Torres and Cape Hospital and Health Service

Clinical Services Plan 2019-2029

Queensland Government

Torres and Cape Hospital and Health Service Clinical Services Plan 2019 – 2029.

For more information contact:
Strategy, Planning and Performance Unit
Office of the Chief Executive
Torres and Cape Hospital and Health Service
PO Box 5607, Cairns Qld 4870

All data presented was accurate at the time of publication.

Acknowledgement of Country

Torres and Cape Hospital and Health Service acknowledges and respects the Traditional Owners of the land on which we live and work, and acknowledges their continuing connection to the land and community which we serve.

We pay respect to them, their culture, and their Elders past, present and future.

Acronyms

Acronym	Meaning
ASR	Age standardised rate
CHHHS	Cairns and Hinterland Hospital and Health Service
COPD	Chronic obstructive pulmonary disease
CSCF	Clinical Services Capability Framework
ED	Emergency department
ENT	Ear, nose and throat
GIT	Gastrointestinal tract
GP	General practitioner
HHS	Hospital and Health Service
ICT	Information and communication technology
MPHS	Multipurpose Health Service
NDIS	National Disability Insurance Scheme
NPA	Northern Peninsula Area
PHC	Primary health centre
PHCC	Primary health care centre
PTSS	Patient Travel Subsidy Scheme
QLD	Queensland
SA	Statistical area
SEIFA	Socioeconomic indexes for areas
TCHHS	Torres and Cape Hospital and Health Service

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Messages from the Torres and Cape Hospital and Health Service

This Clinical Services Plan identifies the key issues and health needs in our community, and a plan of how to best respond to those issues and needs over the next 10 years. The Plan aligns to My health, Queensland's future: Advancing health 2026, and the Queensland Government's vision for keeping Queenslanders healthy and giving all our children a great start.

We proudly service communities from as far north as Saibai Island in the Torres Strait, south to Wujal Wujal, east to Cooktown and west to Pormpuraaw. Each community is unique and culturally diverse, as are their health care needs.

This Plan reflects on past achievements to build a strong foundation for our future direction to realise Queensland Health's service planning directions to transform, optimise and grow to best service communities.

It recognises how far we have come and sets out our aspirations for the next decade as we strive for equity in access and health outcomes for all to Close the Gap, particularly for those who are most disadvantaged.

Good foundations already have been laid and I would like to thank former chair Bob McCarthy, who led the health service from its foundation, for the solid work he has already done in supporting the Clincal Services Plan. I would also like to thank all who contributed to the Plan including community members, the Community Advisory Networks, our service partners and all staff.

This Plan represents an important next step in our shared journey to deliver contemporary and high quality healthcare services that are truly responsive, integrated, connected and culturally appropriate.

Elthies (Ella) Kris
Board Chair

I am very pleased to present our Clinical Services Plan. The Plan establishes a vision for Torres and Cape Hospital and Health Service (TCHHS) services to operate at the top level of their capacity, capability and technology. It builds a foundation for us to deliver more services closer to home by improving current and future health service capability for our hospitals, that will in turn provide better services for our communities.

Equitable health outcomes for TCHHS residents compared to other Queenslanders, and closing the gap in life expectancy for Aboriginal and Torres Strait Islander peoples, remains our key focus.

The Plan was developed in partnership with our Clinical Council, who assisted with identifying clinical priority areas from clinician-based evidence.

The Plan presents six priority areas with 27 key actions that span health promotion and prevention activities, primary health care and acute care and enablers such as workforce and technology.

We are committed to implementing the Plan to guide the health service's continued improvement, underpinned by the supporting elements of our workforce, infrastructure, funding arrangements, and our information and communication technology.

Successful delivery of the key actions against each priority area will make a meaningful difference for our staff and the communities we care for.

Beverley Hamerton
Health Service Chief Executive

Executive summary

This Clinical Services Plan provides the direction and focus required to meaningfully improve the health outcomes of our people over the next 10 years.

Overview

Torres and Cape Hospital and Health Service (TCHHS) is the main provider of primary health care, acute and aged care services in the Torres Strait Islands, Northern Peninsula Area and Cape York region. The region is characterised by a remote and dispersed population.

The TCHHS covers an area close to 7.5% of Queensland, but the resident population is less than 1% of Queensland's population. These communities are extremely remote, and located in areas that require significant travel, have limited access during the wet season, or are only accessible using an aeroplane or barge, which are infrequent and expensive forms of transport. This creates challenges for patients to access health services and to ensure that services are co-ordinated and delivered as close to home as possible.

In addition, the region experiences some of the highest rates of socioeconomic disadvantage in both Queensland and Australia. The population has a lower life expectancy than the rest of Queensland at 61 years (19 years lower), higher rates of chronic disease such as diabetes and heart disease, and is also more likely to engage in risky behaviours such as excessive drinking and smoking.

Given these challenges it is important to develop a Clinical Services Plan to identify the key needs and issues in our community and develop priorities on how best to respond to those needs and issues. This Plan sets out the priorities for TCHHS over the next 10 years and takes into consideration existing Queensland Government health policy, including My health, Queensland's future:Advancing Health 2026, and TCHHS' Strategic Plan.

The aim of the Clinical Services Plan is to continue to improve the life expectancy and health of our population through comprehensive, culturally appropriate primary health care, health promotion and prevention, and appropriate acute services.

How has this Clinical Services Plan been developed?

This Plan has been developed in three phases and is underpinned by a review of TCHHS demographic and service data and extensive consultation with TCHHS staff, clinical staff and the community, as per Figure 1.

Next steps

This Plan presents a series of priorities and actions that if successful will have a significant impact on the health outcomes of our people. Successful delivery of these actions will rely on the development of detailed implementation and enabling plans such as a Workforce Plan, an Infrastructure Master Plan and Technology Plan to continue to build on these actions.

Implementation plans for each priority area and actions will identify the steps required to realise the vision for health services in the Torres Strait Islands, Northern Peninsula Area and Cape York outlined in this Plan.

Demographics of our region

Population growth in the Torres Strait Islands, Northern Peninsula Area and Cape York region is projected to grow slowly at 0.63% per annum over the period 2016-2031, compared to 1.66% for Queensland (Figure 2). The majority of this growth is expected to occur in Weipa and its surrounds.

However, the age distribution of people is expected to change significantly, with the proportion of people aged 60 years and over to increase from 11% to 16% *(Figure 3)*. While the proportion of older people will remain below the rest of the state (25%), it represents a significant shift for our population with a greater number of older people than in the past.

Our population is also unique. Approximately 65% of our population are Aboriginal and Torres Strait Islander peoples, which bring cultural and linguistic diversity to our region *(Figure 4)*.

Figure 1: Process to develop the Clinical Services Plan.

Current and future service needs and issues
A review of challenges in delivering services, and consideration of the changing population and its health status on service delivery.

Consultation
Site visits, a broad staff survey and targeted consultation, to validate phase 1 and identify gaps in services and priority going forward.

Developing the priorities
Summarising the findings of the first two phases, to agree on a set of service priorities to address the gaps and needs identified.

Consultation summary

Figure 2: Population growth.

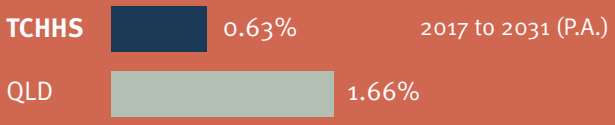


Figure 3: Age distribution.

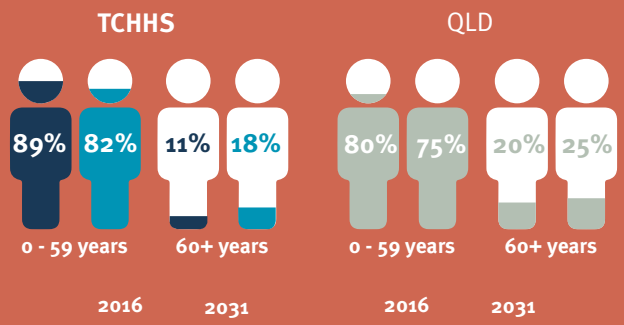


Figure 4: Aboriginal and Torres Strait Islander peoples.

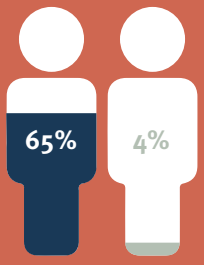


Figure 5: Socioeconomic status.

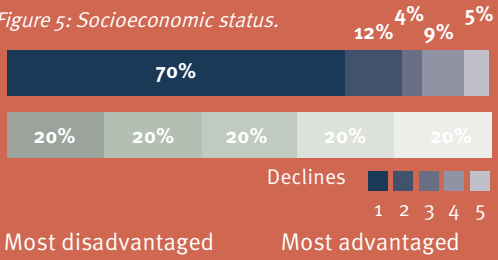


Figure 6: Average age at death.

Figure 7: Risk factors.

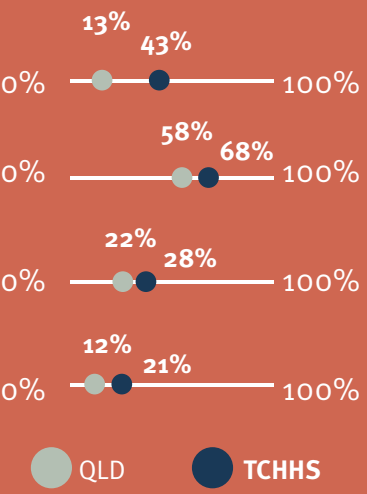


Figure Sources
1. *Queensland Population Projections, QGSO*
2. *2016 Census of Population and Housing*
3. *Queensland Health, Queensland Government, 2018 Chief Health Officer reports, licensed under Creative Commons Attribution 3.0 sourced on November 2018.*

However, as our population is very remote, access to key services, affordable and high quality housing and sustainable employment is challenging. As a result, our people represent some of the most socioeconomically disadvantaged people in Queensland, with 70% being in the lowest quintile of socioeconomic disadvantage, compared with 20% of Queensland *(Figure 5)*.

Health status of our people

Lower socioeconomic status is often associated with poorer health outcomes; the Torres Strait Islands, Northern Peninsula Area and Cape York have some of the poorest health outcomes in Queensland and Australia.

Life expectancy in the Torres and Cape region is 61 years on average –19 years behind Queensland as a whole (Figure 6). There is also a significant gap between non-Indigenous and Aboriginal and Torres Strait Islander peoples who live on average to 59 years of age, or 8 years less than non-Aboriginal or Torres Strait Islander peoples.

This gap in life expectancy is partly due to modifiable risk factors such as obesity, lifetime risky drinking, and daily smoking which are more prevalent in TCHHS than in Queensland *(Figure 7)*. These risk factors contribute to the development of chronic diseases like diabetes, heart disease and kidney disease, and some cancers.

Limited access to both primary health care and specialist services in remote areas also contributes as many residents find it difficult to access care to prevent their health deteriorating.

Summary of service needs and issues

Six service needs and issues have been identified:

1. **People in the Torres and Cape region are ageing faster than Queensland as a whole.** There is a rapidly growing ageing population, which increases overall demand for health care in our region, as well as emphasising the need for greater specialist aged care services such as healthy ageing and end-of-life care.
2. **Health and socioeconomic status are among the worst in Queensland.** The prevalence of modifiable health risk factors such as drinking and smoking is high, and there are similarly high rates of chronic disease. These are related to a number of factors including remoteness which often results in limited access to affordable, nutritious food, stable employment, and adequate housing. Addressing the gap in health status requires multifaceted solutions that acknowledge the unique environmental factors that contribute to poorer health outcomes.
3. **Access to primary health care is inconsistent across the region.** For various reasons affordable and timely primary health care is not available in all communities in the Torres Strait Islands, Northern Peninsula Area and Cape York. This creates additional demand for emergency departments, or people simply not accessing health care, highlighting the need to ensure equitable access exists across the region.
4. **Many services are delivered far from home, creating barriers to access.** Many services are delivered away from home, which means there is a significant burden on our residents who have to travel. Access to transportation is limited in many areas or unaffordable in communities that rely on access to health services via aeroplane. Further, many people travel for extended periods of time and are away from their families, which creates challenges. Improving the capability and capacity of local services will help by allowing us to deliver more services closer to home.
5. **There is limited coordination of services between providers within TCHHS and externally.** While there are efforts to coordinate services across the TCHHS, the experience of the community and staff is that more could be done, particularly for those with chronic conditions accessing specialist outreach services. Constraints in technology and information systems result in poor information sharing between care providers (e.g. primary health care and acute care) which contributes to fragmented services. 9
6. **There are numerous workforce sustainability and capability issues that limit the ability of TCHHS to deliver on key priorities.** The remote location of many communities presents challenges in recruiting and retaining a sustainable workforce.

This means a high turnover of staff is experienced in very remote communities, which impacts continuity of care, the quality of the patient experience, and engagement with health services.

Priority areas

To respond to these issues and needs, six priority areas have been developed. The priority areas span health promotion and prevention activities, primary health care and acute care, and enablers such as workforce and technology. Successful delivery of key actions against each priority area will make a meaningful improvement in the health outcomes of our people.

The priority areas are summarised in *Figure 8* below.

Figure 8: Priority areas for the Torres and Cape region.

1 Background and purpose

Background and purpose

The Torres and Cape Clinical Services Plan 2019-2029 sets a strategic direction for delivery of health services in the unique regions and communities of the Torres Strait Islands, Northern Peninsula Area and Cape York.

Torres and Cape Hospital and Health Service covers one of the most remote regions in Queensland –with the Torres Strait, Cape York and Northern Peninsula Area being some of the most unique in the state. The region has a dispersed, small and ageing population that experiences some of the poorest health outcomes in Queensland, if not Australia.

Life expectancy remains lower despite recent improvements, especially for Aboriginal and Torres Strait Islander residents. The prevalence of risk factors such as obesity, daily smoking, and excessive consumption of alcohol remain high; as does the rate of hospitalisations, many for preventable conditions.

Compounding the health status and experiences of many communities across the Torres Strait Islands, Northern Peninsula Area and Cape York is the uniqueness of living in the region –with limited and expensive transport routes, long distances to travel to access many essential services, and the lack of many opportunities available to people living in larger regional and metropolitan centres.

Some of this is changing –with improved road access expected over the next five years as more roads are sealed, better transport and logistics routes, and technology providing additional opportunities to improve access to health care.

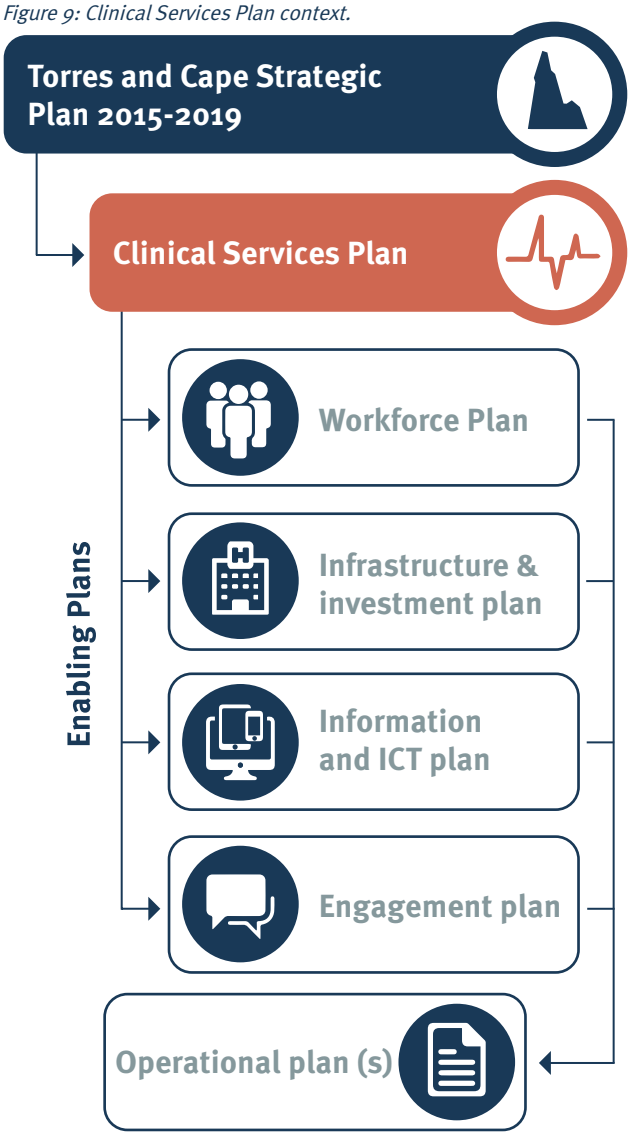
This Clinical Services Plan (Plan) has been developed in the context of these changes –particularly recognising that if we are to genuinely change the trajectory of health outcomes for our community, we need to think and act differently about how, where and what health services are delivered.

The Plan sets the direction and service priorities for TCHHS over the next ten years, to enable TCHHS to deliver high quality health care in the face of change.

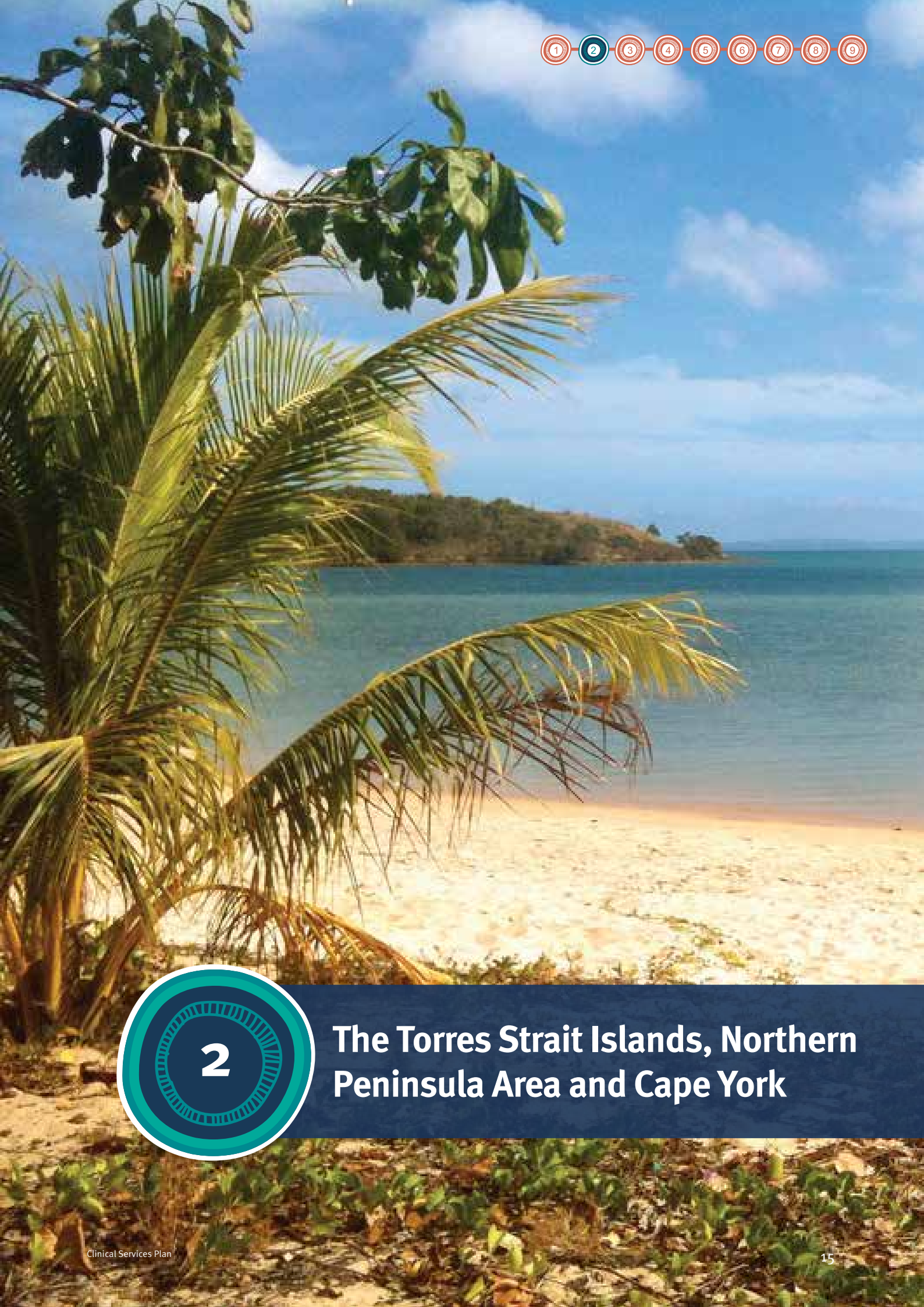
The Plan aligns with the TCHHS Strategic Plan, and the Queensland Government's priorities for advancing the health of Queenslanders.

A series of enabling plans (e.g. Workforce, Infrastructure) will be developed to support the priorities and actions that have been identified in the Plan. These enabling plans will provide a more detailed blueprint in key areas for how we will deliver the clinical services outlined in the Plan, as shown in *Figure 9*.

Figure 9: Clinical Services Plan context.



The Clinical Services Plan is supported by a range of plans which build on the directions and priorities outlined in the Plan.



2 The Torres Strait Islands, Northern Peninsula Area and Cape York

The Torres Strait Islands, Northern Peninsula Area and Cape York

TCHHS enjoys a tropical climate and is warm much of the year. Rainfall and extreme weather in the wet season can interrupt the transport network making health service delivery challenging, especially in remote areas.

Torres and Cape HHS

TCHHS is Queensland's northernmost HHS, spanning a geographic area of 130,238 square kilometres from the islands north of the mainland in the Torres Strait to south of Cooktown. The area is home to 26,966 people (in 2017), or less than 1% of Queensland's total population. The population is located mostly along the coast or on small islands in the Torres Strait, and spread across both the east and west of the Cape York Peninsula.

Climate and weather

The Torres Strait Islands, Northern Peninsula Area and Cape York region has a tropical climate with a higher average temperature (26˚C) compared with the rest of Australia. It also has a significant amount of rainfall, which occurs largely during the wet season between October and March. Further, the Torres Strait and Cape York can be subject to extreme weather conditions such as cyclones and heavy rainfall, which can cause damage to infrastructure and reduce access to roads and the ability to fly via aeroplane or helicopter. This has flow on effects to key services such as health care. These weather conditions are likely to become increasingly severe with climate change.

Transportation

Transportation is one of the biggest challenges in providing health services to such a geographically dispersed population. Access to transport can make delivering health care difficult, and transporting critically ill or unwell patients is an ongoing challenge.

A significant transport network links the various small communities spread across the Torres Strait Islands, Northern Peninsula Area and Cape York.

The network comprises a series of modes from road and air transport to barge and ferry transport.

The two main challenges with navigating this network across the Torres Strait Islands, Northern Peninsula Area and Cape York are that many roads are currently unsealed and make travel difficult seasonally; and alternative transport options are limited, infrequent and expensive.

However, it is expected that key transport routes (particularly the road to Weipa) will be completely sealed by the early 2020s, which will make most of Cape York accessible by road. This is expected in turn to encourage further tourism in the region –and also potentially open opportunities.

Travel times between communities are also very high. Many communities are hours away from their closest hospital or to access alternative transport options such as air travel.

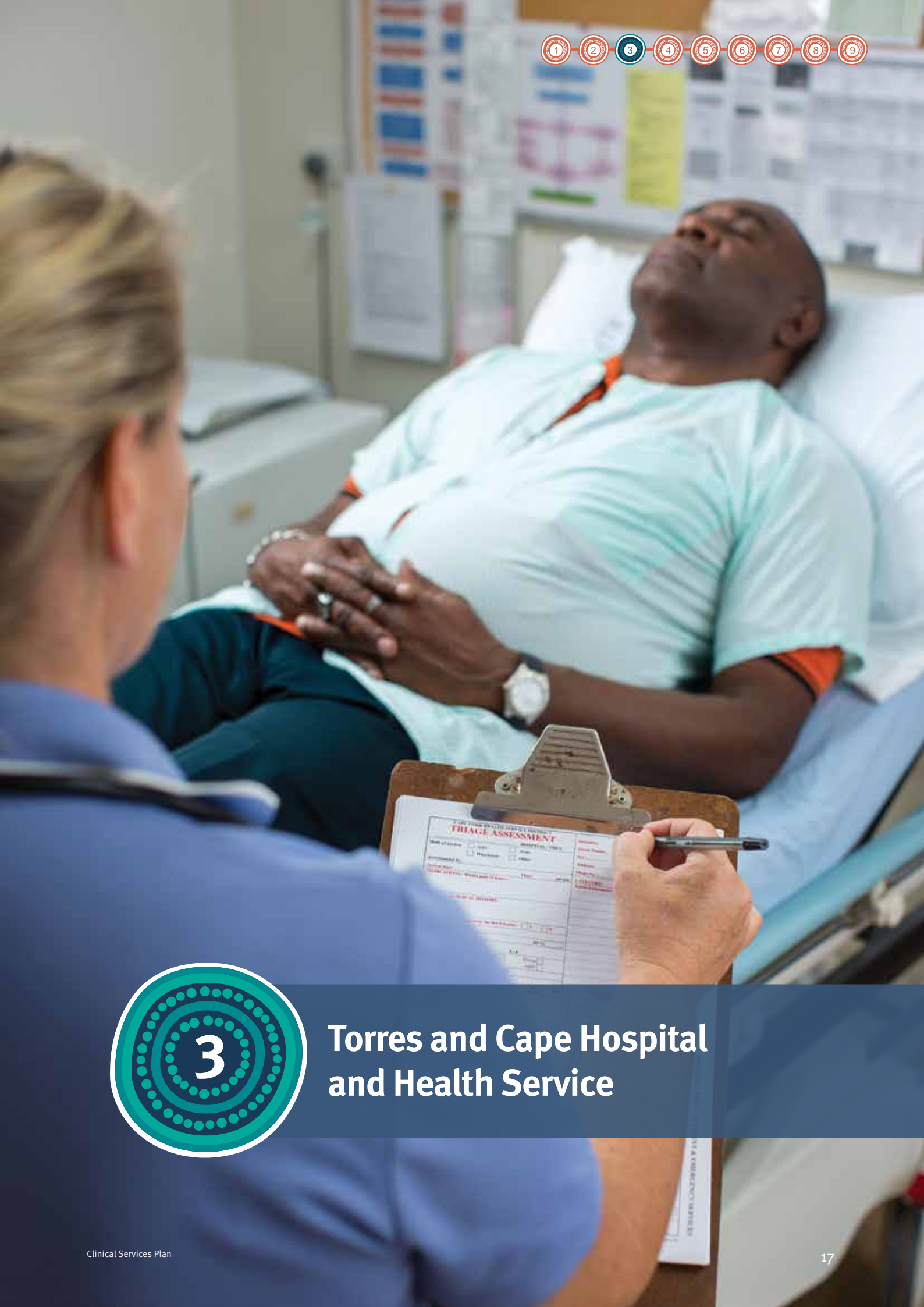
Air travel between the communities is limited – particularly when the departure or destination airport is not Cairns. Flights from a community such as Weipa are only available to other locations such as Kowanyama and Lockhart River once a week. Flights in the Torres Strait and Northern Peninsula Area are available 6 days a week and run multiple times a day, enabling people to travel between the islands on the same day.

Air travel is significantly more expensive than other forms of transport. This is particularly noteworthy given the extreme socioeconomic disadvantage experienced by many TCHHS residents, which means air travel is not a viable option without support from the Patient Travel Subsidy Scheme (PTSS) or similar schemes.

Economy and tourism

The public sector is the largest employer, accounting for 43.5% of the employed population. The major private industry in the region is metal ore mining which employs 10.6% of the employed population. Mining operations are based around Weipa.

Tourism is a growing industry in the Torres and Cape region. According to Tourism Research Australia, there were 106,000 visitors to the Torres and Cape region, staying five nights on average in 2016. Tourism means people access health care in the Torres Strait Islands, Northern Peninsula Area and Cape York, particularly emergency departments, primary health care and pharmacy services and if tourism increases, this demand will also increase.



3 Torres and Cape Hospital and Health Service

About TCHHS

TCHHS is the main provider of health services throughout the Torres Strait Islands, Northern Peninsula Area and Cape York region of Far North Queensland.

TCHHS provides primary health services at 31 Primary Health Care Centres (PHCC) *(Figure 10)*. By volume, these centres provide the majority of the TCHHS' health services and are supported by the HHS' four hospitals (Figure 11):

1) Weipa Integrated Health Service
2) Cooktown Multipurpose Health Service
3) Thursday Island Hospital
4) Bamaga Hospital.

Service Partners Apunipima Cape York Health Council and the NPA Family and Community Services provide services from adjoining and/or collocated sites at some primary health care sites.

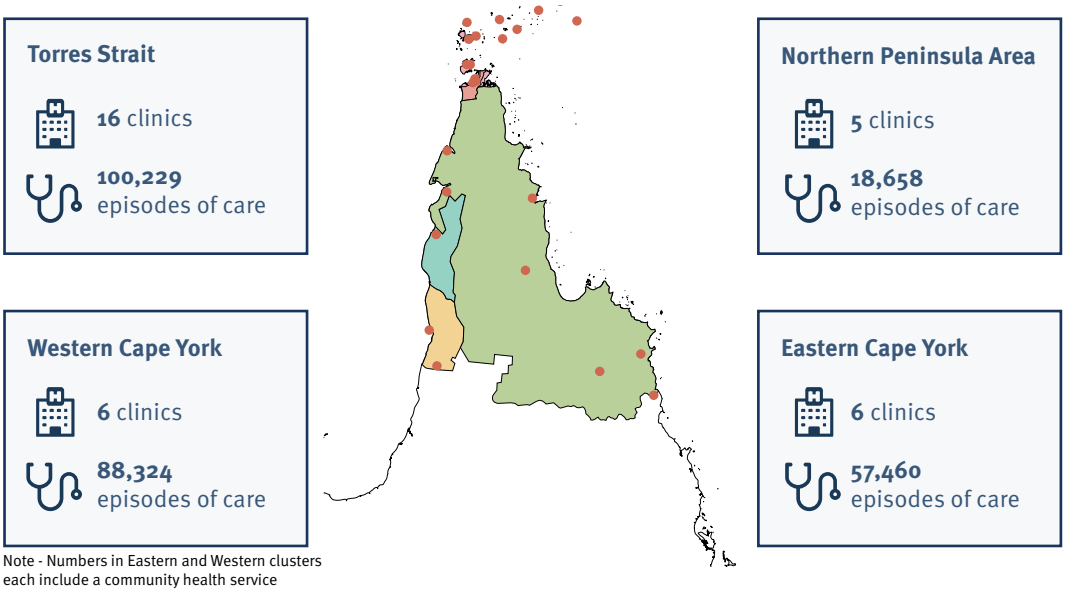
Two of the hospitals function as Multipurpose Health Services (Weipa and Cooktown) that also have residential aged care beds. TCHHS is the only supplier of residential aged care in these areas. Indeed, across the Torres Strait Islands, Northern Peninsula Area and Cape York, TCHHS is the major health and aged care service provider, with limited services offered by private and non-government providers.

Key services provided externally to the HHS include:

- Weipa Community Care Association's Aged Care Facility
- Star of the Sea Elders Village, Thursday Island
- St John's Community Care providing community-based aged care and disability services on Thursday Island
- primary health care, health promotion and prevention work, and other health and social services offered by the numerous Aboriginal medical services
- private GP practices in Weipa and Cooktown
- social services including domestic and family violence services, housing, and other programs provided by local councils
- specialist outreach services delivered by Cairns and Hinterland Hospital and Health Service (CHHHS).

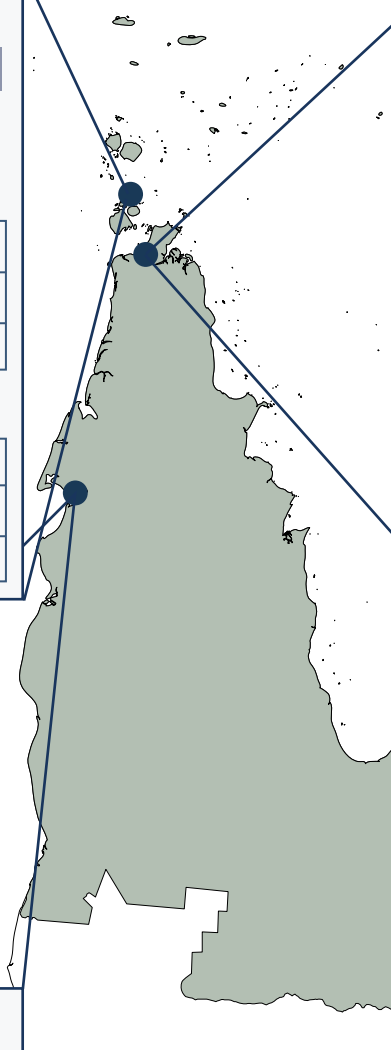
The four hospitals all transfer to other sites when highly acute or specialised services are required. In the first instance, referrals are to Cairns, with patients transferred to Townsville or Brisbane if more specialised services are required. Patients are typically airlifted in these cases, though many patients travel to Cairns via other means (e.g. commercial air travel, road) for outpatient appointments and elective hospital admission.

Figure 10: Primary health care in TCHHS.



Note - Numbers in Eastern and Western clusters each include a community health service

Figure 11: Hospital care in TCHHS.



Thursday Island Hospital

32 Beds CSCF: 3

Average Occupancy: 36%

2017/18 Activity summary

Inpatient Separations	3,321
Emergency Presentations	4,782
Outpatient OoS	5,189

Top SGR's by volume

Renal Dialysis	1,201
Obstetrics	173
Immunology & Infections	130

Bamaga Hospital

14 Beds CSCF: 2

Average Occupancy: 28%

2017/18 Activity summary

Inpatient Separations	606
Emergency Presentations	5,104
Outpatient OoS	102

Top SGR's by volume

Renal Dialysis	60
Obstetrics	59
Immunology & Infections	56

Note: Non Subspecialty Surgery separations were for digestive system disorders, minor injuries, and abdominal pain.

Weipa Integrated Health Service

22 Beds CSCF: 3

Average Occupancy: 64%

2017/18 Activity summary

Inpatient Separations	1,446
Emergency Presentations	7,497
Outpatient OoS	6,170

Top SGR's by volume

Renal Dialysis	140
Obstetrics	139
Immunology & Infections	116

Cooktown Multipurpose Health Service

29 Beds CSCF: 3

Average Occupancy: 66%

2017/18 Activity summary

Inpatient Separations	1,603
Emergency Presentations	4,884
Outpatient OoS	8,400

Top SGR's by volume

Renal Dialysis	222
Obstetrics	126
Immunology & Infections	126

Bed counts do not include bed alternatives. Bed counts include residential aged care beds.

Our people

The Torres Strait Islands, Northern Peninsula Area and Cape York population is growing slowly and is relatively young compared to the rest of Queensland. However, the population is ageing with the population aged over 60 years increasing from 11% to 16% of the population over the next ten years

Population growth and ageing

The estimated resident population of TCHHS was 26,966 people in 2017. Projected population growth is low, with growth expected at 0.63% each year from 2016 to 2031, well below Queensland at 1.66% per annum *(Table 1)*. The fastest growing regions within TCHHS are Weipa and the Northern Peninsula. Growth in these regions accounts for more than half of the projected growth.

Like the rest of the state, the population in the Torres Strait Islands, Northern Peninsula Area and Cape York is also ageing. On average, Torres Strait Islands, Northern Peninsula Area and Cape York is ageing more rapidly than the Queensland population, with the proportion of people aged over 60 projected to increase from 11% to 16%. Over the same period, the state-wide median age will increase by only two years.
This has significant implications for how we plan health services for the future –while Torres Strait Islands, Northern Peninsula Area and Cape York are expected to maintain a relatively young population compared to Queensland (Figure 12), we are also expecting higher than average growth of the number people over 65[1]. We need to plan for both a younger population (where we can affect health outcomes early), and an ageing population and the complexities this brings.

Population characteristics

The HHS has a large Aboriginal and Torres Strait Islander population with 65% of residents identifying as Aboriginal and Torres Strait Islander *(Figure 13)*. The population of TCHHS is socioeconomically disadvantaged compared to Queensland, with 70% of the population falling in the most disadvantaged quintile *(Figure 14)*. The relationship between socioeconomic disadvantage and health outcomes is complex, though populations within the lower quintiles of social disadvantage have low incomes and lower attainment of formal education, which have been shown to be strong predictors of a range of physical and mental health problems[2].

Table 1: Estimated population growth.

Region - statistical area (SA) 2	2017 Estimated resident population	2031 Population projection	Compound annual growth rate (CAGR)
Aurukun	1,343	1,453	0.56%
Cape York	8,078	8,509	0.37%
Kowanyama - Pormpuraaw	1,791	1,905	0.44%
Weipa	4,077	4,864	1.27%
Northern Peninsula	3,008	3,556	1.20%
Torres	3,798	4,089	0.53%
Torres Strait Islands	4,871	5,068	0.28%
TCHHS Total	**26,966**	**29,433**	**0.63%**
Queensland	**4,928,457**	**6,206,566**	**1.66%**

Source: QGSO population projections by SA2 (based on 2016 census).

Figure 12: Age distribution.

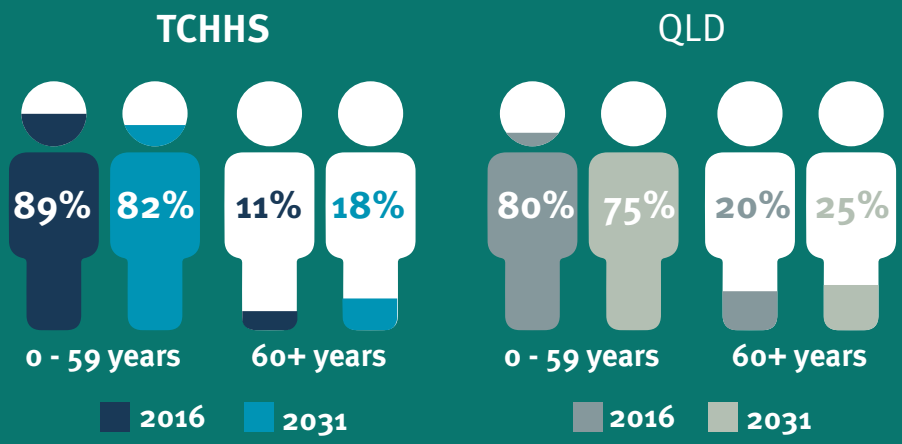


Figure 13: Aboriginal and Torres Strait Islander peoples.

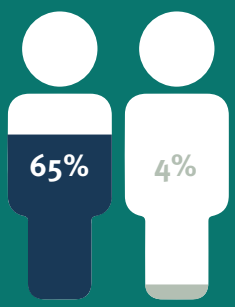
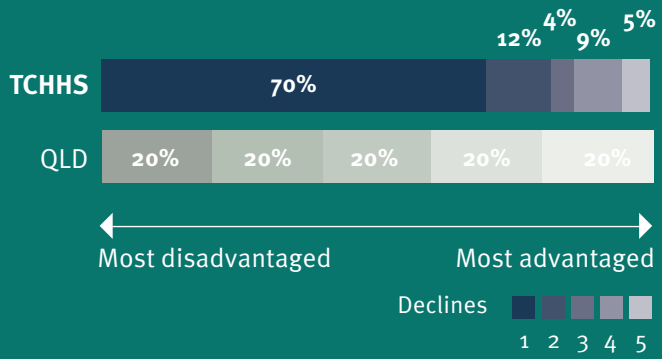


Figure 14: Socioeconomic status (SEIFA index).



Source: All figures from QSGO

[1] *The compound annual growth rate of the population over 65 years is projected to be 5.5% in TCHHS from 2016 to 2026, compared to 3.1% in Queensland.*

[2] *NQPHN Needs Assessment, 2016*

Social determinants of health

Social determinants of health have a significant impact on individual's health and are largely responsible for health inequities – the "unfair and avoidable" differences in health status between different groups of people[1].

Social determinants of health are factors outside the health care system that can affect how healthy people are. These factors include access to clean drinking water and adequate housing, educational attainment and employment. All parts of the health and human services system are needed to improve the social determinants of health which are just as important, if not more important, to achieving health outcomes as access to health services.

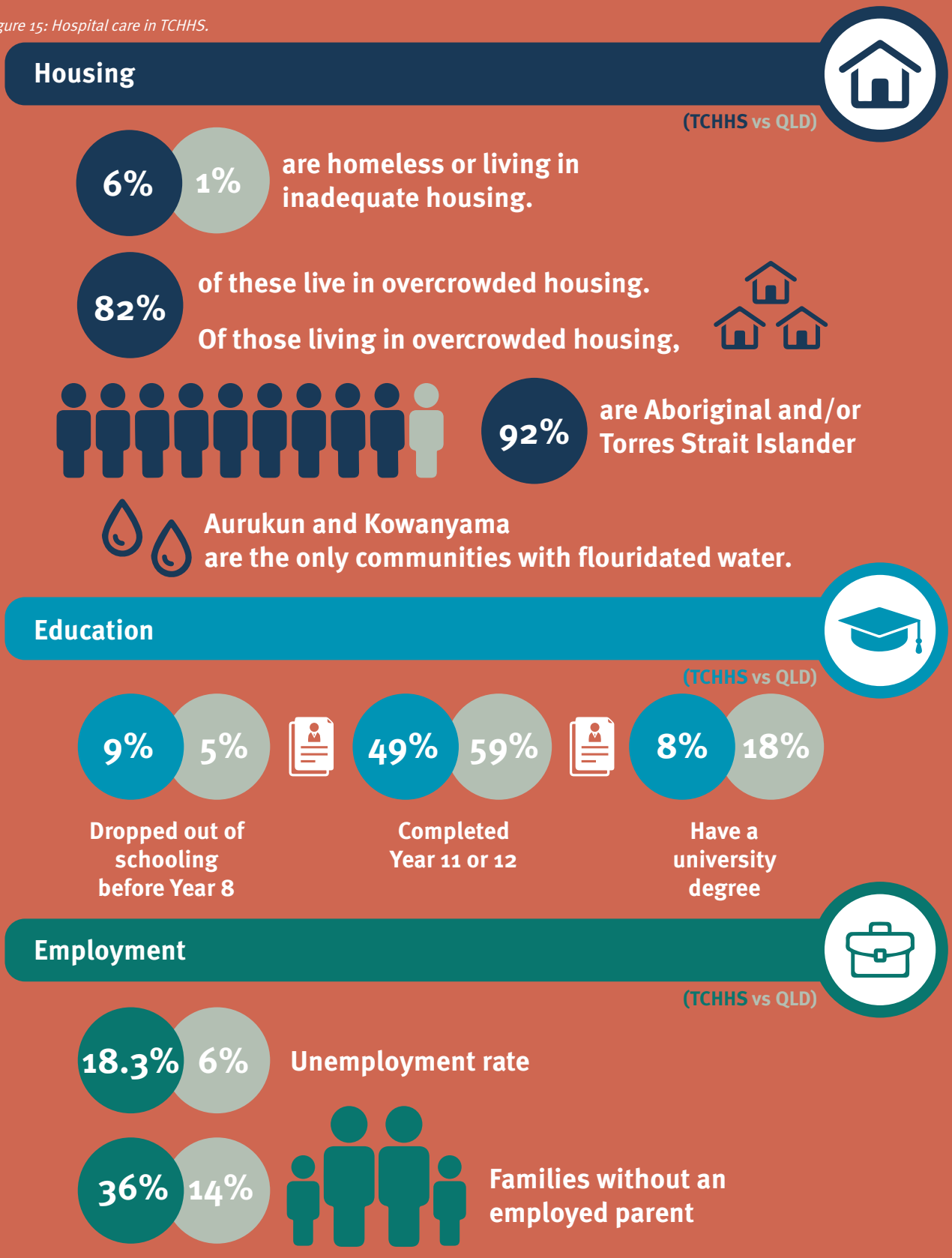
In the Far North SA3[2] (Figure 15), 6% of the population are homeless or live in inadequate housing, compared to 1% of Queenslanders. The majority (82%) of these are living in overcrowded housing, and this disproportionately affects Aboriginal and Torres Strait Islander peoples. At the 2016 Census of Population and Housing, 92% of those living in overcrowded housing were Aboriginal or Torres Strait Islander[3]. 7.3% of households were multiple family households compared to 1.8% of households in Queensland.

The majority of communities in Torres Strait Islands, Northern Peninsula Area and Cape York do not have access to fluoridated water, with the exception of Kowanyama (which has naturally high levels of fluoride in the water supply) and Aurukun.

Educational attainment is lower in Torres Strait Islands, Northern Peninsula Area and Cape York compared to the state as a whole, with 49% of the population aged over 15 years having completed Year 11 or 12, compared to 59% of Queenslanders. Nine percent of the Torres Strait Islands, Northern Peninsula Area and Cape York population dropped out of schooling before Year 8 compared to 5% of Queenslanders. There is a corresponding difference in the proportion of the population with a Bachelor degree or higher, which is 8% in Torres Strait Islands, Northern Peninsula Area and Cape York compared to 18% in Queensland. There is a greater proportion of the population with certificate level qualifications in Torres and Cape region, which reduces the overall difference in the proportion of the working age population with a non-school qualification to 4%[4].

The unemployment rate in Torres Strait Islands, Northern Peninsula Area and Cape York is high at 18.3%, compared to 6% in Queensland. Within TCHHS, the Torres Strait Islands SA2 had the highest unemployment rate at 27.8%. No SA2 within Torres Strait Islands, Northern Peninsula Area and Cape York has a single digit unemployment rate except Weipa[5].

Figure 15: Hospital care in TCHHS.



[1] *WHO, 2018*
[2] *Homelessness estimates were only available at the SA3 level. Far North SA3 includes all of Torres and Cape HHS as well as Tablelands and Croydon – Etheridge SA2s, which fall within the boundaries of CHHHS. The population of Croydon – Etheridge and Tablelands is 22% of the total population of Far North SA3 (32,390).*
[3] *54% of the Far North SA3 population are Aboriginal or Torres Strait Islander.*
[4] *55% in TCHHS; 59% in Queensland.*
[5] *The unemployment rate is not available for Aurukun SA2.*

Health needs and outcomes

TCHHS experiences poor health outcomes, lower life expectancy, and increased prevalence of risk factors like smoking, excessive drinking and obesity compared to Queensland.

Risk factors

The prevalence of health risk factors is higher in the Torres Strait, Northern Peninsula Area and Cape York than in the rest of Queensland, with a greater proportion of residents drinking, smoking, and being overweight or obese than the statewide rate in 2018 *(Table 2)*. There has been an improvement, particularly in obesity (reduced 6% since 2016) and daily smoking (reduced 8% since 2016). Smoking during pregnancy remains particularly widespread.

Burden of disease

High prevalence of risk factors is associated with more frequent hospitalisation for a range of conditions including coronary artery disease, diabetes, chronic obstructive pulmonary disease (COPD), and pneumonia and influenza in 2018 *(Figure 16)*. Hospitalisations for mental health and behavioural disorders are an exception to this trend, with TCHHS residents having almost half the age standardised rate (ASR) of the state as a whole, possibly indicating problems accessing inpatient mental health services which are not provided locally.

Potentially preventable hospitalisation

The age standardised rate of potentially preventable hospitalisations is also more than double the statewiderate (7,675 vs. 3,695). Diabetes complications, cellulitis, and dental conditions were the largest contributors to possibly preventable hospitalisations. Mental health is also well known to be strongly associated with people developing chronic conditions and poorer health outcomes. Mental health is difficult to measure in the Torres and Cape due to under-reporting but consultation with the communities has identified that mental health is a growing issue.

Age at death

Despite improvements, life expectancy for TCHHS residents remains lower than for the rest of Queensland. The current (2018) median age at death is 61 years (increased2 years since 2016), which is 19 years below that of the Queensland median age at death of 80 years. A related statistic is that 74% of deaths in TCHHS are premature (occur before age 75); 35% of these are related to lifestyle factors like daily smoking and obesity.

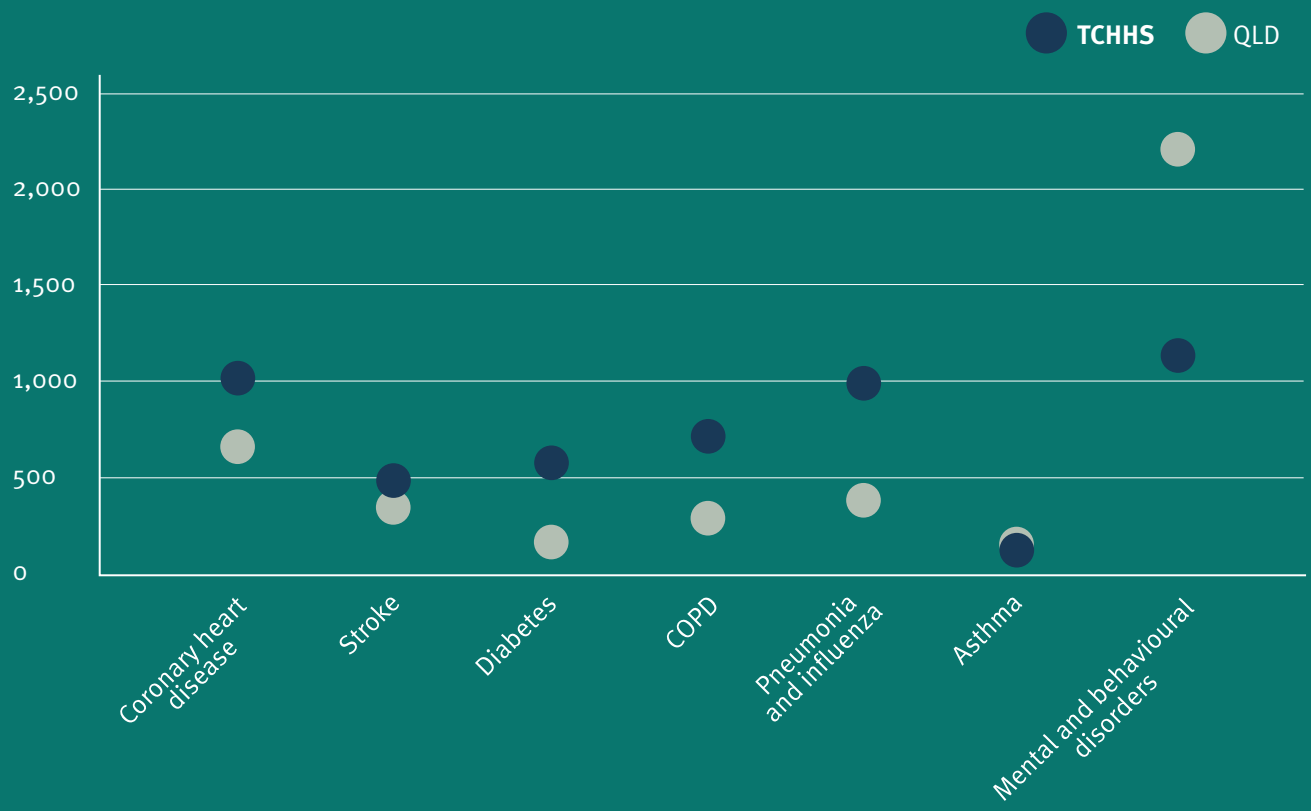
The large gap in life expectancy is partly due to the significant Aboriginal and Torres Strait Islander population, whose median age at death is 59 years, which is consistent with the statewide life expectancy for Aboriginal and Torres Strait Islander peoples. However this is not the only factor, as the median age at death for non-Aboriginal and Torres Strait Islander peoples in TCHHS is only 67 years compared to the rest of Queensland.

Table 2: Health risk factors in TCHHS and the whole of Queensland (2018).

Health risk factor	Proportion of the population (%)		Difference between TCHHS and QLD (%)
	TCHHS	Rest of Queensland	
Smoking during pregnancy	45.1	12.0	+33.3
Adults that are overweight or obese	61.7	60.4	+1.3
Lifetime risky drinking	27.8	22.0	+5.5
Daily smoking	13.4	11.1	+2.3

Source: Queensland Health, Queensland Government, 2018 Chief Health Officer reports, licensed under Creative Commons Attribution 3.0 sourced on 23 November 2018

Figure 16: Age standardised rate of hospitalisations per 100,000 population, TCHHS vs. whole of Queensland (2018).



Source: Queensland Health, Queensland Government, 2018 Chief Health Officer reports, licensed under Creative Commons Attribution 3.0 sourced on 23 November 2018.

[2] Stephens, A.S., Gupta, L., Thackway, S. and Broome, R.A., 2017. Socioeconomic, remoteness and sex differences in life expectancy in New South Wales, Australia, 2001–2012: a population-based study. BMJ open, 7(1), p.e013227.

Health service activity

The following section summarises historical and projected activity across TCHHS facilities for primary health care and inpatient services.

Primary health care

In 2017–18, 219,352 primary health care consultations were undertaken by TCHHS (Figure 17). The most common consultations were for general consultations, pharmacy (scripts) and wound management care. TCHHS primary health care activity has declined by 8% since 2016-17.

Inpatient services and future demand

TCHHS also delivered 7,008 inpatient separations in 2017–18 (Table 3). Thursday Island Hospital delivers the most, representing almost half of the overall separations. The four hospitals are expected to grow, with Weipa and Bamaga being the fastest growing due to their areas containing the highest population growth.

By 2031–32, there will be almost 18% more activity delivered across the HHS than there is today (Table 4). In terms of patient need, there will be a significant increase primarily driven by renal dialysis, which is projected to increase to 4,257 separations, followed by cellulitis. These are currently the highest volume services demanded by TCHHS residents and are expected to remain the highest in the future. Both conditions are targets for effective health promotion and early prevention or management.

Other areas of growth for the next 10 years include, general medicine, digestive system diagnoses and other orthopaedic activity.

Outpatient services

There were 19,875 outpatient occasions of service delivered by TCHHS in the 2017–18 financial year (Table 5). Overall, outpatient activity increased from 2016 to 2018 by 23%, driven by increased activity at all facilities except at Bamaga Hospital where there has been a sharp decline in outpatient activity (likely to be due to changes in reporting of activity).

CHHHS is a major provider of outpatient services to the Torres and Cape population and has delivered 10,008 occasions of service to the TCHHS population for services such as antenatal and post-acute care.

Emergency department

Emergency department presentations have increased by 22% over the three years to 2017–18 *(Table 7)*, driven by growth in Category 4 and 5 presentations which are likely to represent more primary health care-type services. The most common reasons for presenting include many primary health care-type services such as wound management and administering medication.

Patient transfers

Given the remoteness of the majority of our population, travelling to access health services is very common. In 2017–18, self-sufficiency for the TCHHS was 58% (excluding renal dialysis). This means out of a total of 9,150 hospital admissions for residents of the Torres and Cape region, 3,869 had to travel outside of the HHS to access care. Of these, the majority (86%) were provided care in CHHHS.

In 2016–17 there were a total of 928 emergency retrievals for TCHHS residents. This includes all emergency department transfers and inpatient transfers from a TCHHS facility, including internal transfers. *Figure 18 (page 28)* outlines the top five conditions, by volume, for which inpatients and ED patients were transferred within and outside TCHHS in 2016-17. The major flows are shown with solid arrows; the lower volume flows are shown with dotted arrows. The major flows account for 80% of all transfers.

Figure 17: Summary of primary health care activity.

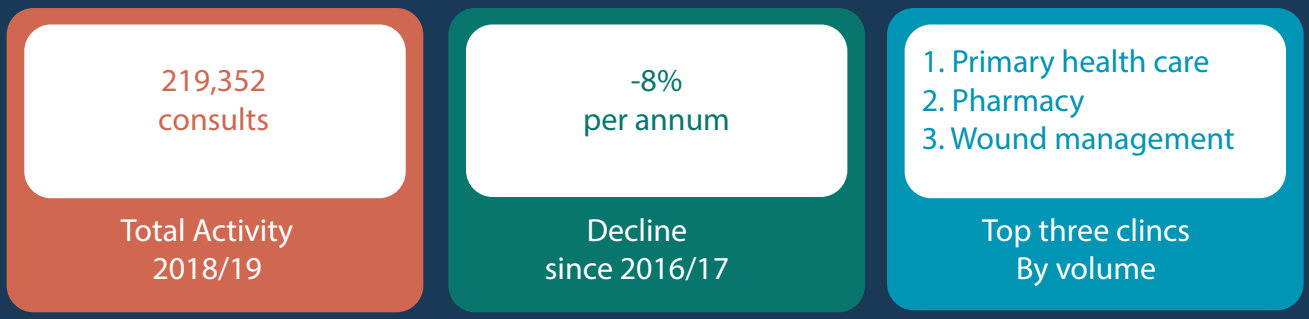


Table 3: Summary of inpatient activity (separations).

Place of Treatment	2017-18	2031-32	CAGR
Bamaga Hospital	612	734	1.3%
Cooktown Hospital	1,636	2,203	2.1%
Thursday Island Hospital	3,231	3,070	-0.4%
Weipa Hospital	1,529	2,249	2.8%
Total	7,008	8,256	1.2%

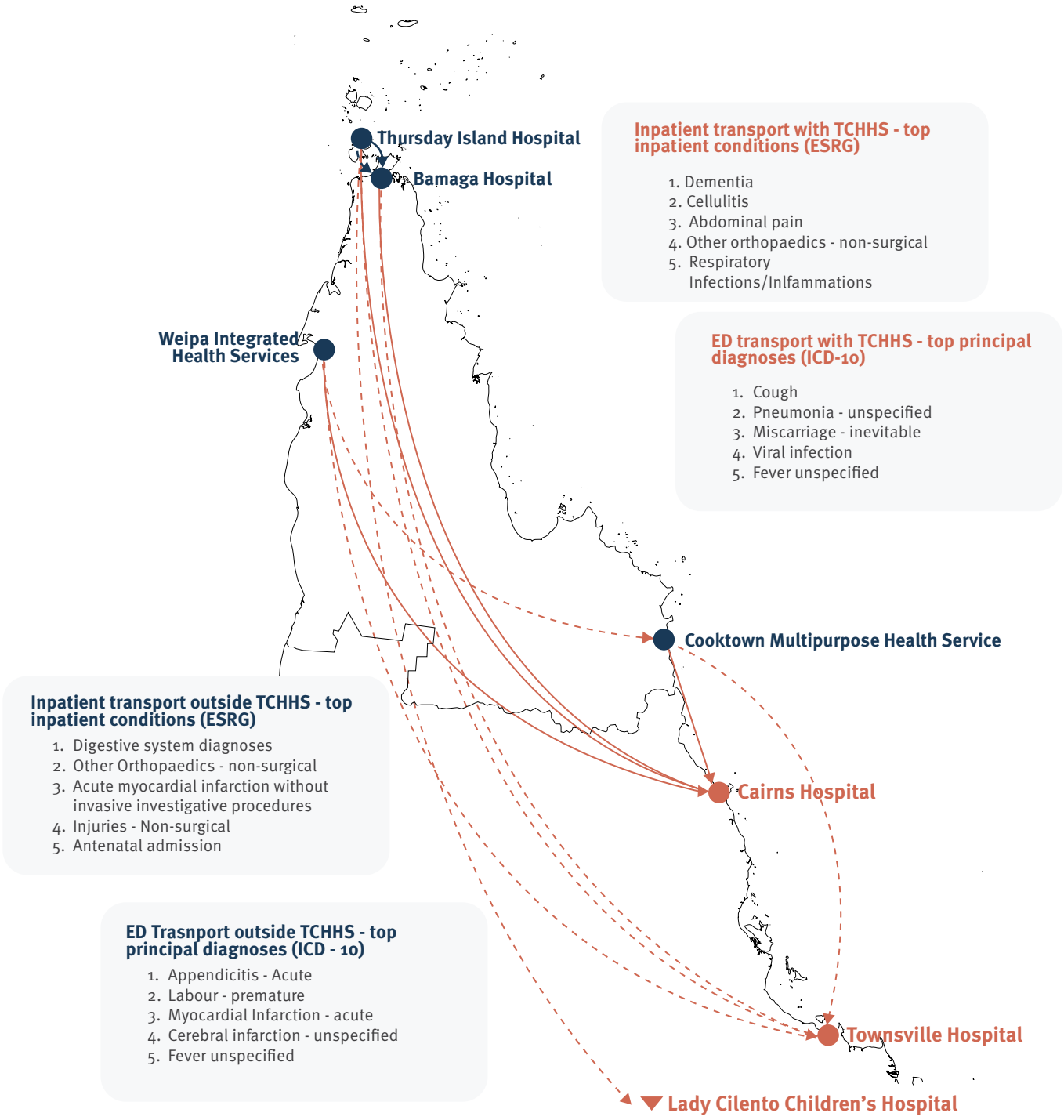
Table 4: Future demand: highest volume services in 2031–32.

Current (2018)		Projected (2032)	
ESRG	Separations	ESRG	Separations
Renal dialysis	2,899	Renal dialysis	4,257
Cellutitis	1,060	Cellulitis	2,022
Injuries (non-surgical)	677	Other General Medicine	1,377
Other general medicine	635	Digestive System Diagnoses	1,193
Chest pain	530	Other Orthopaedics (non-Surgical)	1,174

Table 5: TCHHS outpatient activity by place of treatment.

	Outpatient occasions of service		
Facility	2016	2017	2018
Aurukun PHCC	-	-	13
Bamaga Hospital	1,254	611,	102
Cooktown MPHS	7,444	7,572	8,401
Thursday Island Hospital	3,971	3,527	5,189
Weipa IHS	3,442	3,882	6,170
Outpatients Total	16,111	15,592	19,875

Figure 18: Inpatient and emergency department transfers by TCHHS facilities, 2016-17.



4 Health needs and issues

Health needs and issues

The following summarises the key health needs and issues:

(1) People in the Torres Strait, Northern Peninsula Area and Cape York region are ageing faster than Queenslanders as a whole

The number of people aged over 60 is expected to significantly increase from 11% to 16% over the next 10 years. Elderly people tend to access all forms of care more, which will impact the demand for primary health care and acute services. This also means access to high quality, culturally appropriate aged care services is key.

(2) Health and socioeconomic status are amongst the worst in Queensland

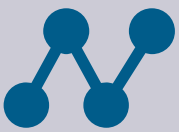
The prevalence of modifiable health risk factors such as drinking and smoking is high, and there are similarly high rates of chronic disease. These are related to a number of factors including remoteness which often results in limited access to affordable, nutritious food, stable employment, and adequate housing. Addressing the gap in health status requires multifaceted solutions that acknowledge the unique environmental factors that contribute to poorer health outcomes.

(3) Inconsistent access to primary health care in the region

Access to primary health care can be challenging given the availability of services in some areas, particularly in very remote communities. Other areas have access to primary health care; however, these services are not affordable or cannot be accessed in a timely manner. Consultation identified that many people used emergency departments as a substitute to primary health care.

(4) Many services are delivered far from home, creating barriers to access

Many people access services further away than their closest acute hospital, generally in Cairns, which creates isolation from families and communities. Low clinical capability levels and access to support services like imaging and pathology mean self-sufficiency is low and residents have to travel to access appropriate care. Telehealth is not currently used to its full potential. The lack of accommodation for patients and their families also means some patients travel to Cairns who could be managed locally.



(5) There is limited coordination of services between providers within TCHHS and externally

While there are efforts to coordinate services across the TCHHS, the experience of the community and staff is that more could be done, particularly for patients with chronic conditions accessing specialist outreach services. Constraints in technology and information systems result in poor information sharing between providers (e.g. primary health care and acute care) which contributes to fragmented care.

(6) There are numerous workforce sustainability and capability issues that limit the ability of TCHHS to deliver on key priorities

Given the small population and remote nature of the region there are challenges in recruiting and retaining a sustainable workforce that delivers on the needs of the community. This means a high clinician turnover is experienced in very remote communities. This reduces continuity of care, the quality of the patient experience, and engagement with health services.

5 Looking forward

Policy context

The Plan describes how we can make changes to clinical service delivery today to realise the strategic goals of current government policies in the future. It is especially focused on improving primary health care for Aboriginal and Torres Strait Islander peoples.

The Plan aligns with existing Queensland and Commonwealth Government health policies including:

- The Torres and Cape Strategic Plan, which commits to excellence in health care, improving partnerships with other organisations that improve health, workforce development and strong governance. (This is currently in the process of being updated.)

- My health, Queensland's future: Advancing health 2026, Queensland Health's strategy which commits to promoting wellbeing through healthy behaviours and action on the social determinants of health, delivering equitable, high quality health care, reducing fragmentation in services, and pursuing innovation.

- Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033, the Queensland Government investment strategy in health care across the lifespan to meet the national government targets of halving the gap in child mortality by 2018 and closing the gap in life expectancy by 2033.

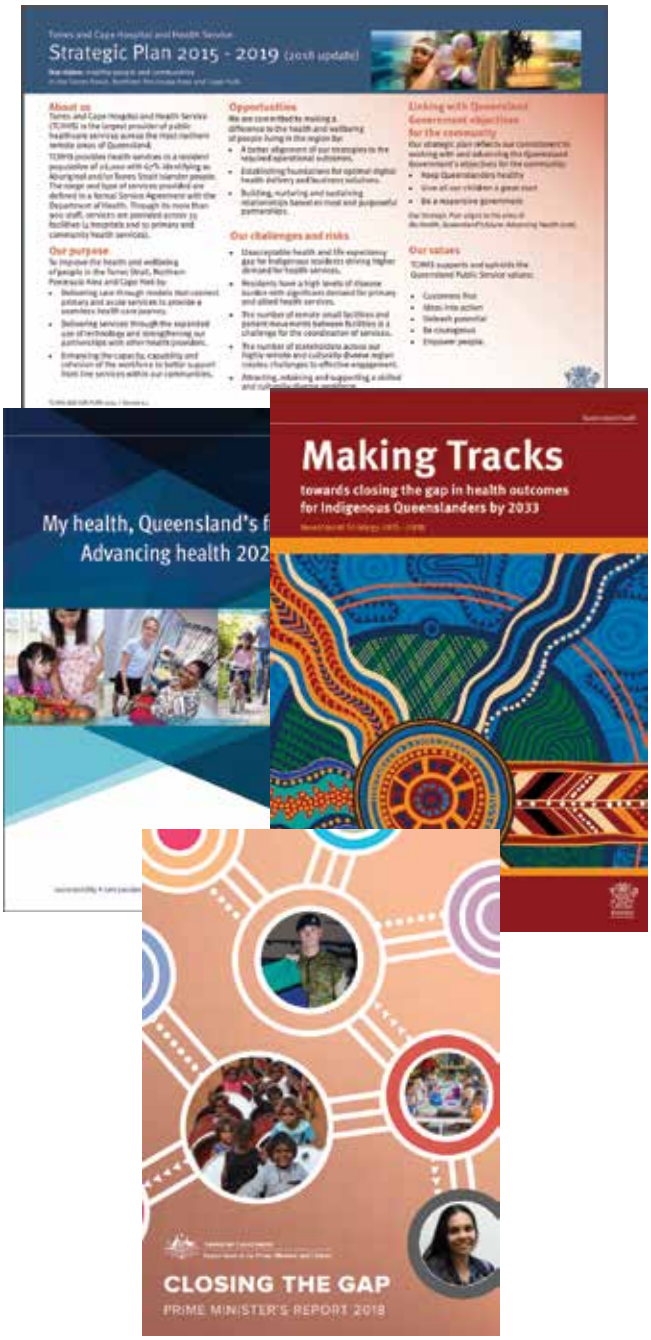
  The strategy focuses on the risk factors for chronic disease and the biggest contributors to the health gap –mental illness, cardiovascular disease, diabetics, chronic respiratory disease and cancer.

  A core principle of Making Tracks is the transition of primary health care services to community control.

- The national Closing the Gap agenda.

- Rural and remote health service framework –the Queensland Health framework for developing safe and sustainable rural and remote health services.

As well as specific policy documents, there are currently broad reforms underway in the disability services sector as Queensland transitions to the National Disability Insurance Scheme (NDIS), and reforms in aged care to increase the availability of person-centred aged care, especially community-based care. TCHHS is currently in the process of considering options for the future of NDIS service delivery.



6 Priority areas for action

Priority areas for action

The priority areas of the Plan identify opportunities to improve the delivery of health care services in the Torres and Cape HHS over the next ten years.

As part of the delivery of this Plan, we have identified six priorities that address the needs of our community and developed a series of actions to realise the changes to service delivery over time.

These priorities are focused on delivering the clinical services our changing population needs and improving health and wellbeing in the HHS.

Priority One: Health promotion and prevention

We will lead, in partnership with other organisations, an improvement in health outcomes for our community by delivering proactive and targeted health promotion and prevention services that focus on empowering people to take ownership and control of their own health.

Priority Two: Primary health care and enabling greater community choice

We will continue to invest in sustainable primary health care in order to improve access, quality, and ultimately health outcomes. Core to this will be developing a proactive Indigenous Health Worker-led model of care that allows continuity and builds strong relationships between our clinicians and our community. This model will be applied consistently across TCHHS.

We will position ourselves to allow our communities to have greater choice in primary health care services. We will do this respectfully, in partnership with individual communities, and in a way that ensures ongoing, sustainable service delivery.

Priority Three: Sustainable acute services

TCHHS will deliver more care as close to home as possible for our patients by improving the sustainability of our acute, secondary health services by increasing our self-sufficiency. We will grow services within their current clinical capability levels, improve coordination of specialist outreach services, and develop new and enhanced services over time.

Priority Four: Healthy ageing, and end-of-life care

We will increase our capacity to provide culturally appropriate, aged and end-of-life care for our community to age and die in their place of choosing.
We will develop a sustainable workforce to deliver community-based services; and increase the availability of residential aged care services locally within our communities.

Priority Five: Workforce development

We will develop a flexible, sustainable and local workforce that enables patient-centred, culturally appropriate health care to deliver improved health outcomes to our community. Our workforce will be nurtured by exploring opportunities for local members of our communities to develop into our future clinicians, particularly for Aboriginal and Torres Strait Islander peoples.

Priority Six: Enabling our future health services – technology, information, infrastructure, investment

We will continue to invest in innovative technologies; information systems and infrastructure that better support us in delivering on our priorities through sharing of information, new models of care enabled by technology and high quality accommodation for our staff and patients.

Priority One: Health promotion and prevention services

We will lead, in partnership with other organisations, an improvement in health outcomes for our community by delivering proactive and targeted health promotion and prevention services that focus on empowering people to take ownership and control of their own health.

Description

Life expectancy and health status in our region are amongst the lowest in Queensland. We have one of the highest rates of hospitalisations in Queensland and the greatest rate of premature deaths –one third of which relate to modifiable risk factors. Increasing our focus on health promotion and prevention will give people the skills and knowledge to look after their own health. Access to prevention activities will significantly reduce risk factors like unhealthy diets and smoking while pregnant. In the long term, this will improve our health outcomes and reduce the incidence of chronic disease. Evidence also shows that greater focus on the health of potential mothers, antenatal care, and in the first 1,000 days of a child's life will help give our children the foundation for a healthy life and have the biggest impact on life expectancy for future generations. Success will rely on embedding promotion and prevention in all aspects of our services –through dedicated programs, partnerships with key agencies (such as the Northern Queensland PHN, Aboriginal Medical Services, regional councils, non-government organisations and government agencies, such as housing and education), and through our core primary and acute health services. We also need to focus on supporting our communities to "make the right choice, the easy choice."

To increase the relevance, cultural appropriateness, and effectiveness of health promotion and prevention activities, that respect Aboriginal and Torres Strait Islander culture of health and wellbeing, programs will be designed and delivered by community leaders and peers who will share their own stories and experience. Along with our partners, we will make use of existing materials and resources (e.g. by using and adapting statewide or other campaigns and materials), and invest in resources and materials to achieve a meaningful change in health outcomes.

Actions

Transform:

1. **Strengthen partnerships with local community groups and organisations.** Ensure that annual operational plans include actions for each community to strengthen partnerships and work with key organisations (including the Health Partners Group) to coordinate a local approach to health promotion and prevention within each community. This should combine available funding sources and all stakeholders (e.g. schools and community groups), to deliver coordinated services and greater continuity of care. The Indigenous health promotion stream will lead this activity.

Optimise:

2. **Focus health promotion and prevention programs on key areas including the first 1,000 days of life, nutrition and healthy eating, mental health and sexual health.** All programs will focus on empowering communities and individuals to control their health, and providing education/improving health literacy. This should also acknowledge the Aboriginal and Torres Strait cultural perspectives and wellbeing.

Grow:

3. **Dedicated health promotion and prevention resources.** Invest in dedicated, evidence-based health promotion and prevention resources (workforce and materials), within TCHHS and in partnership with the Northern Queensland Primary Health Network (PHN), Aboriginal Medical Services, and CHHHS (in particular) to ensure coordination of activities and avoid duplication.
4. **Increase proactive screening.** Particularly for rheumatic heart disease, hearing, oral health, cancer, sexual health, prenatal, mental health, blood-borne viruses and including through providing greater access to child and adult health checks.

Priority Two: Primary health care and enabling greater community choice

We will continue to invest in sustainable primary health care services in order to improve access, quality, and ultimately health outcomes. Core to this will be developing a proactive Indigenous Health Worker-led model of care that facilitates continuity to build strong relationships between our clinicians and our community, that will be applied consistently across Torres and Cape HHS.

Description

Access to high quality primary health care should be at the core of every health system. TCHHS is the major provider of primary health care in the region. This is for many reasons, including the lack of private providers due to market size. This includes providing primary health care in relatively large primary health care clinics in larger population centres, through primary health clinics on many islands in the Torres Strait, and communities in Cape York and the NPA. In many instances, the need to provide primary health care can conflict with the other core responsibilities of the TCHHS, particularly the need to properly resource safe, quality acute hospital services.

In line with Government directions, TCHHS will continue to invest to build strong, sustainable primary health care services that can be transitioned to community control where communities request it.

To achieve this, we will invest in primary health care –in the workforce, in infrastructure, and in services themselves -to improve access, quality and consistency across TCHHS. We will improve clinician and business support, and set up services to have a sustained and greater community role where appropriate.

Actions

Transform:

1. **Develop and implement a primary health care model of care that is sustainable, patient-centred, holistic, proactive, and consistent across the HHS.** The model of care should allow for flexibility at the local level to tailor components to meets their communities' needs. The model of care should:
   - Be patient, family and community-centric.
   - Be Indigenous Health Worker-led, supported by a multidisciplinary team, and employ a case management approach to care, particularly for chronic disease management, so that services are coordinated.
   - Focus on continuity of care for patients by a known health practitioner, allowing care providers to develop long-term therapeutic relationships with their patients.
   - Incorporate technology to support a more transparent and collaborative approach between providers (i.e. information sharing) and patients, and to support patients to receive services closer to home (i.e. use of telehealth).
   - Be supported by information management systems that allow information sharing.
   - Include system navigation as a core component; and not just through nurses but across different professional groups.
   - Be underpinned by safety and quality and appropriate clinical governance

2. **Continue enabling communities to have a greater role in primary health care services.** This includes:
   - Engaging communities in discussions regarding the various transition models available and working together to increase community choice and involvement in the delivery of primary health care. The focus of these activities should be ensuring genuine input into the future of primary health care in their local communities. This should occur in all communities, particularly where primary health care services are well prepared for greater community involvement and choice, such as communities in the Northern Peninsula Area.
   - Defining roles and responsibilities between Queensland Health and other providers to reduce potential duplication and confusion in service provision.
   - Leading with the Queensland Department of Health toward development of a robust framework to assess whether communities are ready to take on increased choice in primary health care delivery, and to identify, in partnership with communities, the key areas for TCHHS to bridge prior to giving communities greater involvement.

- Improving the transparency over costs and resources to ensure that primary health care services have, in addition to the right model of care, a mature business model that provides for the sustainability of services in the event services are entirely transitioned to community.

Transform and Grow:

3. **Continue to develop and implement the Torres and Cape Renal Plan.** The plan should focus on strategies and initiatives including education and early intervention to help prevent chronic kidney disease progressing towards patients requiring dialysis or potentially experiencing renal failure. It will also acknowledge the direction for TCHHS to have a greater role in directly providing renal services, with specialist support from Cairns.

Grow:

4. **Increase access to primary health care through:**
   - Future workforce planning to ensure equitable access across the different regions within TCHHS, considering the availability of staff, and operational and geographic challenges, and safety and quality.
   - Prioritising new investment in primary health care services in mental health, alcohol, tobacco and other drugs and oral health services across the whole of TCHHS, including more remote areas.
   - Exploring models to deliver public primary health care services in Weipa, which currently has limited access to affordable and timely primary health care, to prevent over utilisation of Weipa Hospital's emergency department.
   - Collaborating with Northern Queensland Primary Health Network (PHN) to undertake an annual review of service provision to identify and address gaps.
   - Improved use of technology and virtual services to ensure most remote parts of TCHHS have equitable access to PHCC services.

Priority Three: Sustainable health services

TCHHS will improve the sustainability of our acute and sub-acute health services by increasing our self-sufficiency and providing as much care as close to home as possible for our patients. We will grow services within their current clinical capability levels, improve coordination of specialist outreach services, and develop new and enhanced services over time.

Description

Our population is dispersed geographically, with many people having no local access to acute hospital services. Private travel is not always affordable or realistic even with subsidies, and some patients and their families are required to relocate to be closer to services, while others delay access. Significant resources are devoted to transporting patients to TCHHS hospitals, and to hospitals in other regions such as Cairns.

In the future, we will reduce the number of patients that require travel by providing more services locally where this can be done safely and sustainably. To do this, we will need to optimise our workforce through different models, in partnerships with other providers (including our key partner, CHHHS) for specialist services, and invest in technology to provide remote support from higher level services.

We will also improve the amount and quality of affordable accommodation for patients and their families for those who are required to travel.

Actions

Transform:

1. **Bettercoordinate outpatient services, including technology-enabled solutions.** A centrally coordinated approach for specialist outreach services should be developed to ensure orderly delivery of services. Travel for outpatients should be reduced by increasing use of telehealth. The viability of telehealth hubs in key communities to improve access should be explored.

Optimise:

2. **Strengthen our hub and spoke model.** Clearly outline referral pathways, senior clinical support / clinical governance, and outreach from our major hubs (Cooktown, Weipa, Thursday Island and Bamaga) to each of our clusters of primary health care clinics and other services.

Grow:

3. **Enhance clinical support services,** including medical imaging capability at Thursday Island and Weipa, pathology services at Cooktown, pharmacy services at Bamaga and sub-acute and outreach allied health services at Thursday Island.
4. **Enhance acute services in our hospitals through improved self-sufficiency (including in outpatients) and by expanding the rural generalist model** across the following specialities:
   - *Bamaga*–renal dialysis, aged care, outpatients
   - *Cooktown*–cardiology, chemotherapy, endocrinology, gastroenterology, oncology, mental health, general medicine, obstetrics, palliative care, rehabilitation, renal dialysis and medicine, respiratory, dentistry, gynaecology, general surgery, obstetrics, orthopaedics, and diagnostic endoscopy
   - *Thursday Island*–chemotherapy, renal dialysis and medicine, general medicine, rehabilitation and sub-acute services, mental health, diagnostic endoscopy, ear, nose and throat (ENT), gynaecology, general surgery, orthopaedics, upper gastrointestinal tract (GIT) and urology
   - *Weipa*–mental health, general medicine, obstetrics, orthopaedics, rehabilitation, renal dialysis and medicine, respiratory medicine, dentistry, diagnostic endoscopy ENT and gynaecology.

Additional services will be provided by rural generalists on site supported remotely by specialists. These changes will be considered in the context of future funding agreements.

5. **Enhance sub-acute services through greater use of allied health-led service models.** Develop and implement new allied health-led sub-acute service models to provide greater access locally to clinically appropriate services.

Priority Four: Aged and end-of-life care

We will increase our capacity to provide culturally appropriate, sensitive, aged and end-of-life care for our people to age and die in their place of choosing. We will develop a sustainable workforce to deliver community-based services; and increase the availability of residential aged care services locally within TCHHS communities.

Description

Over the next 10 years, the number of TCHHS residents aged 60 years and over is expected to increase from 11% of the population to 16%, which means aged and end-of-life care services will need to expand to take care of our people –and most importantly, wherever possible allow people to die at home, on Country with family and community wherever possible.

Residential aged care services will require expansion, particularly at key sites such as Weipa, Bamaga and Cooktown; however, access to community-based services to deliver aged and end-of-life services is also important. These services are limited despite most people preferring ageing and end-of-life care to be provided at home and on Country.

Actions

Grow:

1. Expand culturally appropriate aged care services across the region. This will improve access to key services, including:
   - Increasing access to community-based aged care services across TCHHS by strengthening the capacity and skills of existing workforce and working with our key aged care partners including the Commonwealth Government and local aged care providers.
   - Providing access to more residential aged care services at Cooktown and Weipa, including the ability to provide care for dementia patients in a safe environment. This includes a focus on identifying cognitive impairment, and responding to individual needs with tailored care in partnership with the patient and carer using culturally appropriate tools and resources.
   - Increase access to residential aged care services in Bamaga for the NPA region, through the development of Bamaga Hospital into a Multipurpose Health Service (MPHS) –initially with six residential aged care beds.
   - Increase respite services in order to better support carers supporting their ageing relatives and members of the community at home.

2. **Improve the local provision of end-of-life and palliative care.** Work with communities to increase resourcing available to support local primary health care staff and families to allow people to die at home (including community-based palliative care). Services should be culturally appropriate and workforce strategies should aim to increase involvement from the Aboriginal and Torres Strait Islander workforce in the delivery of end-of-life and palliative care. This includes adapting existing materials to be locally relevant, readily available, and easy to understand.

   We will also provide access to education and training for staff focused on improving the standard and cultural appropriateness of locally delivered end-of-life care.

Priority Five: Workforce development

We will develop a flexible, sustainable and local workforce that enables patient-centred, culturally appropriate health care to deliver improved health outcomes to our people. We will explore opportunities for community members to become future clinicians, particularly for Aboriginal and Torres Strait Islander people/s.

Description

Key to the success of delivering patient-centred models of care is having a local, stable and sustainable workforce that is empowered to deliver services to their full scope of practice. To enable this, the majority of our workforce should be local members of our community, who develop long-term therapeutic relationships with their patients, supported by Queensland Health workforce training and development initiatives.

Our population is predominately Aboriginal and Torres Strait Islander, yet this is not reflected in our workforce. Although services will increasingly be designed around an Indigenous Health Worker-led model, there is an absence of career development and remuneration to support a sustainable Indigenous Health Worker workforce, which has limited our ability to maintain them at the forefront of service delivery. Improving employment opportunities for Aboriginal and Torres Strait Islander peoples across all disciplines and building a sustainable local workforce will be a priority for TCHHS.

Actions

Transform:

1. **Increase the participation of Aboriginal and Torres Strait Islander people/s in TCHHS workforce.** Develop a workforce plan that has at its core, increased representation of Aboriginal and Torres Strait Islander peoples across all disciplines and professions within TCHHS.
2. **Define career pathways, training and opportunities for Indigenous Health Workers and practitioners in partnership with the Department of Health and other organisations.** Advocate for the development of a formal career structure for Indigenous Health Workers and practitioners and sponsor their development, through training and education support, traineeships and/or guaranteed placement upon graduation.

Optimise:

3. **Investigate flexible workforce models.** This includes models not traditionally used by Queensland Health that can be used to better deliver services in communities with limited access to acute services.
4. **Improve clinician ability to practice to their full scope.** Support clinicians to practice to the top of their scope through formalised arrangements and communications to staff, and also provide training and opportunities to maintain their skills levels. This is applicable across all disciplines.
5. **Increase administrative support to clinicians to increase their focus on safe, quality care.** Enable clinicians to focus on clinical practice and spending time with their patients or delivering proactive promotion and prevention activities by ensuring appropriate administrative support –this will also facilitate more robust data collection and improve Medicare Benefit Schedule (MBS) billing rates.
6. **Build a culture based on learning and innovation, quality and safety.** Devise workforce strategies and actions to promote a culture of learning and innovation as well as technological literacy to enable greater use of technology in service delivery.

Grow:

7. **Expand the rural generalist model across all disciplines (allied health, nursing and medical).** Continue developing and expanding the rural generalist model across TCHHS, with a focus on specialist skills in chronic disease management, internal medicine and general surgery. This should be core to our acute services model of care, with specialist support provided by telehealth from Cairns or other specialist centres.
8. **Dedicated health promotion and prevention resources.** Invest in dedicated, evidence-based health promotion and prevention resources (workforce and materials), within TCHHS and in partnership with NQPHN, Aboriginal Medical Services, and CHHHS (in particular) to ensure coordination of activities and avoid duplication.

Priority Six: Enabling our future health services

We will continue to invest in innovative technologies; information systems and infrastructure that better support us in delivering on our priorities through sharing of information, new models of care enabled by technology and high quality accommodation for our staff and patients.

Description

As technology advances, there are new opportunities for us to deliver services in ways that are patient-centred and closer to home. As new technology-enabled models of care emerge, we will continue to explore their role, particularly technology that supports access to specialists in Cairns and allows us to deliver more services locally.

To allow technology to play an increased role in the delivery of our health services, we must focus on building appropriate infrastructure including spaces for telehealth in our facilities and accommodation for patients and staff.

Embracing technology also includes developing a mindset amongst our people, so they are willing to try new things, innovate, and be leaders in rural and remote health delivery in Australia and the world. Adequate investment is required to deliver on all six priorities. TCHHS will be one of several investors in the Plan. To achieve equality of health outcomes, we need to work with our partners to both grow the funding pool and encourage innovative investment models.

Actions

Transform:

1. **Improve electronic clinical information systems and supporting infrastructure.** Continue to implement electronic clinical information systems across TCHHS sites, including stable and secure WiFi and consider ways to better integrate and share information between primary health care centres and acute hospitals.
2. **Improve data quality.** Develop a strategy to improve data quality, collection, recording, storage and reporting, combined with audit, availability of data and information.
3. **Enable easy data sharing and improve data management systems.** Develop a data sharing protocol across the HHS that outlines arrangements (including security, ownership and use of data) to enable better sharing of information between services and providers.
4. **Develop technology-enabled models of care and build infrastructure that supports these models.** Investigate and implement technology-enabled models of care, including telehealth service models and remote services delivered with specialists based in Cairns. This will be supported by Infrastructure Master Planning that is technology enabled. A particular focus of this should be ensuring improved access for the remote parts of TCHHS.
5. **Work with the Department of Health and service partners in TCHHS to find and implement alternative funding models** for specific priorities or communities (such as alliance commissioning).

Optimise:

6. **Simplify governance and reporting in primary health care services.** This will ensure appropriate organisational and clinical governance model that supports the primary health care model.

Grow:

7. **Improve patient and staff accommodation.** Ensure Infrastructure Master Planning adequately plans for and incorporates appropriate accommodation for staff, patients and their families. This includes the quantity of housing stock and the quality of all housing options.

Transform, optimise and grow

Priority actions for this Plan have been aligned to Queensland Health's service planning directions: transform, optimise and grow

In developing the Plan, we have considered Queensland Health's service directions and identified services in three categories:

1) What can we can transform –that is, what existing services, resources or infrastructure can be re-purposed to deliver outcomes that more closely align to the health needs of the community.
2) What we can optimise, including strategies and programs of work to optimise the efficiency or appropriateness of the use of existing resources.
3) What we should grow. After considering transform and optimise, what services need to grow taking into account the opportunities to transform and optimise existing services.

Priority Area	Action	Transform	Optimise	Grow
Priority One: Health promotion and prevention services	Strengthen partnerships with local community groups and organisations.	√		
	Focus health promotion and prevention programs on key areas including the first 1,000 days of life.		√	
	Dedicated health promotion and prevention resources.			√
	Increase proactive screening.			√
Priority Two: Primary health care and enabling community choice	Develop and implement a new primary health care model of care that is holistic, proactive and consistent across the Torres and Cape HHS.	√		
	Continue enabling communities to have a greater role in primary health care services.	√		
	Continue to develop and implement the Torres and Cape HHS Renal Plan.	√		√
	Increase access toprimary health care.			√
Priority Three: Sustainable health services	Better coordinate outpatient services, including technology-enabled solutions.	√		
	Strengthen our hub and spoke model.		√	
	Enhance clinical support services.			√
	Enhance acute services in our hospitals and improve self-sufficiency.			√
Priority Four: Aged and end-of-life care	Expand culturally appropriate aged care services across the region.			√
	Improve the local provision of end-of-life and palliative care.			√
Priority Five: Workforce development	Increase the participation of Aboriginal and Torres Strait Islander peoples in TCHHS workforce.	√		
	Define career pathways, training and opportunities for Indigenous Health Workers in partnership with the Department of Health and other organisations.	√		
	Expand the rural generalist model. Strengthen our focus on developing and expanding the rural generalist model across TCHHS, with a focus on specialist skills in chronic disease management, internal medicine and general surgery.	√		
	Build a culture of learning and innovation.	√		
	Investigate flexible workforce models.		√	
	Improve clinician ability to practice at top of scope.		√	
	Increase administrative support to clinicians to increase their focus on clinical activities.		√	
Priority Six: Enabling our future health services –technology, information, infrastructure, investment	Improve electronic clinical information systems and supporting infrastructure.	√		
	Improve data quality.	√		
	Develop technology-enabled models of case and buildinfrastructure that supports these models.	√		
	Work with the Department of Health and service partners in TCHHS to find and implement alternative funding models.	√		
	Simplify governance and reporting in primary health care services.		√	
	Improve patient and staff accommodation.			√

7 Future services

Future service model

The future service model will focus on improving self-sufficiency by defining roles and responsibilities for each acute site under a hub and spoke model and also refine the way primary health care services are delivered

The TCHHS Strategic Plan, the health service needs and issues identified in this Plan, as well as the actions identified to address them identify an overarching ambition for TCHHS to:

- Improve health outcomes for the TCHHS resident population.
- Improve self-sufficiency and self-determination, where safe and sustainable to do so –to provide a better patient experience by reducing the burden of travel on patients and time away from their families.
- Achieve this in particular by embracing new technologies and ways of working –different workforce models, embedding telehealth as a core part of our models of care, and adopting a mindset and preparedness to take advantage of new technology (including a willingness and open-mindedness to pilot new technologies).

The future service model for Torres and Cape HHS is outlined below in terms of:

- Clinical service capability levels in line with the Clinical Services Capability Framework (CSCF) v3.2.
- Scope of services to be provided in each of the major hub sites (particularly in terms of future service enhancements).
- A better focus on the hub and spoke model to strengthen support relationships between acute facilities and primary health care clinics and provide greater consistency in service delivery.
- Considerations for a future model of primary health care delivery (to be developed separately, and considering and considering the community's choice of provider).

The service model has been developed considering the Department of Health's Rural and Remote Health Service Framework, which provides guidance on planning for health services in rural and remote areas within Queensland, the CSCF and consultation outcomes.

Enablers of self-sufficiency

Investment in a number of key elements that must be in place to increase self-sufficiency:

- Workforce. A greater focus on the rural generalist model; with specialist support remotely (from Cairns –by telehealth as the starting point, and visiting and outreach services as required); nursing and allied health-led services (clinics, nurse endoscopists etc.).
- Partnerships. Particularly with CHHHS, Townsville, and Brisbane-based specialists, and potentially private providers.
- Technology. A focus on telehealth including a 'mindset / cultural shift', and preparedness to take advantage of technology.
- Links with research and education institutes.

In addition, a strengthened hub and spoke model will ensure hubs are sustainable, but can also provide the required support (medical, nursing, allied health and otherwise) to smaller clinics and facilities within their region; and where possible, facilitate the transfer / transport of patients to the closest hub (rather than Thursday Island or direct to Cairns). This is outlined further below.

Future service capability

Table 7 identifies the future service model in terms of clinical service capability level, hub and spoke roles, and service enhancements by facility; with further discussion on the hub and spoke model and primary health care model considerations in the following section.

Table 7: Future enhancements to the hub and spoke model.

Hub facilities	Cooktown	Weipa	Bamaga	Thursday Island
Spoke facilities	PHCCs: Lockhart River, Coen, Hope Vale, Laura, Wujal Wujal	PHCCs: Mapoon, Napranum, Aururkun, Kowanyama, Porpuraaw	PHCCs: Bamaga PHC, Injinoo (GP led), New Mapoon, Seisia, Umagico	Hub site to some patients presenting at Bamaga. PHCCs: Thursday Island, Saibai, Boigu, Dauan, Darnley, Murray, Stephen, York, Yam, Coconut, Warraber, Badu, Kubin, Mabuiag, St Pauls and Horn Island.
Current CSCF	**Level 3**	**Level 3**	**Level 2**	**Level 3**
Future service enhancements				
Model description	Regional district hospital – CSCF Level 3, improving sustainability at this level	Regional district hospital – CSCF Level 3, improving sustainability	Rural hospital – CSCF Level 2; planned to become a multipurpose health service	Regional district hospital – CSCF Level 3, improving sustainability – hub site for PHCCs but also increasingly Bamaga and Weipa, including the delivery of outreach services.
Medical	• Expand in line with population growth • Enhancement of sub-acute services, including step-down	• Expand in line with population growth • Enhancements to sub-acute services, including step-down	• Expand in line with population growth • Enhancements to sub-acute services, including step-down	• Expand in line with population growth • Enhancements to sub-acute services, including step-down
Surgical	• ENT • Ophthalmology • General surgery • Minor orthopaedics • Gynaecology	• ENT • Ophthalmology • General surgery • Minor orthopaedics	• N/A • Consideration in future (incorporated into Master Planning)	• Maintain current services, capability • Some improvements to ENT, gynaecology, minor orthopaedics
Procedural	• Expand endoscopy • Expand dialysis (take over satellite unit from Cairns) • Oral health • Chemotherapy	• Introduce self-dialysis / nurse- supported dialysis (to also support smaller communities where appropriate) • Chemotherapy • Oral health	• Renal dialysis (self / nurse-supported) • Oral health	• Expand dialysis • Chemotherapy
Maternity	• Maintain (sustainable through improved surgical/procedural services)	• Consideration of low-risk birthing in the future; including through supporting / investigating innovative midwifery models that can appropriately and safely accommodte the risk asssociated.	• Maintain current Midwifery Group Practice model, investigate innovative midwifery models and the potential for birthing supported by Thursday Island in the future as models of care evolve.	• Maintain
Mental Health	• Expand community based services • Pathways/protocols for support in inpatient setting as required	• Expand community based services • Pathways/protocols for support in inpatient settings as required	• Expand community based services • Pathways/protocols for support in inpatient setting as required	• Expand community based services • Ability to support low-risk patients in an acute seting with telehealth support from Cairns
Clincal Support	• Pathology • Diagnostic imaging	• Pathology • Diagnostic imaging	• Pharmacy	• Pathology • Diagnostic imaging

Hub and spoke model

A rural hub and spoke model typically consists of a 'hub' that has responsibility for coordinating services across one or more satellite or 'spoke' centres, and delivers core services that are not available in the spokes. The TCHHS uses this model between acute facilities. Currently, a significant number of services are delivered outside of TCHHS, particularly by Cairns. This is likely to continue, as Cairns' role in the region is to deliver specialist services that are unavailable in other TCHHS facilities. However, there will be a greater role for services in referring more patients more locally. Numerous key elements must be in place to enable the success of a hub and spoke model. These include:

- Defined roles and responsibilities. Each site within the Torres and Cape HHS should have a role to play in hub and spoke model. This has been explained in Table 8. However, it is worth noting that this be developed further to understand the exact clinical capability that each site will deliver within the region.
- Communication and training for staff, including for ancillary services such as ambulance services. The roles and responsibilities of each site should be communicated to key staff, with training provided to those who make decisions regarding the most appropriate location for a patient to receive care. Confusion regarding the ability of each site to deliver particular services will undermine the success of the hub and spoke model.
- A strong transport and logistic networkthat can easily facilitate the movement of patients between the hubs and spokes, underpinning its sustainability.

There is also a role for technology in delivering a successful and sustainable hub and spoke model, including to share capabilities and expertise between the hub and spokes in real time.

Primary health care model

Comprehensive consultation with clinical staff and communities identified the importance of primary health care in improving the health outcomes of our people. Presently, there are inconsistencies in the way primary health care is delivered across the HHS due to resourcing constraints and some confusion surrounding key roles and responsibilities. To address this, and to support community choices, an action for TCHHS is to develop a contemporary and consistent model of primary health care.

The key principles of best practice for a primary health care model of care in the Torres and Cape HHS include:

- Proactive. Services should be proactive, where possible enabling primary health care staff to outreach to the community to provide health promotion and prevention activities or follow up on previous interactions with primary or acute care. Proactive care is particularly important for improving the health of those people with chronic conditions.
- Case management approach. In order to improve patient outcomes and experience, particularly for people with chronic diseases, employ a case management approach that responds to the complex needs of the community through a structured approach that coordinates and integrates services around the patient.
- Culturally appropriate and sensitive. Many people in the Torres and Cape HHS are likely to have different cultural expectations or practices to those who might be taking care of them. Recognition of these cultural differences is important in the delivery of primary health care services in order for Aboriginal and Torres Strait Islander peoples to receive effective care. In this context, primary health care services should be developed with involvement from local communities. Services should be led by Indigenous Health Workers, with a multidisciplinary team with the appropriate cultural awareness training.
- Continuity of care. Continuity of care encompasses the length and quality of the relationship between the primary health care clinician and the patient and the ability to build a long-term view of the patient's health needs. It is widely considered to deliver better patient satisfaction and better health outcomes. Continuity of care is key given the small size of the communities, and requires a detailed workforce plan to underpin its success.

These principles set out the core of best practice primary health care in Torres and Cape HHS. In implementing this model, primary health care services should adjust the model to suit local needs and preferences. Services should be designed in a mindset of continual improvement and safety and quality, particularly through technology, innovation in service delivery, and learnings from past experiences. This will enable services to be safe, patient-centred, allow high quality services to be delivered as close to home as possible, and improve service coordination through information sharing with other providers.

8 Next steps

Next steps

Enabling plans will be developed to articulate how workforce and infrastructure will enable the Clinical Services Plan across TCHHS. Operational plans at HHS to facility level will also be developed to implement the actions identified in the Plan

To support the delivery of the actions identified in the Plan over the next 10 years, the next step for TCHHS is to develop a detailed implementation plan that covers all priority areas. This should include appropriate governance arrangements and executive accountability for each action.

In addition to this, the following enabling plans should be developed to ensure appropriate resources and enablers are in place to achieve the objectives of the Plan:

- Workforce Plan, that outlines the future of the workforce, the needs of TCHHS, and strategies covering issues such as workforce models, recruitment and retention of staff and training and professional development
- Infrastructure Master Plan, outlining capital infrastructure requirements over the medium to long-term
- Information and Communications Technology (ICT) Plan, outlining required ICT infrastructure and planned investment across TCHHS
- Engagement Plan, describing how stakeholders will be engaged throughout TCHHS' activities, the principles that will guide this engagement, and the process for conducting stakeholder engagement activities
- Diversity Plan, identifying the diversity of consumers using TCHHS services, identifying high risk groups and describing how this diversity information and risk stratification is incorporated into the planning and delivery of care
- Funding and Investment Plan, that outlines the medium to long-term funding required to deliver on the Plan and future health services for the TCHHS.

This suite of plans will be supported by annual operational planning at the HHS, service stream and facility level. Operational planning will articulate how the priorities and actions identified in the Clinical Services Plan will be actioned, monitored through reporting and the outcomes evaluated to assess the success of each action.

9 Appendices

Appendix A: Inpatient self-sufficiency

SRG	TCHHS	CHHS	Other HHS	Total separations	Self-sufficiency
Renal Dialysis	1,200	4,598	1	5,799	21%
Obstetrics	255	417	112	784	33%
Non Subspecialty Surgery	468	250	24	742	63%
Respiratory Medicine	369	155	37	561	66%
Immunology and Infections	421	127	6	554	76%
Orthopaedics	217	303	18	538	40%
Cardiology	333	116	19	468	71%
Non Subspecialty Medicine	294	148	12	454	65%
Neurology	196	115	6	317	62%
Ear, Nose and Throat	165	92	18	275	60%
Unqualified Neonate	130	123	13	266	49%
Diagnostic GI Endoscopy	177	39	8	224	79%
Urology	68	129	16	213	32%
Gynaecology	89	104	14	207	43%
Chemotherapy and Radiotherapy	37	139	17	193	19%
Ophthalmology	154	28	7	189	81%
Gastroenterology	141	39	3	183	77%
Upper GIT Surgery	92	82	3	177	52%
Dentistry	131	23	3	157	83%
Haematology	115	32	7	154	75%
Endocrinology	105	37	3	145	72%
Plastic and Reconstructive Surgery	75	67	3	145	52%
Drug and Alcohol	84	49	10	143	59%
Qualified Neonate	12	100	30	142	8%
Neurosurgery	75	36	16	127	59%
Non-Acute	79	44	2	125	63%
Psychiatry -Acute	51	57	7	115	44%
Interventional Cardiology	102	11	113		0%
Vascular Surgery	22	54	2	78	28%
Renal Medicine	33	36	5	74	45%
Medical Oncology	14	38	14	66	21%
Rheumatology	37	23	1	61	61%
Rehabilitation	8	31	15	54	15%
Dermatology	36	8	2	46	78%
Breast Surgery	11	15	26		42%
Dental Surgery	20	2	22		0%
Cardiac Surgery	20	20			0%
Colorectal Surgery	3	14	3	20	15%
Head and Neck Surgery	3	12	1	16	19%
Tracheostomy	9	6	15		0%
Extensive Burns	4	2	8	14	29%
Thoracic Surgery	1	4	8	13	8%
Haematological Surgery	2	9	11		18%
Total	**5,707**	**7,826**	**513**	**14,046**	**41%**

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