

Rural and remote health service planning process

June 2013



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This document has been prepared as a guide to assist Hospital and Health Services (HHS) in partnership with communities, Medicare Locals and other service providers to undertake rigorous and transparent needs based health service planning in rural and remote communities. Each community is unique and therefore planning should be tailored to community requirements.

Assistance is available to undertake the health service planning process for rural and remote communities.

Rural and remote health service planning process

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For more information contact:

System Policy and Performance, Department of Health, GPO Box 48, Brisbane QLD 4001, email statewide_planning@health.qld.gov.au, phone 07 3234 0461.

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- Department of Health divisions and communalised business units' staff
- Hospital and Health Services' staff.

1. Introduction

Delivery of health services occurs in an increasingly dynamic environment, with ever changing community expectations, government priorities and technological advances. The budgetary setting is constrained and there are ever increasing pressures and demands on the public health system¹.

In rural and remote Queensland the complexity of providing health services is magnified by unique community characteristics. Many communities are: geographically dispersed; have an ageing population; have low population density; limited and ageing infrastructure; and higher costs associated with healthcare delivery². In contrast, some rural communities are experiencing rapid growth associated with resource and mining development. In this context, it is essential that services are well planned, with the capability to respond to evolving changes in order to meet community need.

2. Purpose and scope

The *Rural and remote health service planning process* aims to provide Queensland communities with a common approach to planning, design and delivery of health services that supports change in rural and remote health service delivery into the future.

The document is intended to be used by communities, local health service providers and community groups to help identify and develop new and innovative ways to address specific needs or unique characteristics, strengths and challenges experienced in the local communities, areas or regions.

The process is supported by additional documents including:

- Guide to health service planning V2 2012 *
- Clinical Service Capability Framework (CSCF). The CSCF provides minimum health service requirements for health services, support services, staffing and safety

¹ Sten A, John B, Rick E, Lyne L. The planning process: the health planner's toolkit. Health Systems Intelligence Project. Ontario: Ministry of Health; 2006

² Australian Commonwealth Government, National Strategic Framework for Rural and Remote Health, 2012

standards in public and licensed private health facilities to ensure safe and appropriately supported clinical services.

**To view this document, go to www.health.qld.gov.au and search for the name of the document*

By focusing on specific issues and solutions relevant to rural and remote health, the Process aims to inform decision-making to improve health outcomes and return on investment for rural and remote Queenslanders.

It is designed to encompass the full range of health-related services provided in rural and remote settings. This includes: prevention and screening; early intervention; treatment and aged care services; and the delivery of specific health services including primary healthcare, hospital and emergency care, mental health, maternity and newborn health.

It also recognises the needs of specific population groups including: older people; babies and children; Aboriginal and Torres Strait Islander people; people with chronic disease; refugees; and people from culturally and linguistically diverse backgrounds.

3. Planning and principles

The guide identifies seven planning principles underpinning public sector health service planning including:

- person focused services—services are integrated across the health sector (including within and across public, private and non-government systems) to facilitate continuity of care
- health outcome focussed services—improving the health and wellbeing of rural and remote communities
- quality services—promoting delivery of consistent clinical practice and models of innovative service delivery staffed by a flexible and skilled workforce
- safe services—providing consistently safe and appropriately supported health services
- sustainable services—developing, integrating and delivering services in a sustainable way, making efficient and effective use of limited resources
- accessible services—delivering safe and sustainable services as close as possible to where people live
- culturally appropriate services—considering cultural diversity and health needs of specific groups.

4. Health service planning process

Building on the guide, this planning process supports services to respond to: changing service demand; improved rural and remote health service delivery models; emerging trends in service delivery; and new policy initiatives. It encompasses the process of aligning existing health service delivery arrangements with changing patterns of need, making the most effective use of available and future resources including workforce. Importantly, health service planning is based on identifying and addressing the health needs of service users—or potential users.

The process is an adaptation of the guide, which provides further detail specific to integrated health service planning in Queensland. It is designed to integrate with the guide and other existing policies and planning at the national, state and local levels.

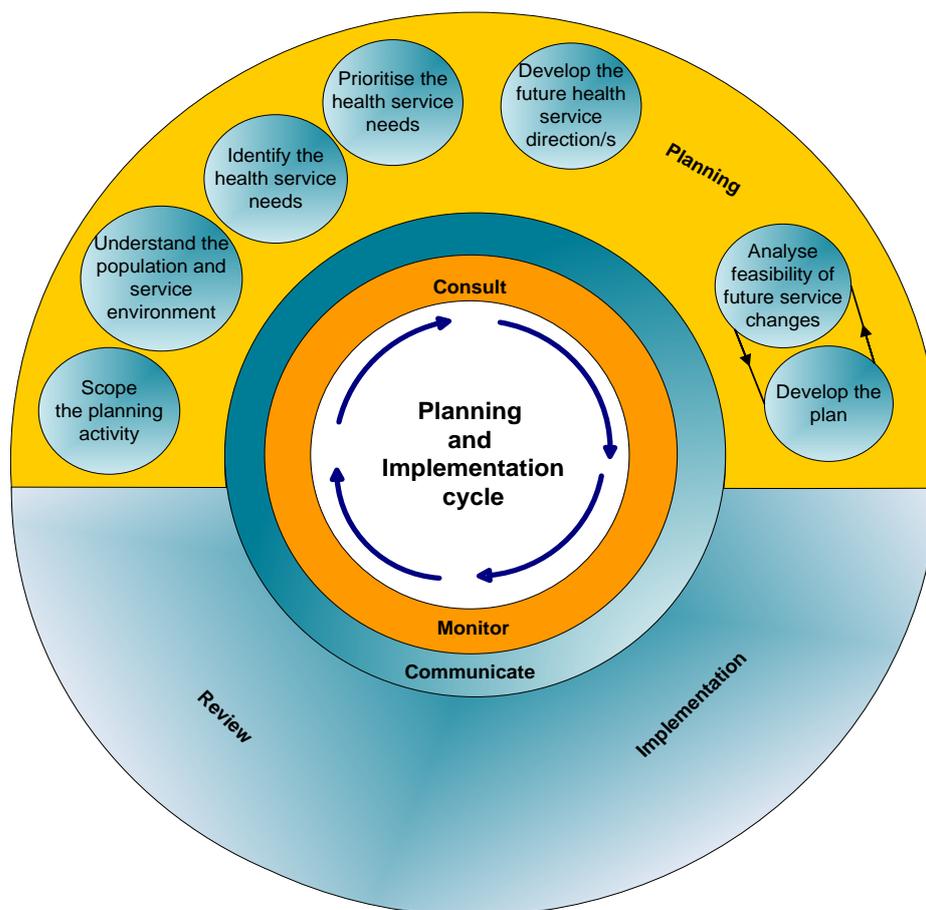
The process provides a comprehensive process for needs based planning that, if followed, will facilitate a collaborative and evidence-based approach to improving the health service system and rural and remote population health outcomes.

Figure 1 illustrates the health service planning and implementation cycle as described in the Guide. It shows the components and indicates the cyclical nature of planning. The process does not end with the development of a planning document, but requires ownership by communities, local health service providers and community groups to progress implementation, monitoring, review and evaluation of planning outcomes. The evaluation outcomes are used to inform future planning in rural and remote communities.

Important considerations to note about the planning process and implementation cycle include:

- some components will be developed in parallel with others as they inform each other
- each component builds on previous components to ensure the approach is based on evidence
- a complementary project management methodology should be applied to manage the planning project
- the development of an implementation plan and an evaluation strategy is required for each plan—essential to robust planning is the evaluation of planning outcomes and measurement of the success of a plan against pre-determined criteria
- dedicated staff and budgets need to be allocated to the planning project, as well as to the future
- once the process is completed the information communication technology (ICT) strategy and investment plan should be reviewed to ensure that it underpins the planning process from the outset
- community engagement comprising a broad range of stakeholders is a fundamental part of rural and remote health service planning implementation and review of health service plans.

Figure 1 Health service planning and implementation cycle—adapted from the guide



Once strategic and service priorities are defined, it is important to examine the role of ICT as a key activity during the health service planning process.

Consideration should be given to both the existing and proposed ICT arrangements in supporting new service delivery models and responding to changing service demand. This is vital to ensure the most effective use of resources and support for both the clinical and administrative workforce in rural and remote areas.

5. Consumer and community engagement

Consumer and community engagement is an integral part of health service planning and a mechanism that empowers local consumers and communities to have a greater say in their hospital and health services.

Effective engagement by health service organisations with rural and remote consumers and the community is integral to better, more transparent healthcare for consumers, their families and carers. Engagement enables consumers to actively work as partners with clinicians and empowers local communities to have a greater say in planning, design, delivery and evaluation of their hospital and health services, contributing to more efficient and effective healthcare delivery.

A focus on rural and remote health service planning provides a significant opportunity for: collaboration and partnering for better outcomes across sectors of the healthcare system; connecting healthcare in rural and remote communities; and enabling shared approaches to consumer and community engagement. Working in partnership provides an opportunity to:

- achieve greater involvement of diverse consumer and community members in healthcare processes
- ensure cultural appropriateness in the planning process and outcomes
- foster rich engagement that enables health service organisations to plan, design and evaluate services central to the needs of people who use those services
- provide a seamless journey for people when accessing health services.

Effective consultation should include careful consideration of:

- the purpose of consultation—what purpose will consultation serve the planning activity and how will it inform the outcomes of planning
- when to consult—there are several components of the planning process where consultation can be used to inform planning; consideration needs to be given to which components require input from stakeholders for a given planning project
- who to consult—this will be determined by the purpose of consultation; consideration of the relevant stakeholders to engage at each stage will be required in order to maximise effectiveness of the consultation activities
- how to consult—consultative methods in rural and remote communities can include focus groups, surveys and/or public meetings; more robust methodologies ensure greater confidence that all interested individuals and organisations are effectively engaged.

Appendix 1 provides further information regarding the community engagement process.

6. Implementing the planning process

The following is a summary of necessary components for the health service planning process. Although undertaken in the following sequence some components will be developed in parallel as they inform each other and each component builds on the previous one to ensure the approach is based on evidence. Further detail on the planning process specific to rural and remote communities is provided at Appendix 2.

6.1 Scope the planning activity

The purpose of this component is to identify the scale of the planning exercise and the parameters for the planning activity. The scope will be specific to the local community and rural and remote planning requires significant collaboration.

6.2 Understand the population and service environment

This component creates a snapshot of the current population and service situation to understand the health service users, their health status and the services they access. It is important to understand the population and the adequacy of existing services in supporting health needs. This component can represent a substantial body of work. It involves extensive information collection, interpretation and data analysis. Undertaking a comprehensive data gathering and analysis process will ensure all relevant data and information informs the plan for service change. This component gathers, scans and profiles information from the following areas:

- broad policy environment—this process gathers and analyses information for strategic purposes. It ensures the plan for service change considers and aligns with government service priorities and policy. Environment scanning also considers service trends emerging through literature and clinical guidelines to ensure consideration of innovative service models, including integrated health care delivery through ICT.
- geographical context—provides an analysis of the geographical catchment/s which will highlight the challenges, limitations, risks and opportunities that the physical area presents in delivery of health services.
- health status and analysis of epidemiological data—used to describe the distribution of disease in a population. Epidemiological information may be analysed to help identify key causes of health burden—significant diseases and health conditions—and illness and death. The information also supports analysis of the comparative health status of those in the focus population with those living elsewhere in Queensland or—where relevant—nationally or overseas.
- population demographics—is one of the main elements for informing the identification of health service needs. Profiling the population provides an understanding of the size, distribution and density of the population now and in the future. It also provides information on cultural and linguistically diverse populations and where relevant information on transient/itinerant populations including tourists and non-resident workers on fly in/out working arrangements.
- current service arrangements—provides a picture of the services currently provided in the planning area and those that are planned for the future. Profiling should also consider the services provided by the broader health service network including services provided by specialist and regional hospitals and by other agencies including public, private and community-based service providers. Information should be grouped based on the care continuum including: preventative; primary; ambulatory; acute; maternity; subacute; mental health; and aged care services. Profiling current service arrangements also captures information regarding the appropriateness of the enabling functions of: workforce; assets—capital infrastructure; information management; information communication technology and funding in supporting the current service arrangements.
- service activity—provides a description of historical service patterns. Indicators of service supply and demand inform the understanding of services people are using and how particular health services respond to the needs of people accessing services. To ensure consistency with current service profiling, service activity should

be presented across the care continuum as described in profiling of current service arrangements.

- future services—provides a picture of what services may be provided in the future. Generally, for services where there is comprehensive capture of service activity data, including patient demographic information, disease prevalence incidents information, linear projections of historical activity data and population base benchmark data, waiting list data and the use of the Acute Inpatient Modelling (AIM) tool is recommended in Queensland. The tool is capable of generating a base case projection to give an indication of future demand based on historical supply. The tool assumes that nothing will change in future years, except that activity will increase/decrease in line with trends from the past five years—adjusted for population growth/decline—and changing demographics such as ageing. The tool can also be used to model different variables or scenarios that planners may wish to consider when determining potential service options.

For services which focus on a specific population group, or which are only provided at a limited number of facilities or do not have comprehensive data, rates or beds per population methodology may be more appropriate. In some cases a weighted population may be used to account for variations in health service need associated with age, sex or ethnicity.

Services which respond directly to specific diseases may be projected based on incidence or prevalence rates and an understanding of current treatment norms. For example, some cancer services are projected based on cancer incidence rates whilst dialysis projections rely on prevalence data. Appendix 2 provides further information relating to each of the areas listed above.

Potential key stakeholder consultation point

Consultation should obtain feedback regarding: accuracy of information; validation of the services currently offered; and information on barriers to utilisation of current services. It is important to allow community members and clinicians to provide input to help validate the data and gaps and to utilise additional data sources which may add valuable insight or background information.

6.3 Identify health service needs

This component of health service planning builds on the findings from the previous two components—scope the planning activity and understand the population and service environment. Health service needs are identified through the analysis of all the information collected from earlier stages of the planning process including qualitative data—information emerging from consultations—and quantitative data—derived within earlier components.

There is no defined single, consistent approach to identifying and no single particular indicator of need can be considered a definitive measure. However, single issues or themes emerging across multiple indicators will support a higher level of confidence in the validity of the needs assessment. Further information relating to identifying health service needs is located in Appendix 2.

It is important to consider what evidence there is to substantiate unmet needs of the population, particularly as expressed need may be influenced by multiple variables such as health literacy levels and constrained resources. This can be difficult and opinions may vary.

6.4 Prioritise health service needs

Prioritisation of health service needs requires the development of criteria by which the identified needs will be assessed. The criteria should be relevant to the local health service planning context. Involving relevant stakeholders should assist in determining the final prioritisation of service needs. Criteria are likely to consider: whether the need has been validated through a range of sources; does the potential solution to health need align with government direction and health priority areas; how wide spread is the extent of the health need; what is the risk or consequences if the need is not addressed. Further information relating to prioritising health service needs is located in Appendix 2.

Determining health service requirements relies on the analysis of research, qualitative information collected through consultation phases and other information collated in the previous components. The delivery of health services occurs within a resource limited environment so service needs/requirements and their solutions require prioritisation within the context of workforce, mode of service delivery, information communication technology, capital and financial environment.

Engagement with the community and key stakeholders at this stage is vital. Prioritisation of health services requires the development of criteria by which the identified needs will be assessed. Criteria should be relevant to the local health service planning context. Involving relevant stakeholders should assist in determining the final prioritisation of service requirements.

Potential key stakeholder consultation point

Consultation should provide education and communication regarding health services currently provided and the health need. Initial discussions regarding gaps and future service options within a resource limited environment should also occur. This is an opportunity to involve other health service providers in the development of future service directions to meet identified service gaps or health needs of the community. It is important to validate these priorities with the community, other health service providers within the Hospital and Health Service, private and non-government service providers.

6.5 Develop the future health service direction

The prioritised health service requirements—identified within the previous component—will provide the platform for determining the service directions. Service directions should describe clearly and succinctly the future direction/s to address the issues/needs for which the plan is seeking to address. The service direction may include identification of partnerships with local agencies and aim for agreed commitment to plans with all stakeholders.

Succinct and clearly defined service directions assists stakeholders' understanding about the intent for the future. That is, a common focus on what needs to be achieved and will support strategy development targeted to meet prioritised needs and resolve health service issues. Further information relating to health service directions is located in Appendix 2.

6.6 Identify and analyse future service changes

At this stage of the planning process a much more comprehensive understanding of the requirement for future service change is known. This stage should clearly describe: what services are expected to be provided in the future; the workforce required to provide them; who is expected to access them; and what activity—in terms of throughput—is anticipated/being planned. A range of alternative options are likely to be explored. For further information relating to identifying and analysing future service changes refer to Appendix 2.

Potential key stakeholder consultation point

Discuss transparently the service direction and the opportunities and risks for each service option. The aim is to obtain community ownership of future directions and support for future service model. This includes ensuring:

- community is aware of their role, understands all service options including issues and opportunities and is supportive of the proposed changes
- all health service providers are aware of the linkages that will be required as part of the service changes and have a realistic understanding on the impact of service changes on their service.

6.7 Develop the plan

At this point the preferred service solution is fully developed and articulated for operationalising the plan. The service direction should be supported by clear service objectives and strategies that describe each of the future services, timeframes for delivering and identification of resource implications.

Performance indicators to support evaluation of subsequent implementation of planning outcomes should also be described. The process for the review of service changes is clearly documented. For example, a health service plan which is well designed will:

- be published and communicate clear service directions to stakeholders
- provide feasible, cost effective solutions to meet the identified need
- prioritise service delivery strategies to best accommodate the changing healthcare needs of the population
- clearly articulate strategies to guide future service provision
- guide changes in service delivery models in line with existing and emerging best practice to enhance patient safety and outcomes
- articulate links between services and service providers to coordinate service provision

- identify partnerships and collaborative approaches between health service providers across the health service continuum
- establish a process for ongoing reviews inclusive of the community and other stakeholders.

Potential key stakeholder consultation point

Opportunity for final comment on service directions and strategies for service changes. Consultation normally occurs on a draft proposal prior to final endorsement.

6.8 Implementation and review

Whatever the scale of the planning activity, final outcomes will require clear documentation to support those accountable to lead and drive service delivery changes and implement service enabling actions.

The development of an implementation plan and evaluation strategy for the health service plan is essential for robust planning, implementation and monitoring and evaluation of planning outcomes and measurement of the success of a plan against pre-determined criteria.

Ongoing key stakeholder consultation

Consultation normally occurs throughout the implementation and review period. This could inform future planning.

7. Other resources

A range of additional resources are available to further support the health service planning process including:

- National Strategic Framework for Rural and Remote Health
www.ruralhealthaustralia.gov.au/internet/rha/publishing.nsf/Content/NSFRRH-homepage
- Queensland rural and remote health service framework, February 2014
- Guide to health service planning V2 2012*
- Clinical Service Capability Framework*
- Health Consumers Queensland, Consumer and Community Engagement Framework*
- Engaging Queenslanders: an introduction to community engagement
www.qld.gov.au/web/community-engagement/guides-factsheets/introduction/index.html
- Guideline for Building Performance Evaluations*
- HHS clinician engagement strategy and consumer engagement strategy may be available on individual HHS websites
- HHS and Medicare Local Protocols may be available on Medicare Local and HHS individual websites.

**To view this document, go to www.health.qld.gov.au and search for the name of the document*

Appendix 1 Community engagement

The information provided in this document is a basic outline of community engagement. Queensland Government has made a strong commitment to empowering communities and the health workforce to make decisions about local healthcare solutions³. As set out under Part 2 Section 40 of the *Hospital and Health Boards Act 2011*, HHSs must develop and publish a consumer and community engagement strategy. The Act prescribes responsibilities including engagement with primary health care, Medicare Locals and other organisations in the planning process. Such strategies are often also a requirement in accreditation standards such as the Australian Council on Healthcare Standards (ACHS).

Community engagement allows local community members and groups to provide feedback on health service needs and potential solutions. There are three levels of community engagement that can be adopted; information, consultation or active participation. While Health Service Chief Executives, Hospital and Health Boards and the Department of Health have the ultimate say on service directions, active community engagement throughout the planning process will ensure all parties consider potential service solutions and are also aware of the practical constraints of implementation. Involving external stakeholders and the community at the outset will encourage buy-in of the project and create a sense of ownership for those involved.

Many individuals involved as community representatives will bring perspectives from other industries which add to the development of local solutions and innovation within health services. Communities also bring local human and financial resources to support the development of local health services. Every community is different and will find innovative ways to support the provision of local high quality health services.

Community engagement should not be seen as an isolated event, but an ongoing process. For example, a community network established during a planning process should be maintained to provide continued input and review into health service models, plans, projects or committees.

Participants

Participants can include individuals, groups and bodies, elected representatives, commercial and industry groups and other people or organisations that might have a stake in the direction of health services. It is important to be inclusive and representative.

Representatives from general practices and local healthcare services should also be included in the engagement and planning process to ensure the resulting services are fully integrated across the community.

Private, non-government and government-funded health services staff should be considered as they can provide valuable insights and solutions. Alternatively, they could be invited as partners or stakeholders and either involved throughout the process as permanent members of a network, or only when issues are relevant to the services or consumers they represent.

³ Queensland Health, Blueprint for better healthcare in Queensland, February 2013

As the health needs of the community are identified and health services adapt to meet these needs, the role of a community network will continue to develop. The group may at times need to be advocates on behalf of their community and at other times be the catalyst for community acceptance of changes in health service delivery within the community.

The engagement process

Regardless of who is participating, information and support must be provided to members involved in the engagement process to ensure they have the knowledge required and feel empowered to be active participants.

Local residents have an understanding of the history and demographics of their community, as well as the health needs and priorities of their local population. However, community members involved should be provided with support to develop a detailed understanding of the current health services provided by their HHS and other organisations within their community. They may also need to become familiar with the various ways health services are funded and provided within their community and in other communities.

In addition, local residents may benefit from having a common understanding of current service activity and capacity, burden of disease, geographical environment, health data, budgets, health system regulations, human resources and proposed solutions. HHSs should communicate in a transparent manner quantitative and qualitative information that informs service changes. Other health services such as general practice, Queensland Ambulance Service, Medicare Locals, local government, private providers and non-government services may also share information. If data is not available the specific reasons for this should be made clear. An example of this may be data that could identify individual patients. Community members may wish to engage individuals or organisations to support them in understanding information provided to them.

There must also be a process in place to ensure the broader community is fully informed of the vision and process for planning local health services. This can be established through media such as newspapers, websites, Facebook or newsletters. Community meetings may be suitable for significant issues or changes where input from the broader community is desired.

Establishing a shared service direction and objectives for the plan is an important first step in the process to ensure all involved are working together towards the same goal. This service direction should be supported by the Department of Health, community members and other stakeholders. The service direction for the planning process will assist in defining the process to allow more effective use of resources.

Determining the goal the organisation wants to achieve through community engagement will result in better outcomes for all involved. The most important aspect of community engagement is managing expectations. Be clear at every stage of the engagement process with community or stakeholders regarding their ability to actually influence the negotiable and non-negotiable decisions and be able to explain decisions optimising outcomes with limited resources. Otherwise the community could be providing input into something that they have no influence over and will feel disillusioned and frustrated if they feel they haven't been heard.

Golden rules of engagement are:

- information is the catalyst for quality engagement
- establish early negotiable and non-negotiable areas
- do not promise what cannot be delivered
- be honest
- provide multiple avenues for involvement
- close the loop.

Appendix 2 Guidance on components of the planning process

Understand the population and service environment

Scan broad policy environment

In scanning the broad policy environment consider:

- government priorities—Australian Government and State Government—and commitments
- departmental priorities and commitments
- local interpretation of changing or emerging health policy
- changing service directions of all providers
- national and international scanning of literature for new or emerging service models and innovation in areas such as ICT.

To help with information sharing and decision making, summary documentation including references to source documents should be prepared as background information for community members and others involved in the service planning process.

Profiling the geographical context

Local government, the Queensland Government Statistician and the Australian Bureau of Statistics (ABS) are key sources of information that are available to support profiling the geographical context. Planning should consider:

- size, boundaries and location to main populated areas and referral centres with travel time and transport options
- brief description of the main aspects of the area such as economic activity and tourism
- impacts of major industries within the area on health services
- localities or geographic conditions within the catchment that may present difficulties for delivery of health services
- degree of remoteness—according to the Australian Statistical Geography Standard (ASGS).

Profiling the health status

Planning should consider:

- key causes of health burden—significant diseases and health conditions, key causes of illness and death
- health related behaviours including alcohol consumption, body mass index and smoking
- potentially preventable factors
- environmental and occupational risk factors
- infectious diseases

- the comparative health status of those in the focus population with those living elsewhere in Queensland or (where relevant) nationally or overseas.

Data sources

- Health Statistics Unit including Queensland Hospital Admitted Patient Data Collection and Perinatal Data Collection
- Office of Chief Health Officer for population health reports
- General Practice: primary healthcare population profiles
- Primary Health Information Development Unit: health survey
- National Health Performance Authority 2013, *Healthy Communities: Australian's experiences with primary healthcare in 2010–11*.

Data may also be sourced from other agencies such as Royal Flying Doctor Service, Queensland Ambulance Service, child safety and police.

Profiling the population demographics

Planning should consider:

- current estimated and projected population—size, distribution and density
- socio-economic and disability status and social disadvantage of the community compared to state averages—health determinants
- significant trends for geographic catchments in the planning area or among particular age or ethnic groups
- age breakdown—provide the main characteristics of the population and how they may be changing e.g. getting older/younger. More specific age group breakdowns e.g. young people aged 15–25 years may be required
- estimated current and projected Aboriginal and Torres Strait Islander population—size, population share and distribution
- estimated culturally and linguistically diverse populations including refugee populations—size, population share and distribution
- transient/itinerant population—non-resident workers, visitors and potential cross-border flows—what is known about numbers and key features of these groups as potential health service users
- implications of population characteristics on health service needs.

Data sources

- Australian Bureau of Statistics (ABS) is a key source for historical, demographic and socio economic data
- Infobank provides comprehensive demographic data from the ABS and the Queensland Government Statistician often available by HHS and age and sex
- Government Statistician has an interactive website that enables generation of regional profiles.

Profiling of current service arrangements

Information on service levels, types and models of service delivery should be described, including:

- service description—level, setting, hours of service, type of patient, providers
- service specific requirements e.g. interventions, referral pathways, transfer arrangements, specific expertise of clinicians
- workforce requirements—minimum staff employed, orientation, continuing education and training e.g. basic life support
- support service requirements—minimum support, clinical and non-clinical, services required to deliver a particular capability level of service
- relationships with higher level services
- funding of services—state or the Australian Government, private
- specific risk considerations and mitigating strategies
- effectiveness of service model e.g. what is working well and what is not e.g. what issues are facilitating/hindering the service model
- clinical support functions required to support the service e.g. pharmacy, radiology
- non-clinical support functions required to support the service e.g. kitchen, laundry, morgue.

Modalities of service delivery may include—these are examples only:

- ICT platform including shared electronic health records and discharge summaries, Telehealth and eHealth systems
- outreach service model
- visiting services including fly-in, fly-out models
- other service providers e.g. general practitioners, private allied health, local government and residential aged care.

Each plan should consider services provided across the care continuum including and where relevant the following service groupings.

Preventative and primary healthcare services

- Preventative health services refer to a broad range of health promotion, prevention and protection services, such as injury prevention, screening services, communicable disease prevention and management of environmental health risk factors. List each program provided locally, the organisation responsible, the funding source and organisation responsible for the program. Identify gaps in services and potential programs relevant to the community demographic.
- Primary healthcare services are often the patient's first point of entry into the health system. Primary healthcare services address existing health problems or established risk factors of individuals and small targeted groups providing curative, health promotion, preventative and rehabilitative services. The majority provider of primary health services across the HHS is general practice. Describe the general practice model (private/medical superintendent with right to private practice/visiting medical officer or a mixed model). Include hours of operation and any additional services provided.

- Describe allied health, early childhood services, school based programs, Department of Education, Training and Employment, Medicare Locals, private providers, industry based services and non-government organisations. Include the relationship to acute services.

Ambulatory services

- Ambulatory services refer to a broad range of emergency medical services, oral health services, public outpatient services—including pre-admission—post acute and other specialist, allied health, nursing and ancillary services.
- identify current use of Telehealth to provide increased access to services
- identify the capacity of service providers to respond in a critical event.

Acute care services

- Acute care services refer to the health activities carried out in hospitals, including emergency, day surgery and a wide range of elective care. Acute care services are provided for patients experiencing an exacerbation of an existing health condition, or who are experiencing the onset of a new illness or injury requiring hospitalisation or specialist services.

Maternity and neonatal services

- Maternity services—antenatal, birthing, post natal and neonatal services may be provided in a range of settings including the hospital, community and other environments. The service plan should describe:
 - current model of care
 - relationships with other public and private providers locally or in another community
 - arrangements for higher level of care (where required) and for birthing services if not available locally.

Sub-acute care services

- Sub and non-acute services include rehabilitation, palliative care and geriatric evaluation and management services.

Mental health and alcohol and other drugs

- Mental health and alcohol and other drugs services span the health continuum from promotion, prevention and early intervention activities through to acute and extended treatment services for children through to adults.

Aged care

- Aged care services may include high and low residential aged care or flexible care places (Community Aged Care Packages (CAPS) and Extended Aged Care at Home (EACH) packages) and Home and Community Care (HACC) services.
- Include relationships with other aged care providers, including multi-purpose health services, residential and non-residential services located within the local community.

Access to higher level care

Current options for transfer of patients requiring additional care are important when considering rural and remote health services. These services may be for emergency, elective and outpatient care. Therefore it is important to identify:

- the number of patients requiring hospital to hospital transfer by road or air and their destinations
- reason/condition for transfer
- numbers of admissions or occasions of service for residents of the catchment area
- referral data for ambulatory care services including specialist services e.g. ear, nose and throat (ENT), paediatrics
- protocols for patients returning from higher level services.

Profile of service activity

For readability this information should be presented using the same service groups used to describe service arrangements.

Some indicators of service demand—by permanent and non-permanent residents of the catchment of interest, regardless of the location of the place of treatment, include:

- distribution of activity volumes between private, public and other services
- patient flows for particular services—within and outside of the catchment of interest
- rates of service utilisation (compared to other populations for the same service).
Level of self-sufficiency which is an indicator of how services meet local needs
- weighted activity units provided in comparison to facilities of similar size and communities of similar population.

Preventative and primary healthcare services

- clinic type
- occasions of services
- proportion of adults and children
- general practice:
 - daily totals—number of patients seen
 - length of time to first available appointment
 - percentage of bulk billing
 - referrals to public and private providers
 - Medicare billing data by postcode or statistical local area.

Ambulatory services

- emergency care presentations, triage category, wait time, change overtime, annual growth, proportion of adults and children
- outpatient clinic type—as per Tier 2 outpatient clinic definitions—and occasions of service
- retrieval, transfers and referral patterns.

Acute care services

- separations—emergency and elective, procedures, bed days and occasions of service—volumes, occupancy, change over time, average annual growth
- number of physical beds, operational beds and volume of activity
- stay type—same day/overnight
- level of care as assessed against Clinical Service Capability Framework
- time in procedural or operating rooms
- volume of same day and overnight admissions
- average length of stay
- top ten diagnostic related groups (DRGs) admissions
- peer service comparisons—Independent Hospital Pricing Authority (IHPA) classification and National Efficient Cost
- number of National Weighted Activity Units (NWAU)/Queensland Weighted Activity Units (QWAU) currently delivered
- case complexity—through cost weights linked to particular DRGs.

Maternity and neonatal services

- procedures, hospital admissions—separations, bed days and occasions of service—volumes, occupancy, change over time, average annual growth
- number of physical beds, operational beds and volume of activity
- stay type—same day/overnight
- level of care as assessed against Clinical Service Capability Framework
- retrieval, transfers and referral patterns.

Sub-acute care services

- respite
- occasions of services/bed days
- volume of activity
- care type
- length of stay—same day/overnight.

Mental health and alcohol and other drugs

- care/treatment type
- hospital admissions—separations
- non admitted patient occasions of service—home visits, community and outpatient services
- transfers and referral patterns
- quarterly statistical reports from non-government service providers including number of clients supported, places provided, waiting lists, hours of service delivery.

Aged care

- number of funded residential beds—high and low care—number of operational beds

- number of Community Aged Care (CACP) and Extended Aged Care at Home (EACH) Packages
- number of aged care beds compared to Commonwealth benchmark
- admissions, separations, average length of stay, occupied bed days
- Home and Community Care (HACC) funded services
- current levels of utilisation—waiting lists
- number of aged care assessment team (ACAT) assessments completed.

Data sources

Note: data sources used will be tailored to planning requirements. Sources may be added/varied depending on local providers.

- Queensland Hospital Admitted Patient Data Collection (QHAPDC): Morbidity data for admitted inpatients in Queensland public hospitals and licensed private hospitals and day surgery units.
- Monthly Activity Collection (MAC): Admitted and non-admitted patient activity and bed availability for information for public acute hospitals, psychiatric hospitals, nursing homes and hostels and multi-purpose health services.
- Emergency Department Information System (EDIS): Tracks patient attendances, movement and subsequent care in the emergency department. Not all facilities use EDIS, but most of the larger hospitals will.
- Medicare billing data is available from the Australian Government. Please note there may be a cost to obtaining this information.
- Alcohol and other drugs treatment services: National Minimal Data Set
- Community health data: No standard activity data captured centrally. Individual facilities/services need to be approached to determine availability of data.
- Consumer Integrated Mental Health Application (CIMHA): Mental health provision of service data.
- General Practice data: should be sourced from local General Practice or Medical Specialist with right to private practice.

Other relevant data from other sources, such as Retrieval Services Queensland, Queensland Ambulance Service, Royal Flying Doctor Service, aged care services, mental health services and other service providers should be considered as available and relevant.

Note: collecting, interpreting and analysing health service activity data is a specialised skill. This component may require support from HHS data managers or health information experts to ensure quality and validation of data sources and collections.

Describe current workforce profile

A description of the current workforce profile by service type as per grouping described above should be included—including any unfilled roles. The following should be considered:

- full-time equivalent staff levels
- qualifications and credentials

- scope of practice
- age and gender
- length of tenure
- leave balances
- workforce turnover rates.

Where possible both the public and private workforces should be described as well as any model of care arrangements that exist, particularly those that cross HHS e.g. services provided on an outreach basis or Medicare Local boundaries to deliver services.

A description of the broader health workforce should be included, such as, general practice, allied health, private providers, industry based services, education and other government services, non-government services and other health related services.

Where available a historical workforce profile should be considered. To be of the most value, in terms of observing trends or change over time, a profile of workforce over the most recent three to five years is recommended to support an effective statistical analysis.

Describe land and buildings

The plan should provide a description of the current infrastructure of all holdings including accommodation. The condition of the infrastructure and adequacy of physical design to meet current service requirements should be included. Key considerations for assessing the site and existing infrastructure include:

- land related issues, helicopter landing sites, site access and car parking, town plan zoning, cultural/heritage issues, environmental issues, external utilities on the site
- condition of buildings and building services, compliance with relevant standards and codes, lifecycle of capital infrastructure, residual capacity of building services and rectification strategies
- list other health infrastructure not operated by HHS.

Scope and understand your current ICT environment

- Document a profile of all ICT assets i.e. the supporting infrastructure, technologies and applications used by both clinical and business areas to perform their required functions and support health service delivery. Build and maintain a register of ICT assets which includes costs and risks associated with the assets.
- Assess how well those assets are function—technical condition.
- Assess how important they are for supporting the delivery of health services—business impact.
- Determine current risks and challenges attributed to the underpinning ICT.

Determine future requirements

With future service delivery requirements identified and a profile of current ICT environment known, each HHS can then identify opportunities to enhance service delivery through the use of ICT. In determining a future ICT profile, HHSs should consider:

- What services could benefit from additional ICT support?

- If ICT can be used to support a reduction in the cost of service provision in the longer term?
- Can existing ICT (platforms, technologies and system) be further leveraged to meet required health service delivery outcomes?
- Can the number of ICT asset (e.g. applications) performing the same function be rationalised across the HHS to reduce support costs?
- How ICT is being used to support delivery of health services in rural and remote areas both nationally and internationally.

Develop an ICT strategy an ICT portfolio (investment plan)

To underpin health service plans, HHSs can develop a local ICT strategy and investment plan to guide future investment in ICT—to ensure ICT is focused on promoting innovation in health service delivery and aligned with strategic priorities. This will provide a basis for HHSs to monitor the performance of ICT in supporting business and health service delivery outcomes, manage change and measure benefits.

Describe Telehealth enabled clinical services

Telehealth is a key example of how ICT is being applied to deliver health services to rural and remote regions. A description of the current enabling technology platform and Telehealth capacity within a planning area to identify opportunities and constraints that may impact implementation of Telehealth enabled clinical services.

Information gathered should include (but not be limited to):

- Wide Area Network (WAN) link size
- video conferencing contention ratio associated with the size of the WAN link
- availability and location of wireless infrastructure
- number of videoconferencing systems currently/awaiting install on the WAN link
- physical location of videoconferencing systems, including suitability for clinical consultation taking into account system/room design, privacy and accessibility
- configuration and type of videoconferencing systems (wall mount, desk top, trolley mount, wireless/powered, software client, videoconferencing codec model, monitor size)
- existing or planned integration of peripheral devices e.g. digital stethoscope, ultrasound, document camera
- primary use of existing videoconferencing systems (retrieval services, clinical scheduled/unscheduled care, education, administration)
- process to access/book videoconferencing system/room
- average monthly usage of existing videoconferencing systems
- capacity for growth in the number of videoconferencing systems on the WAN link
- contact details for local system support
- consider the Telehealth capacity of general practice and current level of use for private and public consultations
- access to tele-radiology for reporting of medical imaging examinations ability to share information e.g. medical images, with partners including private sector.

Data sources

- Tandberg Management System (TMS): Provides detailed system and conferencing records for every videoconferencing system on the network
- Health Services Information agency (HSIA): for support in developing local ICT strategies, investment plans and ICT asset registers.

Describe current funding sources

It is important to consider the financial context of health service delivery. Financial resource allocation and the services delivered as part of that allocation will form a large part of defining current service capacity. Financial allocations should be benchmarked against similar facilities across the state and in context with location and the services currently provided and should:

- identify current annual budget—recurrent and non-recurrent costs
- benchmark against similar facilities
- compare to indicative block funding allocation
- compare to funding allocation based on national efficient price
- identify external funding currently accessed by the local facility.

Other health funding currently provided to the community

As there are multiple sources of funding for health services, it is important to identify other current funding provided to the community. This will assist to identify potential future partnerships and may include

- Australian Government funded health services e.g. HACC, Rural Health Outreach Fund, Medical Outreach Indigenous Chronic Disease Program and Medicare Local services
- State Government funded services not based with HHS e.g. disability services
- Medicare funded services—in both dollar value and in comparison with other similar locations
- private health insurance for the population as a comparison with other similar locations
- services funded through private health insurance, Department of Veteran Affairs (DVA) fee for service and other health service funding available
- health services funded by industry and other government services
- funding provided by non-government or charitable organisations e.g. Royal Flying Doctor Service, Red Cross, Queensland Cancer Fund.

Data sources

- Local HHS data
- HHS Service Agreement
- Department of Veterans Affairs
- Medicare Locals

Information may also be sought from a range of other service providers.

Project future services

There are a number of different ways of projecting activity to estimate possible future demand. The most appropriate projection methodology will need to be determined based on the type of service being planned, availability of data and current understanding of health need.

Generally, for services where there is comprehensive capture of service activity data, including patient demographic information, disease prevalence incidents information, linear projections of historical activity data and population base benchmark data and the use of the Acute Inpatient Modelling (AIM) tool is recommended in Queensland. The tool is capable of generating a base case projection to give an indication of future demand based on historical supply—assuming that nothing will change in future years, except that activity will increase/decrease in line with trends from the past five years (adjusted for population growth/decline) and changing demographics such as ageing. The tool can also be used to model different variables or scenarios that planners may wish to consider when determining potential service options (this is also discussed in more detail in the final component).

For services which focus on a specific population group, or which are only provided at a limited number of facilities or do not have comprehensive data, rates or beds per population methodology may be more appropriate. In some cases a weighted population may be used to account for variations in health service need associated with age, sex or ethnicity.

Services which respond directly to specific diseases may be projected based on incidence or prevalence rates and an understanding of current treatment norms. For example, some cancer services are projected based on cancer incidence rates whilst dialysis projections rely on prevalence data.

For Queensland public services, a number of health service planning guidelines describe methodologies for projecting future health service requirements. Development of the health service planning guidelines has been as a result of extensive research into national and international methodologies currently in use.

The guidelines aim to provide service planners, clinicians and managers with common agreement of methodologies to be used in determining service requirements. Application of guidelines is required for all service planning projects to support a robust and consistent approach to achieving service delivery goals across the Queensland public health system.

Detailed information about health service planning guidelines can be found at the Department of Health Electronic Publishing Service (QHEPS) Policy and Planning Branch (PPB) health service planning website.

Projecting aged care services

Residential aged care service requirements are determined based on a ratio of places per 1000 persons as described by the Australian Government.

Support

The Health Service Research, Analysis and Modelling Unit (HSRAM) within the PPB can assist in developing projections for inpatient services. HSRAM is the only source of projection data from the corporately-endorsed Acute Inpatient Modelling (AIM) tool. HHS staff should make requests for assistance or data through the PPB. For more information visit

http://qheps.health.qld.gov.au/ppb/html/ppb_dataanalmodel_home.htm

Data tools include:

- AIM—projection tool for most inpatient activity for Queensland Health facilities
- Health service planning guidelines—have been developed by the Policy and Planning Branch for projection methodologies of some inpatient and non-inpatient services.

Identify the health service needs

Health service needs are identified through the analysis of the information collected from earlier stages of the planning process including:

- qualitative data e.g. issues emerging from consultations
- quantitative data—derived within earlier components.

The following indicators of need have been identified in the literature:

- felt need—refers to what people say is needed
- expressed need—refers to need inferred by service utilisation patterns—data
- normative need—refers to expert opinion for example, evidence-based guidelines
- comparative need—refers to need identified by comparing services or resources or similar communities⁴.

An assessment of need may require a process of reviewing lots of information from a range of data sources in order to identify a pattern, where similar issues or needs are indicated and supported by multiple indicators. Needs should be validated through more than one source of evidence e.g. projected population data, expert opinion, consultation, community profile and literature review). Once needs are identified, it can be useful to group similar service needs or issues that may require similar service responses. This can assist in providing some structure for the prioritisation process—the next component. For example, it may be appropriate to group service needs into categories or themes such as those associated with:

- population growth
- particular clinical health issues
- service organisation and relationships.

Prioritise health service needs

This table provides an example of possible health service need prioritisation criteria.

⁴ Sten A, John B, Rick E, Lyne L. The planning process: the health planner's toolkit. Health Systems Intelligence Project. Ontario: Ministry of Health; 2006.

Element	Questions
Validation as need	Has the need been identified using more than one method (for example, consultation, community profile, literature review and data analysis)?
governmental direction	Does the potential solution for this need align with government strategic directions, targets, election promises or other commitment or formal obligation?
corporate consistency	Does the potential solution for this need align with the identified strategic directions or targets?
magnitude	How widespread is/what is the extent of the health need? Is it associated with the greatest historical growth?
urgency	Does a potential solution have to be put in place immediately, or are longer term solutions possible?
feasibility	Can the potential strategy be implemented within available resources—financial, workforce, information management or assets (capital infrastructure)? Can the potential strategy be implemented within the particular environmental conditions including geographical, political, social and/or financial?
sensitivity	Is the potential strategy likely to be accepted by stakeholders? If not, why not?
risk	What are the potential consequences if the need is not addressed?

Apply the prioritisation process

Prior to commencing the prioritisation process, it is necessary to have:

- determined prioritisation criteria including local-specific criteria
- clearly identified the health service needs—as a result of previous component.

The priority setting process can then be undertaken. The most common technique used for priority setting is a scoring system based on weighted criteria—from least to most important. Scores are then applied to each need to determine order of importance.

The rating is most effectively done by a representative group of stakeholders. However, note that priority setting with stakeholders is a competitive process and careful consideration should be given to how this process is facilitated as part of project management. It is critical to distinguish genuine needs from ‘wants’ that are not supported by evidence. Clear documentation of prioritisation criteria and the process used is integral to ensure transparency.

Develop the future health service direction/s

The benefit of having clearly defined service directions is that it assists stakeholders to be clear about the intent for the future i.e. a common focus on what needs to be achieved, and will support strategy development targeted to meeting prioritised needs and resolving health service issues. Service direction/s should be amenable to action and should provide:

- a vision for the future
- a clear picture of intent

- realistic aspirations
- explicit and transparent goals
- an achievement horizon
- alignment with Australian Government, Queensland Government, Departmental and HHS strategies and objectives.

The prioritised health service needs—identified within the previous component—will provide the platform for determining the service directions. This will be simplified if the needs have been grouped into emerging themes or categories. The next step is to develop overarching or strategic service directions which, if implemented, will outline what will be accomplished.

Identifying potential partnerships

Over the last 10 years partnerships between HHSs and other service providers have developed to reduce duplication and fragmentation of services. Into the future these partnerships will continue to expand and move towards more integrated services with the implementation of local governance through the Hospital and Health Boards and closer working relationships with primary health care providers through the development of Medicare Locals. It is important that service integration and partnerships are identified and formalised as part of a local health service model and described in service directions.

Identify and analyse future service changes

A range of alternative service options are likely to be identified and analysed. The purpose of the development and analysis of service options is to:

- clearly describe future health services including the requirements on workforce redesign, ICT, infrastructure and funding
- provide clear identification of the implications, benefits, limitations and risks of each possible service option—including service enabling requirements
- provide decision makers with evidence to make informed decisions recommending option/s to progress to implementation based on the outcome of the planning
- identify health service partnerships and the process required to formally establish partnerships and the benefit of these service delivery models
- identify potential sources for additional health service funding if new or service models are developed.

Generally, service changes will have two basic types of resource implications—those that can be implemented within current resources e.g. resources may be used differently however no additional resources are required to implement changes in service delivery; or those strategies that will require additional resources. The extent to which implementation is feasible within existing resources should be assessed in the first instance, prior to determining the need for additional resources. The possibilities of using existing resources differently should be fully explored including new models of care, changes to staffing mix and task sharing. It may be necessary to identify more cost effective and efficient ways of delivering services within existing resources. This could include re-organisation of existing services and/or changes in service investment, where appropriate.

Specific resource implications of planning activities may include:

- infrastructure, such as new or redeveloped buildings, equipment for the provision of clinical services—beds, clinical treatment equipment, technology systems—and non-clinical infrastructure—car parking, records storage areas
- human—both clinical and non-clinical staff
- support service functions, such as clinical—pharmacy, pathology and radiology—and non-clinical—catering, maintenance services, cleaning and general costs associated with these resources.

Detailed budgets and staffing models should be developed for each option. It is important to clearly identify the resource implications and associated risks of any proposed service changes.

Glossary

Australian Bureau of Statistics (ABS)	The Australian Bureau of Statistics is the official and central statistical organisation for the Australian Government. The primary responsibility of the ABS is to provide official statistics that serve the needs of all levels of government.
Accessibility/Remoteness Index of Australia (ARIA+)	Accessibility/Remoteness Index of Australia (ARIA) was developed by the Commonwealth Department of Health and Aged Care and the National Key Centre for Social Applications of Geographical Information Systems. ARIA measures remoteness based on the physical road distance between a settlement and four classes of service centre. In 1999 a further revision of ARIA called ARIA+ was developed that incorporated more information on the location of service centres. ARIA+ was used to create the 2006 ASGC Remoteness Structure.
Bed days	The number of full or partial days of stay for patients who were admitted for an episode of care and who underwent separation during the reporting period. A patient who is admitted and separated on the same day is allocated one patient day.
Consumers	Consumers are people who use, or are potential users, of health services including their family and carers. Consumers may participate as individuals, groups, organisations of consumers, consumer representatives or communities. Source: Health Consumers Queensland <i>Consumer and Community Engagement Framework (2012)</i>
Consumer engagement	Consumer engagement informs broader community engagement. Health consumers actively participate in their own healthcare and in health, policy, planning, service delivery and evaluation at service and agency levels. Source: Health Consumers Queensland <i>Consumer and Community Engagement Framework (2012)</i>
Community engagement	Community refers to groups of people or organisations with a common local or regional interest in health. Communities may connect through a community of place such as a neighbourhood, region, suburb; a community of interest such as patients, industry sector, profession or environment group; or a community that forms around a specific issue such as improvement to public healthcare or through groups sharing cultural backgrounds, religions or languages. Source: Health Consumers Queensland <i>Consumer and Community Engagement Framework (2012)</i>
Criteria for success	Criteria for success are used to demonstrate the achievement of outcomes of a planning activity in terms of accomplishing service directions or meeting the intent of the planning. Source: Department of Health <i>Guide to health service planning v 2 (2012)</i>

Clinical Services Capability Framework (CSCF)	CSCF has been designed to guide a coordinated and integrated approach to health service planning and delivery in Queensland. It applies to both public and licensed private health facilities and will enhance the provision of safe, quality services by providing service planners and service providers with a standard set of minimum capability criteria. The CSCF is updated from time to time.
Health service need	Health service need refers to the gap between what services are currently provided to a given population and what will be required in the future to improve the health status of a community (and avoid a decline). Source: Department of Health <i>Guide to health service planning v 2 (2012)</i>
Health service planning	Health service planning aims to improve health service delivery and/or system performance to better meet the health need of a population. It encompasses the process of aligning existing health service delivery arrangements with changing patterns of need. Source: Department of Health <i>Guide to health service planning v 2 (2012)</i>
Health service planning guidelines	Health service planning guidelines provide commonly agreed on methodologies to be used in determining future service requirements
Medicare Locals	Medicare Locals are local primary healthcare organisations
Model of care	A model of care outlines best practice patient care delivery through the application of a set of service principles across identified clinical streams and patient flow continuums. An overarching design or description of how care is managed, organised and delivered within the system. Source: Department of Health <i>Guide to health service planning v 2 (2012)</i>
Occasions of service	Occasions of service include any examination, consultation, treatment or other service provided to a non-admitted patient in each functional unit of a health service facility on each occasion such service is provided.
Population projection	An estimate of the future resident population of a given area. The Queensland Government produces updated population projections for all Queensland on a regular basis.
Primary healthcare	Primary healthcare is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems. Comprehensive primary healthcare includes health promotion, illness prevention, treatment and care of the sick, community development and advocacy and rehabilitation. Source: <i>Australian Primary Health Care Research Institute Primary health care position statement (2005)</i>

Queensland Hospital Admitted Patient Data Collection (QHAPDC)	<p>The Queensland Hospital Admitted Patient Data Collection (QHAPDC) is the corporate repository for demographic and morbidity data on all admitted patients separated (an inclusive term meaning discharged, died, transferred or statistically separated) from both public and licensed private hospitals and private day surgeries in Queensland</p> <p>The system used to collect data for QHAPDC in public hospitals is known as HBCIS (Hospital Based Corporate Information System). All patient separations and patient days (or occupied bed days) that occur in public hospitals are recorded via direct or indirect access to an operational HBCIS system.</p>
Rural and remote community	<p>Rural and remote communities are defined in this paper as those communities with an Australian Standard Geographical Classification (ASGC) Regional Area of RA2 and RA3—regional or Remoteness Area of RA4—remote or RA5—very remote.</p> <p>Source: <i>Australian Bureau of Statistics Australian standard geographical classification (2011)</i></p>
Service delivery model	<p>Service delivery models are an adaptation of an organisation's model of care and describe where and how work is carried out. Service delivery models suit the local environment and resources to best meet the overarching organisational requirements.</p> <p>Source: Department of Health <i>Guide to health service planning v 2 (2012)</i></p>
Service directions	<p>Service directions describe the direction/s for the organisation to address the identified issues/needs. Service directions assist stakeholders to be clear about the intent for the future and support strategy development targeted to meeting prioritised needs and resolving health service issues.</p> <p>Source: Department of Health <i>Guide to health service planning v 2 (2012)</i></p>
Service options	<p>Service options describe the most appropriate service arrangements, configurations or models of care proposed to sustainably address future health service needs.</p> <p>Source: Department of Health <i>Guide to health service planning v 2 (2012)</i></p>

