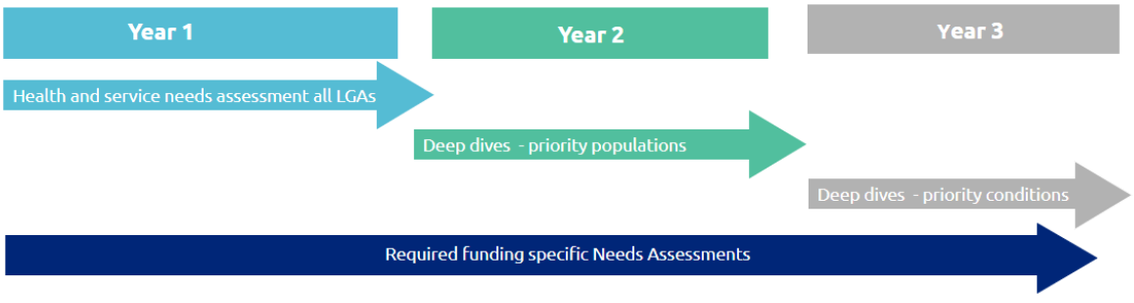


Figure 6: Triennial needs assessment investigations

The PHN implements an iterative NA process, continuously concentrating attention and analysis on priority issues and needs for action. This process involves four key steps, as outlined in Figure 7. below.

1.8 Key Needs Assessment steps

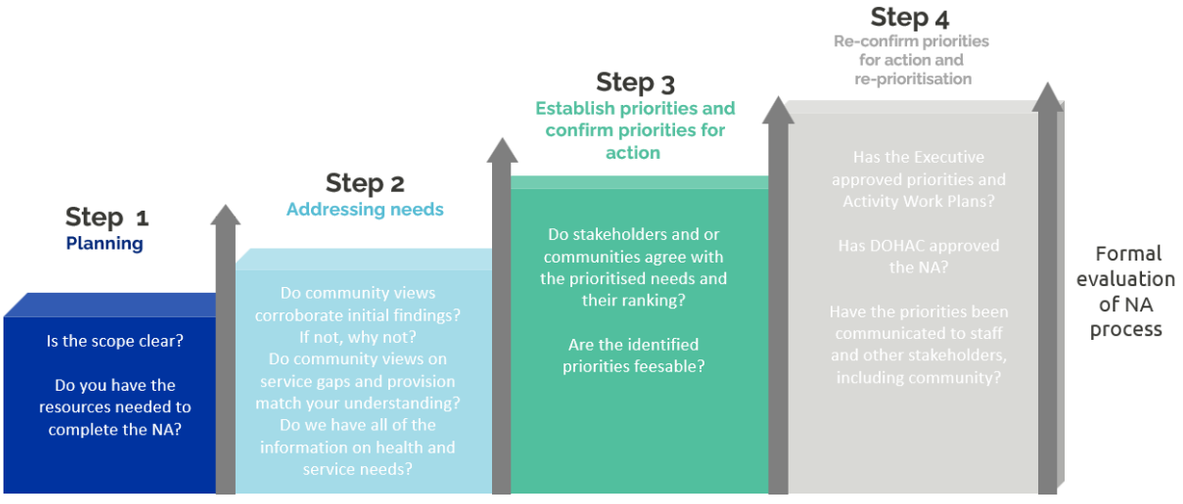


Figure 7: Overview of the PHN's stepped approach to Needs Assessment phases

Iterative and ongoing refinement- At the conclusion of each step, a formal review is conducted, marking the steps' completion, or indicating the necessity to revisit specific activities for full completion. This iterative process involves a progressive narrowing of focus as it advances.

Evaluation and integration- Following the NA process, the PHN should assess their experience and glean valuable lessons to enhance subsequent NA activities. This, in turn, lays the groundwork for improving consultation and information gathering procedures in the future. NA is a recurring process, periodically verifying current evidence and spotlighting emerging issues and needs.

Monitoring progress and change- Employing approaches that enable the PHN to gauge progress and change over time is crucial. While over shorter periods of time it is difficult to see significant changes at a population level, individual changes at an LGA level may be more visible and may become evident at an LGA profile level.

Mandate for enacting change- The five phases outlined in the framework below, encompass both "assessing need" and "priority setting," represent the initial steps in any strategic planning process. In essence, conducting a NA is a systematic process that involves gathering and analysing information, considering community and stakeholder views, and identifying priority health issues, needs, or service gaps within a population. This process also considers evidence-based interventions and strategies to achieve desired improvements, ultimately leading to priority setting and action planning.[10]

NA in the realm of healthcare can be broad, focusing on various aspects such as population health needs within a region or a specific local catchment. Alternatively, it can zero in on specific health problems or conditions like diabetes or mental health. Given that the NA primarily deals with incremental changes, ongoing evaluation enables the PHN to make well-informed resource allocation decisions.

Furthermore, NA serves as a foundation for informing the planning and development of health services. This can encompass addressing gaps in general practice access across a region, planning for expansions in allied health or mental health services, or reshaping service models to provide more extensive access to multidisciplinary disease management services.

While the PHN primarily focus on primary care initiatives and programs, its purpose is to increase equity of access to primary care services. They also provide support to clinicians and service providers in their efforts to improve patient care. Consequently, the NA and PHN have a comprehensive scope, examining the healthcare continuum to understand community needs, identify opportunities for service integration and coordination, implement relevant population health strategies, and develop locally tailored primary healthcare services that align with local catchment needs and priorities.[8]

1.9 Needs Assessment and Planning Framework

The five phases of the PHN's Needs Assessment and Planning Framework are visualised in Figure 8, below.

Below we introduce the key focus within each phase of the process. The details for each are provided in *The Needs Assessment and Planning Toolkit.*

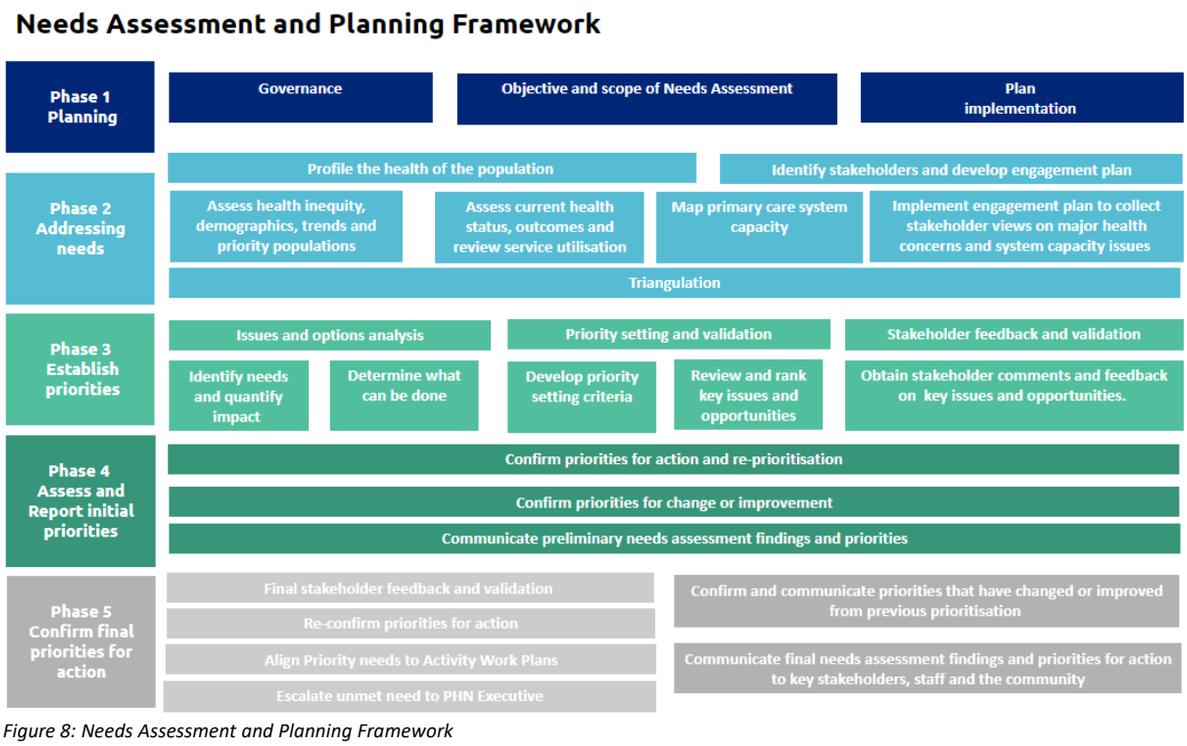


Figure 8: Needs Assessment and Planning Framework

Phase 1 Planning

Phase 1 includes planning the objectives and processes involved in undertaking a NA. This includes determining the scope and objectives of the NA. During *Phase 1*, the PHN planning team will appoint a project lead, develop a NA project plan describing timelines, data and information-gathering methods, the stakeholder and community engagement process, a communication plan, resourcing and technical skill requirements, and a risk management strategy. Key processes in *Phase 1* are summarised in Table 1 below.

Table 1: Phase 1 Key Processes

Phase 1: Planning

Governance

Objective and scope of NA

Plan implementation

Governance

The PHN has a skills-based board of Directors, including the CEOs of the Hunter New England and Central Coast Local Health Districts. Our executive team is made up of our CEO and five executive managers (see figure 9).

Clinical Councils and Community Advisory Committees provide our board and executive with local clinical and community perspectives.

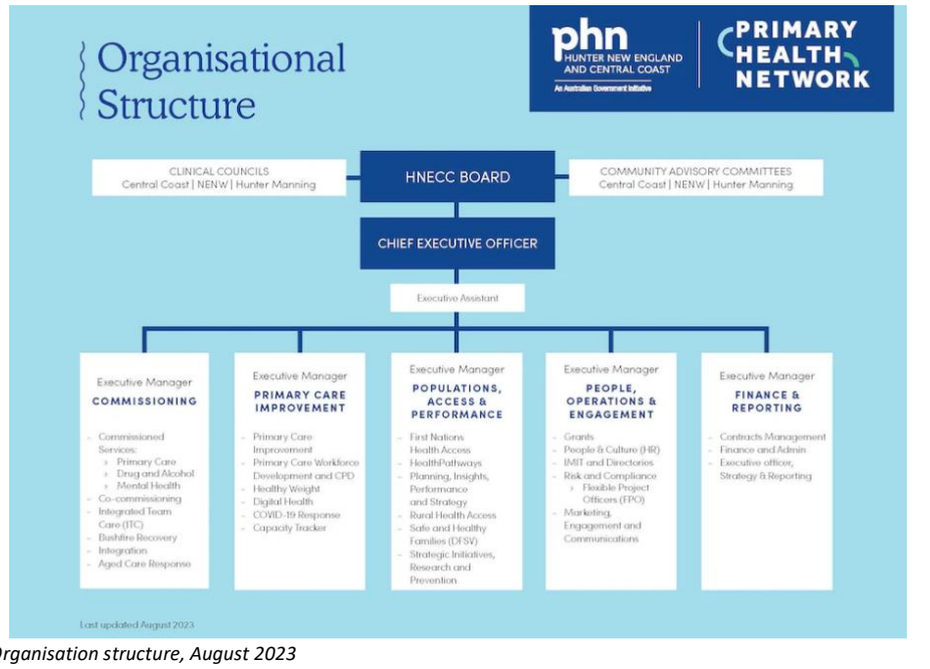


Figure 9: PHN Organisation structure, August 2023

Objective and Scope of Needs Assessment

The objective of the NA is to develop an evidence based, prioritised list of health needs across the Hunter New England and Central Coast region that reflect community consultation and input. The prioritised needs will inform PHN Strategic direction, activities in response to DoHAC and result in commissioned services and programs that address health needs. These services and programs will

be monitored and evaluated, and this information will be used to inform further iterations and updates to the needs assessment.

Objectives

- Identify Healthcare needs: Determine the prevalent health issues, gaps, and challenges faced by the community or priority populations.
- Assess service utilisation: Evaluate the current utilisation and effectiveness of existing healthcare services and resources including those commissioned by the PHN.
- Engage stakeholders: Involve relevant stakeholders for their inputs and insights to ensure a comprehensive understanding of needs and priorities.
- Develop recommendations: Generate actionable recommendations and strategies to address identified needs effectively.

Scope

- Definition of scope: The PHN will clearly define the boundaries and parameters of the NA. This includes the geographic area, population demographics, specific health issues and services under consideration.
- Data collection methods: The PHN will identify the methodologies, tools, and sources to gather comprehensive data such as qualitative and quantitative data utilising data governance structures for most appropriate method.
- Timeframe and resources: The PHN will establish the timeframe for the assessment and allocate necessary resources, including the PHN team, budget, and technology.

Defining and allocation roles and responsibilities

- Team formation: Define roles for individuals or teams involved in the NA, these will include project leads, data analysts, or marketing, engagement, and communication.
- Responsibility matrix: Outline specific responsibilities and tasks for each team member or group to ensure clarity and accountability.
- Training and support: Provide necessary training, resources, and support to enable team members to execute their roles effectively.

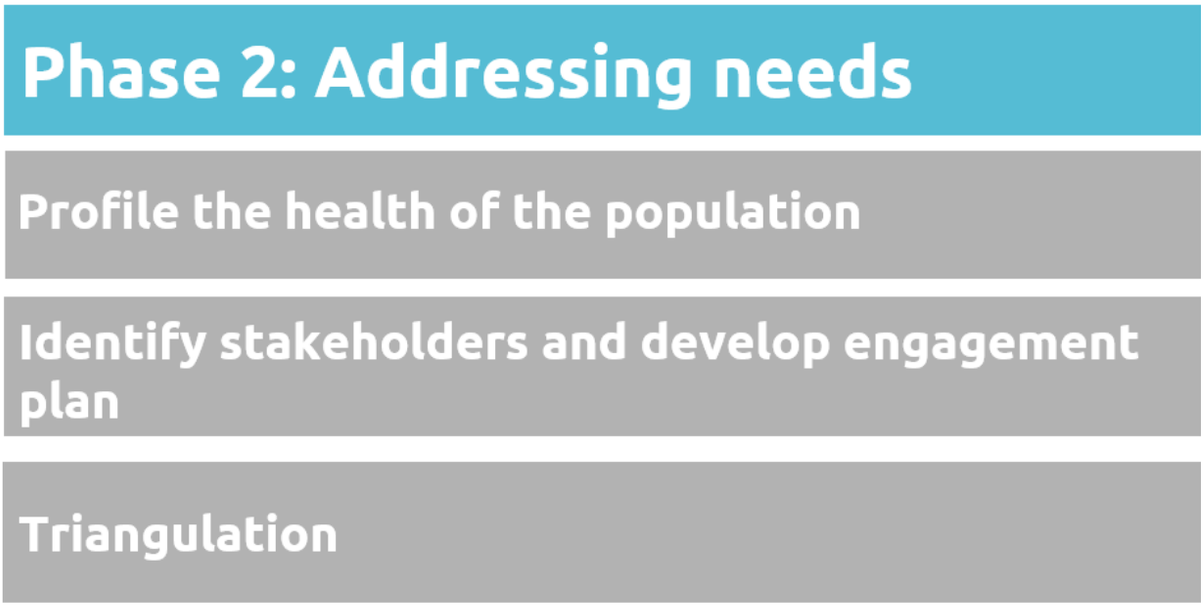
Plan Implementation

To ensure the PHN completes the needs assessment in time for the DoHAC deliverable due date of November, The PHN will establish a project plan, in line with the PHN's project management process. This process is led by the Executive Officer –Planning Insights Performance and Strategy and includes the allocation of roles and responsibilities and outlines the resources, steps and timings including consultations with stakeholders as well as the potential risks the project team may face and how they will be managed before being executed by the planning team. The Plan is endorsed by the Populations Access and Performance Executive Manager. The risk management component of the project plan will be developed in consultation with the PHN's Risk Manager and in line with the Risk Management Framework.

Phase 2 Addressing Needs

Phase 2 is the commencement of the formal NA process. It is concerned with data collection and analysis, as well as consultation with local communities, GPs and health professionals, and other stakeholders to gather views about the key influences on health and wellbeing, gaps in primary care services or programs, and the capacity of the primary health care system. Key steps in *Phase 2* are summarised in Table 2.

Table 2: Phase 2 key processes



Profile the health of the population

The PHN develops profiles for the entire region and the 23 LGAs that make up the region. The PHN uses an LGA approach as it offers a consistent boundary approach to that of the State acute healthcare system and is well understood by communities and local councils.

Current health status

Current health status involves a comprehensive evaluation of the existing health conditions prevalent within of the PHN community. This assessment includes analysing epidemiological data, prevalent diseases or health issues, trends in illnesses or conditions, and their impacts on the population's well-being. Understanding demographic profiles, socio-economic factors, and prevalent health behaviours further enriches this analysis, offering a holistic view of the communities' health needs. [11]

Health service usage

Health service usage delves into an exploration of how healthcare services are accessed and utilised within the targeted community. This assessment involves analysing patterns of healthcare utilisation, including primary care, specialist services, hospital admissions for preventable admissions and avoidable emergency department presentations, preventive care, and health-seeking behaviors. Understanding the frequency, distribution, and barriers to accessing healthcare services aids in identifying gaps and areas for improvement within the current healthcare delivery system.

Map primary care system capacity

Mapping primary care system capacity involves evaluating the existing infrastructure, resources, and capabilities of the primary care system serving the community. This includes assessing the availability of healthcare facilities, primary care providers (such as general practitioners, nurses, and allied health professionals), their distribution across geographical areas, and the range of services provided. Evaluating the primary care system's capacity helps identify areas of strength and

potential weaknesses, enabling the development of strategies to enhance access, quality, and responsiveness to community health needs. [10]

Mapping primary care system capacity provides an opportunity to investigate and identify potential duplications in terms of service delivery. In the event duplication does exist there are increasing opportunities to identify this with both State and Commonwealth Government policy branches and propose recommendations that encourage consideration of bi-partisan approaches to funding services with increased capacity to service communities but do not duplicate effort or investment.

Population health tool

The PHN's Population Health Tool supports decision making, it provides a reliable and consistent process for the PHN to analyse, interpret and prioritise health data so that we can make informed health needs decisions and expose that information to the public with confidence.

The Population Health Tool helps the PHN to:

- Identify key themes of health needs.
- Contextualise severity of identified themes against state and national values.
- To analyse variation between LGAs within HNECC region on various health and demographic variables.
- Communicate these rankings to key internal stakeholders to inform decision making.

The Population Health Tool uses an algorithm to analyse health needs at both the PHN level and the Local Government Area (LGA) level and includes data from the entire PHN region. This data is compared with State and National data and provides a comparison of how well LGAs across the Hunter, New England, and Central Coast regions fare in relation to them. This information is used to develop LGA and priority population profiles which are then taken into communities as part of stakeholder consultation to sense check the information against local knowledge, understanding and perception.

Health profiles

Using data from the Population Health Tool develop population profiles that include geographic and demographic information for each LGA in the region. The profiles will derive from ABS Census data and include characteristics such as ethnicity, gender, age, and will be collected to assist with health planning in our region, integrating, analysing, and summarising information and data from many sources such as but not limited to the Public Health Information Development Unit (PHIDU) and the Australian Institute of Health and Welfare (AIHW). Within the PHN region there are 23 LGAs, an overarching PHN regional profile will be developed and data in this profile will be compared to National and State averages and determine magnitude of local issues and identify areas needing higher levels of intervention. In addition to the LGA profiles, priority need, and condition specific profiles may also be developed.

Identify stakeholders and develop engagement plan

There is a distinct difference in the meaning between community and stakeholders, and the terms, often used in conjunction, should not be used interchangeably. The word 'community' includes individuals and groups of people, interest groups and citizen/community groups.[15] A community may also be a geographic location (community of place), a community of similar interest(s) or a community of affiliation or identity (such as an industry or sporting club). In contrast, the word 'stakeholder defines individuals, a group of individuals, organisations, or a political entity with a specific stake in the outcome of a decision to the impact of a policy, project, or proposition. [15] Community and stakeholder involvement sits at the core of the practice of engagement.

The NA stakeholder engagement process will help to identify and involve people that may be affected by the decisions we make or can influence our implementation of activities from the NA improvement process. Engaging with the right people in the right way will significantly increase the effectiveness and positive outcomes of the NA. This plan defines who needs to be engaged, how best to engage and what needs to be communicated. During Phase 1 of the NA an overarching stakeholder engagement plan is developed (See Appendix B).

The PHN engages with key stakeholders through the NA process on multiple occasions. The following are examples of PHN stakeholders, Clinical Councils. Community Advisory Committees, Local Health District, Health Service providers, NGOs, Health professionals, Rural Workforce Agencies, Members of the public, General Practitioners and Special Interest Groups.

By collaborating with stakeholders representing different populations the PHN seeks to understand a diverse range of perspectives.

The PHN adopts the five core principles of IAP2 these are essential elements to the practice of engagement. All five foundations are required for effective engagement.[15] These are:

- **Decision/impact orientated-** we engage to make decisions, have impact or implement change.
- **Values based-** there can be individual values, organisational values, community or societal values, and also process values. Values affect how people perceive the decision, participate (or not) and perceive the outcome.
- **Relationship focused-** we build relationships with our participants, resulting in an increase of good will, understanding and effective interaction
- **Goal driven-** reach engagement project needs a clear purpose and objectives
- **Equity centred-** each engagement needs to stand the test of equity.[15]

The PHN utilises multiple methodologies to engage with key stakeholder groups, these are described below.

Community Conversations

- LGA based webinars to engage residents, community leaders, and various key stakeholders in discussions about healthcare priorities and needs based on LGA profiling of local context.
- Community events participation: attend and actively participate in local events interacting with the community, listen to their concerns, and gather feedback.
- First Nations focus: engagement of community, Local Lands Councils, Aboriginal Medical Services, and other key First Nations groups in the region's LGAs through "Yarn Ups".

Service Provider feedback

- Webinars where healthcare providers can voice their concerns, suggestions, experiences, and perspectives.
- Surveys and questionnaires undertaken and initiated on specific health concerns or areas of work, for common themes as part of the gathering of comprehensive feedback on healthcare needs and challenges.

PHN team and advisory group consultation

- Workshops/seminars: engage PHN staff, clinicians and community advisors in workshops or seminars to discuss healthcare issues, potential solutions, and strategies for improvement. This will include sense checking information and gaining qualitative information to improve insight into community issues and potential solutions.

Informal consultations through social media

- Online platforms engagement: utilise social medica channels to conduct polls, Q&A sessions, and open discussion regarding healthcare concerns.

- Online surveys: create and share online surveys through social media platforms to reach a wider audience and collect diverse perspectives.

PeopleBank

- PeopleBank is the PHN's initiative to include residents across the region in conversation about improving local health. Consumers, clinicians, and the wider community are important in our effort to improve local health outcomes, and we're committed to consult about what works and what needs to change. The use of PeopleBank results in a more representative sample of the region.
- PeopleBank enables the PHN to target consultations online to specific LGAs, health conditions or areas of health interest and expertise. Registered participants in People bank can elect multiple areas of interest that they are willing to be consulted on. They can agree to be surveyed, interviewed or to participate in focus groups. They can have multiple areas of interest.

Focus groups based on priority populations

- Targeted group sessions: focus groups specifically tailored to diverse and priority populations or specific health needs to gather detailed insights and perspectives. This is more appropriate to conversations on areas that may be considered sensitive and not amenable to surveys.
- In year 2 and 3 of the needs assessment process the PHN undertakes "deep dives", working with priority LGAs to further investigate issues in these communities and gain a deeper knowledge of issues. This results in the development of place-based initiatives to address those specific needs.

Triangulation

Triangulation, the final stage in Phase 2 of the needs assessment process amalgamates insights gleaned from community and stakeholder consultations along with data analyses. This process compares and validates findings, empowering the project team to pinpoint and affirm primary needs and significant concerns within the PHN region and its communities.[12] Integral to the NA, triangulation permits the exploration of assumptions and perspectives regarding specific issues from diverse angles. Employing multiple analytical methods helps counter biases or limitations present in the data. Triangulation is used to clarify the exact nature of a problem or issues and the underlying determinants of causal factors that need to be addressed. [12]

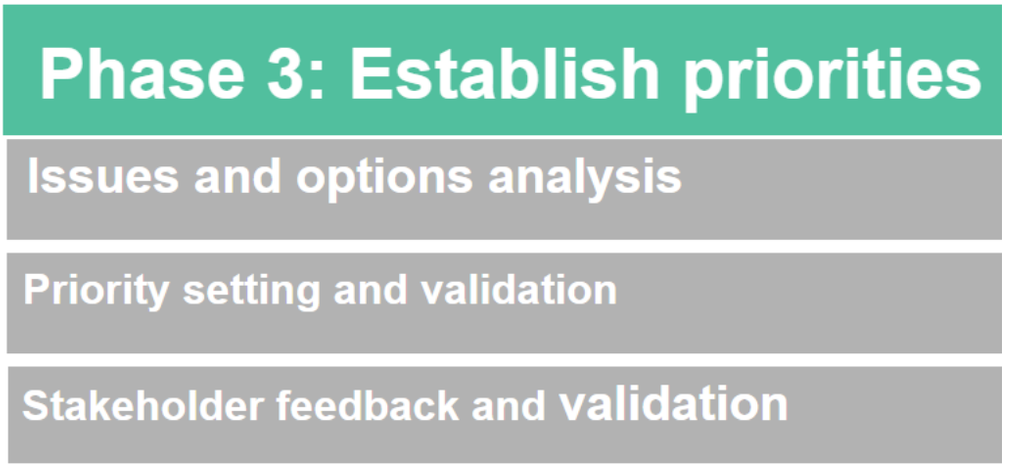
Phase 3 Establish Priorities

Phase 3, the priority- setting process involves systematically assessing each key issue/need. This includes reviewing the size, scale, and potential consequences of each issue/need in relation to health risks or effects on the utilisation or effectiveness of health services.

The PHN can then determine what can be done with the available funding, utilising evidence about effective interventions and/or service development strategies which are available to address the identified needs. Stakeholder feedback on what is realistic and feasible is also considered to reach a shortlist of needs which can be reviewed, rated, and ranked against defined priority setting criteria, and a recommended final list of priorities for action to be reviewed with stakeholders.

Clear goals, objectives and expected outcomes are confirmed by the PHN to match the recommended priorities for action and investment. Finally, comments and feedback are obtained from stakeholders on the proposed priorities to validate the options selected and gain their commitment for implementation. Key steps in *Phase 3* are summarised in Table 3 below.

Table 3: Phase 3 Establish Priorities



Issues and options analysis

Issues and options analysis constitutes a pivotal phase within the NA, encompassing a systematic examination of identified concerns and available alternatives or solutions.[12] This process involves a comprehensive evaluation of the health-related challenges or requirements prevalent within a community or a specified population group[12]. It encompasses a thorough exploration of various factors contributing to these issues, such as epidemiological data, social determinants, health disparities, and specific health needs. Simultaneously, it scrutinises potential interventions, strategies or service models aimed at addressing these identified concerns. This analysis ensures a nuanced understanding of the multifaceted challenges and a well-informed selection of approaches to effectively meet the identified needs within a given context.[12]

Priority setting and validation

The Population Health Tool provides the PHN with a baseline for consultation through identification of health priorities and behaviours. This enables the planning team to create a baseline for consultation with communities and key stakeholders. Population health profiles for each of the 23 LGAs across the HNECC region are developed and mapped against a list of the most prevalent causes of preventable deaths and most prevalent health conditions.

Through consultation with stakeholders the PHN can obtain qualitative information including community experience and context to inform a second round of prioritisation.

During the second round of prioritisation, the PHN reviews and rank issues and opportunities to develop an updated needs list. A ranking system is deployed to support prioritisation of key issues, which are then recommended to the PHN Board and Executive for endorsement.

Prioritisation ranking method:

- One point for issues higher than the National or State Level.
- One point if the issue is identified as a need by any community, health professional or through PHN staff.
- One point for an identified service gap.

After the scoring process, a total is determined, and higher scoring issues are proposed to the PHN Board and Executive for endorsement and consideration of funding allocations.

Stakeholder feedback and validation

PHNs are encouraged to conduct a thorough review of health issues exhibiting substantial impact potential and considerable feasibility for change. Collaborating with representatives from working parties and individuals nominated by consumer/community or stakeholder reference groups, the aim is to curate a condensed list of confirmed needs and viable action options. These refined priorities move to the final phase of priority setting in phase three.

Flexible approach

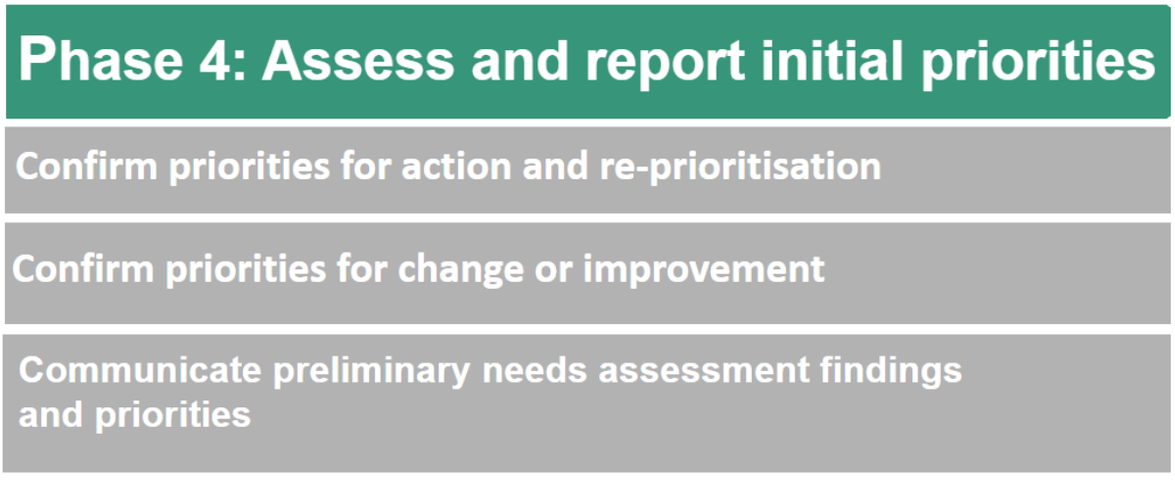
This Framework and *Toolkit* should be used by the PHN flexibly, acknowledging varied approaches can be adopted to work in individual communities or with identified priority groups. For example, in rural and remote areas there may be significant challenges in undertaking face-to-face community consultations; in this case, appropriate and creative approaches should be adopted.

Phase 4 Assess and Report initial priorities

This phase involves documentation of discoveries related to needs and the reasoning behind priority selection, with the objective of informing PHN strategic planning, investment decisions, health enhancement, service planning processes, and collaborative partnerships. In this phase, the formal approval of these priorities is secured from the PHN Executive. Furthermore, these identified priorities are communicated to both the community and various stakeholders.

Key steps in *Phase 4* are summarised in Table 4 below.

Table 4: Phase 4 Assess and report initial priorities



Confirm priorities for action and re-prioritisation

Finalise priority needs list and report to CEO for Endorsement (Need and Unmet Needs Briefing Paper):

Create a comprehensive briefing paper detailing the identified needs, rationale for prioritisation, and the potential impact of addressing these needs. Present the briefing paper to the PHN Executive/CEO for review, discussion, and formal endorsement of the identified priorities.

Confirm priorities for change or improvement

Develop Needs Assessment for DoHAC:
Compile all relevant information and findings into the structured template to submit to the DoHAC, ensuring the NA aligns with the objectives, priorities, and strategic directions.

Communicate preliminary needs assessment findings and priorities

Submit NA to DoHAC:
Formal submission of the completed NA report to DoHAC according to the submission process.

Upon DoHAC approval:
Notify the PHN team about the DoHAC's approval and endorsement of the NA findings and priorities through internal communication. Ensuring that the approved priorities align with the PHNs strategies and objectives for implementation.

Communicate changes to the PHN team and community, all stakeholders

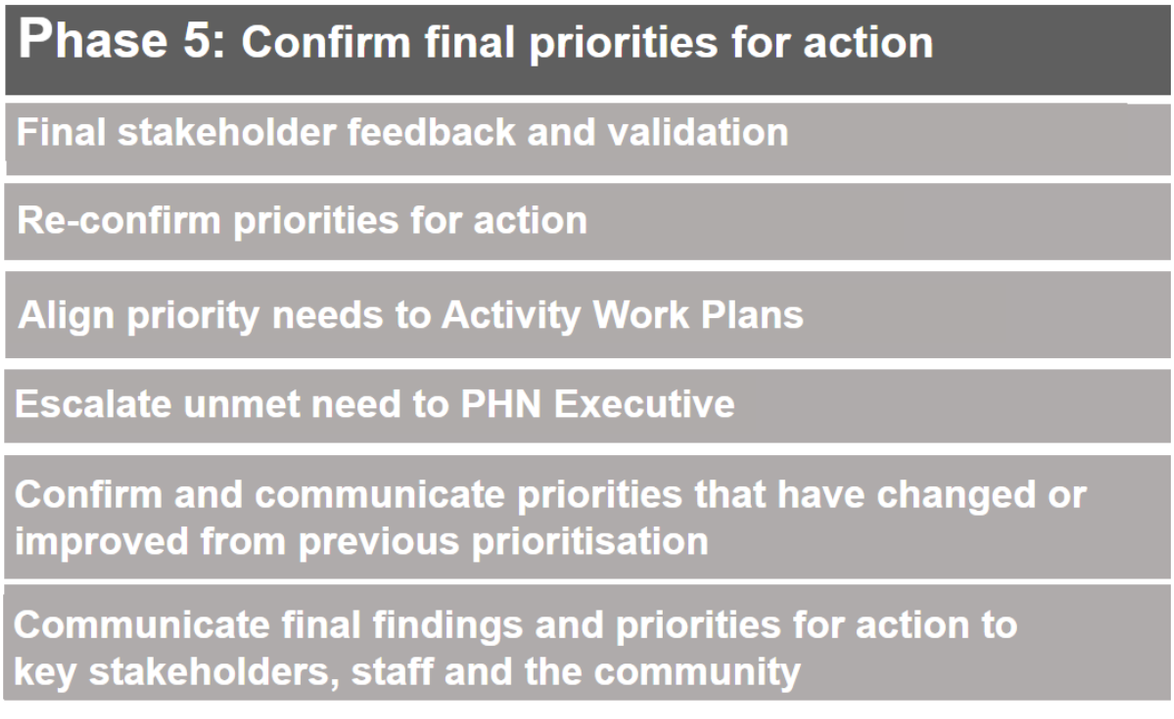
Present to the PHN team and stakeholders through targeted communications, the outcomes of the NA to inform their work. This is achieved through targeted communications and the production of Needs related products including: Needs Assessment Full Report, Priority Needs List, Activity Work Plans mapped to need, LGA Profiles

Phase 5 Confirm final priorities for action

Phase 5, which follows similar steps to Phase 4, incorporates the steps mentioned above while adding crucial dimension: re-prioritisation based on the feedback and insights gathered during the community and stakeholder consultation process.

Key steps in Phase 5 are summarised in Table 5 below and are further detailed in part 2 planning.

Table 5: Phase 5 Confirm final priorities for action



Final stakeholder feedback and validation

The PHN will validate, through community and stakeholder consultation the revised priorities and ensure they resonate with the broader consensus which informs how the PHN re-confirms its priorities.

Re-confirm priorities for action

Reassessing the established priorities in consideration of the feedback and observations provided by community and stakeholder consultations enables the PHN to refine the initial priorities and align them more closely with the evolving needs of the community to ensure they respond to the identified challenges. It also ensures consideration of community perspectives, perceptions, needs, and suggestions. Remaining activities that form part of phase 5 move into the planning component and are articulated below.

Part 2: Strategic and Activity Planning

2.1 Align priority needs to Activity Work Plans

When the PHNs NA has been completed we work to identify priorities and options for commissioned services and PHN activities The PHN can use several levers to respond to service gaps or priority population group needs including:

Consideration of available financial resources and strategic investment of funding in meeting the Strategic objectives of the PHN through service development and delivery, and /or activities.

Identifying local needs and priorities to tailor national program funding allocated through PHN funding schedules in areas such as mental health, after hours primary health care, aged care, or First Nations Health.

Developing shared strategies and priorities based on a mutual understanding of community needs to put practical remedies in place to address gaps or better coordinate services through partnerships with Local Health Districts, General Practitioners, Allied Health professionals and the wider primary health care sector.

Developing shared service agreements and pathways with Local Health Districts and agreed roles and responsibilities with service providers, public health services and other appropriate partners.

Working in partnership with key stakeholders in primary care and/or local communities to promote health and wellbeing.

Establishing and building partnerships to attract special purpose or incentive funding from a variety of sources.

The three-yearly NA cycle is an important vehicle for the PHN to develop a mutual understanding of the key primary health care needs of its local communities and priority population groups. This will lead to identifying and implementing evidence-based interventions and activities to address priority needs effectively. The three-yearly NA cycle is additionally a key building block for the strategic planning process.

The second key deliverable for all funding contracts with the Department of Health and Aged Care (DoHAC), annual Activity Work Plans (AWPs) outline the PHNs response to key Strategic challenges, ensure all PHN activities are responsive to the identified needs of the region, as well as the aims and objectives of the relevant funding schedule.

The PHN, submits individual activity work plans against the following funding agreements with DoHAC:

- Core and flexible funding (including health system improvement, flexible and corporate governance)
- Primary Mental Health (including Head to Health and Headspace)
- Bilateral Mental Health (including suicide prevention and Headspace enhancements)
- Pilots and Targeted Programs (including Kaden Cancer Care Centre, Movement Disorder Nurses, Domestic, Family and Sexual Violence, Greater Choice for at Home Palliative Care, GP Access After Hours- Hunter)
- Aged Care and Care Finders
- Commonwealth Psychosocial Support
- Alcohol and Other Drugs
- Integrated Team Care – focusing on capacity building primary care responses to First Nations health and workforce, supporting improved cultural competency and appropriateness and commissioning of care coordination, and outreach services for chronic conditions
- After Hours (including Homelessness and Multicultural Health)
- Other DoHAC projects such as innovation grants

Activity Work Plans are developed and contributed to by program managers and subject matter experts within the PHN and outline the intentions for activity delivery in the next 12 months. They are approved by the relevant Executive Manager and finally endorsed by the CEO before submission.

The PHN's internal process to review and update AWPs commences in January each year and completed plans are submitted in April, seeking approval for work to commence in the upcoming financial year. It is a DoHAC requirement that upon execution of a funding variation an updated AWP is returned within four weeks. Figure 10 presents a diagram of the workplan process.

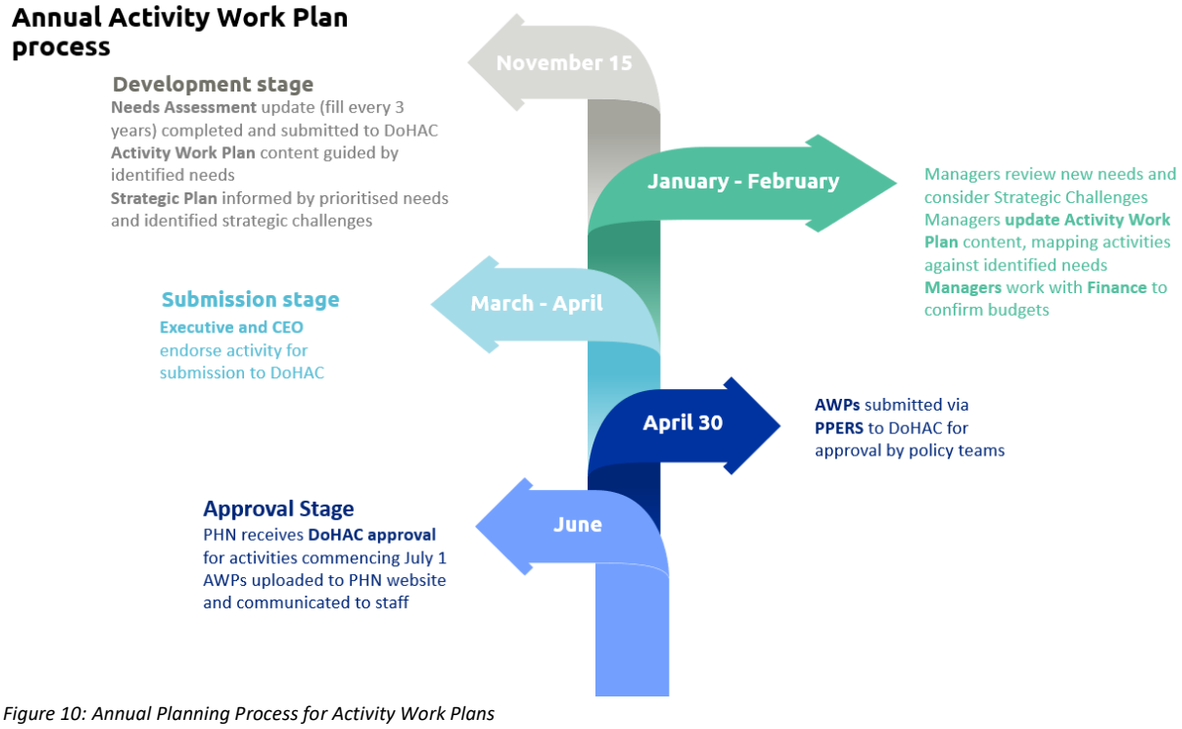


Figure 10: Annual Planning Process for Activity Work Plans

Activity Work Plan inclusions

PHNs are supplied with a standardised template to complete activity work plans, as outlined in Table six below, and required to submit formally online through the Department's Primary Health Network Program Electronic Reporting System (PPERs).

Table 6: Activity Work Plan reporting template example

Variable	Description
Activity title	Title for activity *Including unique reference numbering*
Existing, Modified or New activity	Drop down list *If activity is existing or modified, provide the relevant reference/s from previous Activity Work Plan/and page number*
Program Key Priority Area	Drop down list *7 Commonwealth priorities*
Needs Assessment Priority	As identified in the Priorities, Options and Opportunities Section of the Needs Assessment, provide the number, title and page reference for the priority that this activity is addressing.
Aim of Activity	Describe what this activity will aim to achieve, and how it will address the identified need.
Description of activity	The description of the activity should include both the strategy, and outcome to be achieved. *How the activity and/or services will be delivered.*
Target population cohort	Specific population i.e., youth, older people, general population
Indigenous specific	Drop down list (Yes/No) *If yes, briefly describe how this activity will engage with the Indigenous sector.*
Coverage	Describe where the activity will be provided *Where area covered is not the whole PHN region, provide the statistical area as defined in the Australian Bureau of Statistics (ABS), or LGA*
Consultation	Provide details of stakeholder engagement and consultation activities to support this activity.
Collaboration	List and describe the role of each stakeholder that will be involved in designing and/or implementing the activity, including stakeholders such as Local Health Networks, state/ territory governments, or other relevant support services.
Activity milestone details (duration (dates for activity (planning procurement) and service delivery	Provide the anticipated activity start and completion dates (**including** the planning and procurement cycle) **If applicable,** provide anticipated service delivery start and completion dates (**excluding** the planning and procurement cycle)
Commissioning method and approach to market	Set of three questions dealing with approach *Including approach, co-design, joint commissioning, previous history.*
Decommissioning	Drop down list (Yes/No) *If yes, provide a description of the proposed decommissioning process and any potential implications.*
Planned expenditure & Funding sources	Table indicates funding sources across years and relevant to the schedule.

2.2 Escalation of unmet need

The PHN's phase five NA process ensures priorities remain relevant and well-informed, serving the evolving health needs of the community while maintaining a transparent and inclusive approach.

Unmet needs are escalated to the Executive team with a series of recommendations on where efforts could be made to respond further if appropriate resourcing becomes available. This endorsement ensures when possible and appropriate, the PHN can adjust priorities and that any changes can be effectively communicated to PHN staff, communities, and stakeholders, demonstrating the organisation's commitment to an inclusive and responsive approach to planning and activity delivery.

2.3 Confirm and communicate priorities that have changed or improved

In the process of confirming and communicating changes or improved priorities, the next crucial step involves a comprehensive review and validation of finalised findings from the needs assessment. Engaging key stakeholders forms the cornerstone of phases 2.4.1, aiming to discuss and authenticate any alterations or enhancements in the identified priorities. It's essential to meticulously document these confirmed changes, outlining the rationale behind the revisions. Simultaneously, drafting a communication plan that delineates the internal dissemination of this information to PHN staff and devising a strategy for public communication remains pivotal. Establishing feedback mechanisms to ensure stakeholders comprehend the rationale behind these modifications is crucial.

2.4 Communicate final needs assessment findings and priorities for action to key stakeholders, PHN staff and the community

Subsequently, in communicating final findings and priorities, the focus shifts to the preparation of tailored and concise communication materials, including a suite of NA products, summarising the conclusive results of the assessment, these materials are strategically tailored and produced to resonate with diverse stakeholder groups, including PHN staff, key stakeholders, and the wider community. This process is supported through the development of a communications plan in Phase 1, as part of Plan and Implementation.

Needs assessment products

The PHN will not only populate the template from the DoHAC but will also create a tailored document for PHN staff, and all other stakeholders, including the community suitable for grant applications and to inform their planning.

After the Needs Assessment submission is approved by DoHAC, additional products will be developed. These products will be co-designed with the PHN's Marketing Engagement and Communications (MEC) team for the LGAs to ensure accessibility and relevance. The objective is to facilitate easy access to data and information such as posters and a concise document that summarises valuable information to their communities. Readability of the documents will ensure that they are easy to digest and sources will ensure that they are credited and accurate. A table of the products is provided below (table 7).

Table 7: Needs assessment products

Product & Context	**Audience** **Due date**

Reporting template Needs Assessment	**The Needs Assessment reporting template.** **What is it?** The NA reporting template outlines the reporting requirements that the PHN must complete and submit to the Department of Health and Aging via PPERS in November of each year. Department of Health deliverable.	Department of Health and Aged care PHN Staff and key stakeholders Every three years
Needs Assessment Report (Annual)	Publicly available version on website. Informs PHN program work and decision making.	PHN staff Service providers Community Reviewed and updated annually
Priority Needs List	Publicly available version on website. Informs PHN program work and decision making.	PHN Board PHN staff Service providers Community Reviewed and updated annually
Health profiles	Publicly available versions on website. Provides specific health prioritised health data by priority populations or LGAs or by specific health conditions across the region.	PHN staff Service providers Community Reviewed and updated annually
The Framework	**Needs Assessment.** **What is it?** Part 1 presents the overarching framework and provides a high-level explanation of the approach the PHN implements to undertake needs assessments. **Strategic and Activity Planning** **What is it?** Part 2 explains the PHNs process for using the outcomes of the needs assessment to inform PHN Strategic Planning and implementing activity in response to need through the annual Activity Work Planning process.	PHN staff Other PHNs Reviewed and updated annually
The Needs Assessment and Planning Toolkit	**The Needs Assessment and Planning Toolkit.** **What is it?** The Toolkit details the 'how to' of each phase in the framework. It provides the procedures required to complete the phases of the NA.	PHN staff Reviewed and updated annually

PHN annual planning timeline

The diagram below (Figure 11) provides a high-level overview of the timing of our annual planning activities. It has been designed to align with submission of required DoHAC deliverables.

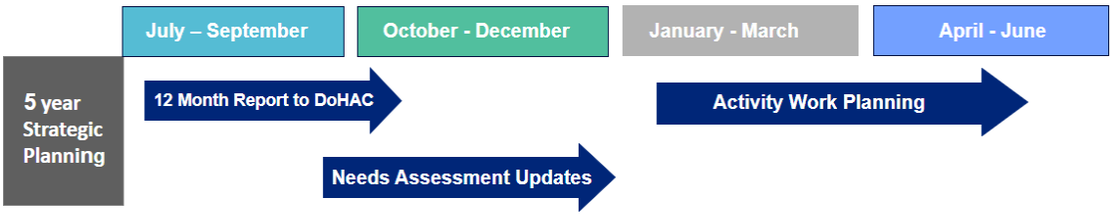


Figure 11: PHN Annual Planning DoHAC deliverable timeline

3. Framework supporting information

3.1 Building on international best practices

This Framework draws on approaches to health NA and priority setting used in the United Kingdom, United States, Canada and New Zealand as well as population health NA, service development and performance reporting approaches used by the Australian Government and the States and Territories [9,10]

Some of the international examples considered include: the *Health Need Assessment: A Practical Guide (2005)*; *Community Health Needs Assessment and Health Improvement Plans* and Centre for Disease Control guidance from the USA; guidance on *Priority Setting in the LHINs (2009) Community Engagement Guidelines (2011)* for Local Health Integration Networks in Ontario, Canada; and the World Bank *Guide to Assessing Needs (2012)*.[10]

Health organisations, such as the former Primary Care Trusts in England, Local Health Integration Networks in Ontario, Canada, District Health Boards in New Zealand and State Departments of Public Health and/or Local Health Boards in the United States, have been using regional NA to inform service planning, purchasing and commissioning or to develop cross-sectoral community and public health improvement plans since the 1990s. [10]

Despite differences in these national health systems and the funding mandate of the primary health care organisations' undertaking the process, there are some common features in the NA and priority-setting approaches used internationally. The consistent elements include:

- A systematic NA process is used to identify local needs and feed priorities into a regional strategic service plan or funding agreement informed by national health priorities. This is usually on a three-yearly cycle;
- Structured consultation and feedback processes that involve clinicians, local communities, and representatives of population groups in identifying needs and assessing viable solutions;
- Access to consistent national or state data sets to inform local planning;
- Use of expert guidance and evidence to assess gaps or inform local priority setting, such as policy frameworks for national health priority areas, clinical guidelines, and epidemiological reviews of effective interventions;
- A focus on health inequities and where possible and appropriate consideration of the experience of patients and people from priority groups; and
- Formal priority-setting processes using either nationally defined or locally determined criteria to evaluate and set priorities.

3.2 Data Context and Sources

The PHN sources l data from the following including but not limited to:

Geographic, demographic and health – Local Government Level

- Australian Bureau of Statistics Census Data
    - Socio-economic indices for Areas (SIEFA)
    - Profiles of Health including National Health Survey, National Health measures survey, National Aboriginal and Torres Strait Islander Health Survey

- Australian Institute of Health and Welfare
- National Health Performance Authority
- PHIDU, social health atlas
- NSW Cancer Institute
- New South Wales Bureau of Crime Statistics and Research (BOSCAR)
- Australian Childhood Immunisation Register

Service Level Data – Local Government Level

- Data from PHN commissioned services and grant programs
- Local General Practice Data through PenCAT for consenting General Practices
- National Health Service Directory and HealthDirect
- Health workforce data through HeadsUPP that is available to share publicly
- Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS) and Practice Incentives Program (PIP)

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Revision History

Version	Status*	Author	Date	Reason for amendment
V0.0	Draft	Laura Shepherd	14.12.2023	Creation of framework
V1.0	1st Issue	Jacqui Smith	19.12.2023	Inclusion of Planning into Needs Assessment Framework to consolidate, revision of draft

Appendix A: Needs Assessment and Planning Toolkit inclusions List

Phase	Procedure required
PHASE 1 Planning	1.1 How to define scope assign resources 1.2 How to develop a PMP 1.3 How to define a stakeholder engagement plan
PHASE 2 Addressing needs	2.1 How to assess health inequities, demographic trends and priority needs groups 2.2 How to assess current health status/outcomes and health service utilisation 2.3 How to map service and capacity 2.4 How to use the Population Health Tool 2.5 How to create a health profile 2.6 How to have community conversations including how to run a webinar 2.7 How to get service provider feedback 2.8 How to consult with PHN teams and advisory groups 2.9 How to work with social media and media campaigns 2.10 How to use PeopleBank 2.11 How to run focus groups 2.12 How to conduct Yarn Ups 2.13 How to approach the triangulation process
PHASE 3 Establish priorities	3.1. How to conduct an issues and options analysis 3.2. How to undertake priority setting and validation 3.3. How to obtain stakeholder feedback and validation 3.4 How to conduct a focus group 3.5 How to develop a regional survey
PHASE 4 Assess and Report initial priorities	4.1 How to confirm priorities for action 4.2 How to confirm priorities for change or improvement 4.3 How to communicate preliminary findings and priorities
PHASE 5 Confirm final priorities for action	5.1 How to get final stakeholder feedback and validation 5.2 How to reconfirm priorities for action 5.3 How to align priority needs to AWPs
	5.4 How to write a brief for unmet needs
	5.6 How to confirm changed priorities
	5.7 How to communicate findings

Appendix B: Stakeholder engagement

Types of stakeholders

Consultation will include (but is not limited to) the following: Clinical Councils; Community Advisory Committees; Local Health Districts; Health Service providers; Non-Government Organisations; Health professionals; Rural Workforce Agencies; and members of the public.

Level of influence spectrum

Inform	To provide balanced, objective, accurate and consistent information to assist stakeholders to understand the problem/s, alternatives, opportunities and/or solutions.
Consult	To obtain feedback from stakeholders on analysis, alternatives, and decisions.
Involve	To work directly with stakeholders throughout the process to ensure that their concerns and needs are understood and considered.
Collaborate	To partner with the stakeholder including the development of alternatives, making decisions and the identification of preferred solutions.
Empower	To place final decision making in the hands of the stakeholder.·· Stakeholders are enabled / equipped to actively contribute to the achievement of decisions / outcomes.

Methods of engagement

These methods will vary according to the level of engagement required but may include: Public forum/Focus Group; Targeted workshop/Webinars; Interviews; Meetings, one-on-one, focused conversations and surveys.

Stakeholder Engagement Plan

Overarching engagement purposes	To build an evidence base needs assessment by mobilising community, clinician, and subject matter expert knowledge to create sustainable opportunities and options for the PHN to address. To continue to build relationships with a range of key stakeholders across the PHN footprint.
Engagement leadership (for engagement roles)	Project sponsor (Exec Manager PAP) PIPs Executive Officer Communication/Marketing lead
Risk Management	Timeframe blow-out Low stakeholder input The feedback loop post engagement is not closed with stakeholders leaving them to feel as if their voice isn't being heard or valued
Mitigation measures	Plan robust and realistic timeframes Accountability of timeframes Work with community in a more collaborative manner to reach an amenable solution Allow time to build relationships and a shared understanding with stakeholders Reinforce and communicate parameters and outcomes of engagement Conduct stakeholder mapping Manage expectations and communications

Stakeholder analysis matrix

Community or stakeholder group, individuals, sectors or known groups	**Topics of interest**	**Level of interest (low, moderate, high)**	**Impacts: Potential impacts or consequences**	**Level of impact (low, moderate, high)**	**Level of influence (from spectrum)**	**Engagement needs or expectations. Includes barriers and enablers to engage**	**Benefits of engagement**	**Quality of relationship (very poor, poor, neutral, strong, very strong)**
Clinical councils	Current/prioritised health needs Community needs Service gaps/barriers Opportunities and options for action	High	Increased access to opportunities to improve health of population	Moderate/Low	Inform, involve and consult	Early involvement to share needs Understand demographics Test design of engagement for inclusivity Seek advice and feedback on current needs	Test design of engagement for health professionals Strengthen relationships Subject matter knowledge and perspective	Very strong
Community Advisory Committee	Current/prioritised health needs Community needs Service gaps/barriers Opportunities and options for action	High	Increased access to opportunities to improve health of population	Moderate	Inform, involve and consult	Early involvement to share needs Test design of engagement for inclusivity Understanding demographics Seek advice and feedback on current needs	Test design of engagement for general community Subject matter knowledge and perspective Strengthen relationships Diversity of thinking	Very strong
Local Health District	Current/prioritised health needs Community needs Service gaps/barriers	Moderate	As per topics of interest	Moderate	Involve and collaborate	Stakeholder to provide data or evidence regarding new needs	Strengthen relationships Working in partnership	Very strong

	Opportunities and options for action					Information is accessible Seek advice and feedback on current needs		
Health Service providers	Current/prioritised health needs Community needs Service gaps/barriers Opportunities and options for action	High	As per topics of interest	Moderate	Consult and involve	Seek advice and feedback on current needs	Strengthen relationships Subject matter knowledge and perspective Working in partnership	Strong
Aboriginal Medical Services	Current First Nations health needs Service gaps/barriers Opportunities and options for action	High	As per topics of interest	Moderate	Involve, consult and collaborate	Early involvement to share needs Test design of engagement for inclusivity Seek advice and feedback on current needs Inclusive engagement methods needed	Strengthen relationships Subject matter knowledge and perspective Test design of engagement for inclusivity	Strong
Health professionals e.g. Allied Health, RACF, primary care (non GPs)	Community needs Service gaps/barriers Opportunities and options for action	Moderate	As per topics of interest	Moderate	Involve	Seek advice and feedback on current needs Early involvement to share needs	Strengthen relationships Subject matter knowledge and perspective	Strong
General Practitioners	Community needs Service gaps/barriers Opportunities and options for action	Moderate	As per topics of interest	Moderate	Involve	Seek advice and feedback on current needs Early involvement to share needs	Strengthen relationships Subject matter knowledge and perspective	Strong

General Community	Current/prioritised health needs Community needs Service gaps/barriers	Moderate	As per topics of interest	Moderate	Involve	Understanding demographics Early involvement to share needs Seek advice and feedback on current needs	Strengthen relationships	Strong
Special Interest Groups (SMEs in Mental Health, First Nations Health, AoD, Older people, population health)	Current/prioritised health needs Community needs Service gaps/barriers Opportunities and options for action	Moderate	As per topics of interest	Moderate	Involve	Seek advice and feedback on current needs Stakeholder to provide data or evidence regarding new needs	Subject matter knowledge and perspective Strengthen relationships	Strong
NGOs e.g. EveryMind, Head Space	Current/prioritised health needs Community needs Service gaps/barriers Opportunities and options for action	Moderate	As per topics of interest	Moderate	Involve	Seek advice and feedback on current needs Stakeholder to provide data or evidence regarding new needs	Subject matter knowledge and perspective Strengthen relationships	Strong

Community/stakeholders	Engagement leadership	Engagement purpose	Engagement objectives	Influence	Methods
Clinical councils	Project manager Comms/marketing lead	Problem solve Identify a problem or opportunity Build relationships	Obtain qualitative data and confirm current health and community needs Confirm current service gaps/barriers Identify/feedback on the potential opportunities and options for action	Moderate	Focused conversation Focus groups Interviews
Community Advisory Committee	Project manager Comms/marketing lead	Problem solve Identify a problem or opportunity Build relationships	Obtain qualitative data and confirm current health and community needs Confirm current service gaps/barriers Identify/feedback on the potential opportunities and options for action	Moderate	Focused conversation Focus groups Interviews
Local Health District	Project manager Comms/marketing lead	Problem solve Identify a problem or opportunity Build relationships	Obtain qualitative data and confirm current health and community needs Confirm current service gaps/barriers Identify/feedback on the potential opportunities and options for action	Moderate	Focused conversation Focus groups Interviews
Health Service providers	Project manager Comms/marketing lead	Share information Identify a problem or opportunity	Obtain qualitative data and confirm current health and community needs Confirm current service gaps/barriers	Moderate	Focused conversation Focus groups Interviews Workshops
Aboriginal Medical Services	Project manager Comms/marketing lead	Problem solve Identify a problem or opportunity Share information	Obtain qualitative data and confirm current health and community needs Confirm current service gaps/barriers Identify opportunities and options for action	Moderate	Focused conversation Focus groups Interviews Workshops
Health professionals e.g. Allied Health and RACF, other primary care	Project manager Comms/marketing lead	Share information	Obtain qualitative data and confirm current health and community needs Confirm current service gaps/barriers Identify opportunities and options for action	Moderate	Focused conversation Focus groups Interviews Workshops
General Practitioners	Project manager Comms/marketing lead	Share information	Obtain qualitative data and confirm current health and community needs Confirm current service gaps/barriers Identify opportunities and options for action	Moderate	Focus groups Workshops
General Community	Project manager Comms/marketing lead	Share information	Obtain qualitative data and confirm current health and community needs Confirm current service gaps/barriers	Moderate	Focus groups Workshops
Special Interest Groups (SMEs in Mental Health, First Nations Health, AoD, Older people, population health)	Project manager Comms/marketing lead	Problem solve Identify a problem or opportunity Share information	Obtain qualitative data and confirm current health and community needs Confirm current service gaps/barriers Identify opportunities and options for action	Moderate	Focused conversation Focus groups Interviews Workshops
NGOs Informed by SME EveryMind, Head Space,	Project manager Comms/marketing lead	Problem solve Identify a problem or opportunity	Obtain qualitative data and confirm current health and community needs Confirm current service gaps/barriers Identify opportunities and options for action	Moderate	Focused conversation Focus groups Interviews Workshops

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