Service Plan
2016 - 2026
Torres and Cape Hospital and Health Service
Acknowledgment

The Torres and Cape Hospital and Health Service (HHS) Strategy, Planning and Performance Unit would like to acknowledge the assistance of the following individuals and agencies who contributed to the plan including:

- Members of the public who participated in consultation meetings or provided written submissions, in particular the Community Advisory Networks of Cooktown Multi-Purpose Health Service, and Weipa Integrated Health Service.

- Other partners service groups who generously gave their time to collaborate on planning for health services across the HHS, specifically:
  - Apunipima Cape York Health Council: Cleveland Fagan- Chief Executive
  - Commonwealth Aged and Community Care: Sue Renton-Assistant Director
  - Northern Peninsula Area Family and Community Service: Lisa Sarago- Acting Chief Executive
  - Northern Queensland Primary Health Network: Robin Moore- Chief Executive
  - Royal Flying Doctor Service: Angela Jarkiewicz- Regional Services Manager

- Individual staff and teams across the service who generously gave their time to inform the plan through consultation meetings and participation in the survey.

- The project’s owner, Health Service Chief Executive, and members of the project’s Senior Working Group and Steering Group who provided expert opinion and planning guidance.
Contents

Executive summary 4
Introduction 5
Policy and planning directions 6
Torres and Cape Hospital and Health Service 9
The Hospital and Health Service 10
Population profile 11
Clinical Service Capability 12
The Health Service Needs 15
Objectives and strategies 16
Implementation, monitoring and review 22
Appendix A 23
Glossary 24
References 26

Effective from 28 June 2016  Version 1.0 TCHHS-SPP-PLAN-1-0902
Executive summary

Torres and Cape Hospital and Health Service (the HHS) is the primary provider of public health services across large remote areas of northern Queensland (Figure 1).

The communities served are unique and culturally rich with the traditions and languages of the First Australians, Aboriginal and Torres Strait Islander people who collectively represent a significant proportion (64 per cent\(^1\)) of the resident population (25,610\(^2\)).

The health and life expectancy gap between Aboriginal and Torres Strait Islander residents and Queenslanders (as a whole) is the principal challenge for the health service.

Poor health and health outcomes are strongly associated with socioeconomic disadvantage and remoteness, and result in a higher demand for health services and early death. Irrespective of Indigenous status, residents generally have a higher prevalence of risk factors and disease burden compared to Queensland and Australian populations.

Service integration and coordination with other health providers is restricted by outdated patient information systems with limited sharing between providers. Additional demands particularly for community care, aged care, disability and mental health are associated with the limited representation of other providers within some communities, increasing ‘non-core’ service demand upon the health service.

Health measures and patterns in resident use of health services signal the need for improved access to high quality and timely primary health services, including earlier intervention, and community based chronic disease management.

To achieve this, a focus on the patient to better meet their health care needs as well as cultural and social needs of the Aboriginal and Torres Strait Islander people to produce better health outcomes is required\(^3\). Improved service integration, coordination with other service partners, and improved health literacy levels and self-care rates with the Communities will be core to future service delivery.

With the recent introduction of the national non-admitted patient level data in conjunction with the expanding eHealth environment, Medicare Review and the commencement of procurement through the Primary Health Networks; it is probable that in the future Commonwealth Government funding, particularly for chronic disease services will follow the patient to a provider of choice.

In 2017-18, the implementation of a new Far North Queensland digital primary health patient information system (Regional eHealth Project) is expected to support a substantial step forward in the quality of care\(^4\) and business capability. As part of the new system, the HHS should pursue a tiered approach to chronic disease management (from self-care to managed care) to better target resources in alignment with patient requirements.

Improvements could be achieved through implementation of “Hospitals (and Teams) without Walls”, with a focus on early intervention and chronic disease management. This would aim to remove ‘late presentation’ chronic disease activity from the hospital inpatient beds, and replace that activity within clinic and/or community settings to keep people out of hospital.

Workforce planning to review future requirements should address the current imbalance between disciplines at some sites; expand ‘top of scope’ roles such as rural generalist, and development of multi-disciplinary teams\(^5\) including specialist lead roles.

Within the next five years, the capability level of HHS services is not expected to increase but capacity improvements can be achieved through expansion of services already within the HHS capability levels including renal dialysis services, maternity services and addressing local demand for residential aged care services through conversion of Bamaga Hospital to a multi-purpose health service. It is expected that low-volume-high-complexity and/or technologically-expensive tertiary services will continue to be referred to other HHSs.
Introduction

The Torres and Cape HHS Health Service Plan 2016–2026 (the Plan) is a future orientated planning document to guide the provision of safe and sustainable public health services to 2026.

Initiated by the Torres and Cape Hospital and Health Board, planning was undertaken to meet responsibilities under the Hospital and Health Boards Act 2011 and Hospital and Health Boards Regulation 2012 (the Act) including:

- as a principal provider of public health services undertaking health service planning within the defined geographic area of the HHS, whilst considering the impact on the broader health service system.
- implementing State-wide service plans that apply to the HHS and undertake further service planning that aligns with the State-wide plans.
- cooperating with other providers of health services, including other services, the department and providers of primary healthcare, in planning for, and delivering, health services.

Planning commenced in December 2015 and was undertaken in alignment with Queensland Health guidelines. Consultation with community members, stakeholder groups including Community Advisory Networks, partner groups and HHS staff informed development of the Plan and it was completed during February-April 2016. A working group of senior staff representing services across the HHS developed strategies to address the key issues in April 2016. The Plan’s strategies will be implemented through the HHS’s operational planning process.

The Plan presents information from a variety of sources including State and Commonwealth government strategic directions (Appendix A), population projections and health status data; and historical and contemporary trends in resident use of health services and service activity. Additional information, including methodologies are provided within the background documents:

- Geographic and Population Profile
- Health determinants and Disease Profile
- Activity Profile
- Projections Profile.
Policy and planning directions

This section provides an overview of the contemporary national and state policy, and recent sector developments that have been used to inform the planning.

National Healthcare Agreement and National Health Reform Agreement

Commonwealth Government objectives, roles and funding for health services are defined within the National Healthcare Agreement and the National Health Reform Agreement (2011). Under the combined agreements, the Commonwealth has lead responsibility for:

- system management, policy and funding for primary health care
- establishing Primary Health Networks to promote coordinated primary health care service delivery at a regional and local level
- working with each State on system-wide policy and state-wide planning for primary health care services
- promoting equitable and timely access to primary health care services.

Nationally there are nine Health Priority Areas (cancer control, cardiovascular health, injury prevention, mental health, diabetes, asthma, obesity, dementia, arthritic/musculoskeletal conditions.) aligned with significant contributors to the burden of illness and injury in the Australian community. Performance of the health system is measured through the National Performance Framework, and the Australian Commission on Safety and Quality in Health Care that leads and coordinates improvements in national quality and safety.

The National Indigenous Reform Agreement defines six targets to “Close the Gap” in inequalities that exist between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander Australians, with two health-specific targets:

- to close the gap in Aboriginal and Torres Strait Islander people’s life expectancy within a generation (by 2033); and
- to halve the gap in mortality rates for Aboriginal and Torres Strait Islander children under five within a decade (2018).

The National Framework for Rural and Remote Health (2012) promotes a national approach to policy, planning and delivery of rural and remote health services. The National Primary Health Care Strategic Framework (2013) provides national directions for a coordinated approach in primary health care planning and service delivery. Additionally, the Commonwealth is expected to release (in late 2016) a new National Strategic Framework for Chronic Conditions to further move away from a disease-specific approach and provide national direction applicable to a broad range of chronic conditions by recognising that there are often similar underlying principles for the prevention and management of many chronic conditions.

Medicare Benefits Schedule Review

In 2016-17, the Commonwealth Government will begin implementation of a two year trial of “Health Care Homes”, which will involve voluntary enrolment of patients, with chronic and long-term diseases, registering with a general practice, which will then provide a multidisciplinary approach to the person’s care under a care package funding allocation. In addition, the Commonwealth Government will continue to review Medicare arrangements through the Medicare Benefits Schedule Review.

Northern Queensland Primary Health Network (NQPHN)

Primary Health Networks (PHN) are the key Commonwealth Government platform established to increase the efficiency and to improve coordination of primary health services. Commissioning functions will commence from July 2016 for services including primary health, primary mental health, after hours general practice and aged care. The HHS is a founding member of the NQPHN.
The National Child and Adult Public Dental Scheme

In 2016-17, the Commonwealth Government will introduce a new Child and Adult Public Dental Scheme including a national efficient pricing in dental services, along similar lines as activity-based hospitals funding. It envisages that the initial agreement will be for a period of five years.

The National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is expected to be implemented in the HHS from July 2018. Program areas from health which have been identified as potentially in scope for the NDIS include (but are not limited to) aids and equipment, community mental health, high cost home support and services provided to long stay younger people with disability in public health facilities.

Opt out My Health Record trial

Far North Queensland is one of two national sites to participate in an opt-out trial for the implementation of the National My Health Record. The trial is planned to commence July 2016 and will cover the Mackay, Townsville, Cairns and Hinterland, and Torres and Cape Hospital and Health Services.

Aged Care

During 2016-17, the Commonwealth will be implementing a remoteness classification system to inform funding for aged care services following The Aged Care Financing Authority report, Financial Issues Affecting Rural and Remote Providers, which identified greater cost pressures in rural and remote areas. The report made no recommendations in regards to multipurpose services, but provides guidance around the financial validity of remote aged care provision.
Queensland policy directions

In May 2015 the Queensland Government ratified *The Queensland Government’s Objectives for the Community* with a focus on creating jobs and a diverse economy, delivering quality frontline services, building safe, caring and connected communities and protecting the environment.

In 2016, the Queensland Government endorsed *Not Now, Not Ever. Putting an End to Domestic and Family Violence in Queensland*, detailing Queensland Health responsibilities for identifying support, training and referral service models in public and private maternity services and emergency departments.

The *Queensland Department of Health Strategic Plan 2014–2018* (2015 update) outlines six strategic directions that inform system level priorities being:

1. Healthy Queenslanders: promote and protect the health and wellbeing of current and future generations of Queenslanders
2. Safe, equitable and quality services: ensure there is access to safe, equitable and quality services that maintain dignity and consumer empowerment
3. A well-governed system: sound management of funding and delivery of performance for the whole system
4. Strategic policy leadership: develop, implement and evaluate evidence-based policy that sets system-wide direction
5. Broad engagement with partners: build partnerships with all levels of the community to plan, design, deliver and oversee health services
6. Engaged people: cultivate a culture that harnesses capability and values our people.

Making tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033: investment strategy 2015-2018 outlines Queensland Health’s investment priorities for Aboriginal and Torres Strait Islander health. Priority actions include:

- Improving cardiac health through implementation of *The Queensland Aboriginal and Torres Strait Islander cardiac health strategy 2014-17*.

- Strengthening the mainstream community and hospital based mental health services through a Queensland Aboriginal and Torres Strait Islander mental health strategy.

- Implementation of a regional sexually transmissible infections strategy.

The *Queensland Mental Health Drug and Alcohol Services Plan 2016-21* will inform planning, delivery and investment for State funded mental health and alcohol and other drugs services. Complementary planning documents include:

- *The Queensland Alcohol and Other Drugs Action Plan 2015-17*
- *The Queensland Suicide Prevention Action Plan 2015-17*
- *The Queensland Mental Health Promotion, Prevention and Early Intervention Action Plan 2015-17*.

State-wide health service plans that have been used to inform development of the Plan are listed in Appendix A.
Torres and Cape Hospital and Health Service

This section provides an overview of the HHS’s strategic planning directions, and key findings from the population, health and service profiles that have informed development of the health service needs.

**Strategic directions**

The Torres and Cape Hospital and Health Service Health Strategic Plan 2015-2019 (2016 update) defines the organisations’ vision, purpose and service objectives. Directions utilised to inform the development of the Plan are:

**Vision**

The vision of the organisation is: “Healthy people and communities in the Torres Strait, Northern Peninsula Area and across Cape York”

To achieve the vision the TCHHS will:

- Respect Aboriginal and Torres Strait Islander peoples and cultures.
- Work in partnership with communities and other organisations.
- Provide high quality, innovative and effective remote health services.

**Purpose**

The purpose of the organisation is: To improve the health and well-being of people in the Torres Strait, Northern Peninsula Area and across Cape York through partnering with communities.

**Service objectives**

The service objectives defined within the strategic plan are:

- Care is person centred- Consistently deliver safe, patient centred, culturally appropriate, responsive and innovative healthcare in partnership with Torres Strait, Northern Peninsula and Cape York communities.
- Care is supported through partnerships-Grow partner relationships to enable integrated health service delivery.
- An engaged, valued and competent workforce-Maintain and develop a capable and competent workforce to meet current and future requirements.
- A well governed organisation-Deliver safe and accountable services through efficient, effective, responsible and innovative use of resources.
The Hospital and Health Service

Torres and Cape HHS is the primary provider of public health services across 130,238 square kilometres of northern Queensland with challenging land and sea environments that present physical barriers to the access and delivery of health services, significant distances between communities, between health services sites and to the major referral hospital located in Cairns.

The HHS has two major service boundaries, the Northern Sector and the Southern Sector (Figure 1).

There are four major townships, Thursday Island and Bamaga in the Northern Sector and Cooktown and Weipa in the Southern Sector that function as service hubs to the surrounding communities.

In the Northern Sector, Thursday Island is the administrative and commercial centre of the Torres Strait and is the most heavily populated of the Torres Strait Islands. Thursday Island services extend to clustered groups of outer islands which are grouped as the Eastern Cluster, Central Cluster, the Near Western Cluster and the Top Western Cluster.

Bamaga is located 40 kilometres from the northern tip of Cape York within the Northern Peninsula Area, and services the local communities of Injinoo, Umagico, New Mapoon and Seisa.

In the Southern Sector, Cooktown located on the east coast of the Peninsula is the main service centre for the Aboriginal communities of Hope Vale and Wujal Wujal, and the communities of Rossville, Laura and Lakeland.

Weipa located on the west coast of Cape York, is the main service centre for the Aboriginal communities of Mapoon, Napranum, Aurukun, Kowanyama, Pormpuraaw and Lockhart River. Coen is a small community situated on the Peninsula Development Road midway between Weipa and Cooktown.
Population profile

Further information is provided within the background paper Geographic and Population Profile. In summary, the key population profile findings are:

**HHS population**
- 25,610 as at 30 June 2014
- 31,070 people by 2036

**Extensive remoteness** (Very Remote 81.9 per cent) results in residents experiencing poor accessibility to goods, services and social interaction when compared to other Queenslanders.

**Extreme levels of socioeconomic disadvantage** (73.2 per cent Quintile 1 compared to 20 per cent for Queensland in 2011) 10 are widespread, and contribute to higher demand for health services.

Aboriginal or Torres Strait Islander residents represent a significant proportion (63.7 per cent or 14,730 people11) of the resident population compared with Queensland (3.6 per cent). In 2011, residents identified themselves as:
- 41% Aboriginal
- 41% Torres Strait Islander
- 17% Aboriginal and Torres Strait Islander

The HHS has a large proportion of younger residents (0-14 years) and smaller proportion of older residents (aged 45 years+) in comparison to Queensland.

36% of Aboriginal and Torres Strait Islander residents speak an Australian Indigenous Language at home.

**Homeless people and people with disabilities**
People who are homeless or dislocated, and people with disabilities15 generally have higher demand for health services. In preparation for the introduction of the National Disability Insurance Scheme, the HHS needs to ensure people with core disabilities are recognised and referred, to encourage growth in the disability sector services.

At the time of the 2011 census, 2.6 per cent of the resident population identified a core activity need for assistance compared to 4.4 per cent for Queensland. This is considered to be under-recognition of the level of resident disability considering significantly higher rates (than non-indigenous Australians) of disability are associated with Aboriginal and Torres Strait Islander populations13 14. Nationally, the Australian Institute of Health and Welfare reports the prevalence of disability in the Indigenous population in Australia is 2.4 times higher than that in the non-Indigenous population.15

**Non-resident population**
Non-resident populations create additional demand for services.16 For the HHS, the main non-resident groups are associated with the resource sector and tourism. The utilisation of health services by non-residents has been reviewed as part of HHS’s historic activity, and taken into account in the projections of activity for future health services.

**Population health priorities**
The current health status of the resident population is an important determinant in defining future health service requirements. Further information is provided within the background paper Health determinants and Disease Profile. In summary, the key health profile findings are:
- Life expectancy for both Indigenous and non-indigenous residents is amongst the lowest in Queensland.
- The rate of premature deaths, total preventable deaths and preventable deaths was significantly higher than for Queensland in 2014.

- Cancer, heart disease, injury and suicide, and endocrine diseases including diabetes were the leading cause of deaths for both resident males and females between 2007 and 2011.
- Resident health behaviours including general and maternal smoking levels, obesity levels, and risky drinking levels (all types) are significantly higher than the state average, and are predicted to continue to drive current and future health service demand.
- Chronic disease and comorbid disease are present in significantly high proportions in the inpatients of HHS hospitals. Nearly a third of all hospitalised adults had diabetes, and around one quarter had cardiovascular disease and/or renal disease as a principal or additional reason for hospitalisation in 2014-15.
- Ten per cent of the entire resident population were registered as a diabetic on a primary health information system in 2016. This figure excludes the undiagnosed (estimated to be an additional 1 in 1217), compared to six per cent for other remote area Australians18.
Clinical Service Capability

This section describes the health services current capability levels and referral relationships. Health services across Queensland are provided under a tiered model as supported by the *Clinical Service Capability Framework for Public and Licensed Private Health Facilities* version 3.2. (CSCF v3.2).

HHS residents access state and super speciality services (Level 6 CSCF v3.2) at Townsville or Brisbane; while the majority of regional specialities to Level 5 CSCF v3.2 are provided outside of the HHS at Cairns Hospital (Figure 2).

HHS hospital services are provided at Thursday Island Hospital (Level 4 CSCF v3.2), Weipa Integrated Health Service (IHS) (Level 3 CSCF v3.2), Cooktown Multi-Purpose Health Service (MPHS) (Level 3 CSCF v3.2) and Bamaga Hospital (Level 2 CSCF v3.2).

The HHS has 31 Primary Health Care Centres (Level 1 CSCF v3.2) that provide a range of primary care (including primary emergency) and ambulatory type services.

• Within the Northern Sector, there are 21 primary health care clinics:
  • Badu, Boigu, Poruma (Coconut Island), Erub (Darnley Island), Dauan, Ngurupai (Horn Island), Kubin and St Pauls (Moa communities), Mabuiag, Mer (Murray Island), Saibai, Ugar (Stephen Island), Thursday Island (Waiben), Warraber (Sue Island), Iama (Yam Island), Masig (Yorke Island), Bamaga, Umagico, New Mapoon, Seisia and Injinoo (which transitioned to a General Practice led service in 2015).

• Within the Southern Sector, there are ten primary health care clinics:
  • Aurukun, Coen, Hope Vale, Laura, Lockhart River, Kowanyama, Mapoon, Napranum, Pormpuraaw and Wujal Wujal.
The HHS provides a number of services through a mixed model of locally located services and visiting teams including mental health, oral health and breast screen.

Public health services are provided in partnership with the Tropical Public Health Service in line with public health related legislation and reporting requirements as outlined in the Public Health Practice Manual, including a specialist communicable disease, epidemiology and surveillance, disease prevention and control service; a specialist environmental health service, and regulatory monitoring, enforcement and compliance activity on behalf of the Department of Health.

Visiting specialist services are provided on a fly in-fly out basis for specialties including obstetrics, general medicine, paediatrics, endocrinology, psychiatry and orthopaedics.

The HHS has an administrative hub located in Cairns that provides some administrative functions including finance, travel and business support.

The HHS is accredited under the Australian Health Service Safety and Quality Accreditation Scheme. Accreditation of residential aged care facilities is by the Australian Aged Care Quality Agency. General practices owned or managed by the HHS are externally accredited in accordance with the current edition of the Royal Australian College of General Practitioners published accreditation standards (version 4). Mental health services maintain accreditation against the NSQHS Standards and the National Standards for Mental Health Services. Medical imaging services are accredited by NATA against the Diagnostic Imaging Accreditation Scheme.
**Service partners**

Major service partners include Apunipima-Cape York Health Council, Northern Queensland PHN, Queensland Ambulance Service, Wuchopperin Health Service, Mookai Rosie Bi-Bayan, Northern Peninsula Area Family and Community Service and the Royal Flying Doctor Service. Torres and Cape HHS and its key partners promote cooperation in the planning and delivery of health services to communities and collaborate wherever possible.

**Service drivers and priorities**

Further information is provided within the Activity Profile (Attachment 3). In summary, the key findings of the service activity review are:

- Outflows to other HHSs for adult resident overnight and same day services have increased, with a corresponding decrease at HHS hospitals over the five years to 2014-15.
- In 2014-15, the most common reasons residents utilised Queensland hospital beds were for non-subspecialty medicine, renal dialysis and obstetrics.
- A significant proportion of all resident hospital separations in 2014-15 were potentially preventable, with the largest causes being diabetes and other chronic disease. These type of hospitalisations occurred at nearly double the proportion of the rest of Queensland.
- The HHS provided a third of all resident women’s non-complicated maternity deliveries in 2014-15.
- Weipa IHS provided the highest number of emergency department presentations in 2014-15, but a significant proportion were for ‘walk in-walk out’ low acuity presentations.
- Aged care bed types experienced high demand (with overflow to acute beds) during four years to 2014-15.
- 64,596 outpatient occasions of service were provided at hospital sites in 2014-15.
- Primary health services delivered a significant amount (10 per cent of total activity in 2014/15) for pharmacy occasions of service in 2014/15.
- Future projections to 2026-27, indicate the most common reasons residents will access Queensland public hospital bed days will change from 2014/15. Psychiatry acute will move from the eighth to the second highest reason in 2026-27. (Figure 3).
- Status quo projections indicate no additional requirement for acute hospital beds to 2026, although growth in renal dialysis chairs and residential aged care beds is required in Weipa, Cooktown and Bamaga.

**Figure 3: Top 10 Total resident bed days by SRG 2013-14 actual vs 2026-27 projected**

<table>
<thead>
<tr>
<th>Top 10 resident bed days 2013-14</th>
<th>Top 10 resident bed days 2026-27</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Obstetrics</td>
<td>1. Obstetrics</td>
</tr>
<tr>
<td>2. Other Non-Acute</td>
<td>2. Psychiatry - Acute</td>
</tr>
<tr>
<td>3. Orthopaedics</td>
<td>3. Orthopaedics</td>
</tr>
<tr>
<td>5. Qualified Neonate</td>
<td>5. Respiratory Medicine</td>
</tr>
<tr>
<td>6. Respiratory Medicine</td>
<td>6. Immunology &amp; Infections</td>
</tr>
<tr>
<td>7. Immunology &amp; Infections</td>
<td>7. Rehabilitation (non-acute)</td>
</tr>
<tr>
<td>8. Psychiatry - Acute</td>
<td>8. Other Non-Acute</td>
</tr>
<tr>
<td>10. Non Subspecialty Medicine</td>
<td>10. Qualified Neonate</td>
</tr>
</tbody>
</table>

Source: Queensland Health 2016  Note: Excludes Renal Dialysis
The Health Service Needs

Health service needs have been identified through a range of planning activities including consultation, expert opinion and review of service utilisation in comparison to Queensland.

The key health service needs are:

• Strengthen partnerships with communities and other primary health care providers to improve the health literacy of the population.
• Reduce the rate of potentially preventable deaths.
• Improve the quality of primary health services to better manage chronic disease and reduce preventable hospitalisations.
• Decrease the burden of future chronic disease in communities by enhancing antenatal and child health services including mental health.
• Reverse the growing trend in resident hospitalisations flowing out to other HHSs for services within the HHSs capability levels, and provide more services closer to home.
• Provide service models to move more chronic disease activity from hospitals into the ambulatory settings, and reduce chronic disease related hospitalisations.
• Improve access to community and home-based health services.
• Encourage growth in support type services particularly non-government disability and aged care.
• Review the workforce skills/ mix/ model for delivery to better meet changes in community needs, service demands and prepare for the introduction of a digital environment.
Objectives and strategies

This following section contains the objectives and strategies to address the identified priority health needs. The strategies were developed in conjunction with a working group consisting of representation of multidisciplinary senior staff held in April 2016.

**Objective 1: Increasing focus on prevention and early detection**

To improve early detection and management of disease in community settings, the HHS should improve responsiveness of its early intervention services, and work with other providers to improve the quality primary health services that are accessible, timely and culturally appropriate.

**Prevention and early detection strategies**

- Encourage better access to mental health services by refocusing and rebranding services to be health and well-being orientated.
- Improve child and youth early intervention services by:
  - Improving immunisation coverage by implementing an internal system to track overdue immunisations and increase the follow up of adolescents with the introduction of the new Australian School Vaccination Register from January 2017.
  - Increasing completion of Northern Sector's child health assessments and care planning by dedicating a Medical Officer to oversight/complete.
  - Expand the School Based Youth Health Nurse program across the HHS.
- Improve cancer screening rates by:
  - Optimise use of My Health Record and its links to the National Cancer Screening Register that from May 2017 will incorporate the National Cervical Screening and the National Bowel Cancer Screening Programs.
- Implementation of the National Medical Services Advisory Committee’s recommendation to replace the current two yearly Pap test with a five yearly Human Papillomavirus test from May 2017.
- Active promotion of the (Commonwealth funded) bowel cancer screening program offered to people turning 54, 58 and 68 years old in 2017, and additional cohorts from 2018 to 2020.
- An expansion of colonoscopy services across Weipa and Cooktown, in addition to Thursday Island.
- Enhancement of skin check services at Weipa, Cooktown and Thursday Island in conjunction with general practices.
- Improvement of Breast Screening rates by working with the visiting service to improve participation of women 50 years and older.
- Improve rates of hearing screening services by working with Australian Hearing to train and support a number of Northern Sector Indigenous Health Workers (IHWs) to become Community Audiologists.
- Improve rheumatic heart disease treatment compliance rates by reviewing practices of the Townsville paediatric rheumatic heart disease system that has highest compliance rate in Queensland (2016).
- Increase community engagement thorough consistent and meaningful communication with local health groups and community administration; and development of spaces within health services that are welcoming, educational, culturally appropriate and enable access to self-help services.
- Continue to work with the Commonwealth and non-government partners to promote smoking prevention and cessation programs.
Objective 2: Address the priority health needs of residents

To better address the priority health needs, the HHS should increase its focus on services where demand is highest, and improve early and consistent management of chronic disease in both ambulatory and inpatient settings.

Primary and ambulatory services strategies

- Improve targeted chronic disease management by introducing a stratification tool for chronic disease management (rather than managing the whole registered population) to filter chronic conditions that require case management, care management, and those that can be managed with supported self-care.
- Better manage diabetes, COPD, cardiac and renal disease in the community by planning to source funding to establish a General Physician position to lead multidisciplinary chronic disease teams.
- Improve managed care adherence and reduce avoidable hospital admissions by implementing Care Coordinators for priority diseases diabetes, COPD, cardiovascular disease, chronic kidney disease and mental health.
- Develop and implement work practices, tools and staff training in case management for multi-disciplinary teams and embed as normal practice.
- Develop a workforce model for Northern Sector primary health services for enrolled patients to include a Medical Lead (GP), Case Manager, and Multidisciplinary team with case conferencing for complex patients, with performance monitored by Care Coordinators. Review and reallocate Northern Chronic Disease Team resources to enable outer islands staff to provide their own population screening and recall where ever possible.
- Introduce “Teams without Walls” for chronic disease services to expand Post-Acute Rehabilitation and Aged Care services at Thursday Island, and community based service capacity at Weipa and Cooktown.
- Undertake a quality review of the management of and outcomes for patients with diabetes and lower limb complications, including utilisation of High Risk Foot care plans to achieve a reduction in potentially preventable hospitalisation for cellulitis.
- Better address the needs associated with acute cardiac presentations, stress testing and non-acute ECG recalls, and by working with the Cairns and Hinterland HHS’s cardiology service and the Cardiac Information Solution Program cardiac team to improve cardiac services and introduce cardiac rehabilitation services at Cooktown, Weipa and Thursday Island.
- Improve screening and recall for the 450 plus registered Rheumatic Heart Disease patients.
- Improve the early management of kidney disease by developing a renal service strategy to identify the appropriate resources and plan for nurse led renal dialysis services at Bamaga and Weipa.
- Expand renal dialysis services at Thursday Island and Cooktown. Renegotiate contract conditions for services and staff entitlements with Cairns nephrology service to include growth targets, expanded community based care and improved equity of employment.
- Improve mental health services by:
  - Development of a Rural Generalist Mental Health position to work with Mental Health Services, and other HHS staff to support child and youth services, and comorbid mental health and chronic disease in particular.
- Progress a single care plan for mental health consumers with service partners.
- Development of a perinatal and infant mental health service to work in partnership with child health nurses across all sites.
- Providing Suicide Management and Risk Assessment training (screening/identifying high risk consumers and referral on to Mental Health Services) as mandatory training for front line primary health nurses and IHWs in conjunction with the PHN.
- Utilising after hours medical staff on call to manage and assess mental health after hours presentations/enquires.

Hospital inpatient and MPHS services

- Improve opportunistic management of chronic disease by introducing a review of the primary electronic record (Ferret/Best Practice) as part of the hospital admission process.
- Introduce chronic disease portfolios to nurses within acute inpatient services, to opportunistically manage comorbid disease in the inpatient population, perform overdue activities, and provide intensive patient education (maximise low occupancy staffing).
- Develop nurse led clinics for chronic disease and wound management at all hospital sites utilising current staffing (due to low occupancy of hospital beds).
- Appropriately redirect low acuity presentations from the emergency department at Weipa by introducing an after-hours/weekend walk in nurse clinic staffed by a Nurse Practitioner.
- Develop and implement a rotating HHS wide after hours Medical Officer on call service in alignment with growth in digital patient record capability.
• Reduce the number of staffed acute beds at all hospital sites in the lowest occupancy months of March and April by maximising leave and decrease use of locums.
• Plan to encourage more women to birth locally by improving patient accommodation options pre/post-delivery on Thursday Island and introducing dedicated birthing spaces at Cooktown MPHS.
• Seek Government support to plan for the development of low risk birthing services at Weipa IHS.
• Improve aged care service provision in the Northern Peninsula Area by implementing a MPHS model at Bamaga Hospital.

**Objective 3: Improve coordination and patient access through the use of collaborative care models with primary care providers**

To better address service and community demands, the HHS will need to access additional funding streams, increase collaboration with other partners, and work to expand the number of service partners in disability and aged care services to reduce ‘non-core’ demands upon the services.

**Partnership strategies**

- Work with partner groups, particularly Apunipima Cape York Health Council to develop a primary health (including chronic disease) model for discrete Indigenous communities in Cape York. The model should consider the impacts of a probable introduction of “Health Care Home” by the Commonwealth, and the possibility of an introduction of commissioning of primary health through the PHN.
- Improve working arrangements with Apunipima Cape York Health Council to introduce contract performance review processes and activity reporting for HHS contracted services.
- Work with the commonwealth, local government and non-government organisations to better address the aged care demands. Develop a HHS position on the provision of aged care services that meets community needs in conjunction with other providers, and identifies appropriate funding to support any service expansion.
- Monitor and respond to recommendations from the Commonwealth Government’s Medicare Reform and Health Care Home program (2016-17). Additional planning may be required at sites where the HHS is the main provider of chronic care, and for sites where it is not the main provider.
- Partner with the PHN in the joint planning and contracting of Commonwealth funded services including workforce skills development, community education and health literacy programs, My Health Record, after hours general practice services, youth suicide prevention and primary mental health services.
- Partner with the PHN and child/youth mental health service organisations to improve child/youth mental health early intervention services, including exploring development of an Evolve Mental Health Service in partnership with the Department of Communities, Child Safety and Disability.
- Educate staff, consumers and communities about entitlements and assistance available through the National Disability Insurance Scheme (NDIS). Refer all known clients with a core disability including mental health, hearing health, foetal alcohol syndrome and chronic disease to the Department of Communities, Child Safety and Disability, to register for the NDIS in preparation for the roll out in 2018.
- Review the Ear, Nose and Throat (ENT) and ophthalmology service models, equipment and resources in conjunction with service providers, to ensure equity in service access and to improve the rate of diabetic retinopathy screening with introduction of two new Medical Benefits Scheme items 2016/17.
- Work with Education Queensland to expand School Based Youth Health Nurse positions and re-introduce health worker/child health focussed roles for hygiene/dental/skin and wound checks.
- Continue to work with local councils to pursue fluoridation within communities.
- Explore options with Cairns and Hinterland HHS to expedite referral processes, and patient transfer pre and post hospitalisation; and the expansion of telehealth provided specialist services.
- Implement patient care plans as part of new digital patient record that can be developed in partnership with patients and their families to empower patients and their families to be partners in their own care and take greater responsibility for the management of their conditions.
- Improve two way communication with community members, groups, councils and other representative groups to ensure HHS services are aligned and not duplicated, and explore opportunities to ensure services meet Indigenous health needs.
- Work in partnership with tertiary education and research providers to embed research into health service delivery and improve the quality and efficiency of care.
Measurement and improvement of the quality of care should become a focus, particularly for primary health and chronic disease management services. This will be greatly assisted by the introduction of the digital patient record and should result in reducing the number of preventable hospitalisations. A tiered model of primary health care targeted appropriately according to patient need should form part of the digital tools.

System funders are expected to continue to move towards measuring performance through quality and health outcomes. In response, the HHS will need to improve operational and business intelligence, increase controls over its referral process, and improve performance monitoring.

Transparent and motivational performance tools should be provided to enhance staff’s ability to understand their service and contribute to the change.

**Business processes and systems strategies**

- Motivate improvements on priority areas including completion of MBS items and Closing the Gap targets by developing and introducing an internal performance reward system (i.e. similar to QLD Incentive Payments).

- Link contract management to performance reporting for both external providers and contracts with other HHSs. Implement a system to capture all contracted clinical activity to be attributed to HHS as a priority.

- Implement a central referral hub to:
  - monitor progress of patient referrals for outpatients and elective admissions on both HHS and external waitlists
  - centralise hospital clinic bookings
  - maximise telehealth consultations
  - track specialist outreach clinics.

- Plan to monitor, act upon and report variances in healthcare services and outcomes, in alignment with national initiatives and the expanding digital environment.

- Improve the sustainability of Bamaga Hospital and increase capacity at the Thursday Island Wellness centre by undertaking a benefits analysis on redirecting outer island residents requiring non-procedural type or existing (i.e. general physician/ paediatrician, etc.) specialist outpatients clinics to Bamaga Hospital.

- Improve business practices including:
  - utilisation of private health insurance
  - completion of discharge information for coding and reporting timeframes.

- Develop a ‘one stop shop’ for health information, activity data and reporting functions by centralising existing resources.

- Develop and implement internal performance reports and follow up systems for:
  - Care Coordinators targeting chronic disease, comorbid disease and frequent fliers
  - HHS activity reports to share performance, shared priorities and to highlight areas of good performance with broader staff group

- Overdue activities whilst waiting for the new digital system, and establish tracking progress (to teams/individuals) of outstanding items.

- Commence (2016-17) MBS billing for GP registrars for GP-related Medicare benefits for the services they provide while training.

- Plan for the future removal of paper records at PHC sites post digital record implementation, and then at the hospitals once the integrated electronic medical record is in place.

- Pharmacy:
  - Introduce the Closing the Gap (CTG) Initiative to Northern Sector pharmacy services, and remove the co-payment system.
  - Establish a HHS wide Director of Pharmacy and develop a HHS pharmacy workforce plan.
  - Implement iPharmacy at Cooktown and Weipa, and iPharmacy or similar system at smaller sites.
  - Work with current providers of Webster Pack services to improve efficiencies including costs and the quality use of medicines.

- Optimise funding opportunities associated with the introduction of the Child and Adult Public Dental Scheme commencing 1 July 2016, for an expansion in children’s services in particular.
Objective 5: Reshape the workforce to better meet community expectations and service demands

Greater effectiveness would be gained through a review of current workforce capability and capacity, and forecasting future workforce requirements based on future service demands.

Expansion of ‘top of scope’ roles suitable to the remote environment including rural generalists, nurse practitioners, practice managers, and development of multi-disciplinary teams including senior specialist lead roles.

The HHS should also prepare the workforce to become more mobile in response to increased capability within a digital environment that will reshape roles and functions.

Workforce strategies

Develop a workforce plan to provide:

- An improved career path for IHWs inclusive of:
  - Senior leadership and management roles
  - Progression to Aboriginal and/or Torres Strait Islander Health Practitioner
  - Strategies to encourage uptake of school traineeships and qualifications (Certificate 3 and 4)
  - Transition pathways for IHWs and other Indigenous staff to transition into other work streams including allied health co-worker roles, mental health workers, aged care maximising funding opportunities in conjunction with the PHN.
  - Strategies to encourage fostering and employment of Indigenous staff across all professional and non-professional streams.
  - Review of opportunities for the HHS to participate in Commonwealth funded initiatives including:
    - Trainee scholarships and incentives including grants for rural health workforce
    - The Integrated Rural Training Pipeline to retain medical graduates in rural areas
    - Practice Nurse Incentive Program.
  - Improved balance and skill mix by increasing professionalism levels, across some sites.
  - Determine best fit for Medical and Nurse Practitioner workforce across sites.
  - Review of resources where two separate services (North and South) may provide opportunities for better efficiency and standardisation of services, including:
    - Child health
    - Public health
    - Areas where locums are employed for a significant time annually and determine whether it may be more economical to employ internal relief staff (i.e. radiography).
    - Introduction of new roles (practice managers, service navigators, etc.).
  - A plan for growth and decline in some workgroups associated with future service demands, and the implementation of the digital environment including:
    - Aged care demand
    - Mental health demand
    - Allied Health
    - Administration including medical records.

Objective 6: Better align enabler services with service and community needs

Information, Communications and Technology (ICT) is a clinical system enabler. The HHS will need to optimise opportunities to ensure HHS implementation of the digital environment is successful, and to improve business and service capability.

ICT strategies

- Implement an ICT senior responsible officer and resources to ensure the HHS becomes more engaged and proactive with state-wide eHealth planning and investment opportunities, and to lead HHS involvement in ICT projects including:
  - My Health Record
  - Regional eHealth Project (delivery estimated 2 years)
  - Contemporary Workspace (delivery estimated 1-2 years)
  - Interoperability (delivery estimated 2-5 years)
  - Patient Administration System (delivery estimated 3-5 years)
  - Integrated Electronic Medical Record (delivery estimated 2-5 years) at Hospital sites.
  - Develop a HHS position on future Infrastructure upgrade requirements to all sites needed to support digital environment (as part of the state-wide project)
  - Leverage ICT support by partnering with other HHS’s including other rural and remotes.
• Review opportunity to reduce HHS asset costs and increase the responsiveness of the current system, through planned changes to the ICT asset replacement process and the introduction of Zero Client and Desktop Environment.

• Actively plan for expansion of all telehealth components: clinical telehealth service provision; emergency telehealth; training and education; secure store and forward applications; and home monitoring.

• Continue to pursue a hospital decision support tool once the digital environment is implemented (2018/19).

• Increase business intelligence and capability through expansion of programs such as office 365 for use in areas including patient travel and workflows.

**Infrastructure strategies**

• Explore opportunity (2016-17) to access the Rural General Practice Grants Program (Commonwealth) to fund infrastructure improvements to provide environments to increase community health literacy levels.

• Expand residential aged care spaces at Cooktown and Weipa to meet demand.

• Convert six beds at Bamaga Hospital to aged care under an MPH model and other living spaces services as designated within the national aged care standards.

• Progress infrastructure planning for:
  - Bamaga: Improve functionality and condition of dialysis space to enable nurse led renal dialysis service.
  - Cooktown: Address dysfunctional and non-compliant spaces including the operating theatre, birthing suite, CSSD and outpatients/ambulatory services including radiology; and to better address safety concerns through staff only spaces.

• Thursday Island:
  - Refurbish the Thursday Island PHC for community based services
  - Address dysfunctional space within Thursday Island Hospital operating theatre to include a second procedure space
  - Expand the number of negative isolation rooms
  - Improve patient accommodation options at Thursday Island for renal and maternity patients and their families.
  - Inadequate space at Thursday Island pathology.

• Weipa Hospital:
  - Consider repurposing space close to the hospital entry to include a pharmacy space.
  - Any planned extension to Weipa Hospital should include future proofing for maternity services.
  - Address inadequate general parking space and inadequate store docking space at Weipa Hospital.
  - Address storage issues and secure undercover parking for the dental drover.

• Old Weipa Hospital site (if it is retained):
  - Consider options to utilise the site including:
  - For ambulatory (Monday to Friday) services, including relocating the private general practice, mental health and some allied health.
  - For development of a partnership with a mental health non-government organisation focusing on youth mental health, drugs and alcohol.
  - Disposal of the site.
  - It is not recommended that the site be utilised for any service requiring 24hr staffing, including residential aged care.
  - If old Weipa Hospital site not retained, consider redevelopment of current site to cover previous Weipa Hospital infrastructure strategies.

• Staff accommodation needs across the HHS.

• Repurpose or disinvest in infrastructure at Seisa, Injinoo, New Mapoon and Umagico.

Implementation, monitoring and review

The Plan is owned by the Chief Executive, and will be used to inform development of an implementation plan to further specify timeframes and indicative resources.

The Plan’s service objectives and strategies will be implemented through the HHS annual operational planning process, service stream and facility level operational planning. Additional strategies to achieve the service objectives may be added or revised over time, according to unforeseen changes within the HHS or health sector.

Measures of achievement against the objectives should be developed and related to the higher level strategic directions contained within the TCHHS Strategic Plan. The Plan may also be used to inform separate enabler service planning processes, including Infrastructure and Workforce Planning.

The Health Service Plan should be updated regularly (every three to five years) to reflect changes in government, HHS directions and community needs.
## Reference Plans

<table>
<thead>
<tr>
<th>Reference Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queensland Cultural Diversity Policy</td>
</tr>
<tr>
<td>Making tracks towards closing the gap in health outcomes for Indigenous</td>
</tr>
<tr>
<td>Queenslanders by 2033: investment strategy 2015-2018</td>
</tr>
<tr>
<td>Queensland Disability Plan 2014-19</td>
</tr>
<tr>
<td>Queensland Aboriginal and Torres Strait Islander cardiac health strategy</td>
</tr>
<tr>
<td>2014-17</td>
</tr>
<tr>
<td>Queensland Mental Health Drug and Alcohol Services Plan 2016-21 (draft)</td>
</tr>
<tr>
<td>Queensland Alcohol and Other Drugs Action Plan 2015-17</td>
</tr>
<tr>
<td>Queensland Suicide Prevention Action Plan 2015-17</td>
</tr>
<tr>
<td>Queensland Mental Health Promotion, Prevention and Early Intervention Action</td>
</tr>
<tr>
<td>Plan 2015-17</td>
</tr>
<tr>
<td>Not Now, Not Ever. Putting an End to Domestic and Family Violence in Queensland</td>
</tr>
<tr>
<td>Status Report: Queensland State-wide Rehabilitation Services Plan 2008-12</td>
</tr>
<tr>
<td>Queensland Immunisation Strategy 2014-17</td>
</tr>
<tr>
<td>A Trauma Plan for Queensland 2006 (review completed May 2014)</td>
</tr>
<tr>
<td>Status Report: Queensland State-wide Renal Health Services Plan 2008-17</td>
</tr>
<tr>
<td>The diabetes services state-wide health strategy 2013</td>
</tr>
<tr>
<td>Queensland Health Disability Service Plan 2014-2016</td>
</tr>
<tr>
<td>Queensland Rural and Remote Health Service Framework</td>
</tr>
<tr>
<td>National Maternity Services Plan 2010 (Queensland status report for the</td>
</tr>
<tr>
<td>period January 2014-June 2014)</td>
</tr>
<tr>
<td>Cancer Care State-wide Health Service Strategy 2014</td>
</tr>
<tr>
<td>Department of Health Strategic Plan 2014 - 2018 (2015 update)</td>
</tr>
<tr>
<td>Respiratory Medicine Services State-wide Health Service Strategy 2014</td>
</tr>
<tr>
<td>National Strategic Framework for Rural and Remote Health 2012 (report against</td>
</tr>
<tr>
<td>the five key outcome areas for the 2013-14 financial year was submitted to</td>
</tr>
<tr>
<td>Rural Health Standing Committee August 2014)</td>
</tr>
<tr>
<td>National Oral Health Plan</td>
</tr>
<tr>
<td>National Framework for Action on Dementia 2015 - 2019</td>
</tr>
<tr>
<td>Queensland End of Life Strategy</td>
</tr>
<tr>
<td>Adult Brain Injury Rehabilitation State-wide Plan</td>
</tr>
<tr>
<td>Adult Spinal Cord Injury State-wide Plan</td>
</tr>
</tbody>
</table>
## Glossary

<table>
<thead>
<tr>
<th>KEY TERM</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group and total population</td>
<td>Unless otherwise specified all data in this report refer to the total population. Age groups are defined by year span within text as appropriate.</td>
</tr>
<tr>
<td>Age standardised rates</td>
<td>Rates for deaths, hospitalisations, cancer incidence and burden of disease are age standardised to improve comparison between jurisdictions.</td>
</tr>
<tr>
<td>Ambulatory</td>
<td>Refers to clinic services or non-inpatient bed type.</td>
</tr>
<tr>
<td>Avoidable deaths</td>
<td>Comprises those causes of death that are potentially avoidable at the present time, given available knowledge about social and economic policy impacts and health behaviours.</td>
</tr>
<tr>
<td>Burden of disease</td>
<td>User to assess and compare the relative impact of different diseases and injuries on populations. It quantifies health loss due to disease and injury that remains after treatment. Rehabilitation or preventative efforts of the health system and society generally.</td>
</tr>
<tr>
<td>Chronic disease</td>
<td>Diseases of long duration and generally slow progression. In this plan, chronic disease refers to all non-communicable disease and excludes injuries.</td>
</tr>
<tr>
<td>Communicable disease</td>
<td>Includes vaccine preventable disease, sexually transmissible diseases, diseases acquired from animals, vector borne diseases, foodborne and waterborne infections, and tuberculosis.</td>
</tr>
<tr>
<td>Death rate</td>
<td>The number of deaths per 100,000 estimated resident populations on the year the death was registered. Also known as mortality rate (see below).</td>
</tr>
<tr>
<td>Deaths</td>
<td>Refers to any death registered with a state or territory Registry of Births, Deaths and Marriages. Death rates are per 100,000 estimated resident populations on the year the death was registered.</td>
</tr>
<tr>
<td>Disability</td>
<td>Temporary or long-term reduction of a person's capacity or function.</td>
</tr>
<tr>
<td>eHealth</td>
<td>Refers to electronic health information systems, a network of systems and/or electronic patient records.</td>
</tr>
<tr>
<td>Estimated Resident Population (ERP)</td>
<td>The Estimated Resident Population (ERP) is the official ABS estimate of the Australian population. The ERP is based on Census of Population and Housing usual residence counts. It is compiled as at 30 June of each Census year and updated quarterly between Censuses.</td>
</tr>
<tr>
<td>Health adjusted life expectancy</td>
<td>Estimate of the average years of equivalent “healthy” life that a person can expect to live at various ages. Related to life expectancy (see below).</td>
</tr>
<tr>
<td>Health continuum</td>
<td>A conceptualisation of health need, using a continuum comprising six stages. The continuum is not a linear process - rather it is intended to represent stages of health need for people which may arise over time and at various stages of life and disability.</td>
</tr>
<tr>
<td>Health literacy</td>
<td>The ability to understand and interpret health related information. People with higher levers of health literacy are better able to participate in and make decisions about their healthcare. People with lower levels of health literacy are more likely to not attend necessary medical tests, end up in emergency departments more often, and have a harder time managing conditions.</td>
</tr>
<tr>
<td>Health service continuum</td>
<td>Health agencies and health service providers can provide a broad range of services to meet health need. Key service areas on the health service continuum include prevention, promotion and protection; primary healthcare, ambulatory care; acute care; sub-acute care; mental health; and aged care services.</td>
</tr>
</tbody>
</table>
## Glossary

<table>
<thead>
<tr>
<th>KEY TERM</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health service need</td>
<td>The gaps between services are currently provided to a given population and what will be required in the future to improve the health status of a community (and avoid a decline).</td>
</tr>
<tr>
<td>Health service planning</td>
<td>Aims to improve health service delivery and/or system performance to better meet the health need of a population. It encompasses the process of aligning existing health service delivery arrangements with changing patterns of need.</td>
</tr>
<tr>
<td>Hospitalisations</td>
<td>The total number of separations in all hospitals (public and private). A separation is an episode of care which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay ending in a change of status (for example from acute care to rehabilitation).</td>
</tr>
<tr>
<td>Incidence</td>
<td>The number of new cases/occurrences of a disease or condition in a given time period.</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>The number of deaths of children under one year of age in one calendar year per 1,000 live births in the same calendar year.</td>
</tr>
<tr>
<td>Inpatient</td>
<td>A patient who undergoes a formal admission process to receive treatment and/or care from a hospital. Care may occur in a hospital or in the home. Also referred to as an ‘admitted patient’.</td>
</tr>
<tr>
<td>Immunisation</td>
<td>Immunisation coverage data are provided for children who were considered fully immunised at 12, 24 and 60 months of age.</td>
</tr>
<tr>
<td>Life expectancy</td>
<td>Refers to the average number of additional years a person of a given age and sex might expect to live if the age specific death rates of the given period continue throughout his- her life time.</td>
</tr>
<tr>
<td>Local government area</td>
<td>A spatial unit which represents the whole geographical area of responsibility of an incorporated local government council or an Aboriginal or Island council.</td>
</tr>
<tr>
<td>Morbidity</td>
<td>Defined as a state of injury, sickness or disease.</td>
</tr>
<tr>
<td>National health priority areas</td>
<td>The nine national health priority areas are: cancer control, cardiovascular health, injury prevention, mental health, diabetes, asthma, obesity, dementia, arthritic/musculoskeletal conditions.</td>
</tr>
<tr>
<td>Notifiable conditions</td>
<td>Under section 32(1) of the Health Act 1937 any disease or disability may be declared notifiable. The list of notifiable conditions appears in the schedule of the Health Regulations 1996.</td>
</tr>
<tr>
<td>Potentially preventable hospitalisations</td>
<td>These are admissions to hospital that potentially could have been prevented through the provision of appropriate non-hospital health services.</td>
</tr>
<tr>
<td>Teams without Walls</td>
<td>Teams without Walls is an integrated model of care, where professionals from primary and secondary care work together in teams, across traditional health boundaries, to manage patients using care pathways designed by local clinicians.</td>
</tr>
<tr>
<td>Telehealth</td>
<td>Refers to videoconferencing for the purpose of a health consultation, or staff process for the purpose of patient care.</td>
</tr>
<tr>
<td>Significance</td>
<td>The reporting of difference between categories is noted only when the difference is statistically significant (based on non-overlap of 95 per cent confidence intervals). If this criterion is not met, no difference is noted in text.</td>
</tr>
</tbody>
</table>
References


5. Integrated care programmes for chronically ill patients: a review of systematic reviews. Ouwens M et al.


10. Australian Bureau of Statistics, Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia – data only, 2011, (Queensland Treasury and Trade derived)


