Torres and Cape
Hospital and Health Service

Local Area Needs Assessment

Summary Report
December 2022

Queensland Government

Acknowledgement of Traditional Owners and Custodians

Torres and Cape Hospital and Health Service acknowledges and respects the Traditional Owners of the land on which we live and work and recognises 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.

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Joint message from the Chief Executive and the Executive Director of Aboriginal and Torres Strait Islander Health

The Torres and Cape Hospital and Health Service's Local Area Needs Assessment (LANA) contains opportunities to better address the highest priority health and service needs for people of the Torres Strait, Northern Peninsula, and Cape York regions. It is based on the most recently available information including outcomes from community consultations to capture the voices of clients and communities.

We acknowledge the strengths and cultural diversity of the communities we serve and commit to using this LANA for targeted future service improvements to reduce health inequities for the entire population. By sharing the prioritised health needs with communities, service partners, and our staff we aim to acknowledge both the recent achievements made in health and the challenges to maintain good health. We extend an invitation to our service partners, communities, and individuals to continue to collaborate to achieve better health outcomes for all.

Thank you to each and every person who contributed to the development of the LANA including valued staff members, community members, stakeholders, and the First Nations and Clinicians Expert Advisory Panel. Your contributions are truly valued, and we look forward to better health in everyone's future.

Beverley Hamerton
Health Service Chief Executive
and LANA Project Sponsor

Stephen Tillett
Executive Director of Aboriginal
and Torres Strait Islander Health
and LANA Project Steering
Committee Chair

Executive summary

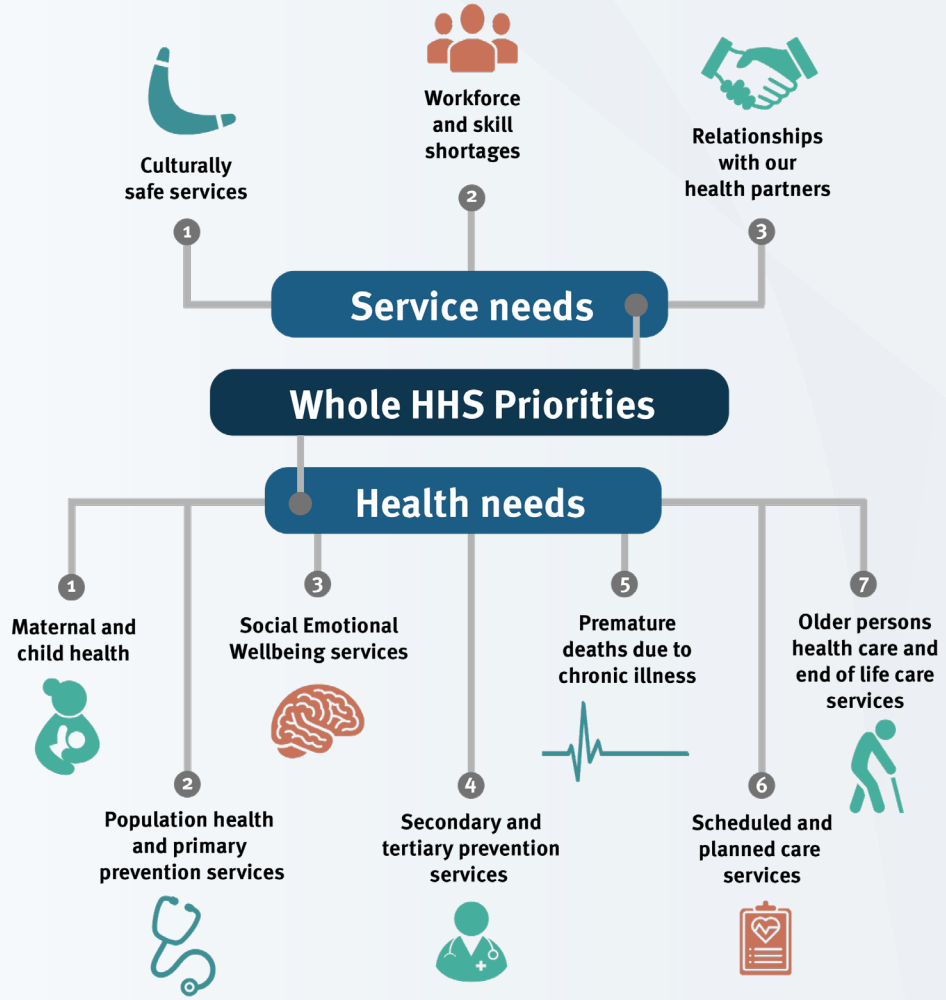
The Torres and Cape Hospital and Health Service (TCHHS) is the main health care provider of primary health care, acute care, and aged care services across the regions of Torres Strait, Northern Peninsula, and Cape York.

TCHHS has developed this Local Area Needs Assessment (LANA) in alignment with the Queensland Health LANA Framework to identify the highest priority health and service needs for the TCHHS region. This was achieved by undertaking an extensive data review, consultation process, reviewing empirical evidence, and ranking through prioritisation criteria. We worked alongside our health partner organisations to achieve these results and held expert advisory panels to ensure the needs were appropriate, relevant, and consumer informed.

The highest priority needs are presented both for service needs that pervade most program areas within the health service, and the health needs that are more specific to a speciality service stream or program area. TCHHS's LANA also details the needs both at a HHS level and Statistical Area 2 (SA2) level to identify localised improvement opportunities.

The LANA will be used to inform service improvement opportunities within operational planning and current funding allocations and to negotiate new funding opportunities with the Queensland Department of Health. It may be used to inform a review of the TCHHS Clinical Services Plan and may be useful for our health partner organisations in their service planning.

Figure 1: Whole HHS priority needs



Geographical terminology

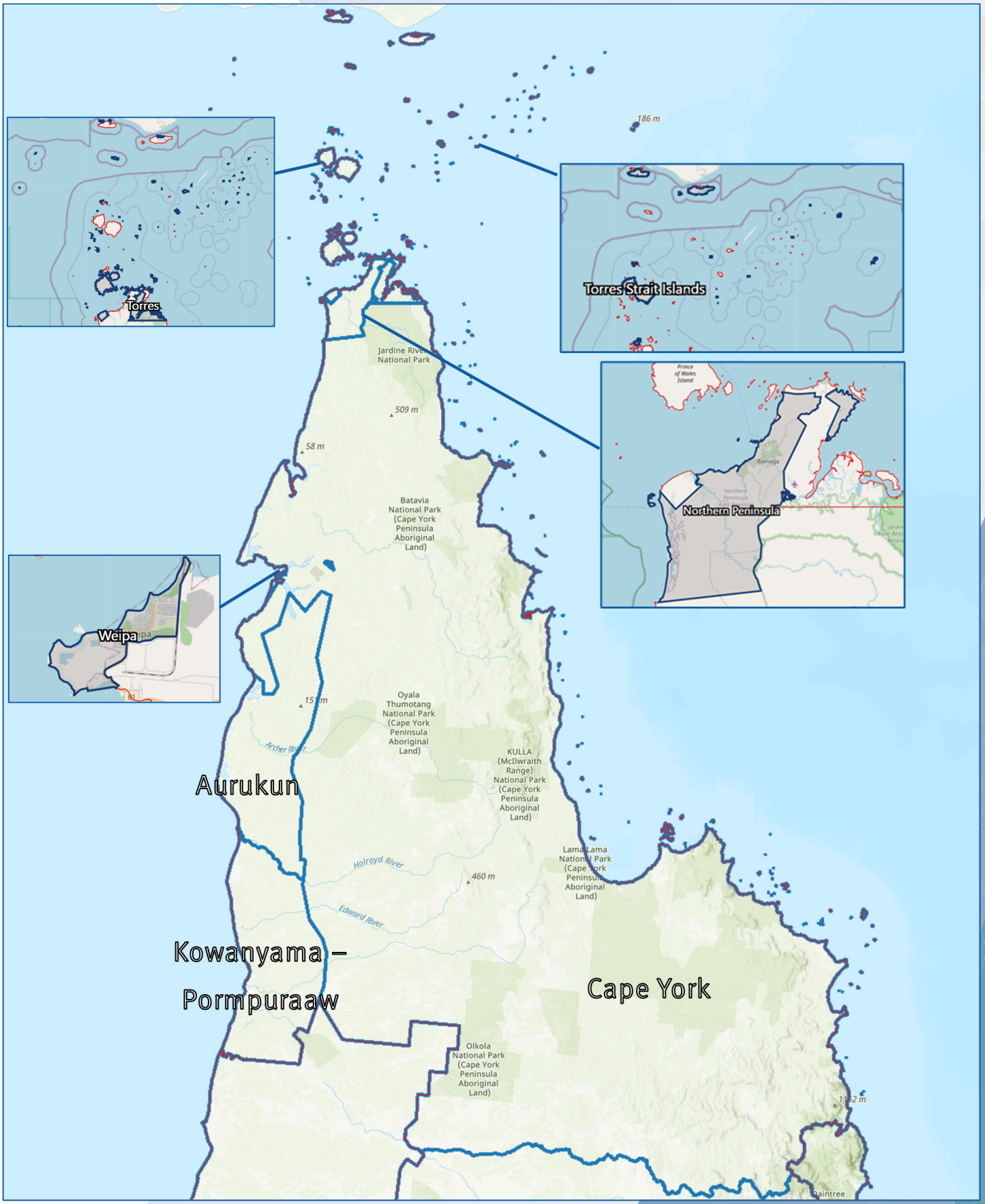
The LANA utilises a whole of Hospital and Health Service (HHS) and the Australian Bureau of Statistics' Statistical Area 2 (SA2) to define localised geographical boundaries and facility catchments (Table 1 and Figure 2).

Further information on acronyms used in this document can be found in Appendix A.

Table 1: TCHHS facilities by SA2

Aurukun SA2	Aurukun Health Service
Cape York SA2	Cooktown Multipurpose Health Service, Hope Vale Primary Health Care Centre, Wujal Wujal Primary Health Care Centre, Coen Primary Health Care Centre, Laura Primary Health Care Centre, Lockhart River Primary Health Care Centre, Mapoon Primary Health Care Centre, Napranum (Malakoola) Primary Health Care Centre.
Kowanyama / Pormpuraaw SA2	Kowanyama Primary Health Care Centre, Pormpuraaw Primary Health Care Centre
Northern Peninsula SA2	Bamaga Hospital, Bamaga Primary Health Care Centre, New Mapoon Primary Health Care Centre, Seisia Primary Health Care Centre, Umagico Primary Health Care Centre, Injinoo Primary Health Care Centre (outreach services only).
Torres SA2	Thursday Island Hospital, Thursday Island Primary Health Care Centre, Thursday Island Community Wellness Centre, Ngurupai (Horn Island) Primary Health Care Centre
Torres Strait Islands SA2	Badu Island Primary Health Care Centre, St Pauls Community Primary Health Care Centre, Kubin Community Primary Health Care Centre, Mabuiag Island Primary Health Care Centre, Boigu Island Primary Health Care Centre, Saibai Island Primary Health Care Centre, Dauan Island Primary Health Care Centre, Mer (Murray) Island Primary Health Care Centre, Erub (Darnley) Island Primary Health Care Centre, Ugar (Stephen) Island Primary Health Care Centre, Iama (Yam) Island Primary Health Care Centre, Masig (Yorke) Island Primary Health Care Centre, Poruma (Coconut) Island Primary Health Care Centre, Warraber (Sue) Island Primary Health Care Centre
Weipa SA2	Weipa Integrated Health Service

Figure 2: TCHHS region in SA2 view



Source: Adapted from Australian Bureau of Statistics (n.d.)

1. Introduction

Advice to the reader: TCHHS is mindful of the deficit discourse that often pervades documents that focus on First Nations people's health which reduces the complexity of First Nations history and culture and inflates measures that highlight disadvantage and perpetuate inequality. This document intends to move away from this type of deficit discourse while still acknowledging the significant health needs of all residents within TCHHS, and wherever possible presents whole of population results and recognises recent improvements in health.

A Local Area Needs Assessment (LANA) systematically reviews the health issues facing a defined population and determines their specific health needs. It identifies health inequities and service gaps which can be used to inform service development and funding allocations or redistributions (Queensland Health, 2021).

This LANA assesses health needs at the Hospital and Health Service (HHS) level and the Australian Bureau of Statistics' geographical boundary of Statistical Area 2 (SA2) to allow for a granular and targeted focus.

Queensland HHS LANAs are expected to be completed every three years, with future renditions to be made in conjunction with the Primary Health Networks (PHNs) and other health partner organisations so that priority health goals are consistent and delivered cohesively.

1.1 Torres and Cape Hospital and Health Service's LANA

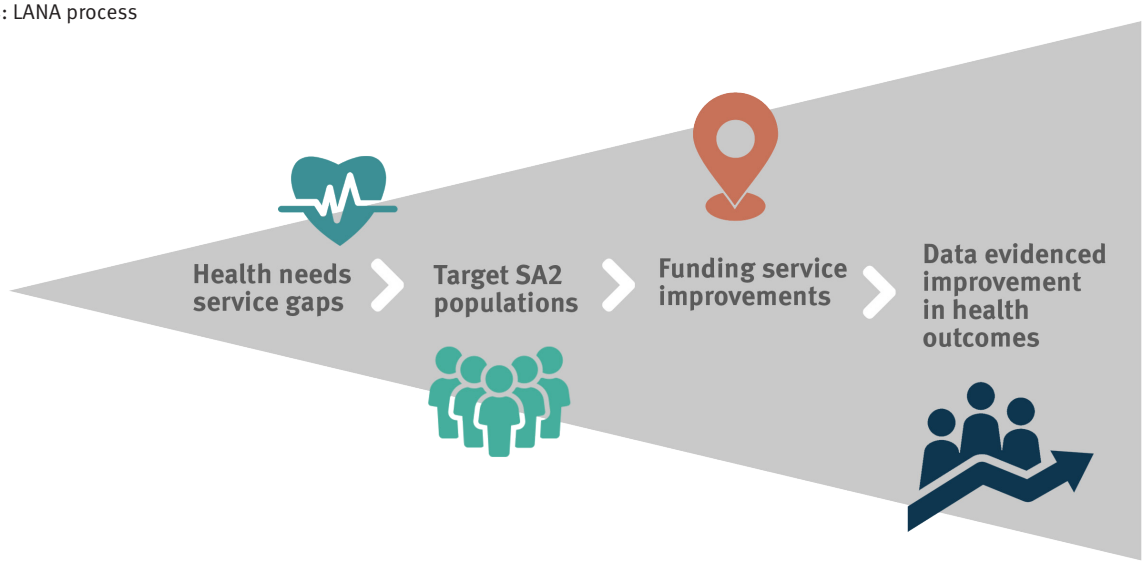
Torres and Cape Hospital and Health Service (TCHHS) began developing this LANA in 2021 with a comprehensive review of service data and production of the *LANA Data Analysis – Quantitative Paper*. In 2022, a LANA Project was established and consultation took place over several months to record concerns from staff, stakeholders, and community members on priority health and service needs. This consultation data was then combined with empirical evidence and the data findings from the Quantitative Paper, and then prioritised through high-level criteria.

Figure 3: LANA project phases

We sought advice from two expert advisory panels and our health partners, and we were able to identify the top priorities for the whole HHS and for each SA2 within TCHHS. The method of the LANA process is described in Appendix B.

This LANA Summary Report provides a high-level summary of the prioritised health and service needs for TCHHS. The LANA documents will be used by TCHHS for internal service improvements and by the Queensland Department of Health to inform a state-wide needs analysis and future funding allocations for priority needs.

Figure 4: LANA process



1.2 A focus on health equity

Advice to the reader: Based on advice from the First Nations Expert Advisory Panel, some health care terms in the document have been changed to be more meaningful and respectful to the local communities. This includes the replacement of the word chronic disease with chronic illness, and the use of the term Social and Emotional Wellbeing services in replacement of Mental Health, Alcohol, and Other Drugs.

With nearly 70% of the resident population of TCHHS consisting of First Nations people, it was essential that a focus on health equity and First Nations health was central to the development of the LANA. This was supported by collaborative consultation processes and shared information, in particular with the development of the concurrent TCHHS Health Equity Strategy 2022.

Evidence supports that First Nations Australians experience greater disadvantages in health which is evident in the significant gap in life expectancy compared to non-First Nations Australians. The leading contributing conditions to this gap are cardiovascular disease, diabetes, respiratory diseases, cancers, social emotional wellbeing illnesses, and injuries. By improving prevention and early intervention for chronic illness, as well as reducing the risk factors that can lead to chronic illness, further improvements can be made for First Nations people's health outcomes (DHAC, 2021).

It is important to acknowledge the significant gains that have been made in the improvement of First Nations population health in Australia over the last 20+ years, including a 43% decrease in cardiovascular disease mortality (Thurber et al, 2020). TCHHS is mindful of the deficit discourse that often pervades documents that focus on First Nations health. With the LANA we do not seek to focus only on the negative statistical disparities between First Nations and non-First Nations people, but also present the long-term health gains that TCHHS has made over the last 5-10 years. This illustrates our progress and how addressing health and service needs through an appropriate focus and funding opportunities can improve population health outcomes (Figure 5). While the improvements in First Nations health should not be overlooked, the purpose of the LANA is to highlight the health issues and gaps that need improvement and to support those arguments through evidence for where improvements are prominently needed.

Figure 5: TCHHS long-term health gains

Median age of death

From 2012-14 to 2020-21, **people lived** for an average of **7 years longer**

Growing older

There are more older people residing in TCHHS with a **2% increase in 65yrs and older** population between 2016 and 2021

Maternal and child health

Maternal smoking

4% less women including 4% less First Nations women **smoked during** any stage of **pregnancy** between 2016-17 and 2020-21

Antenatal visits

More women who gave birth **attended** 5 or more **antenatal visits** - at higher than state results and increasing 0.5% between 2016-17 and 2020-21

Low birthweights

There have been 2% **less low birthweight babies born**, and 2.6%less First Nations low birthweight babies born since 2016-17

Infectious diseases

The number of **Rheumatic Heart Disease** notifications has **almost halved** between 2018 and 2021

Potentially Preventable Hospitalisations

Hospitalisations considered to be **preventable dropped 4%** from 2016 to 2021

Renal dialysis

TCHHS provided **more dialysis services closer to home** (73% increase) for in HHS dialysis over the 5 years from 2018

Workforce changes from 2018 to 2022

Increased Medical staff by 16 more Full Time Equivalent (FTE)

Increased total staff by 81 FTE

Increased proportion of First Nations staff by 3% of total staff FTE, with First Nations clinicians increasing 3% both in medical and nursing. Managerial and clerical also increased by 3%.

In 2021-2022, TCHHS employed 226 First Nations people.

Data Sources:

Median Age of Death-Chief Health Officer TCHHS Clinical Services Plan 2016 and Planning Portal. Extract 5/12/2022
Growing Older - Queensland Regional Profiles: Resident Profile: TCHHS region (ASGS 2012 and 2021)
Maternal Health - Queensland Health Statistical Services Branch, Indigenous Indicators. Extracted 24/11/2022
Infectious Diseases - Queensland Health Notifiable Conditions Register. Extracted 23/11/2022
PPHs - Chief Health Officer (CHO) Report. Extracted 25/11/2022
Renal Dialysis - DSS (ABF Activity). Extracted 30/11/2022
Workforce - HR Business Intelligence, Human Resource Branch, Brisbane. Provided 25/11/2022

1.2.1 Recognising generational trauma

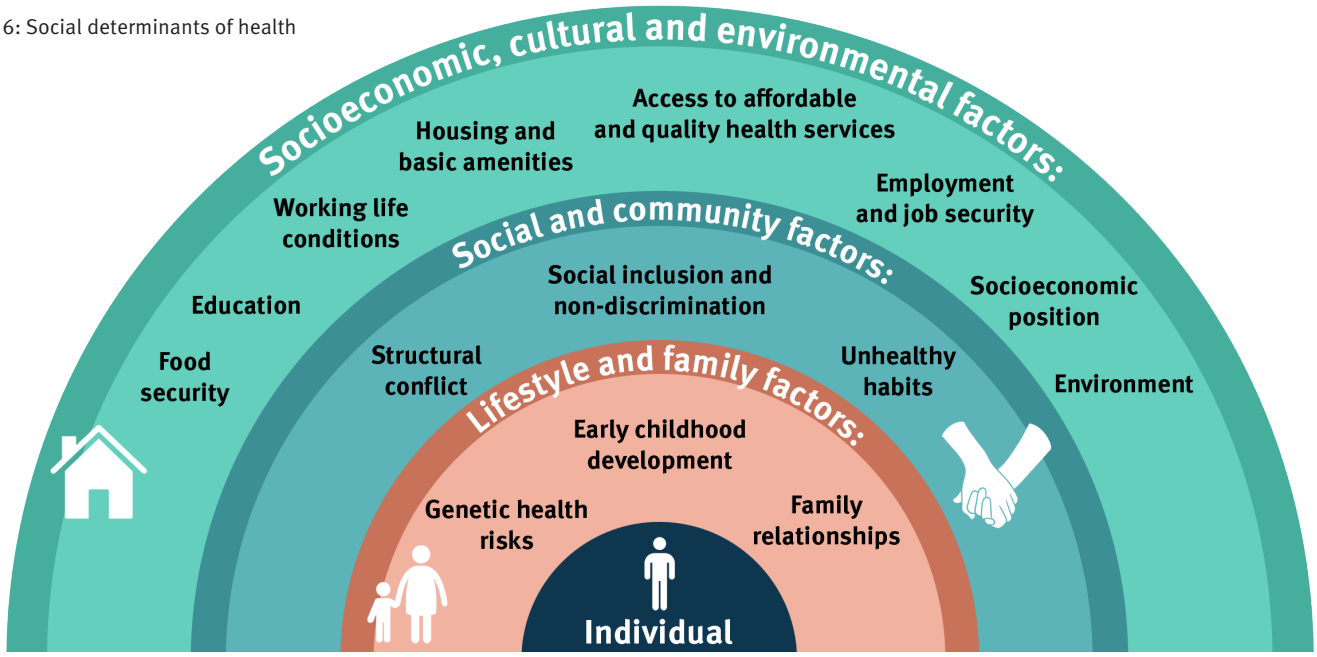
The colonisation of Australia has greatly impacted (and continues to impact) First Nations people through a history of violence, death, loss of cultural practice, dispossession of lands, denial of citizenship, forced removal of children, and other violations of human rights that have created intergenerational trauma and complex posttraumatic stress. (Fiolet et al., 2022). Colonisation also led to the introduction of foreign diseases, ingrained poverty, and inequal access to health care for First Nations people which has contributed to the chronic illness prevalence and life expectancy gap this population now faces today (Coombes et al., 2018).

TCHHS recognises and respects the impact colonisation has made on the First Nations population's health and aims to limit impacts where possible by being culturally responsive and inclusive of protective health factors to improve health and wellbeing. This includes recognition of and support of cultural history, identity, practice, and connections to family, kin, and land (AIHW, 2022b).

1.2.2 Social determinants of health

Social determinants of health are a range of non-medical factors that may affect a person and influence their health outcomes. These factors include education, employment, environment, living in remote locations, high costs of living, access to health care, food insecurity, housing and overcrowding, early childhood development, family stressors, unhealthy habits (e.g., smoking, alcohol use, and drug use), social inclusion, social conflict, discrimination, and more (World Health Organisation, n.d.), and may impact each individual differently.

Figure 6: Social determinants of health



Source: Adapted from World Health Organisation (n.d) and AIHW (2022b)

Social determinants are a major factor in the development and maintenance of significant health issues, and to ignore social determinants is detrimental to a holistic and person-centred view of health care. Poor social determinants of health are evidenced in First Nations populations and contribute to the greater levels of disease burden and the lower life expectancy this population experiences (Butler et al., 2019). This is primarily due to the impacts of colonisation that contributed to the social systems that maintain disparities (AIHW, 2022b).

It is important to note that there are many different cultures, language groups, and lived experiences within the First Nations communities. It is not assumed that all social determinants are the same within each TCHHS community as they affect each rural and remote community differently, but they are acknowledged as significantly affecting the health of a large proportion of the First Nations population across the region.

1.2.3 Holistic health

It is recognised that First Nations people have a holistic concept of health which incorporates many elements such as physical, social, emotional, cultural, spiritual, and community wellbeing.
Good health is perceived as not just the absence of ill health but as a picture of the whole person (AIHW, 2022c). This means that the factors that make up a person's health, including social determinants of health and ill health, must be addressed for a perception of good health to be experienced.

Figure 7: Holistic health

Source: Adapted from NIAA (2017)

1.2.4 Needs amenable to health care

TCHHS acknowledges the significant influence of social determinants of health in the contribution to many health issues. 85% of the TCHHS population are in the lowest Socio-Economic Indexes for Areas (SEIFA) quintile with significant socioeconomic disadvantages. However, it is pertinent to keep in mind that health care can only influence change from a health care stance and many social determinants of health require whole-of-government or cross-sector intervention. In essence, this means TCHHS's focus is on what we have the power to change to enable long-term health benefits, and TCHHS will continue working with our health partner groups and other government departments to influence change in other domains.

1.3 Strategic alignment

The LANA aligns with the TCHHS values and aims to further our Strategic Vision of Healthy people and communities in the Torres Strait, Northern Peninsula Area, and Cape York. It will also be used for internal strategies and plans as they are developed, and by health partners to inform their service planning

Figure 9: TCHHS values

COURAGE	ACCOUNTABILITY	RESPECT	ENGAGE
Driving innovation and giving feedback	Being accountable for the TCHHS communities and their health needs	Acknowledging the differences amongst the communities and respecting their individual needs	Working together with the community to continuously improve health services

The LANA aligns with strategic directions provided through national, state, and regional strategies as illustrated in Figure 8. In particular, the development of this LANA aligns with the:

- *National Health Reform Agreement* (DHAC, 2020b)
- *National Agreement on Closing the Gap* (Closing the Gap in Partnership, 2020)
- *Statement of Commitment to reframe the relationship between Aboriginal and Torres Strait Islander People and the Queensland Government* (DSDSATSIP, 2019)
- *Hospital and Health Board (Health Equity Strategies) Amendment Regulation* (Queensland Legislation, 2021)
- *Unleashing the Potential: an open and equitable health system* (Queensland Health, 2020) (provides the strategic alignment for development and intended use of the LANA to better inform system-wide service planning and delivery)
- TCHHS's *Health Equity Strategy* (2022)
- TCHHS's *Strategic Plan 2019 – 2023* (2021 review).

Figure 8: TCHHS strategic alignment

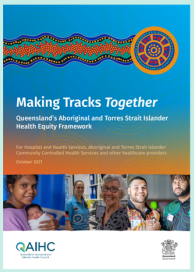
National strategies

Queensland Government strategies

Unleashing the Potential 2020

Advancing Health 2016 - 26

Making Tracks Together Health Equity Framework 2021 - 31



Better Care Together 2022-27

Statement of Commitment 2019

Health Equity Strategies Regulation 2021

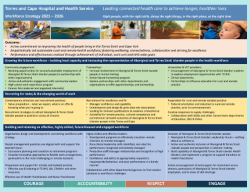
TCHHS strategies and plans

Strategic Plan 2019-23

Clinical Services Plan 2019-29

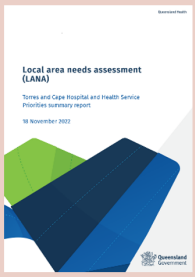
Health Equity Strategy 2022-25

Workforce Strategy 2021-26



TCHHS Local Area Needs Assessment

LANA Data analysis - Quantitative paper 2021



LANA Summary Report 2022

Next steps

Revision of TCHHS strategies and plans

Opportunities for service improvement based on LANA needs

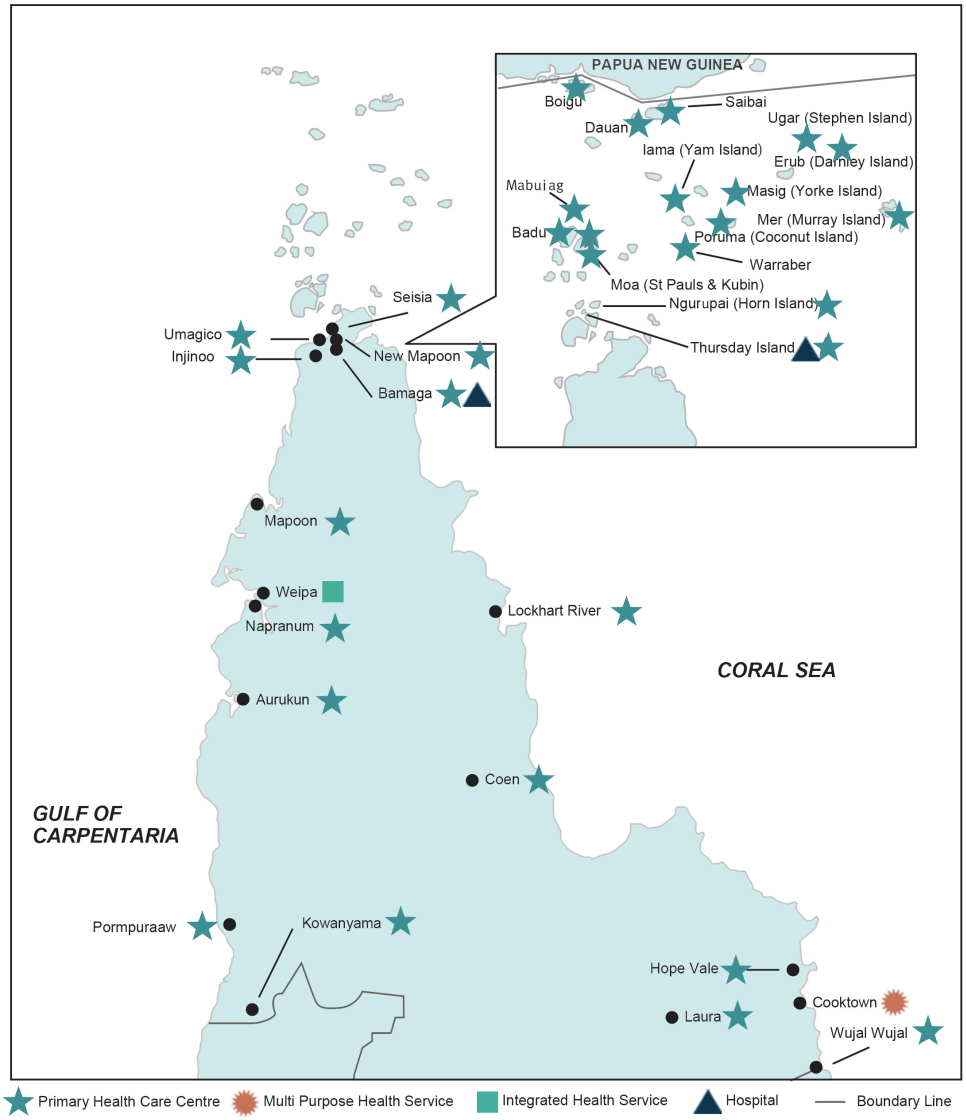
2. Torres and Cape HHS Profile

TCHHS is the main public health care provider for the region which consists of the SA2s of Aurukun, Cape York, Kowanyama – Pormpuraaw, Northern Peninsula, Torres, Torres Strait Islands, and Weipa.
TCHHS provides primary health care, acute care, and aged care services though the 31 Primary Health Care Centres (PHCC) and four hospitals – Weipa Integrated Health Service, Cooktown Multipurpose Health Service, Thursday Island Hospital, and Bamaga Hospital.

TCHHS serves a population of 27,928 people with approximately 68.7% of the population identifying as First Nations people (based on 2019 data[1]). The total area covered is 130,238km^2, approximately 8% of Queensland, and all communities within are characterised as remote or very remote per the Australian Bureau of Statistics' Remoteness Structure.

TCHHS has a difficult geography to navigate which creates challenges for staff and client travel. Servicing communities requires significant travel, and they are often difficult or impossible to travel to during the wet season (November to March). There are significant barriers to health care access including limited travel and accommodation options, and often cost constraints for individuals when accessing health care beyond their local service.

Figure 10: TCHHS facilities



[1] Queensland Health, System Planning Branch (2021c) Planning Portal, accessed 27 August 2021.

2.1 Health partner organisations

Key service partners include the Cairns and Hinterland Hospital and Health Service (CHHHS) for residents that are referred to higher level services beyond TCHHS's capability levels and as a provider of specialist outreach services. Other providers include Townsville HHS (THHS) and Children's Health Queensland who also provide specialist or state-wide level services.

Other key service partners for TCHHS include several Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs), including:

Figure 11: TCHHS's ATSICCHO partners

Apunipima Cape York Health Council (ACYHC)	Torres Health Indigenous Corporation (THIC)	Northern Peninsula Area Family and Community Services (NPAFACS)

These partner services deliver aspects of health care (clinical and non-clinical) such as primary health care which includes chronic illness management, health promotion and prevention work, and other health and social services. Many of the services provided have evolved over time to expand or change which required TCHHS to remain an active collaborator.

In practice, forming partnerships between organisations can be difficult with different funding and service priorities sometimes resulting in duplication or gaps in services. The LANA aims to provide a better understanding of the shared challenges and priorities for improving health and service issues through stronger partnership arrangements. Other key health partnerships and services include:

- Aged care
  - 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
- CheckUP Australia
- Mookai Rosie Bi-Bayan
- Northern Aboriginal and Torres Strait Islander Health Alliance (NATSIHA)
- North Queensland Primary Health Network (NQPHN)
- Private General Practitioner (GP) practices in Weipa and Cooktown
- Queensland Aboriginal and Islander Health Council (QAIHC)
- Queensland Ambulance Service (QAS)
- Royal Flying Doctor Service (RFDS)
- Social service organisations including Domestic and Family Violence services, housing, and other programs provided by local councils
- Wuchopperen Health Service

2.2 TCHHS data profile

The following pages provide an overview of key data measures from the *LANA Data Analysis – Quantitative Paper*. Much of the data is presented at rates per 1000 or similar rates that deidentify information for the privacy of consumers. The data is compared either with a state rate or against the other SA2s if a state rate is unavailable. Further information on the limitations on the data is detailed in the Method in Appendix B.

Figure 12: TCHHS data profile part one

Demography and geography

In 2019 there were **27,928** people in TCHHS

In 2031 it is projected there will be **29,317**

28.3% of the population are aged **14 and under**

7.6% are aged **65 and over**

The **life expectancy** of both males and females is lower than the state rate

The total area covered is 130,238 km², which is approx **8%** of the total Queensland area

Children and young people

Areas with the highest proportion of young people aged **14 and younger** are the Northern Peninsula and the Torres Strait Islands

The proportion of children who are **developmentally vulnerable** across 1 or 2+ domains is significantly higher than the state rate

Maternal and neonatal

Neonatal outcomes in TCHHS are significantly poorer than the state average for low birthweight rate, high birthweight rate, and infant mortality

There is also significant **disparity in neonatal outcomes** between First Nations and non-First Nations persons

Maternal and neonatal outcomes in the HHS are characterised by low socioeconomic status, high fertility, high rates of smoking during pregnancy for First Nations people, and obese mothers.

First Nations people

19,277 people identify as First Nations people

this constitutes **68.7%** of the 2019 estimated resident population for the HHS

32.9% of the First Nations population are aged between **0-14 years**

16.4% are aged **50 years and over**

Ageing population

In 2019, 7.6% of the HHS population were **aged over 65**, well below the Queensland rate of 15.7%

Additionally, 29.0% were **aged over 45**, compared to the state rate of 40.3%

Mental health

Data on **mental health** problems and suicide in TCHHS is limited although suicide is a leading cause of premature death

The relative utilisation of 23% for **mental health services** in FY2019-20 reflects underservicing/ underutilisation of mental health services despite the high prevalence of mental and behavioural problems

Service access, availability, utilisation

There are **workforce shortages** in this HHS relative to the state across various professions

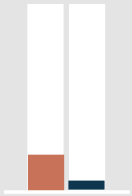
Across all **ED presentations** at TCHHS facilities in FY2020-21, 51% were potentially unnecessary GP-type ED presentations

Figure 13: TCHHS data profile part two

Social determinants of health

About 85% of the population are in the **lowest SEIFA quintile**

The **unemployment rate** for this region is 18.6%, which is more than double the state rate of 7.3%



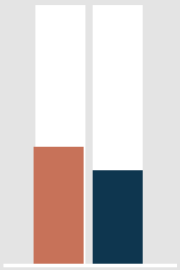
The **crime rate** is considerably higher in this HHS compared to Queensland

The rate of **single parent families** is considerably higher than the state for the HHS overall

This HHS has a higher proportion of **obesity** compared to the state

People with a **schooling level below year 11** is 43.9% for First Nations people (similar to the state proportion)

and 34.8% for non-First Nations people (1.3% higher than the state proportion)



*There are regions where the education level is not stated for a large proportion of First Nations people, which impacts the interpretability and reliability of these statistics. For example, 18.9% of First Nations people did not state their highest level of schooling in the SA2 of Torres.

Chronic disease burden

The **top 3 causes of death** for people aged 74 and under are cancer, circulatory system diseases, and external causes (which include suicide and self-inflicted injuries)

The incidence rate for head and neck, lung, ovarian, and uterine **cancers** are considerably higher than the state

The rate of admissions related to **immunology and infections** are 3.25x higher than expected

Acute rheumatic fever/ Rheumatic Heart Disease is 15x higher among First Nations persons compared to non-First Nations persons

Overcrowding rates are more than double the state average, with more than 1 in 3 First Nations people residing in crowded dwellings

The **sexually transmitted infections** rate is 287 per 10k for the population and 391 per 10k for First Nations persons

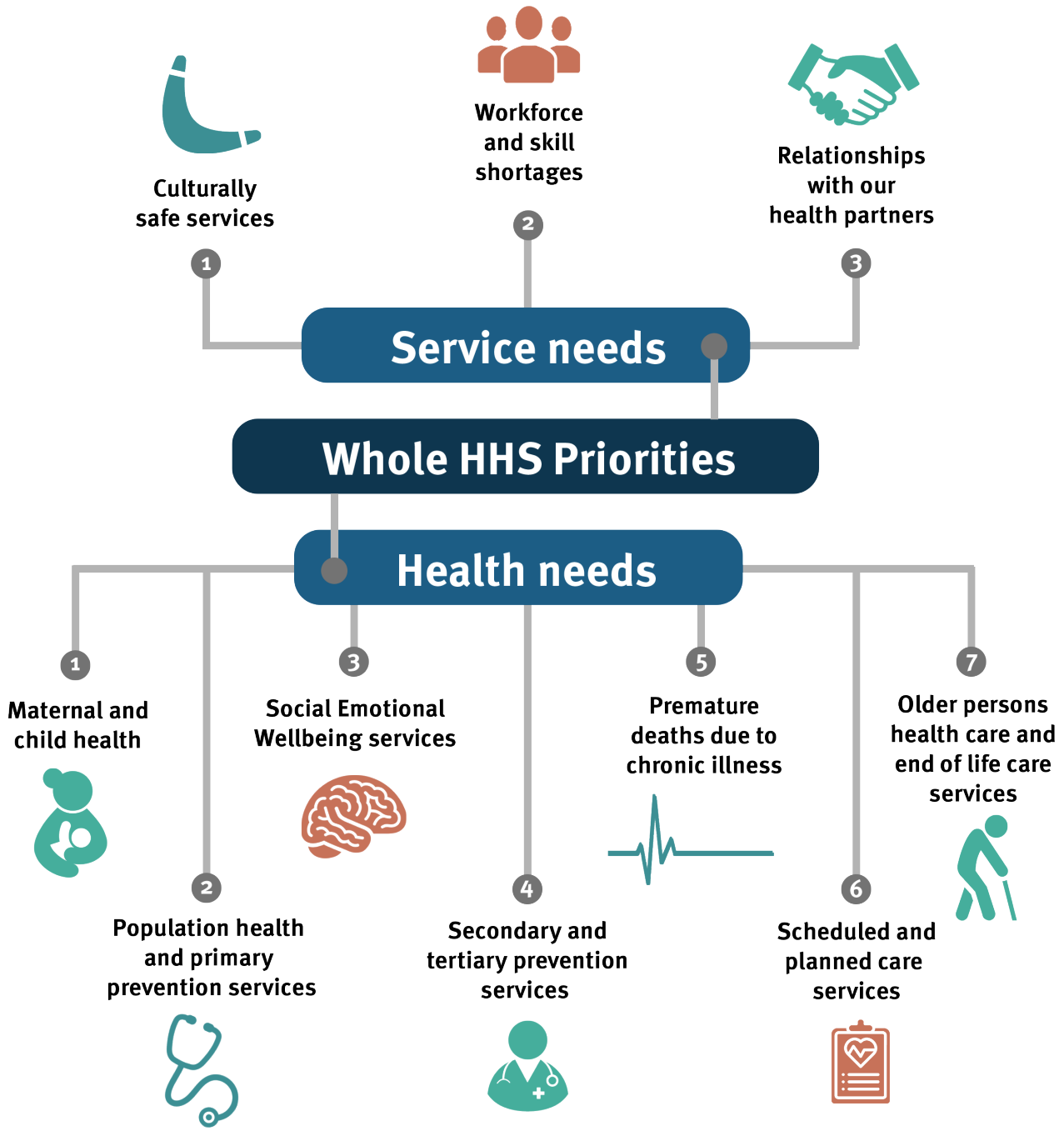
Rates of **vaccine preventable** related admissions are 2.8x higher than the state, with the rate for First Nations people 4.1x higher than the state

3. HHS priorities

This section details the highest priority health and service needs for the HHS. These needs will require the greatest level of support to influence positive health outcomes. The priorities are presented separately as service needs and health needs as the service needs act as constraints that must be addressed in order for the best results from health needs to be attained.

The following pages provide further detail on each priority. The SA2 level nominated health need priorities detailed in sections 4–10 may not always replicate the HHS level priorities in full, but it is recommended that the TCHHS nominated priorities apply to all populations within TCHHS.

Figure 14: Whole HHS priority needs



3.1 Priority service needs

3.1.1 Priority 1: Culturally safe services

Through consultation and data, it was identified that many First Nations respondents do not feel culturally safe when attending our health facilities. This means that they do not feel welcomed, understood, heard, safe, or that they have been treated fairly or without discrimination when seeking health care. There is evidence that supports this in late presentations of illness to health services, later detection of diseases and cancers, and higher than expected Failure to Attend appointment rates.

> *We need more First Nations staff to better understand the clients on a different level other than verbal. Aboriginal culture has a very non-verbal language. It's a feeling.*
> – Community member.

Nationally, there is significant evidence that supports improving cultural safety for First Nations people improves access and the quality of health care delivered (AIHW, 2022a).
This is the number one service need priority for TCHHS as it influences all other priorities regarding First Nations people's health. Cultural safety needs to be pervasive throughout our services.

> *We need holistic health care so that we are treating the client as a person and not as a number. We cannot expect standard treatment methods will apply to every individual.*
> – Community member

> *The cultural aspect of health isn't thought about or talked about enough. It plays a big role for our patients. Sometimes the PHCC is avoided because of shame and fear.*
> – Stakeholder.

3.1.2 Priority Service Need 2: Workforce and skill shortages

Issues with workforce supply and stability affect the health sector across Australia and even globally. Additionally, TCHHS is challenged by significant levels of illness and service barriers which strongly suggests the service demands require a much larger workforce than that which is currently in place. Limited numbers of private services (including General Practitioners (GPs), Allied Health and Dental) has resulted in government services becoming the main providers of health care.

> *The workforce needs to be redesigned to cater to current needs rather than continuously using an aged model.*
> – TCHHS Staff member

There are identified service gaps, skill shortages, and inequitable distribution of staff across the HHS including GPs, Allied Health, Dental, Social Emotional Wellbeing, school-based nurses, Child Health and Child Development staff.

> *We need consistent staff rather than transient agency staff to build stronger relationships with community members.*
> – TCHHS Staff member

Other inconsistencies and gaps originate from changes in service providers, contractual arrangements, short-term staff, high staff turnover, and frequent changes to visiting specialist schedules. These issues continuously impact the ability to resource the workforce effectively.

Recruiting and retaining staff to remote communities is recognised as a challenge nationally. The use of agency/locum staff and the subsequent transient staffing model often results in a disconnect between the community members and the facility staff, as new faces are constantly rotated through, and effective rapport and trust is not built. The lack of consistent staff is compounded by the poor standards of staff accommodation in many communities and the lack of maintenance funding for the upkeep of this accommodation.

Additionally, much of our workforce are ageing and nearing retirement, especially for our Aboriginal and/or Torres Strait Islander Health Workers and Practitioners (ATSIHWPs). Workforce succession plans and trainee-type positions are needed to introduce a new generation of staff who can learn the skills and community knowledge from our current senior staff. Workforce is central to our service and to our partner groups and addressing these workforce issues would enable the improvements needed across the health needs priorities.

> *ATSIHWPs have invaluable community knowledge and yet are not supported to develop. They are cultural consultants and should be treated as such.*
> – TCHHS Staff member

3.1.3 Priority Service Need 3: Relationships with our health partners

Our health partners are key to the provision of comprehensive health care within the region and play a vital part in ensuring health care is culturally appropriate and accessible for all.

> *Overcoming data sovereignty issues with the health partners should be a major priority, otherwise not all health issues are fully exposed.*
> – Stakeholder

Current challenges we face include barriers to information sharing, frequent contractual changes to services arrangements, staffing and recruitment issues that impact upon service provision, issues with interservice client transfers (travel and accommodation arrangements), and duplicated and fragmented health records – all of which contributes to disrupted client journeys.

> *The community gets frustrated with the health pathway disruptions. The coordination of services is not good.*
> – Stakeholder

Building strong, formal partnerships supported by functional and realistic systems and management processes will enable better collaboration for broader health improvements.

There are opportunities to work better with all partners, particularly to improve access to First Nations-led health care.

This would also progress health equity to improve First Nations people's health outcomes through shared decision-making and engagement in health priorities.

We need collaboration across agencies, definitions of roles, and clear scopes and parameters between organisations to avoid duplication and gaps.
– Stakeholder

3.2 Priority health needs

3.2.1 Priority Health Need 1: Maternal and Child health

TCHHS provides maternity services across pregnancy, birthing, and postnatal care under a midwifery group practice model based in Weipa, Thursday Island, and Cooktown, with outreach services provided to other locations. CHHHS provide complex maternity services, including visiting obstetricians and neonatal services in conjunction with THHS.

First Nations women are asking for home birth programs to be able to have their children born on country and be with their families rather than travelling away.
– TCHHS Staff member

Child health services are provided by visiting paediatricians, dedicated services at Weipa and Thursday Island, and/or by primary health care staff (both TCHHS and partners). With a significant proportion of the population (28.3%) under 14 years, child health services and skills has been identified as a high priority health need.
When compared to all Queenslanders, mothers, infants, and children in TCHHS generally experience poorer health results across most measures. There are higher fertility and birth rates than Queensland and most maternal health markers including smoking and healthy birthweight are generally poorer, although most women attain the recommended number of antenatal visits.

Children are not getting a good start to life; we need education and health promotion programs to focus on kids ages 0-14.
– TCHHS Staff member

Many younger residents are born with lifelong health challenges and experience developmental issues or diseases more often and at higher levels than other Queensland children. Although vaccination levels are similar to Queensland, there are regions where the rates for First Nations children fully vaccinated by 2yrs old is lower and needs improvement.
The presence of infectious diseases and early development of conditions associated with chronic illness in children indicates an opportunity to improve prevention and early intervention services to reduce associated hospitalisations.

The first 5 years of a child's health is what is most important to build the foundation for their future. The lack of child health services is impacting the future of the community and we can't make generational change without this.
– TCHHS Staff members

Oral health for children is a high priority need evidenced by higher than expected acute hospitalisations for dental conditions. Skin conditions, ear and eye health, developmental,

disability, and child safety services for younger residents also requires improved access.
Ensuring a good start to a child's life by focusing on the first 1000 days is a much needed step in improving long-term population health, and for these reasons maternal and child health is the highest health need within TCHHS.

3.2.2 Priority Health Need 2: Population health and primary prevention services

Prioritising prevention and helping people better manage their health throughout their lifetime is one of the four long-term priorities in the *National Health Reform Agreement* (DHAC, 2020) and a recommendation of *Unleashing the Potential: An open and equitable health system* (Queensland Health, 2020).

> *People think sickness is inevitable rather than preventable.*
> – Community member

The environment, socioeconomic and living conditions, and the proximity of an international border to the north of TCHHS bring challenges to good health for the population.
Population health services within the HHS are currently limited, largely due to different funding responsibilities amongst the partner organisations and the limited local presence of services at a population health level. Currently TCHHS is heavily reliant on other health partners including local government and CHHHS's Tropical Public Health Service to provide population health and primary prevention services.
Primordial and primary prevention need significant cross sector intervention to influence change, such as by improving health literacy through education, and addressing housing issues that lead to overcrowding (further information on the prevention continuum can be found in Appendix C). The growing levels of chronic illness are increasing the demand on services, and without concerted intervention the impact and cost of chronic illness will only continue to escalate. Evidence for the benefits in preventing chronic illness is strong, particularly at a population health level. It has multiple benefits for clients and communities such as people living longer, increasing quality of life, and for health services in reducing the demand on the system.

> *People have a low expectation of what good health and health care looks like. We need to develop health literacy and health seeking behaviours in community to maintain wellness rather than illness.*
> – Stakeholders

There are a range of infectious diseases that TCHHS experiences (some rarely seen elsewhere in Australia) including multi-drug resistant tuberculosis, acute post-streptococcal glomerulonephritis, syphilis, leprosy, and influenza. Infectious disease and infections are one of the largest causes of hospitalisation, and vaccine preventable diseases (particularly in adults) is a leading cause of preventable hospitalisations.
Population health services need to be strengthened for the surveillance and management of infectious disease, management of outbreaks, immunisation delivery across all ages, and overcoming environmental health challenges where possible.

> *Public Health needs to shift focus from purely responding to infectious diseases to also working in prevention.*
> – TCHHS Staff member

3.2.3 Priority Health Need 3: Social Emotional Wellbeing services

The TCHHS Mental Health, Alcohol & Other Drugs Service (MHAODS) is based out of Weipa, Cooktown, Thursday Island, Bamaga, and Cairns with outreach services provided to the more remote communities. MHAODS is a multidisciplinary team of health professionals who provide a range of integrated services including community case management, crisis response, and extended hour services in Cooktown. RFDS also provide services in some Cape York communities, and psychiatry services are provided by CHHHS on a fly-in fly-out outreach basis.

There is a growing demand for Social Emotional Wellbeing services, compounded by high levels of psychological distress, generational trauma, Domestic and Family Violence, and suicide which remains a leading cause of premature death.

The prevalence and severity of Social Emotional Wellbeing conditions in TCHHS is higher than the state, with the two most prominent disorders being alcohol use disorders and conduct disorders. Despite this evidence, utilisation of Social Emotional Wellbeing hospitalisations is very low – possibly indicative of underservicing or access issues. Drug and alcohol-related episodes of care (separations) are also lower than expected despite lifetime risky drinking being at a higher level than the state.

> *There is a lot of trauma in community that is deeply embedded and entrenched, yet health services do not have a trauma informed approach.*
> – Stakeholder

> *Social Emotional Wellbeing services tie back into the lack of GPs and low acuity services. Chronic Social Emotional Wellbeing conditions need to be managed outside of hospitals and primary care. The hospital is inundated with crisis presentations.*
> – TCHHS Staff member

National Social Emotional Wellbeing workforce and service requirements indicate there are staff and service gaps, including community positions and older persons Social Emotional Wellbeing services (Queensland Health – Clinical Excellence Queensland, 2022). Service mapping between partner groups also shows service gaps across the Social Emotional Wellbeing continuum (see Appendix C), particularly in the care of lower to moderate acuity presentations and enabling access to hospital services for severe illness.

There is significant evidence that people with Social Emotional Wellbeing illnesses often have other chronic illnesses, and experience poorer outcomes for those illnesses including reduced lifespans (Ishida et al, 2020). Opportunities exist to work with service partners to address known gaps and plan for improved services. The need for comprehensive Social Emotional Wellbeing services in our region cannot be understated, especially with respect to the generational trauma that has affected and continues to affect the First Nations population.

> *Social Emotional Wellbeing and trauma is an even greater need than diabetes. There are many passings and so much Sorry Business.*
> – Stakeholder

3.2.4 Priority Health Need 4: Secondary and tertiary prevention services

Secondary and tertiary prevention (see Appendix C) refers to disease prevention and illness management services that generally occur within healthcare settings. Evidence indicates that screening for disease, and early management can reduce the impacts of illness and extend lifespans (DHAC, 2020a).

> *Generational change is needed to overcome chronic illness. Currently it is seen as something out of people's control and inevitable.*
> – Stakeholders

TCHHS provides a range of services including health checks across all age groups, cancer screening services, and chronic illness management programs. Other service partners include ACYHC, NPAFACS, RFDS, GPs and BreastScreen Queensland who provide a range of chronic illness management and cancer screening services. Due to the presence of multiple providers and subsequent fragmentation of health information, there is not a single reliable source indication of all chronic illness. Significant illness measures include higher than expected associated hospitalisations and deaths, and potentially preventable hospitalisations for chronic conditions which are the highest in Queensland.

> *Preventative health is being neglected as the acute care demand is just so massive. We are reactive, not proactive.*
> – TCHHS Staff member

Screening levels for cancer are lower than expected, yet cancer remains one of the highest causes of premature death and is expected to increase as more of the population ages.

> *We need comprehensive, age-based health assessments to pick up the earliest possible points of illness and intervene.*
> – TCHHS Staff member

There are opportunities to work with health care partners to address information gaps between services and to improve the quality of primary health care chronic illness management. Cancer and other disease screening service improvements are needed and should be considered in conjunction with Priority 2: Population health and primary prevention.

3.2.5 Priority Health Need 5: Premature deaths associated with chronic illness

The life expectancy of males and females (HHS population) is lower that the state. In 2017-19, the life expectancy of females was 81.2 (in comparison, the state rate was 84.8), and the life expectancy of males was 76.5 (compared to the state rate of 80.3). For First Nations residents life expectancy is again significantly lower than other Queenslanders. Evidence supports that comprehensive chronic illness management can slow disease progression and extend people's lifespans (DHAC, 2017). *The National Agreement on Closing the Gap* (Closing the Gap in Partnership, 2020) also recommends a focus on the leading chronic conditions and suicide to reduce the number of premature deaths of First Nations Australians.

> *The chronic illness burden is increasing every year because previously the First Nations people weren't living long enough for us to see the full burden. Now it is emerging.*
> – TCHHS staff member

For TCHHS residents, the leading conditions of premature death are ischaemic heart disease, chronic obstructive pulmonary disease, diabetes, and suicide (see Priority Health Need 2: Social Emotional Wellbeing) – all of which have population wide results well above the state. While prevention comes in at a higher priority to enable long-term health change, it is also important to focus on those currently living with chronic conditions and work towards extending their lifespan and improving their quality of life through improved illness management services. This may apply particularly to the Northern Peninsula region which has the lowest proportion of older First Nations people (12.6%) aged 50+ (15.7% Qld).Opportunities for improvement include collaboratively planning with partners to improve the delivery and navigation of disease specific services and programs, including cardiac rehabilitation, chronic obstructive pulmonary disease, and diabetes services.

> *Chronic illness workloads are massive. We need to strengthen and support primary health care and chronic illness management.*
> – TCHHS Staff member

Suicide prevention services are provided by TCHHS and our service partners, including CHHHS's consultant psychiatry service for advice and referral management. Caring for people and families who experience self-destructive and suicidal behaviours is complex and requires a sensitive, tailored, and responsive approach. Many people lost to suicide are unknown to TCHHS's Social Emotional Wellbeing services, meaning improvement in community awareness and early detection is also required. There are opportunities to strengthen partnerships with partners and NGOs to improve referral processes and effective follow-up for people who are at risk of or have attempted suicide. We also need to strengthen our own staff's confidence and competence to identify, screen, assess, and manage suicide risk through participation in state-wide education and training.

> *We need to focus on improving the quality of life for chronic illness clients and ensuring they receive the appropriate support and information to self-manage their illness.*
> – TCHHS Staff member

3.2.6 Priority Health Need 6: Scheduled and planned care services

TCHHS provides a range of planned care and scheduled service care services including planned care surgical and outpatient services, and referrals to other HHSs for more complex services when needed. TCHHS manages and monitors waiting times in conjunction with other HHSs to ensure access to services is both appropriate and timely.

> *We haven't seen a dentist since COVID-19 came into communities. It is often too expensive for people to pay their own way to seek dental care.*
> – Community member

Supporting planned care events to be provided in an appropriate and timely manner will help maintain better health, reduce disease progression, and provide timely access to treatments.

Navigating clients to planned care services provided within other HHSs is often difficult with limited individual support once clients have travelled and is often compounded by issues with language barriers. Improving navigation and patient travel services may improve attendance and reduce issues for clients. There are opportunities to expand the provision of some lower complexity planned services within TCHHS, including endoscopy, ophthalmology, and some gynaecology services.

> *There are many issues with patient travel such as unsuitable accommodation and not being able to have family escorts. The way it is organised brings additional stress on clients.*
> – Stakeholder

Scheduled services include appointment-based services within primary health or ambulatory care for reviews and recalls, including Oral Health, Allied Health, and visiting outreach specialist services. Scheduling of services is often impacted by inadequate information systems, poor communication networks (telephones and internet), and the level of engagement with clients (potentially due to cultural safety issues, lower health literacy levels, unsuitable clinic hours, and/or personal choices). Opportunities exist to improve collaboration with communities and partners to ensure service arrangements are appropriate and better meet community expectations.

> *We should implement more Telehealth and digital solutions to manage wait-lists and recalls.*
> – TCHHS Staff member

3.2.7 Priority Health Need 7: Older persons health and end of life care services

In 2020, 8.0% of the HHS population were aged over 65 which was well below the Queensland rate of 16.1%, with the highest proportion of 65+ year old residents living in Cape York SA2. For First Nations residents, all SA2 areas (except for the Northern Peninsula) have a proportion of approximately 17% of older First Nations people aged 50+ which is higher than the state rate of 15.7%.

> *Moving Elders off country for residential care is distressing to the family, and when the person passes away it is very expensive to bring them home.*
> – Community member

Over recent years it can be seen that the population is on average living longer, but with this comes health needs associated with growing older, including an increasing burden of chronic illness and other diseases including cancer (a leading cause of death in TCHHS. Cancer care

is included in other priority areas including primary prevention (e.g., smoking reduction), and secondary and tertiary prevention (e.g., screening and early detection).

> *There is no transparency or clear pathways for older people in regard to housing or accommodation services or other appropriate supports.*
> – TCHHS Staff member

Older persons services in TCHHS are provided in conjunction with local governments, commonwealth-funded services including Home and Community Care, and non-government community services. TCHHS provides residential aged care services at two of the hospital sites (Weipa and Cooktown), respite services, and some community-based services. Gerontology services are provided by CHHHS. There is currently no dementia specialised accommodation within TCHHS, yet there is evidence of an increasing demand.

With the growing number of older persons in TCHHS communities, there is a strong need to work with partners to increase accommodation support options, community-based aged care, end of life care services, and older persons Social Emotional Wellbeing services. Planning with communities for higher needs services, including residential aged care and dementia care, is also required.

> *Palliative Care is a big service gap. We do not have adequate end of life care services or the staff for it. Most people die in hospital rather than at home.*
> – TCHHS Staff member

End of life services include palliative care and are used in the terminal phase of life (including services for younger people). End of life care is especially important to TCHHS communities to allow people the dignity and choice of dying closer to home, and TCHHS continues to work in conjunction with clients, families, carers, and service partners to improve planning for end of life care. A pop-up palliative care model is in place to provide resources where possible with an expansion of services in progress for 2023. Opportunities for improvement include increasing access to home supports for clients and their families, and continued expansion of coordinated, culturally appropriate, and safe end of life care services available within TCHHS.

3.3 SA2 priority needs overview

The SA2 priority needs are presented in the following sections 4–10. These sections also include service profiles to give an overview of the types of services currently provided (at time of writing of this document).

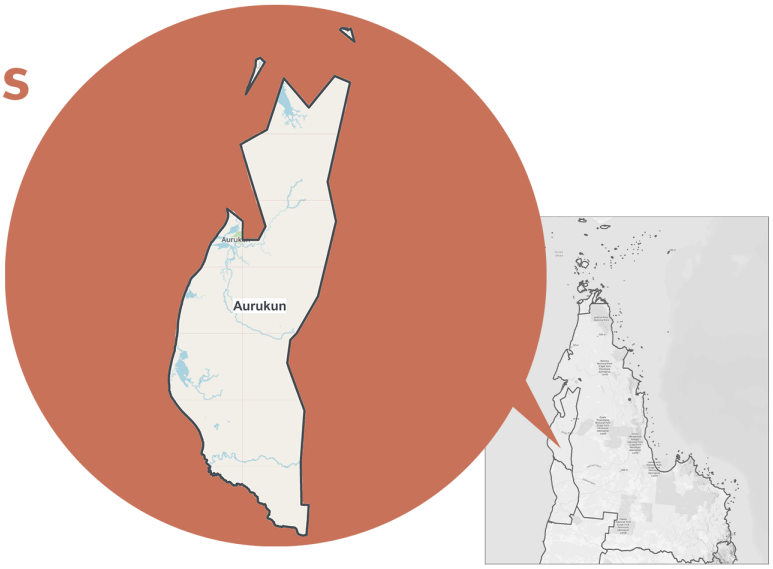
The SA2 priority needs were put through the same prioritisation criteria and panels as the HHS-level needs. They are presented in this document to highlight the needs that are individual to these locations and for if funding or service improvement opportunities become available at this level.

4. Aurukun SA2 priorities

Aurukun is a community on the Western Cape of Queensland. It has a TCHHS Primary Health Care Centre which provides comprehensive primary health care services in partnership with ACYHC and RFDS.

Aurukun experiences many of the poorest results across nearly all social determinants, making it one of the most disadvantaged SA2s in the state.

Due to the presence of multiple providers using separate information systems, the analysis of chronic illness and activity data in primary health is partial for some data sets.



Culturally safe services (1)

Workforce stability (retention and use of agency staff) (2)

Relationships with our health partners, specifically for Domestic and Family Violence services and data sharing (3)

Service needs

Aurukun SA2 Priorities

Health needs

1. **Maternal and child health, specifically developmentally vulnerable children**
2. **Social Emotional Wellbeing**
3. **Potentially avoidable deaths, in particular for First Nations women**
4. **Men's and Women's Health (reproductive and sexual health)**
5. **Vaccine Preventable diseases**
6. **Acute Rheumatic Fever and Rheumatic Heart Disease**
7. **Preventative health checks**
8. **Premature deaths from chronic illness (diabetes, heart disease, and cancer)**

Available services / clinics

P = Partner or private provider **O** = onsite (TCHHS) **V** = visiting (TCHHS)

- Maternal/Child Health **(P)**
- Mental Health and Psychiatry – Adult and Child **(O, P, V)**
- Sexual Health **(V)**
- Allied Health **(V, P)**
  - o Occupational Therapy
  - o Social Worker
  - o Dietetics
  - o Psychology
  - o Audiology
  - o Speech Pathology
- Community Liaison Officer **(O)**
- Corrections Officer **(P, V)**
- Nursing specialities: **(P, V)**
  - o Diabetic Educator
  - o Incontinence
  - o RHD
  - o Respiratory
- Dermatology **(V)**
- Dental **(V)**
- Pharmacy **(P, V)**
- Obstetrics and Gynaecology **(P, V)**
- Opthalmology and optometry **(P, V)**
- Paediatrics **(P, V)**

4.1 Aurukun SA2 service profile

First Nations
90.4% of population

Population
1,418 vs HHS 28k

0-14 yrs
28.2% of population

65+ yrs
0.02% of population

Top consultation results

1. Social determinants
2. Social Emotional Wellbeing
3. Chronic illness

Births per 1000 population
16.2 vs 11.6 Qld

Death rate
6.6 vs 6.1 Qld

Aurukun has the highest fertility rate, and a death rate (second highest) above the state rate of 6.1

Aurukun has the highest results across the HHS for nearly all social determinant measures, including homelessness, single parent families, and schooling levels below year 10. It also has the lowest median family income, and significant levels of unemployment.

Aurukun has the highest SA2 rates across most criminal offences, such as domestic violence, kidnapping, stalking, homicide, physical harm, prostitution, drugs, gambling and liquor, and traffic offences.

Aurukun's First Nations residents die at a younger age than other TCHHS residents.

First Nations women die youngest across the HHS for potentially avoidable events/conditions (and at a higher rate than Qld).

Compared to the other SA2s and the state, Aurukun has the highest proportion of National Disability Insurance Scheme participants, and people with profound or severe disabilities.

Aurukun had the lowest percentage of eligible population accessing oral health care in the HHS and highest acute dental condition hospitalisations. Other high preventable hospitalisations were for convulsions and epilepsy (the highest amongst SA2s).

Aurukun has high results for Social Emotional Wellbeing measures for conduct disorders, alcohol use disorders, drug use disorders and eating disorders – all being significantly higher than the state rate.

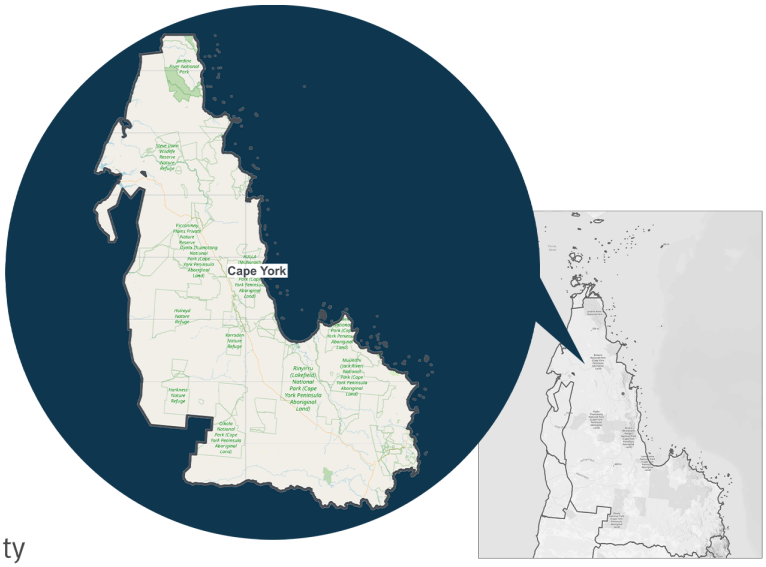
Aurukun has the highest proportion of low birthweight babies, and the lowest completed antenatal visits (8+ visits) for First Nations people compared to the other SA2s.

Aurukun has the highest proportion of Acute Rheumatic Fever and Rheumatic Heart Disease in the HHS.

5. Cape York SA2

Cape York is the largest SA2 within TCHHS with many remote and distanced communities that require considerable travel time to reach. Our health partners in this region include ACYHC and RFDS. There is also one private GP practice located in Cooktown.

Combining the communities within this SA2 with the larger population of Cooktown who generally demonstrated better health measures, which unfortunately dilutes some of the health needs of individual communities. This includes Hope Vale and Lockhart River that demonstrated some of the poorest health measures at an individual community level.



Service needs

1. Culturally safe services
2. Workforce shortages, in particular for Allied Health
3. Relationships with our health partners, specifically for Domestic and Family Violence services
4. Establish a new service (primary health or emergency services) at Lakeland

Cape York SA2 Priorities

Health needs

1. Maternal and child health
2. Social Emotional Wellbeing
3. Premature deaths from chronic illness (cancer, diabetes, heart disease, COPD, and kidney disease)
4. Secondary and tertiary prevention
5. Vaccine Preventable diseases
6. Men's and Women's Health (reproductive and sexual health)
7. Older persons health care and end of life care
8. Primary health including scheduled and planned care

Available services / clinics

P = Partner or private provider **O** = onsite (TCHHS) **V** = visiting (TCHHS)

- Allied Health (P, O, V)
  - o Audiology
  - o Dietetics
  - o Occupational Therapy
  - o Physiotherapy
  - o Podiatry
  - o Psychologist
  - o Social Worker
  - o Speech Therapy
- Chronic Illness Health Worker (P)
- Dental (O, V)
- Dermatology (P)
- Nursing specialities: (P, V)
  - o Diabetic Educator
  - o Continence
  - o RHD
  - o Renal
  - o Respiratory
- Endocrinologist (V)
- General Practitioners (P, O)
- Maternal/Child health and Midwifery (P)
- Mental Health (P, O, V)
- Obstetrics and Gynaecology (V)
- Paediatrician and paediatric cardiologist (V)
- Pharmacy (P, O, V)
- Renal physician (V)
- Respiratory physician (P)
- Sexual health (O, V)
- Sonography and Radiography (O)

5.1 Cape York SA2 service profile

First Nations
51.6% of population

Population
8,250 vs HHS 28k

0-14 yrs
23.5% of population

65+ yrs
0.47% of population

Top consultation results

1. Social Emotional Wellbeing
2. Chronic illness
3. Social determinants

Births per 1000 population
14.9 vs 11.6 Qld

Death rate
5.4 vs 6.1 Qld

Cape York has the highest proportion of older people (65+ yrs.) in the HHS (12.7% vs 15.7% Qld). It also has the lowest rate of births per 1,000 population (14.9) although higher than the state (11.6)

Cape York experiences the highest results for domestic and family violence, kidnapping, and stalking offences compared to other SA2s.

Cape York has the highest results for stroke, arthritis, cancer (incl remission), and lung conditions (incl COPD or emphysema).

Cape York has the second highest results for dementia (including Alzheimer's) and Social Emotional Wellbeing conditions (incl depression or anxiety).

In Social Emotional Wellbeing, there are high levels of alcohol use disorders and conduct disorders compared to the state.

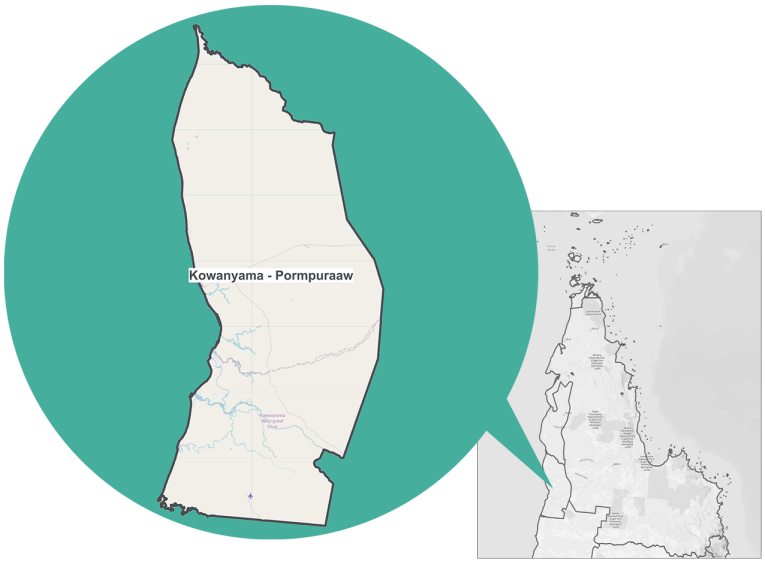
Across all SA2s, Cape York has the highest number of premature mortalities for First Nations women.

Diabetes is a top reason for potentially preventable hospitalisations.

6. Kowanyama - Pormpuraaw SA2

Despite being combined into one SA2, Kowanyama – Pormpuraaw are two distinct communities with differences in some health outcomes and how health care is provided.

These two communities are the most distanced by road to any hospital service, and as with Aurukun, our health partners (ACYHC and RFDS) also deliver primary health care services which may result in some health and service measures having incomplete results.



Culturally safe services (1)

Relationships with our health partners, specifically for Domestic and Family Violence services (2)

Service needs

Kowanyama - Pormpuraaw SA2 Priorities

Health needs

1. **Maternal and child health, including reducing antenatal smoking and child and youth specific health**
2. **Access to scheduled and planned health care and hospital services**
3. **Social Emotional Wellbeing**
4. **Men's and Women's Health (reproductive and sexual health)**
5. **Premature deaths from chronic illness (diabetes, heart disease, COPD, and kidney disease)**
6. **Oral Health**
7. **Disability services**
8. **Primary prevention and risk factors (including obesity)**

Available services / clinics

P = Partner or private provider **O** = onsite (TCHHS) **V** = visiting (TCHHS)

- Allied Health (P, O, V)
  - o Audiology
  - o Dietetics
  - o Occupational Therapy
  - o Physiotherapy
  - o Podiatry
  - o Psychologist
  - o Social Worker
  - o Speech Therapy
- Dental (V)
- Dermatology (P)
- Ear, Nose and Throat (P)
- Endocrinologist (V)
- General Practitioners (P, O, V)
- Maternal/Child Health and Midwifery (P, O)
- Mental health (incl youth) (P, O, V)
- Nursing specialities: (P, V)
  - o Diabetic Educator
  - o Chronic Illness
  - o Continence
  - o RHD
  - o Renal
  - o Respiratory
- Obstetrics and Gynaecology (P)
- Ophthalmology and Optometry (P)
- Paediatrician (V)
- Pharmacy (P)
- Respiratory physician (P)
- Sexual health (O)

6.1 Kowanyama - Pormpuraaw SA2 service profile

First Nations
87.8% of population

Population
1,835 vs HHS 28k

0-14 yrs
29.2% of population

65+ yrs
0.05% of population

Top consultation results

1. Social Emotional Wellbeing
2. Social determinants
3. Maternal/child health

Births per 1000 population
15.8 vs 11.6 Qld

Death rate
7 vs 6.1 Qld

Kowanyama – Pormpuraaw has a birth rate that is a significantly higher than the state birth rate.

Kowanyama – Pormpuraaw has the highest percentage of people residing in social housing, and issues with overcrowding are significant (2nd highest in HHS).

It has the highest level of unemployment (which is significantly higher than the state) and the median weekly family income is second lowest across the SA2s.

Kowanyama – Pormpuraaw has the highest percentage of developmentally vulnerable children (1+ domain) in the HHS and significantly higher compared to the state.

First Nations children immunised by 1yr and 2yrs are the lowest proportion in the HHS and lower than the state.

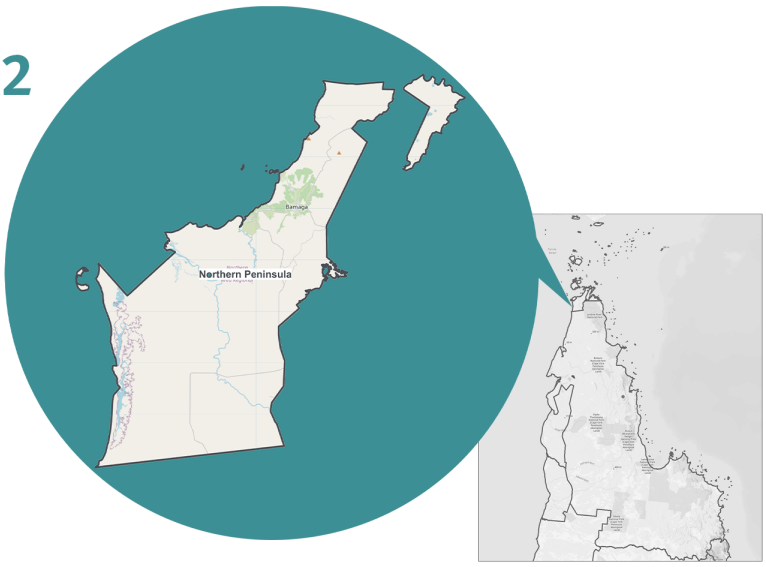
In Social Emotional Wellbeing, there are high levels of alcohol use disorders and conduct disorders.

Kowanyama – Pormpuraaw has the highest results for potential years of life lost for males and females, premature mortality for males and potentially avoidable deaths for First Nations males. It has the second highest results for premature mortality for females and potentially avoidable deaths for First Nations females.

7. Northern Peninsula SA2

Northern Peninsula, also known as Northern Peninsula Area (NPA) consists of the communities of Bamaga, Injinoo, Seisia, New Mapoon, and Umagico. It is the furthermost inhabited region of mainland Australia.

NPAFACS is our main health partner for this region and works in conjunction with the Bamaga Primary Health Care Centre and Bamaga Hospital. Thursday Island Hospital is the main referral hospital serving the Northern Peninsula communities.



Service needs

1. Culturally safe services
2. Workforce succession plan for a new generation of ATSIHWPs
3. Relationships with health partners, in particular fragmented health records
4. Maternal, child health, and school-based health workforce

Northern Peninsula SA2 Priorities

Health needs

1. Maternal and child health
2. Chronic illness
3. Acute Rheumatic Fever and Rheumatic Heart Disease
4. Potentially preventable hospitalisations
5. Men's and Women's Health (reproductive and sexual health)
6. Social Emotional Wellbeing
7. Oral Health
8. Older persons health care and end of life care

Available services / clinics

P = Partner or private provider **O** = onsite (TCHHS) **V** = visiting (TCHHS)

- Allied Health (O, V)
  - o Audiology
  - o Dietetics
  - o Physiotherapy
  - o Speech Therapy
- Endocrinologist (V)
- General Practitioners (O)
- Maternal/Child Health and Midwifery (O, V
- Nursing specialities (O)
  - o Chronic Illness
  - o Renal
  - o RHD
- Mental health (incl AOD) (O, V)
- Optometry (P)
- Renal Physician (V)
- Sexual Health (O)

7.1 Northern Peninsula SA2 service profile

First Nations
87.2% of population

Population
3,163 vs HHS 28k

0-14 yrs
35.6% of population

65+ yrs
0.07% of population

Top consultation results

1. Social determinants
2. Maternal/child health
3. Social Emotional Wellbeing

Births per 1000 population
18.3 vs 11.6 Qld

Death rate
1.6 vs 6.1 Qld

Northern Peninsula has the highest proportion of children and young people (0-14rs) within the HHS. It also has the highest birth rate per 1,000 (higher than the state at 11.6).

Northern Peninsula has high rates of social housing and a high proportion of single parent families.

There are high rates of alcohol use (low and high risk), smoking (incl history of smoking), and iron deficiency levels in Northern Peninsula.

This region has the second highest rate of potentially preventable hospitalisations in the HHS, particularly for cellulitis and iron deficiency anaemia hospitalisations. The high rate of these hospitalisations may be associated with later presentation for treatment and limited access to some services including Oral Health.

The percentage of children fully immunised by 2yrs is second lowest among the SA2s.

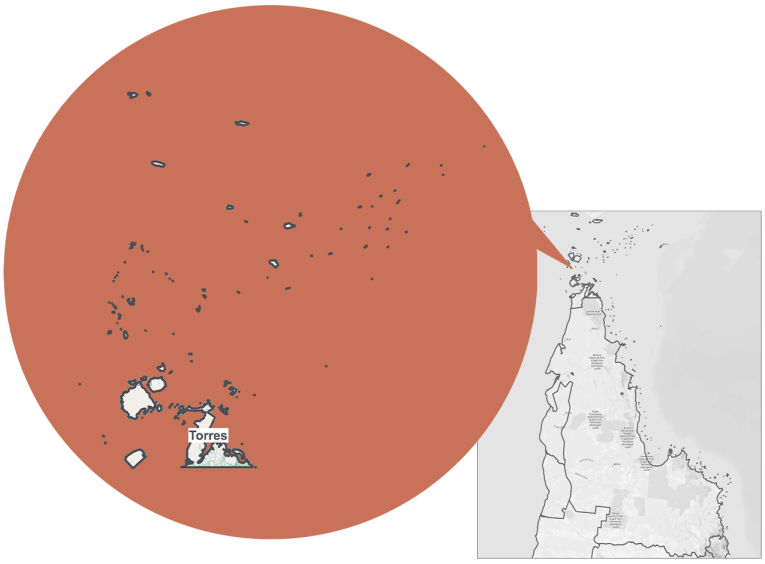
Acute Rheumatic Fever (second highest), and hepatitis (highest amongst the SA2s) are proportionally overrepresented in this region.

Northern Peninsula has the second highest results for alcohol use disorder, drug use disorder, eating disorders, and Attention Deficit Hyperactivity Disorder. There are also high levels for conduct disorders.

8. Torres SA2

The Torres SA2 consists of Thursday Island, Horn Island, and Prince of Wales Island. It also includes some of the uninhabited smaller islands scattered across the Torres Strait.

Health services include Thursday Island Hospital, a Community Wellness Centre, and a Primary Health Care Centre. Thursday Island Hospital is the main hospital for all the Torres Strait Islands and the Northern Peninsula region. The main health partner in this region is Torres Health Indigenous Corporation and Queensland Ambulance Service.



Culturally safe services (1)

Workforce, in particular Allied Health (2)

Service needs

Torres SA2 Priorities

Health needs

1. **Maternal and child health**
2. **Management of chronic illness (diabetes, heart disease, COPD, and kidney disease)**
3. **Secondary and tertiary prevention**
4. **Social Emotional Wellbeing**
5. **GP-type presentations at Emergency Department**
6. **Vaccine Preventable Diseases**
7. **Acute Rheumatic Fever and Rheumatic Heart Disease**
8. **Men's and Women's Health (reproductive and sexual health)**
9. **Oral Health services to reduce related PPHs**
10. **Disability services**

Available services / clinics

P = Partner or private provider **O** = onsite (TCHHS) **V** = visiting (TCHHS)

- Allied Health (P, O, V)
  - o Audiology
  - o Dietetics
  - o Dementia
  - o Occupational Therapy
  - o Physiotherapy
  - o Podiatry
  - o Social Worker
  - o Speech Therapy
- Chronic Illness Health Worker (O)
- Dental (O)
- General Practitioners (P, O)
- Infection Control Health Worker (O)
- Maternal/Child health and Midwifery (O, V)
- Mental Health (incl AOD) (O)
- Nursing specialities: (O, V)
  - o Diabetic Educator
  - o Clinical Governance
  - o Environmental/Public Health
  - o Chronic Conditions
  - o Infection Control
- Ophthalmology (O)
- Paediatrician (O)
- Pharmacy (O, V)
- Sexual health (O, V)
- Sonography and Radiography (O)

8.1 Torres SA2 service profile

First Nations
68.8% of population

Population
3,887 vs HHS 28k

0-14 yrs
25.4% of population

65+ yrs
0.13% of population

Top consultation results

1. Workforce
2. Chronic illness
3. Maternal/child health

Births per 1000 population
17 vs 11.6 Qld

Death rate
3.8 vs 6.1 Qld

This region has the highest result for household composition for group households. This may be due to limited land and housing on the islands which leads to overcrowding.

In Social Emotional Wellbeing data, Torres has the highest result for schizophrenia and the second highest result for conduct disorders. There are also high results for alcohol use disorder, drug use disorders, and eating disorders.

Torres has high percentages of developmentally vulnerable children across 2+ domains.

Dementia (incl Alzheimer's), asthma, and hypertension are highest in Torres compared to other SA2s.

Torres has the highest result for potentially preventable hospitalisations, and particularly for diabetes compared to other SA2s.

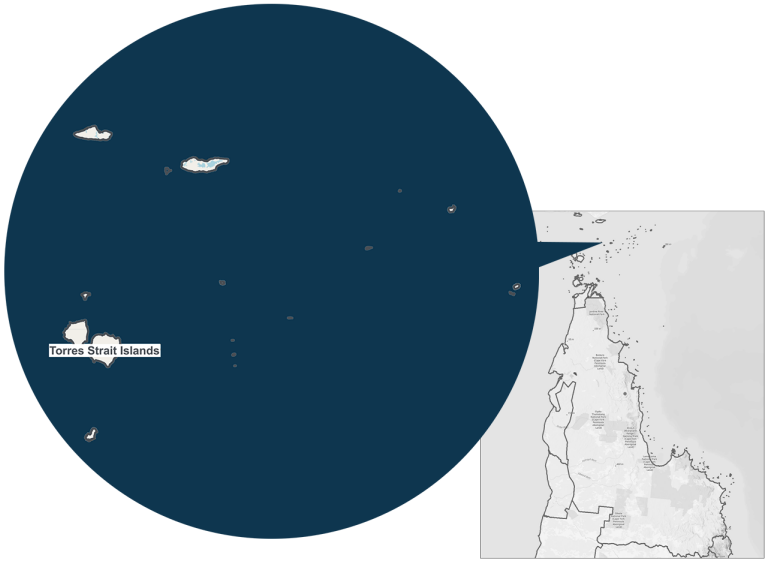
Alcohol use (low and high risk) and cholesterol (high and borderline) levels are the highest recorded in the HHS. Impaired kidney function (including diagnosed, high, low, and moderate) is second highest in the HHS.

There are high rates of smoking (including history of smoking), blood pressure (low and high) and iron deficiency. All of these results may be due to better collection of primary health information in this SA2 and this needs consideration when comparing against other SA2s.

9. Torres Strait Islands SA2

The Torres Strait Islands SA2 are the northern-most point of Australia and share an international border with Papua New Guinea. Travel to and from these islands can be challenging due to air travel, distance, and frequent poor weather during the wet season.

There are 14 PHCCs across the Islands that vary in size and staffing based on population sizes. Thursday Island Hospital is the main hospital service which also provides emergency and outreach services to many of the outer islands.



Service needs

1. **Culturally safe services and overcoming language barriers**
2. **Workforce succession plans**

Torres Strait SA2 Priorities

Health needs

1. **Maternal and child health, including youth specific health**
2. **Access to scheduled and planned care (GPs, Allied Health, Disability, and Oral Health)**
3. **Management of chronic illness (diabetes, heart disease, COPD and kidney disease)**
4. **Potentially Preventable Hospitalisations (vaccine preventable diseases and Oral Health)**
5. **Social Emotional Wellbeing**
6. **Men's and Women's health (reproductive and sexual health)**
7. **Older persons health care and end of life care**
8. **Primary prevention and risk factors, including obesity and hypertension**

Available services / clinics

P = Partner or private provider **O** = onsite (TCHHS) **V** = visiting (TCHHS)

- Allied Health (P, V)
  - o Audiology
  - o Dietetics
  - o Occupational Therapy
  - o Physiotherapy
  - o Speech Therapy
- Dental (P)
- Endocrinologist (V)
- General Practitioners (V)
- Maternal/Child Health (V)
- Mental health (V)
- Nursing specialities (O)
  - o Diabetes Educator

9.1 Torres Strait Islands SA2 service profile

First Nations
91.8% of population

Population
5,104 vs HHS 28k

0-14 yrs
31.7% of population

65+ yrs
0.16% of population

Top consultation results

1. Social determinants
2. Social Emotional Wellbeing
3. Preventative health

Births per 1000 population
17.4 vs 11.6 Qld

Death rate
1.7 vs 6.1 Qld

Torres Strait Islands has the highest proportion of First Nations people in the HHS.
There are high birth rates, and a high proportion of older persons for First Nations (50+) (0.26) and non-First Nations (65+) (0.16).

There is high use of social housing, high proportions of single parent families, and high unemployment rates in this region. Median family income is also low compared to other HHS SA2s.

In Social Emotional Wellbeing data, Torres Strait Islands has the highest result for alcohol use disorders across the HHS and Attention Deficit Hyperactivity Disorder. There are also high results for conduct disorders, drug use disorders, and eating disorders.

This region has the second highest results for diabetes (excluding gestational), hepatitis, and hypertension.

Torres Strait Islands has highest number of potentially preventable hospitalisations for vaccine preventable diseases.

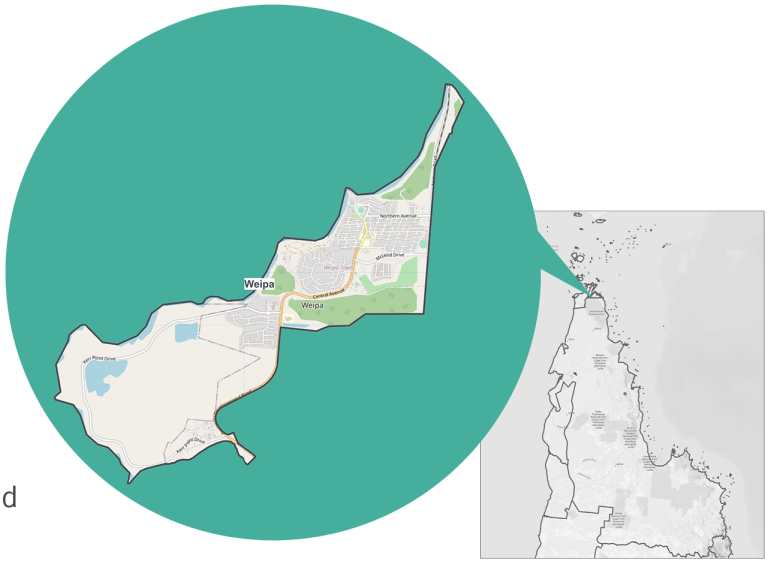
Torres Strait Islands has the highest results for smoking (incl history of smoking), blood pressure (low and high), BMI (obese and overweight), iron deficiency, and impaired kidney function (incl diagnosed, high, low, and moderate).

Torres Strait Islands has the second highest results for alcohol use (low and high risk) and cholesterol (high and borderline). All of these results may be due to better collection of primary health information in this SA2 and this needs consideration when comparing against other SA2s.

10. Weipa SA2

Weipa SA2 is the smallest SA2 geographically and is arguably the most advantaged SA2 within the HHS mainly due to its connections to the mining industry.

Weipa has a fast-growing population and a lower proportion of First Nations people when compared to other SA2s. Weipa Integrated Health Service provides public hospital services, residential aged care, community services, and general practice services. Service partners include Queensland Ambulance Service. There are additional services (Social Emotional Wellbeing and Allied Health services) provided by the mining company for its staff (only) on a telehealth or fly-in fly-out basis.



Culturally safe services 1

Service needs

Weipa SA2 Priorities

Health needs

1. **Maternal and child health**
2. **Potentially preventable hospitalisations, particularly for First Nations people**
3. **Older persons health care and end of life care**
4. **Social Emotional Wellbeing, specifically drug and alcohol related hospitalisations and premature deaths from suicide**
5. **Management of chronic illness**
6. **GP-type presentations at Emergency Department**
7. **Planned care – elective surgery waitlist times**
8. **Secondary and tertiary prevention**
9. **Oral Health**
10. **Disability services**

Available services / clinics

P = Partner or private provider **O** = onsite (TCHHS) **V** = visiting (TCHHS)

- Allied Health (O, V)
  - o Audiology
  - o Dietetics
  - o Diabetes Chronic Care
  - o Occupational Therapy
  - o Physiotherapy
  - o Podiatry
  - o Psychologist
  - o Renal and Outpatient Care
  - o Social Worker
  - o Speech Therapy
- Cape York Kidney Care Health Worker (O)
- Advanced Eye Health Worker (O)
- Dental (O)
- Endocrinologist (V)
- Nursing specialities: (P, V)
  - o Diabetic Educator
  - o Continence
  - o Aged Care
  - o RHD
  - o Renal
  - o Respiratory
- General Practitioners (O)
- Maternal/Child health and Midwifery (O)
- Men's and Women's Health (O)
- Mental Health (incl child and youth) (O)
- Obstetrics and Gynaecology (V)
- Paediatrician and paediatric cardiologist (V)
- Pharmacy (O)
- Medical Imaging, Sonography and Radiography (O)

10.1 Weipa SA2 service profile

First Nations
19.6% of population

Population
4,271 vs HHS 28k

0-14 yrs
26.4% of population

65+ yrs
0.1% of population

Weipa has the lowest proportion of First Nations people in the HHS. It also has the lowest unemployment levels and highest socioeconomic measures mainly due to a stronger local economy associated with the mining industry.

Top consultation results

1. Social Emotional Wellbeing
2. Dental
3. Maternal/child health

Births per 1000 population
17.1 vs 11.6 Qld

Death rate
n.a. vs 6.1 Qld

Weipa has the second highest birth rate in the HHS which is higher than the state rate. In contrast it has a very low death rate and a fast-growing population.

Weipa has the second highest result for potential years of life lost for males.

Weipa has the highest result for conduct disorders. It also has high results for alcohol use disorders.

Weipa has the highest result for Social Emotional Wellbeing conditions (incl depression and anxiety), and the second highest results for asthma, cancer (incl remission), and arthritis.

Weipa has the second highest result for iron deficiency anaemia related potentially preventable hospitalisations.

In contrast to all other HHS SA2s, Weipa appears the most advantaged in social determinants of health measures. This does not mean the population does not have its own associated health needs, but fewer in comparison to other SA2 regions.

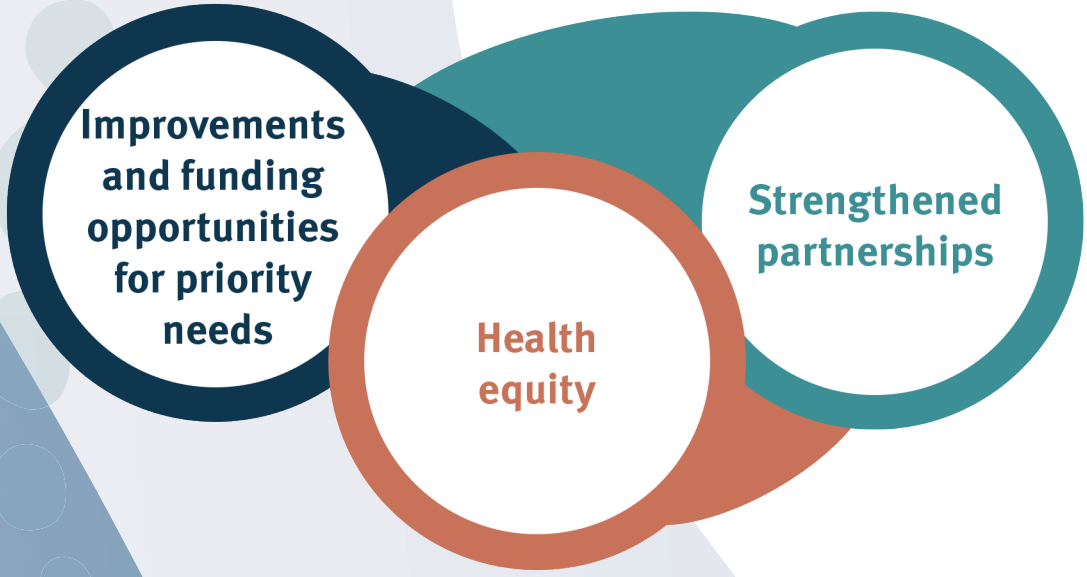
11. Next steps

The priorities identified from TCHHS's LANA are intended to inform where improvements and resourcing (when it becomes available) can be targeted to effect the most meaningful change. The highest priority needs reflect those that require urgent action or focused attention. This does not mean that the other health and service needs are not valid or important, but priority was given to the most severe needs, those amenable to health care, and that can be implemented for long-term benefit.

The LANA identifies opportunities to improve planning, design, and investment in services – including progressing recommendations of the *Unleashing the potential: an open and equitable health system* (2020). These include children in the first 2000 days of life (including pregnancy), people at risk of developing and those already living with diabetes, and people with Social Emotional Wellbeing related illnesses, which have all been confirmed as priority health needs for TCHHS. Specific plans to address these pertinent issues need to be considered in future planning activities for TCHHS.

The LANA will be revised annually and repeated in three years' time, ideally in partnership with the North Queensland Primary Health Network and other health partner organisations. This will ensure our goals are aligned and that we are taking the same steps towards achieving health equity and improving the health of the population for Torres and Cape.

Figure 15: Goals to work towards from LANA 2022



12. Appendix A: Acronyms

Table 2: Acronyms

Abbreviation	Definition
ACYHC	Apunipima Cape York Health Council
AIHW	Australian Institute of Health and Welfare
ATSICCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
ATSIHWP	Aboriginal and/or Torres Strait Islander Health Worker/Practitioner
BMI	Body Mass Index
CHHHS	Cairns and Hinterland Hospital and Health Service
COPD	Chronic obstructive pulmonary disease
DHAC	Department of Health and Aged Care
GP	General Practitioner
HHS	Hospital and Health Service
LANA	Local Area Needs Assessment
MHAODS	Mental Health, Alcohol, and Other Drugs Services
NATSIHA	Northern Aboriginal and Torres Strait Islander Health Alliance
NQPHN	North Queensland Primary Health Network
PHCC	Primary Health Care Centre
PPH	Potentially Preventable Hospitalisation
QAIHC	Queensland Aboriginal and Islander Health Council
QAS	Queensland Ambulance Service
QLD	Queensland
RFDS	Royal Flying Doctor Service
RHD	Rheumatic Heart Disease
SEIFA	Socio-Economic Indexes for Areas
SA2	Statistical Area Level Two
SA3	Statistical Area Level Three
TCHHS	Torres and Cape Hospital and Health Service
THHS	Townsville Hospital and Health Service
THIC	Torres Health Indigenous Corporation
VPD	Vaccine Preventable Disease

13. Appendix B: Method

Queensland Health's *Local Area Needs Assessment Framework* (2021a) defines what health needs are and how they should be assessed to meet the Queensland Department of Health's LANA criteria.

"Health care need can be defined as a gap in a person's health state which would benefit from an appropriate and effective care intervention, i.e., the capacity to benefit from services which may be health education, disease prevention, diagnosis, treatment, rehabilitation, or palliative care. Health need incorporates the wider social determinants of health. Many of the social determinants of health are outside the direct influence of health departments and service providers and require cross sector or whole of government interventions."

Source: Adapted from Queensland Health (2021a).

13.1 Quantitative phase – data review

The *Data Analysis – Quantitative Paper* was produced in conjunction with an external consultancy in 2021. It adhered to the LANA Framework by applying the minimum dataset and using publicly available data sourced from the Queensland Health Planning Portal.

The data in the Quantitative Paper was based on the most recent year(s) of data and at the lowest level of geographic granularity where available. This led to some considerable material data quality issues as the granularity and meaning of data was reduced by factors such as aged data, missing data, deidentified data, data only available at Statistical Area 3 (SA3) level (which includes less remote and metropolitan areas), limitations in understanding standard deviation and statistical significance between areas, lack of data available for benchmarking, and trends over time not provided.

Some of these data inconsistencies or gaps were known and have been acknowledged where pertinent. The source of some of these issues is due to the lack of data shared between TCHHS and our health partner organisations, the age of publicly available data, and poor data collection practices. To remedy some of these issues, TCHHS provided additional chronic illness data, heatmaps of key data results, and further context to the findings. This supported the priorities that had considerable weighting in consultation but little meaningful evidence in publicly available data due to the quality issues.

13.2 Qualitative phase – consultation

Between July and September 2022, engagement was undertaken with a broad range of groups and individuals through online surveys, in person, and virtual meetings to gather consultation data. This included staff, community members, and stakeholders (including our health partners, ATSICCHOs, non-government organisations (NGOs), local councils, and mayors). The 2100+ recorded consultation items were categorised and grouped into high-level themes for ease of analysis.

13.3 Prioritisation phase

Queensland Health's *Local Area Needs Assessment Framework* (2021a) established the criteria that all HHS's must use in the prioritisation of health and service needs as being:

- Alignment with Government/Departmental direction
- Validation of need identified using more than one method (e.g., consultation, community profile, literature review, data analysis)
- Risk of unmet need and any potential consequences if the need is not addressed
- Feasibility within available resources or opportunities to collaborate with other agencies that would enhance feasibility.

Through this criterion, the health and service needs were narrowed down and presented to two advisory panels for confirmation and feedback:

- First Nations Expert Advisory Panel – this panel was held to elevate the voice of the First Nations staff and stakeholders, to ensure their input on the priorities was recognised, and that the needs aligned with what is best for the communities. It was held prior to the Clinicians Advisory Panel to avoid clinical bias and to ensure the priorities were culturally informed in the first instance.
- Clinicians Expert Advisory Panel – this panel consisted of clinical leads and experts from many disciplines who would be able to weigh in on the priorities based on their clinical knowledge and expertise.

Following these panels, the Project Steering Committee and the Health Service Chief Executive reviewed the list of priorities and endorsed them as they are presented in this report.

14. Appendix C: Continuums of care

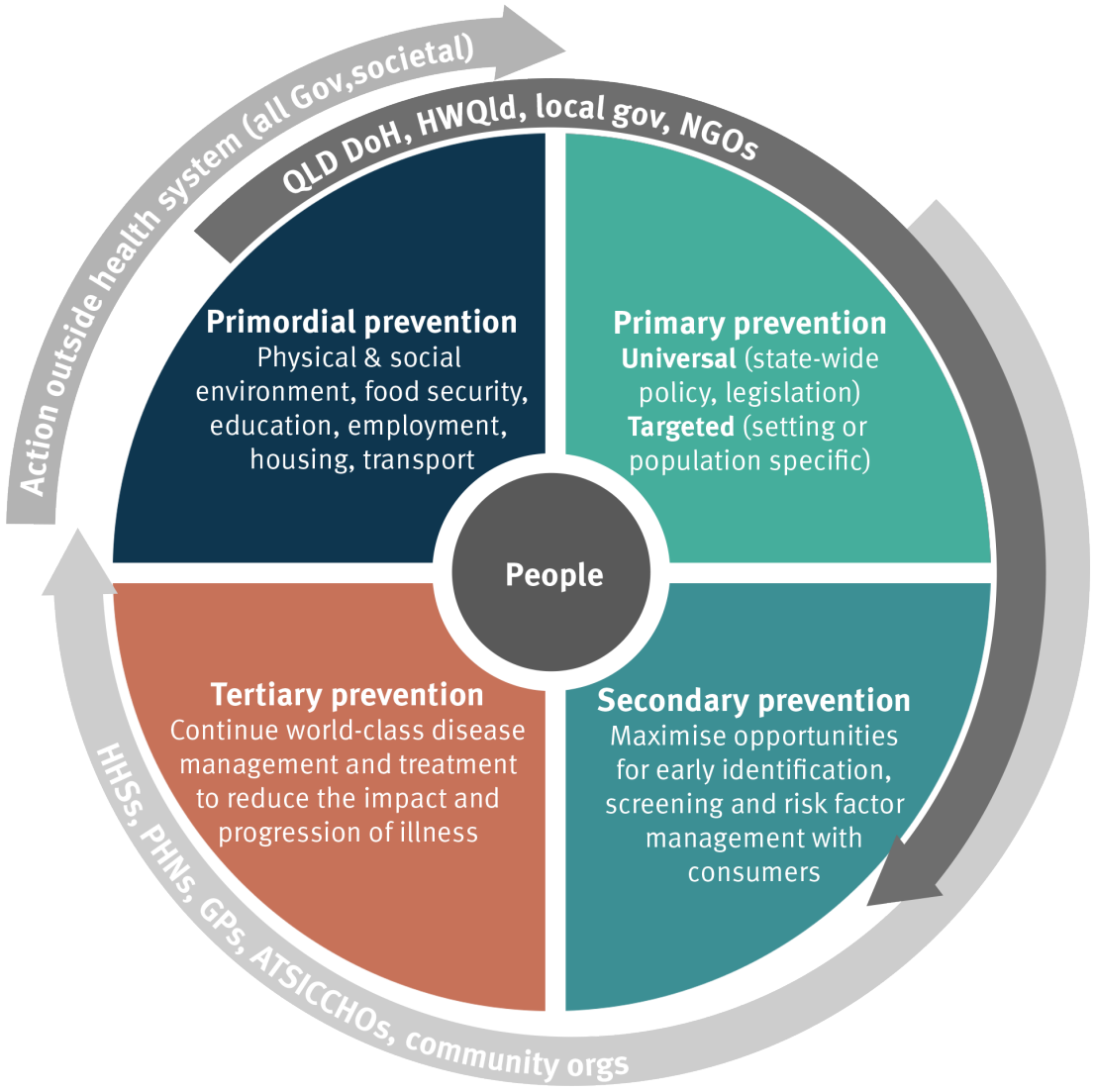
Health needs are identified as falling along continuums that illustrate the types of services that are available for certain health needs. By plotting these continuums, we can pinpoint where issues are developing and maintaining across the lifespan and where action needs to be taken by health care providers and other organisations to implement positive change. They also describe where gaps may exist between service providers for specific health care needs.

The priorities detailed in Section 3 refer to these continuums to show where intervention should be made to influence change for the relevant health needs.

14.1 Prevention continuum

The prevention continuum details the areas of preventative health actions and the responsible parties for implementing them.

Figure 16: Prevention continuum

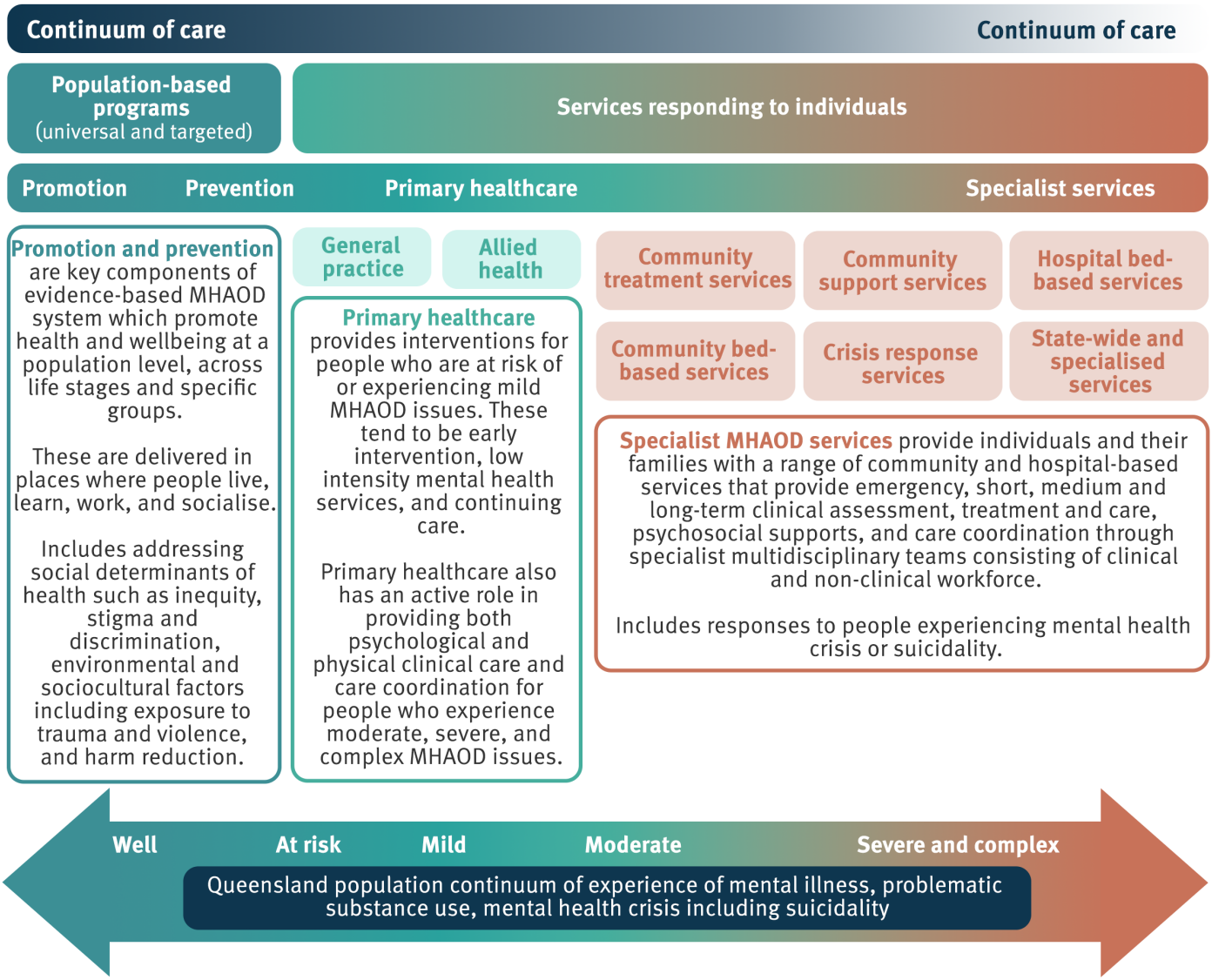


Source: Adapted from Mitchell, et al. (unpublished).

14.2 Social Emotional Wellbeing continuum

The Social Emotional Wellbeing[2] continuum of care (Queensland Health, 2022) describes the types of services that are provided depending on the acuity of care needed in Social Emotional Wellbeing. For example, population-based programs focus on the promotion of good Social Emotional Wellbeing and the prevention of issues. For higher acuity issues, more specific interventions are needed.

Figure 17: Social Emotional Wellbeing continuum of care



Source: Adapted from Queensland Health (2022).

[2] Please note the term Social Emotional Wellbeing is used in place of Mental Health, Alcohol, and Other Drugs (MHAOD) to pay respect to our community members who requested this terminology change. The original continuum adapted from Queensland Health (2022) is based on MHAOD.

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