Wide Bay Hospital and Health Service

Health Service Plan

2022–2037

Queensland Government

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Wide Bay Hospital and Health Service
Health Service Plan 2022-2037

Version control

This version was formally approved by the Wide Bay Hospital and Health Board and Safety and Quality Committee in July 2022.

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Acknowledgement of Traditional Owners

Wide Bay Hospital and Health Service (WBHHS) acknowledges the Traditional Custodians of the land on which we work and live, and recognise their continuing connection to land, water and community. We pay our respects to them and their cultures, and to Elders and leaders past, present and emerging.

WBHHS is committed to delivering health services that acknowledge the Traditional Custodians of the lands and waters on which we work and live. The First Nations people of the Wide Bay, North Burnett and Discovery Coast regions include:

Foreword from Chief Executive and Board Chair

The WBHHS *Health Service Plan (HSP) 2022–2037* offers a sustainable footprint for our region as it experiences key demographic challenges and the ongoing escalation in demand for public health care from its population.

The HSP outlines how WBHHS can future-proof its services in this environment. It is a consultative document that has been developed through extensive engagement with our staff, community and key private and non-government organisation partners. This consultation means the HSP draws on the knowledge of our staff and reflects the needs of our community. It has assessed the key drivers of demand across the health service, reviewed its impact on the local health system and considered future projections for the region.

While the HSP aligns closely with the intent of the *WBHHS Strategic Plan 2022-2026*, it is not a document that looks at short to medium term solutions. Instead, it looks at the longer term and provides a foundation for the delivery of safe, sustainable and accessible health services now and into the future. It looks at how the challenges of the future can be met by addressing current gaps in service delivery and the burden of disease within our communities by drawing on contemporary models of care, technology, partnerships, workforce and infrastructure enhancements. It is also committed to ensuring care is provided in the most appropriate setting for the patient.

Contextually, WBHHS has significant service and infrastructure needs with a new Bundaberg Hospital Detailed Business Case (DBC) completed in 2022 to fit out the shell space above the Hervey Bay Hospital emergency department that will accommodate 35 beds. While the HSP provides an evidence-based approach to our region's health infrastructure needs, it also provides WBHHS with a clear vision for how its care to patients can evolve while remaining true to our values of Collaboration, Accountability, Respect, Excellence, and Through patients' eyes (C.A.R.E. through patients' eyes).

My pledge and commitment as Chief Executive is to strongly advocate for equitable and enhanced health services and associated infrastructure to address the burden of disease across Wide Bay, North Burnett and the Discovery Coast and to meet staff and community needs both now and in the future.

Debbie Carroll
Chief Executive
Wide Bay Hospital and Health Service

The *Health Service Plan (HSP) 2022-2037* provides direction for WBHHS to plan for healthcare services that meet the needs of our community now, and well into the future.

The comprehensive strategy focusses on empowering our talented and professional staff to deliver contemporary, quality and patient-centred care to its community for the next 15 years.

WBHHS faces the challenges posed by the significant burden of disease. This is closely linked to our local population being disadvantaged, both socioeconomically and physically, compared to Queensland as a whole.

This HSP boldly confronts the health service delivery challenges faced by the Wide Bay community by aligning service priorities with the specific burdens of disease faced. The plan will continue to enable WBHHS to adapt to the specific demands that will be placed on it services.

There is a strong commitment to ensuring the WBHHS is continuing to provide equity and accessibility of care across our community – especially in terms to delivering excellent services to older persons, maternity and child health, and to our First Nations community.

Importantly, the HSP establishes how WBHHS will increase accessibility to mental health services, further invest in technology including the accelerated adoption of new virtual care models, work collaboratively with partners to improve the integration of services and strengthen the sustainability of our own workforce. Overall, the HSP is an ambitious yet clear roadmap for building our region's health service.

I wish to acknowledge everyone who contributed during the consultation and development of this plan. The end result is a plan that is a credit to the robust and comprehensive efforts of everyone involved and the Board and I look forward to seeing the plan delivered.

Peta Jamieson
Chair
Wide Bay Hospital and Health Board

Executive summary

Executive summary

The WBHHS *Health Service Plan (HSP) 2022-2037* provides an ambitious roadmap of strategies to be implemented in the next five years, and outlines our longer term 15 year outlook and vision for WBHHS. These service priorities are designed to address the specific burden of disease and community needs within the region now and into the future, and uphold our ongoing commitment to contemporary, quality and sustainable services for our community.

Our environment

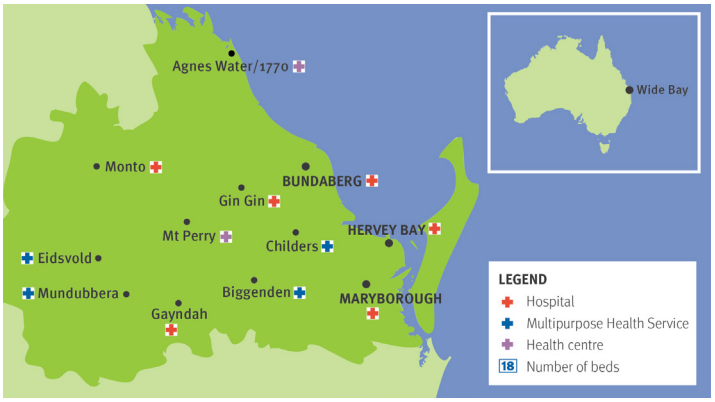
WBHHS's service area covers approximately 37,000 square kilometres, extending along the coast from the southern point of Fraser Island up to the Discovery Coast and inland to the regional towns of Monto, Eidsvold, Mundubbera and Gayndah.

WBHHS is currently operating within a period of significant growth and transformation. The constantly evolving health sector, ongoing disruption associated with COVID-19, advances in treatment and technology, and financial sustainability challenges, reinforce the need for robust and forward focussed health service planning and delivery - that fully leverages the opportunities afforded by strong partnerships across the region.

Despite our significant progress and service enhancements in recent years, we continue to face growing demand for health services, compounded by existing infrastructure and workforce capacity constraints. Key factors driving demand for our health services include:

- **Ageing population** – 25.9% of our population is aged over 65 years (12.8% greater than Queensland), with certain SA2 areas experiencing higher growth rates in the older age groups.
- **Population growth** – the WBHHS population is projected to grow from 219,420 (2019) to 258,112 by 2036. This represents a Compound Annual Growth Rate (CAGR) of 0.96% percent.
- **Socio-economic disadvantage** – over half of the population falls within the most disadvantaged quintile. This can influence healthcare access across the region, as only 35% of Queenslanders in the most disadvantaged quintile have private health insurance.
- **Burden of disease** – 31% of WBHHS adults were obese in 2015-16 compared to 25% for Qld.
- **Causes of death** – the top five causes of death in Wide Bay in 2016-17 were lifestyle related chronic conditions, malignant neoplasms, diseases of circulatory system, coronary heart disease and diseases of respiratory system.
- **Self-sufficiency** – in 2021, 9,819 separations for Wide Bay residents were delivered outside of the HHS, representing a regional self-sufficiency of 84%.
- **Increasing demand for services** – demand for inpatient health services is projected to grow at a rate more than four times the population growth (4% versus 1%).
- **Limited capacity to continue to expand services** –On any planning methodology, Bundaberg and Maryborough have insufficient beds to meet demand. Limited additional capacity presents challenges in implementing transform and optimise measures to reduce bed growth needs.
- **Patient flow, outcomes and experience** is impacted within our facilities, as evidenced by frequent capacity alerts.

Figure 1. Map of WBHHS catchment and facilities



Executive summary

Extensive staff and community consultation was undertaken (reaching over 410 WBHHS stakeholders) to validate and contextualise the evidence developed as part of the HSP planning process. A variety of service delivery challenges were identified through stakeholder consultation:

- External factors influencing service provision and prioritisation of improvement activities
- Primary and community care service gaps impact WBHHS demand, including constrained access to bulk billing GP services
- Workforce capacity constraints requiring targeted effort to build assurance on workforce pipeline and sustainability
- Siloed services and disjointed planning require improved coordination across Wide Bay
- Providing more care in the most appropriate setting
- Need for greater digital capabilities across the spectrum of service delivery
- An ageing population, increased chronic disease prevalence and socioeconomic disadvantage
- Patient flow challenges are underpinned by demand-capacity curve imbalance
- Mental health services are under significant demand pressure
- Self-sufficiency is limited and many residents travel long distances to access services.

Following this extensive consultation and analysis, the HSP identifies five key service priorities and corresponding strategies to future proof our health service. Strategies have been designed and targeted to reflect key drivers of local service demand, analysis of current trends and patient flows, and a view of WBHHS roles and responsibilities within the broader local health system.

Figure 1. WBHHS Health Service Plan development process.

1. Strengthen foundations to optimise and transform

We will increase coordination and agility across our network of services to grow self-sufficiency, capacity and capability to meet local demand.

2. Ensure equity and accessibility of care across our community

We will increase contemporise our services based on best practice models of care to ensure patient access to timely care and sustainability of our health service.

3. Embed technology to bolster sustainable and targeted service models

We will create a sustainable, future-focused health service through accelerating adoption of technology to enable more efficient more efficient delivery of health services.

4. Foster genuine partnerships to drive seamless service integration

We will unlock opportunities for WBHHS and our patients through greater coordination and integration of services with our partners.

5. Nurture and future-proof workforce

We will fully leverage our pool of talent and capabilities to provide assurance in the delivery of sustainable, evidence-based care for our patients.

Implementation

This Plan has been developed in conjunction with our *Local Area Needs Assessment (LANA)* and *WBHHS Strategic Plan 2022-2026*. Integration of these important strategic documents will ensure alignment and clarity of focus as we target priority areas to set the service up for success in delivering contemporary, quality and sustainable services for our community.

We are committed to delivering our service priorities and actions to ensure we are investing in initiatives that are effective and driving improved community health outcomes. This plan outlines a roadmap of action to address key challenges and increasing demand for our services now, and leverages opportunities to continue our journey of transformation and optimisation into the future.

Summary of key service priorities and strategies

Multiple strategies have been identified and mapped to each key service priority

1. Strengthen foundations to optimise and transform

1.1. Identify alternative service delivery settings for subacute patients, to increase bed capacity and provide care closer to home.

1.2. Review our interim demand and bed management strategy to ensure we meet the needs of the community, whilst we are at capacity and awaiting new infrastructure.

1.3. Clearly define the roles and purpose of each facility within WBHHS to optimise the existing service network capacity (including shifting services between facilities, strengthening interface points, and rural site optimisation).

1.4. Pursuit of 'best and most effective use' of our rural facilities and services to provide care closer to home.

1.5. Implement an end-to-end patient flow optimisation strategy.

1.6. Improve communication, coordination, and integration between Bundaberg, Hervey Bay, Maryborough Hospitals and Rural facilities.

1.7. Develop clear and standardised clinical pathways across WBHHS services, including protocols for direct admission and criteria-led discharge.

1.8. Develop targeted hospital pathways for NDIS eligible patients to facilitate discharge when clinically appropriate that reduces unnecessary prolonged hospital length of stay.

1.9. Develop and keep updated an *Infectious Diseases Outbreak Management Plan* and associated supporting materials to ensure WBHHS is well prepared to deal with this on an ongoing basis.

1.10. Develop and implement strategies that target reduction in our high volume of hospital readmissions.

1.11. Review the WBHHS existing built capacity to identify what spaces can be configured to provide additional bed capacity across the network.

1.12. Continue to plan and invest in future infrastructure, focusing on sustainable growth of existing capacity to deliver quality services locally.

1.13. Complete a detailed business case in 2022 for the design, construction, and fit-out of the cold shell in Hervey Bay Hospital Level 2 (Emergency Building).

1.14. Undertake forward planning aligned with the *WBHHS Master Plan* through development of strategic asset master plans for all facilities.

1.15. Continue the planning process for a new Bundaberg Hospital which will also be critically important to achieving an uplift in acuity of services provided for Wide Bay.

1.16. Prepare a detailed service plan and infrastructure business case for Agnes Water.

Summary of key service priorities and strategies

Multiple strategies have been identified and mapped to each key service priority

2. Ensure equity and accessibility of care across our community

2.1. Improve our patients' experience in navigating health services at WBHHS, including at interface points with home and community care.

2.2. Introduce new medical subspecialties to increase the self-sufficiency of WBHHS to facilitate care closer to home.

2.3. Develop a formal strategy for visiting outreach services to improve coordination and access across our communities.

2.4. Provide consistent subacute care closer to home for all of our WBHHS residents, especially residents who live outside of Bundaberg and Hervey Bay.

2.5. Standardise our approach to step down services across WBHHS.

2.6. Proactively shift health services to ambulatory settings where clinically appropriate.

2.7. Scale our Hospital in the Home (HiTH) service.

2.8. Improve chronic disease management through scaling of the integrated care service model.

2.9. Develop partnerships across the system to adopt a rigorous and comprehensive approach to strategic evaluation of models of care.

2.10. Implement a Geriatrician led team focusing on all presentations from aged care facilities as well as older people from the community who are identified as frail.

2.11. Extend the Geriatric Evaluation and Management model of care to include person enablement and rehabilitation for complex health conditions (OPEN ARCH).

2.12. Introduce a Geriatric evaluation and management in the home (GiTH) service to deliver care packages at home and support elderly patients.

2.13. Increase transition care packages (TCP) available to provide short term care to optimise the functioning and independence of older people following hospital discharge.

2.14. Implement a specialist palliative care rural telehealth service.

2.15. Adopt a consistent approach to palliative and end of life care that is close to home.

2.16. Develop and implement the *WBHHS Health Equity Strategy* in 2022, and review on a three yearly cycle going forward.

2.17. Develop targeted culturally appropriate responses to address high burden of disease in the Aboriginal and Torres Strait Islander community.

2.18. Increase access to child development services for children in WBHHS in partnership with primary health and community service providers.

2.19. Undertake a review of our paediatric outpatient clinic service ability to meet local demand.

2.20. Implement targeted care coordination initiatives to enable our patients with a disability to have equitable access and participation in their own healthcare journey.

2.21. Act on mental health, suicide prevention and alcohol and other drugs *Wide Bay Joint Regional Plan 2020-25*.

2.22. Implement initiatives of the *Mental Health Alcohol and Other Drugs Five Year Plan* within the region.

2.23. Implement the priorities of the *Fifth National Mental Health and Suicide Prevention Plan* and the *National Drug Strategy* within the region.

2.24. Plan and implement mental health and suicide prevention services within a stepped care framework.

Summary of key service priorities and strategies

Multiple strategies have been identified and mapped to each key service priority

3. Embed technology to bolster sustainable and targeted service models

3.1. Develop an ambitious virtual care agenda that aligns with the *Queensland Health Virtual Healthcare Strategy (2020).*

3.2. Leverage the opportunities presented by technology advancements system-wide, and modernise for a digital hospital.

3.3. Systematically address key barriers to technology adoption by WBHHS staff, our patients and key stakeholders.

3.4. Define a WBHHS model of care for telehealth that is regularly reviewed and aligns with the *Qld Telehealth Strategy (2021-26).*

3.5. Identify priority Tier 2 clinics and other services for immediate expansion of telehealth models where clinically appropriate.

3.6. Establish Virtual Emergency Department and virtual ward models of care.

3.7. Optimise communication between WBHHS and our health and human service partners through interoperable digital platforms.

3.8. Uplift business intelligence through accurate and predictive performance insights.

4. Foster genuine partnerships to drive seamless service integration

4.1. Strengthen existing partnerships to reduce duplication and address service delivery gaps through targeted investment in local health priorities.

4.2. Develop and implement a strategy to enhance health literacy of patients and carers to support self management.

4.3. Leverage partnerships to develop joint, future-focussed, translational research strategy.

4.4. Implement integrated models of governing and commissioning our region's services to deliver better results with existing resources.

4.5. Develop effective partnerships to support our aging population.

4.6. Scale effective partnership models to other priority cohorts, targeting hospital avoidance.

5. Nurture and future-proof workforce

Quality

5.1. Maximise the individual potential of our staff through providing opportunities for learning, development and career progression.

5.2. Adopt multidisciplinary team based workforce models with a focus on enhanced integration of the allied health workforce.

5.3. Pursue partnerships with universities locally, elsewhere in Australia and worldwide.

5.4 Review of fractional staff positions at rural sites.

Access

5.5. Target and grow workforce capabilities aligned with areas of emerging demand and retention strategies to sustain subspecialty models.

5.6. Adopt creative approaches to use limited workforce, including workforce sharing or co- commissioning models.

5.7. Build HHS workforce capacity and capabilities to meet needs of specific target cohorts.

Sustainability

5.8. Adopt a system-wide focus to support the viability of the health workforce across Wide Bay.

5.9. Strengthen existing partnerships with local education providers to support increased workforce training and immersive placements, including the Regional Medical Pathway.

5.10. Support succession planning to ensure a continuous pipeline of strong clinical leaders.

5.11. Create a culture where all of our staff feel safe and supported to deliver patient centred care.

5.12. Establish a regular cycle of WBHHS workforce planning with targeted strategies.

Background and purpose

Background and purpose

This HSP provides an ambitious roadmap of strategies to be targeted in the next five years, and outlines our longer term 15 year outlook and vision for WBHHS.

The WBHHS *Health Service Plan (HSP) 2022-2037* provides an ambitious roadmap of strategic service priorities over the next fifteen years. These service priorities are designed to address the specific burden of disease and community needs within the region now and into the future, and uphold our ongoing commitment to contemporary, quality and sustainable services for our community.

Our environment

WBHHS is currently operating within a period of significant growth and transformation. The constantly evolving health sector, ongoing disruption associated with COVID-19, advances in treatment and technology, and financial sustainability challenges, reinforce the need for robust and forward focussed clinical service planning and delivery - that fully leverages the opportunities afforded by strong partnerships across the region.

The HSP has been developed within this broader context and in conjunction with our *Local Area Needs Assessment (LANA)*. The LANA enables WBHHS to better understand current and future community health needs, supporting the design and implementation of services that are safe, effective and efficient, and setting the service up for success as we embark on new infrastructure and service opportunities to meet the needs of our population.

The journey to a future-proofed Health Service Plan

Extensive staff and community consultation was undertaken to validate and contextualise the evidence developed as part of the HSP planning process. Consultation identified strategies, key enablers and implementation considerations - reaching over **410 WBHHS stakeholders** including:

Online survey – 92 responses from consumers, multiple responses from external partners and 110 responses from staff

2 major showcases at Bundaberg and Hervey Bay Hospitals reaching over 55 staff.

Targeted consultation meetings with external stakeholders including Regional Councils, CQWBSC PHN, Discovery Coast Consumer Reference Group.

38 focus groups across all facilities reaching **more than 150 staff.**

Building the case for change - the approach

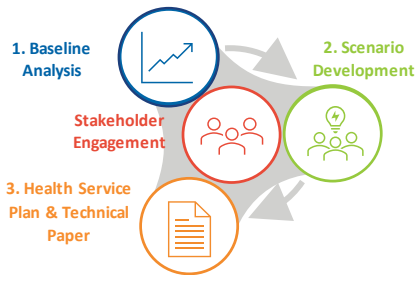
Strategies have been designed and targeted to reflect key drivers of local service demand, analysis of current trends and patient flows, and a view of WBHHS role and responsibilities within the broader local health system. The evidence developed as part of this plan includes:

- Population demographic profile across the various planning regions to identify key areas of growth, where certain patient cohorts are expected to grow, and socio-economic profiles
- Risk factors across the population that are associated with poor health and impact on demand for services
- Burden of disease reflected through the profile of chronic disease and admission rates for key conditions across each planning region
- Activity trends that showcase the historical and forecast activity trends for inpatient, outpatient and emergency departments to understand potential future pressure areas
- Patient flows between services, including services for which WBHHS residents travel outside of the region, or between facilities.

With Census results expected to be released in late 2022, there is an opportunity to ensure the population and burden of disease data is updated to reflect any recent changes and ensure that the strategies identified in this plan target priorities for the WBHHS community. WBHHS acknowledges the importance of consumer input to identify and validate health and service needs and guide our planning processes. As such we will continue to deploy strategies to ensure ongoing engagement with this important stakeholder group, including co-design of solutions to challenges identified within this Plan.

A HSP project steering committee (consisting of WBHHS Executives and senior staff) provided guidance and assurance over the approach to development of the Health Service Plan.

Figure 2. Health Service Plan development process.



Background and purpose

The HSP sets a clear vision for the delivery of safe and sustainable services in our HHS over the next 15 years.

Prioritisation process

A structured approach to prioritisation of health service needs was adopted. A health needs prioritisation session was conducted with the WBHHS Project Steering Committee (PSC) tasked with overseeing the development of the *WBHHS Health Service Plan* and *Local Area Needs Assessment*.

A short-list of 'health needs' and 'health service needs' were presented, and utilising the structure recommended within the LANA development framework these needs were assessed and ranked against key criteria.

Alignment with system and service strategies

The HSP aligns with the *WBHHS Strategic Plan 2022-2026*, and a variety of broader system strategies and policies, including the Queensland System Priorities.

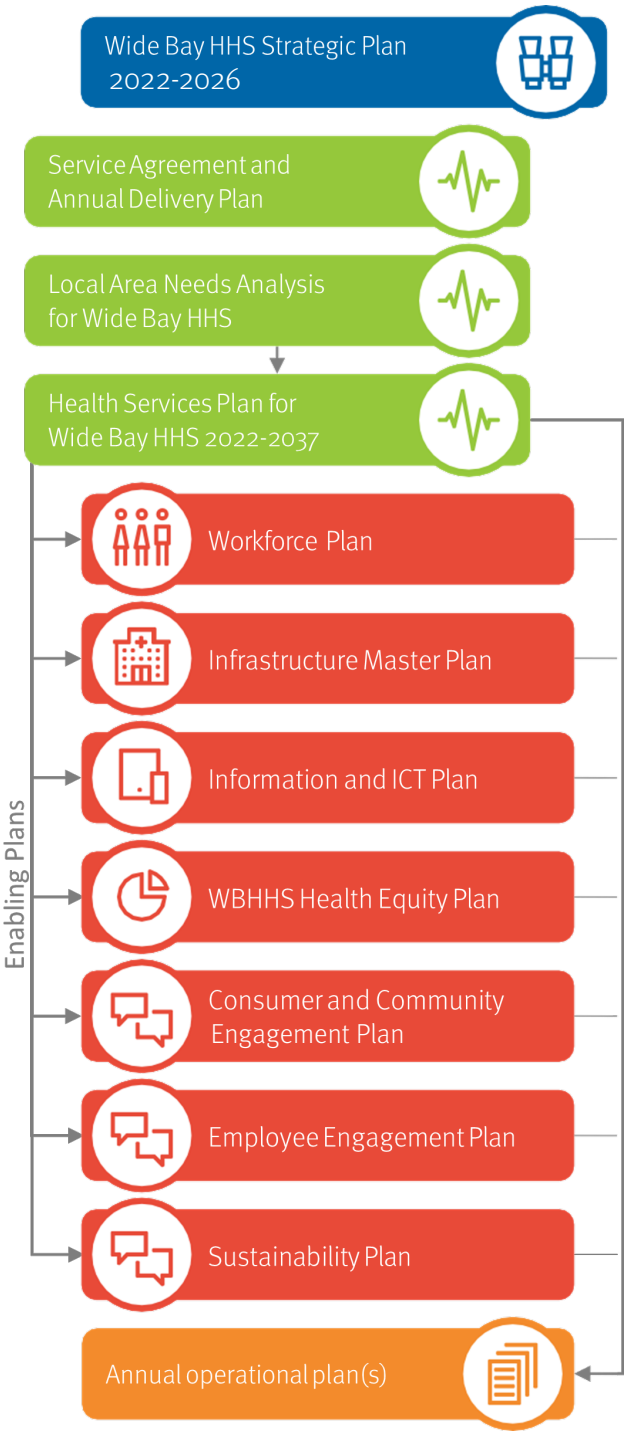
A series of enabling plans (see Figure 3.) will be, or are in the process of being developed to support the priorities and actions that have been identified in the HSP. These plans will provide a more detailed blueprint in key areas for how we will deliver the priorities outlined in the HSP.

Our guiding principles

This service plan is underpinned by guiding principles to ensure development of patient- centred, contemporary and effective strategies:

- People-centred care: focus on improving outcomes for individuals, families, communities and the sector by valuing individuals experiences and engagement
- Equity: recognise the need for equitable access to services that are culturally sensitive, appropriate and safe
- Evidence based models of care underpinned by a focus on safety and quality
- Resources are used sustainably and in alignment with strategic imperatives
- Continuous improvement and growth: address our regions needs through optimisation, transformation, and challenging the status quo.

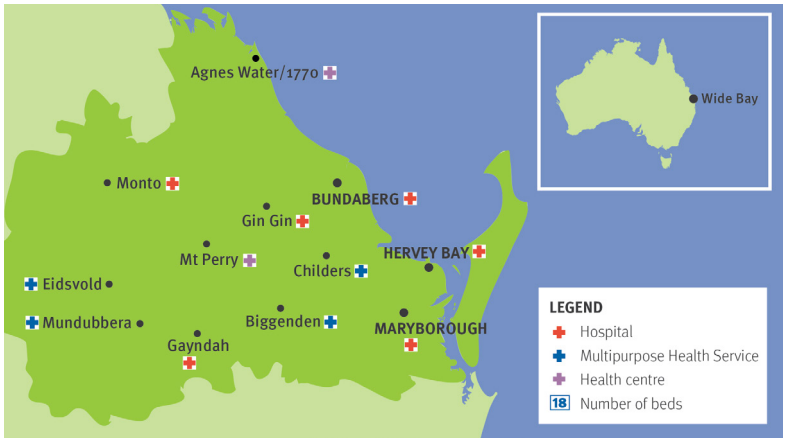
Figure 3. The Health Service Plan is supported by a range of plans which build on the directions and priorities outlined in the Plan.



Population health trends

The region

The Wide Bay catchment is comprised of a growing and ageing population covering the Discovery Coast, Bundaberg, Fraser Coast and North Burnett regions.



The **population of Wide Bay HHS** is **219,420** (Queensland population is 5,094,510).

The region has **grown by 0.7% annually** from 2011-2019 (Queensland growth is 1.5%).

The three largest population centres (by SA3) are: **Bundaberg** (90,687), **Hervey Bay** (60,305) and **Maryborough** (46,416).

Population health trends

By 2036, the **population** is expected to reach **258,112**, representing a **CAGR of 0.96%** (Queensland 6,686,604 and 1.61%)

Aboriginal and Torres Strait Islander peoples comprise 5.3% of the population (Queensland, 4.0%)

Total population

	Children (0-14)	Adults (15-64)	Older persons (65+)
Wide Bay	17.0%	57.1%	25.9%
Qld	19.4%	64.9%	15.7%

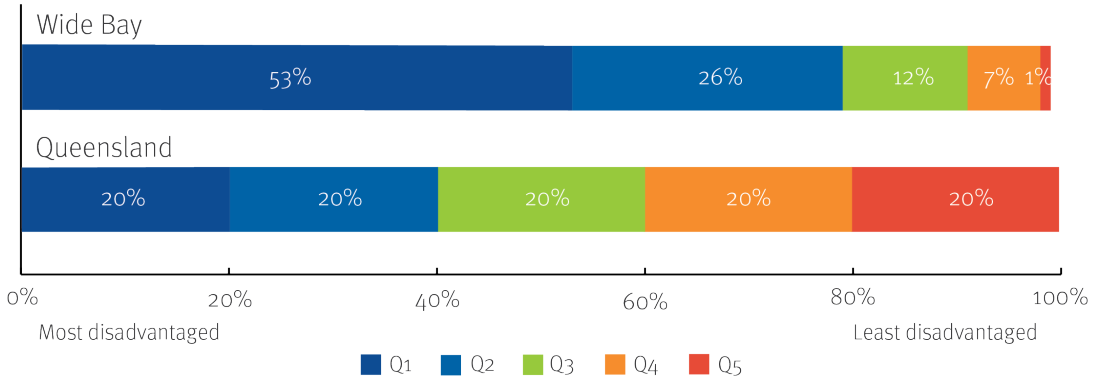
Aboriginal and Torres Strait Islander population

	Children (0-14)	Adults (15-64)	Older persons (65+)
Wide Bay	37.2%	45.6%	17.2%
Qld	34.7%	49.6%	15.7%

Data source for this page: ERP: Queensland Government Statistician's Office (QGSO) – ABS consultancy for QGSO, September 2020.

Social determinants of health

The Wide Bay region experiences far greater rates of socio-economic disadvantage in comparison to the Queensland average. Over half of the population falls within the most disadvantaged quintile. Health care access for lower socioeconomic areas is compounded by the fact that only 35% of Queenslanders in Q1 have private health insurance.



Only **34% finished year 12,** compared to 52.2% of Queenslanders

Rental stress * is over 38% among low income households (Queensland, 28%)
*Spending >30% of gross income on rent

Over 26% of households earn less than $33,800 per year
(Queensland, 17.5%)

The unemployment rate is 11.1%, compared to 7.3% in Queensland

More than **6,000 people face barriers to accessing healthcare***.
The ASR is highest (6 per 100 people) in Hervey Bay. Barriers to accessing healthcare are self reported and can relate to individual or structural barries.

More than **1 in 3 children are developmentally vulnerable,** compared to 1 in 4 across Queensland

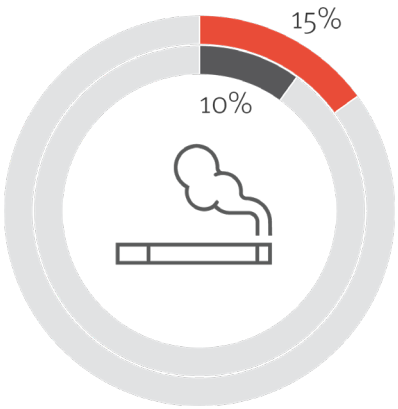
Data source: Australian Bureau of Statistics, 2020. Small Area Labour Markets, 2021. PHIDU, 2018 and PHIDU, 2014.

Health-specific risks and behaviours

Risk factors

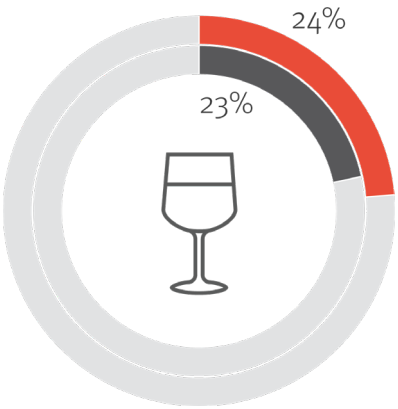
When compared to Queensland and other Qld HHSs, WBHHS has a higher prevalence of a range of health risk factors such as high alcohol consumption, smoking and obesity.

Tobacco



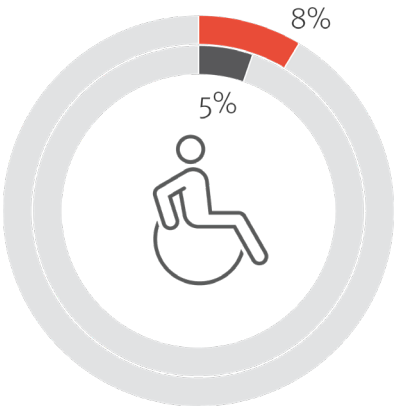
15% of WBHHS adults were **daily smokers** in 2017 - 2018, compared to 10% for Queensland

Alcohol



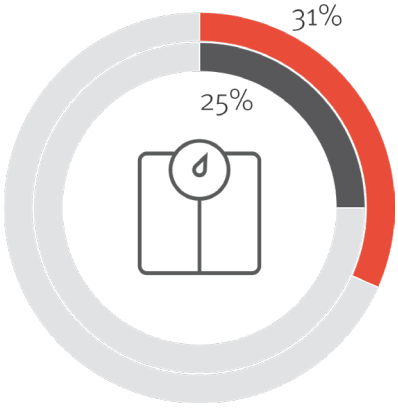
24% of WBHHS adults were **risky drinkers** in 2017 - 2018, compared to 23% for Queensland

Disability



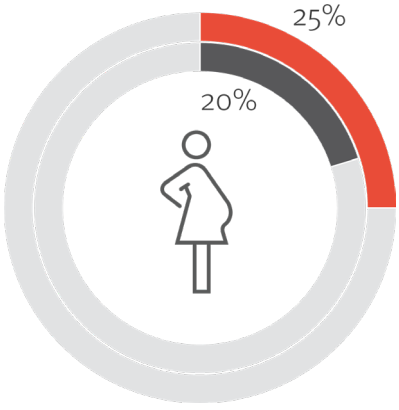
8% of WBHHS residents were living with a **profound disability** in 2017 - 2018, compared to 5% for Queensland

Obesity



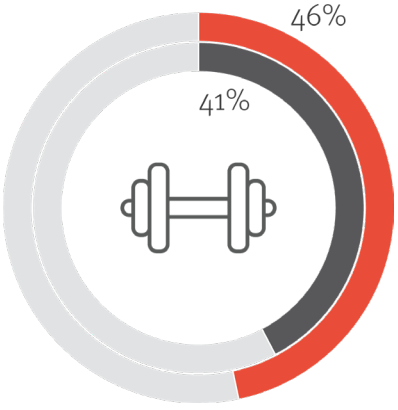
31% of WBHHS adults were **obese** in 2017 - 2018, compared to 25% for Queensland

Obesity during pregnancy



25% of WBHHS mothers were **obese during pregnancy** in 2017 - 2018, compared to 20% for Queensland

Physical activity



46% of WBHHS adults engaged in **insufficient physical activity** in 2017 - 2018, compared to 41% for Queensland

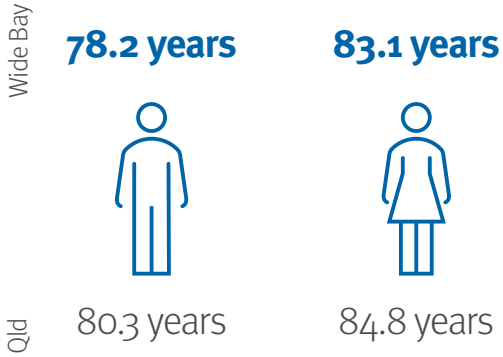
WBHHS Queensland

Data sources: Based on Public Health Information Development Unit (PHIDU). Published 2021.

Health status

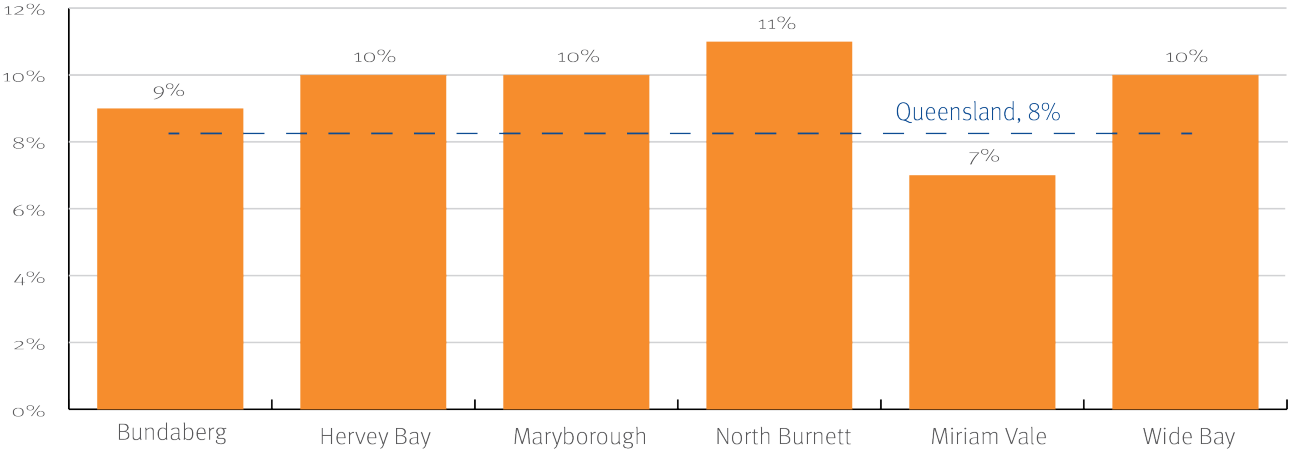
Wide Bay residents live 2 years less than the average Queenslander.

80.6 years



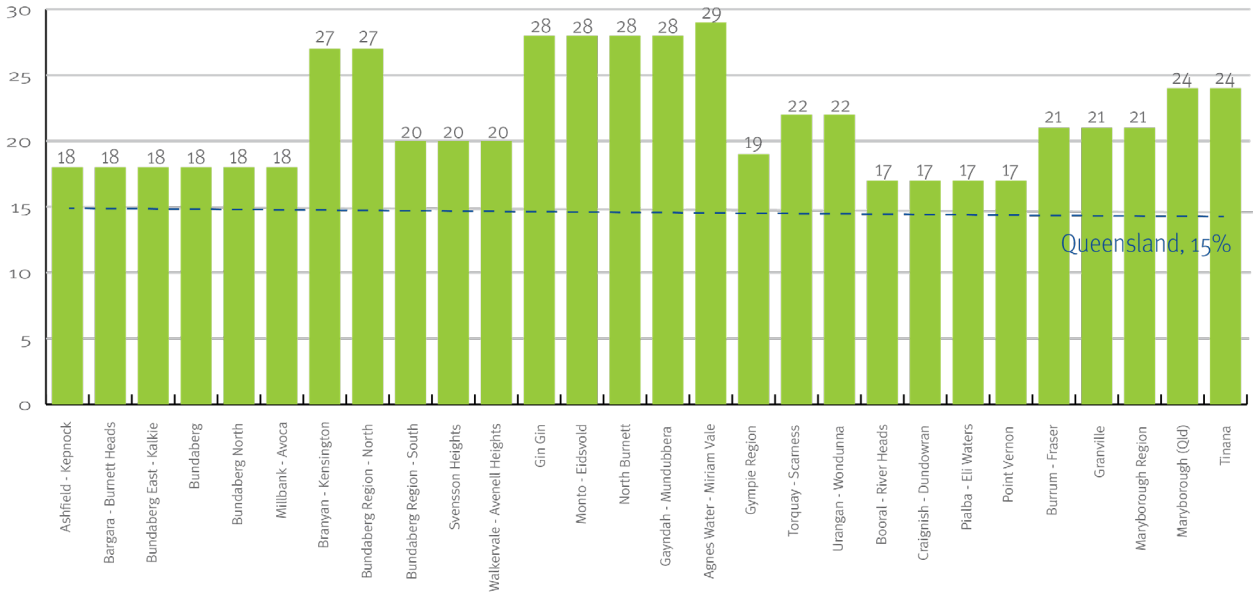
Potentially Preventable Hospitalisations (PPH) are higher in Wide Bay (with the exception of Miriam Vale that may be captured in CQHHS data) compared to Qld average.

Figure 4. Potentially Preventable Hospitalisations across WBHHS facilities compared to Queensland (FY21)..



Rates of suicide in Wide Bay were higher than the state average (15 per 100,000) in every SA2. The areas where residents are most at risk of suicide are Agnes Water – Miriam Vale, Gin Gin, Monto – Eidsvold, North Burnett and Gayndah – Mundubbera.

Figure 5. Age standardised rates of suicide as premature cause of death across Wide Bay (2014-2018).



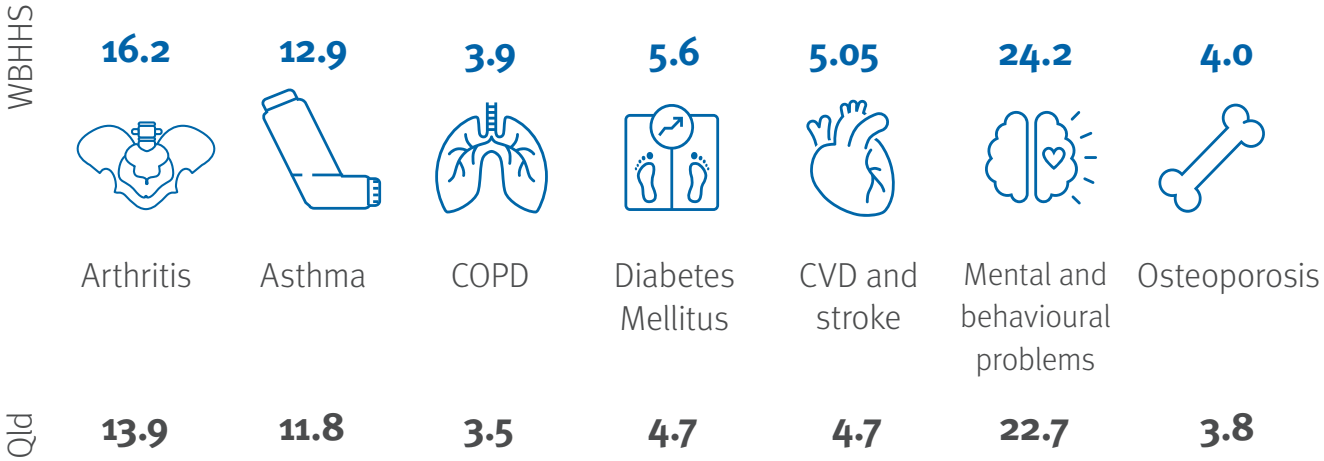
Data sources: Based on Public Health Information Development Unit (PHIDU). Published 2021

Health status

Chronic diseases

When compared to Queensland, WBHHS has a higher prevalence of a range of chronic diseases such as high levels of mental and behavioural problems, arthritis, and asthma.

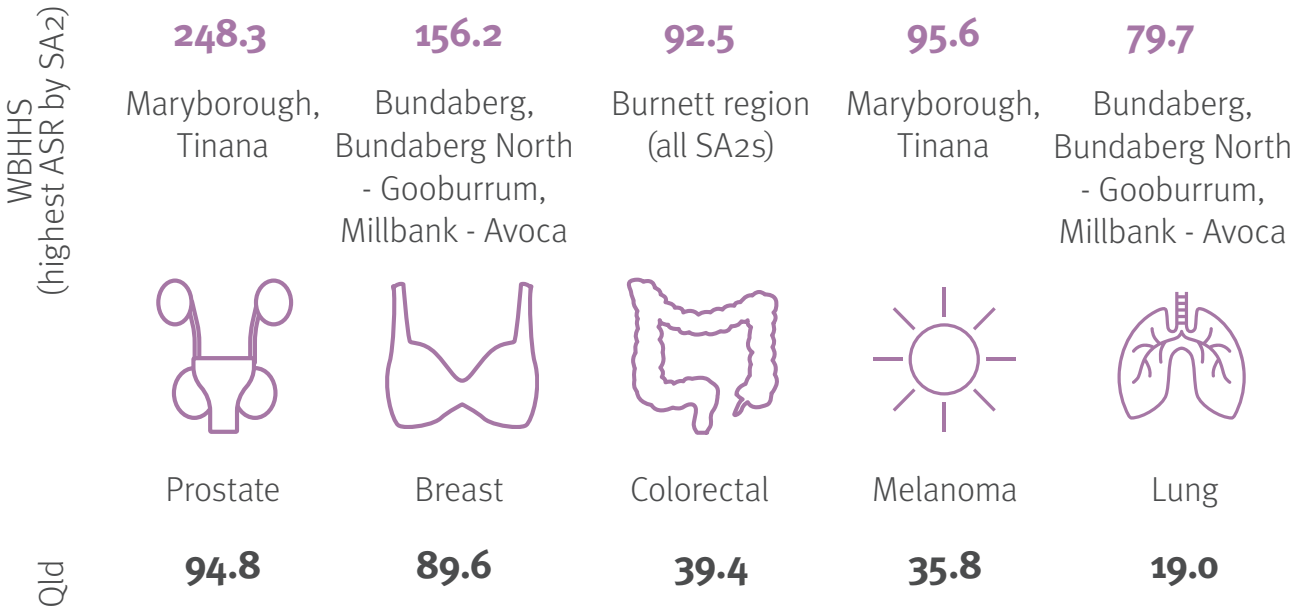
Figure 6. Age standardised rate (per 100,000) for select chronic diseases in Wide Bay (median) and Qld (2010-14)



Cancer incidence

The five most common types of cancer within Wide Bay are prostate, breast, colorectal, lung and skin melanoma cancers. All Wide Bay SA2 areas had significantly higher rates of these cancer types (ASR per 100,000) than the Queensland average, and in many cases occurred at rates more than double the Queensland average.

Figure 7. Highest rates of cancer incidence across WBHHS (by SA2) compared to Queensland by type of cancer.



Data sources: Based on Public Health Information Development Unit (PHIDU). Published 2021.

Current service trends

Overview of service access and utilisation

Outpatient and emergency department activity has grown across WBHHS, with inpatient separations remaining steady, despite the impact due to COVID-19.

Inpatient separations (excluding unqualified neonates and mental health activity) have decreased slightly from 2019 to 2021, with an annual growth rate of -0.2%. Decrease in separations is likely a result of both direct and indirect impacts of the COVID-19 pandemic, particularly the cancellation of elective surgeries for a number of months in 2020. Despite the decrease in separations, bed days have increased by 4.6% annually over this same period, with patients staying in hospital longer. Consultation identified the following causes: discharge delays (e.g. awaiting nursing home placement and NDIS support packages), increase in complex cases, and hospital- wide patient flow challenges.

Outpatient activity increased over the same two-year period, growing at an annual rate of 1.3%.

Total presentations to the emergency department increased by 3.9% annually from 2019 to2021, with the largest growth seen in triage categories 2 and 5. Increasing category 5 presentations indicates there may be some potentially preventable presentations and is likely influenced by primary care capacity constraints locally and consumer expectations of immediate service.

Inpatient activity

Table 1. WBHHS historical activity 2019 to 2021.

Measure	2019	2020	2021	CAGR		
				2019-2020	2020-2021	2019-2021
Separations	78,888	80,310	78,518	1.8%	-2.2%	-0.2%
Bed days	189,176	199,647	202,651	5.5%	1.5%	3.5%
Overnight length of stay	44	4.6	4.8	6.3%	2.9%	4.6%

Outpatient activity

Measure	2019	2020	2021	CAGR		
				2019-2020	2020-2021	2019-2021
Occasions of service	414,099	430,501	424,476	4.0%	-1.4%	1.3%

Emergency Department activity

Activity	2019	2020	2021	CAGR		
				2019-2020	2020-2021	2019-2021
Category 1	514	614	510	19.5%	-16.9%	-0.4%
Category 2	14,305	15,322	15,867	7.1%	3.6%	5.3%
Category 3	47,105	47,704	49,338	1.3%	3.4%	2.3%
Category 4	50,118	49,642	54,589	-0.9%	10.0%	4.4%
Category 5	9,484	9,607	10,947	1.3%	13.9%	7.4%
Total presentations	**121,529**	**122,889**	**131,251**	**1.1%**	**6.8%**	**3.9%**

Inpatient service access and utilisation

Outpatient and emergency department activity has grown across WBHHS, with inpatient separations remaining steady, despite the impact due to COVID-19.

Inpatient activity

Over the past three years, inpatient separations have decreased in WBHHS by 0.2% annually. Over the same period, inpatient bed days have grown by 3.5%. This represents an increase in average length of stay (ALOS) from 4.4 to 4.8 (excluding same day separations).

Of the major facilities, only Hervey Bay Hospital showed positive growth in separations at 2.5% annual growth. Both Bundaberg and Maryborough experienced a decrease in separations, -1.8% and -3.9% respectively. Despite decreasing separations Bundaberg bed days grew by 2.3%. Maryborough bed days decreased by 2.5% and Hervey Bay bed days increased by 6.8%.

Of the rural facilities, Gin Gin Hospital experienced a decline in separations (-4.1%), however bed days at Gin Gin increased by 8.1% annually. Childers Hospital recorded the largest growth in separations, with 12.7% annual growth. Bed days across the rural facilities increased, with the exception of Biggenden and Mundubbera Hospital where the annual fall was 5.2% and 8.7% respectively. Bed days at Gayndah Hospital grew at 50.9% likely partly influenced by an increase in long stay patients and increased complexity.

Table 2. Top 5 ESRG groups by inpatient separations (after renal dialysis and chemotherapy), and corresponding Compound Annual Growth Rate (CAGR) from 2019 to 2021.

Rank	ESRG	Separations			CAGR (2019-2021)
		2019	2020	2021	
1	Other gastroenterology	2,548	2,760	2,579	0.6%
2	Chest pain	2,286	2,491	2,211	-1.7%
3	Other neurology	1,917	1,910	1,814	-2.7%
4	Injuries - non-surgical	1,498	1,567	1,519	0.7%
5	Other orthopaedics - non-surgical	1,521	1,565	1,469	-1.7%

Table 3. Inpatient separations and bed days from 2019 to 2021 by WBHHS facility.*

Facility name	Separations			CAGR (2019-2021)	Bed days			CAGR (2019-2021)
	2019	2020	2021		2019	2020	2021	
Major facilities								
Bundaberg Hospital	35,398	36,014	34,139	-1.8%	71,932	73,271	75,293	2.3%
Hervey Bay Hospital	28,570	29,545	30,022	2.5%	59,822	63,572	68,287	6.8%
Maryborough Hospital	11,449	10,582	10,582	-3.9%	31,283	31,290	29,717	-2.5%
Rural facilities								
Biggenden MPHS	431	468	465	3.9%	1,783	1,703	1,601	-5.2%
Childers MPHS	714	790	907	12.7%	4,324	4,539	4,636	3.5%
Eidsvold MPHS	167	143	173	1.8%	587	622	845	19.9%
Gayndah Hospital	401	464	465	7.7%	893	1,787	2,033	50.9%
Gin Gin Hospital	719	667	661	-4.1%	1,714	1,990	2,004	8.1%
Monto Hospital	670	637	709	2.9%	2,972	3,736	3,641	10.7%
Mundubbera MPHS	338	345	347	1.3%	947	1,074	789	-8.7%
Other facilities	31	34	48	24.4%	12,918	16,063	13,807	3.4%
Total	**78,888**	**80,310**	**78,518**	**-0.2%**	**189,176**	**199,647**	**202,651**	**3.5%**

**Note: Activity numbers do not include separations or bed days for procedural activity (chemotherapy, renal dialysis, endoscopy and interventional cardiology) or mental health. Activity for MPHS facilities is not included.*

Outpatient service access and utilisation

Outpatient and emergency department activity has grown across WBHHS, with inpatient separations remaining steady, despite the impact due to COVID-19.

Outpatient activity

For the whole of WBHHS, outpatient activity had 1.2% growth between 2019 and 2021. Outpatient services at the major facilities have contributed most to this increase. Hervey Bay experienced an annual growth rate of 3.4%, followed by Bundaberg at 2.5% and Hervey Bay at 0.8%. Occasions of service delivered through smaller services and rural facilities decreased by -4.51% annually.

This decrease in outpatient services may be due to workforce availability issues, COVID-19 related consumer behaviour change, changes in the way that outpatient activity is being accessed as well as population decline in rural areas.

The outpatient services accessed most often over the 2019 to 2021 period were orthopaedics, representing over 33,000 occasions of service. Despite being the largest service by volume, orthopaedics occasions of service have declined at a rate of 3.1%.

This is also true for physiotherapy, the second most utilised service with over 23,000 occasions of service which has experienced a 7.1% decline likely due to a reduction of elective surgery in several periods throughout the COVID-19 pandemic.

Table 4. WBHHS Outpatient occasions of service from 2019 to 2021 by facility, including compound annual growth rate (CAGR).

Facility name	Occasions of service			CAGR (2019-2021)
	2019	2020	2021	
Major facilities				
Bundaberg Hospital	159,728	165,920	167,823	2.5%
Hervey Bay Hospital	129,196	137,685	138,076	3.4%
Maryborough Hospital	42,558	41,346	43,251	0.8%
Rural facilities	27,103	27,215	29,081	3.6%
Other facilities	55,514	58,335	46,245	-8.7%
Total	**414,099**	**430,501**	**424,476**	**0.3%**

Table 5. Top 10 Tier 2 clinics by occasions of service volume, including compound annual growth rate (CAGR) from 2019 to 2021.

Rank	Tier 2 code and description	Occasions of service			CAGR (2019-2021)
		2019	2020	2021	
1	20.29 Orthopaedics	36,063	36,018	33,887	-3.1%
2	40.09 Physiotherapy	26,972	26,860	23,288	-7.1%
3	40.28 Midwifery and maternity	21,030	21,804	22,986	4.5%
4	20.07 General surgery	20,577	20,470	21,786	2.9%
5	72.15 Community health services - Child and youth health	19,621	20,552	21,706	5.2%
6	40.07 Pre-admission and pre-anaesthesia	24,565	18,238	18,342	-13.6%
7	20.11 Paediatric medicine	13,966	14,227	14,793	2.9%
8	20.42 Medical oncology (consultation)	10,028	12,995	14,752	21.3%
9	20.38 Gynaecology	11,432	11,598	11,989	2.4%
10	40.58 Hospital avoidance programs	4,448	9,042	11,102	58.0%

Rankings have been determined exclusive of Exclusion codes and COVID-19 Response activity.

Emergency service access and utilisation

Outpatient and emergency department activity has grown across WBHHS, with inpatient separations remaining steady, despite the impact due to COVID-19.

Emergency Department activity

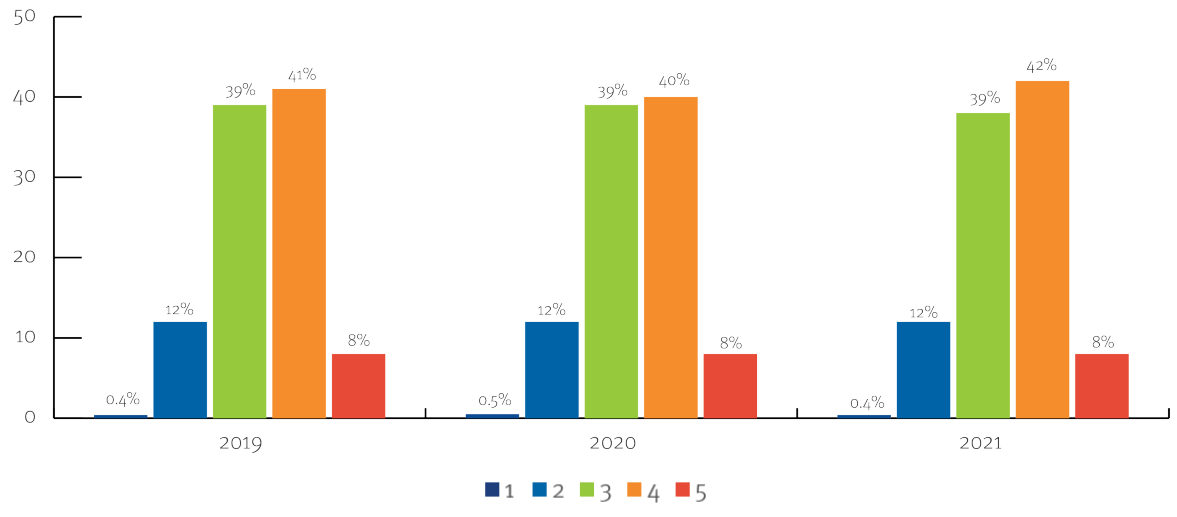
Emergency department presentations across WBHHS have increased by 3.9% from 2019 to 2021. Of the major facilities, Hervey Bay and Maryborough ED presentations each grew at 7.1%, however Bundaberg experienced a decrease in presentations by 0.6%. At the rural facilities, the largest increase in emergency department presentation was at Gayndah Hospital, experiencing an annual growth rate of 25.7%. Presentations also increased at Biggenden Hospital (13.8%), Childers Hospital (13.2%) and Monto Hospital (6.9%). Presentations did decrease at Gin Gin Hospital, Eidsvold Hospital and Mundubbera Hospital.

As a percentage of total presentations across WBHHS, the proportion of presentations per triage category varied minimally over the last three years. Category three and four presentations still make up the vast majority of all emergency department presentations.

Table 6. WBHHS Emergency Department presentations from 2019 to 2021 by facility, including Compound Annual Growth Rate (CAGR).

Facility name	Presentations			CAGR
	2019	2020	2021	
Major facilities				
Bundaberg Hospital	49,740	48,579	49,103	-06%
Hervey Bay Hospital	39,736	40,975	45,595	7.1%
Maryborough Hospital	21,367	22,316	24,501	7.1%
Rural facilities				
Biggenden MPHS	1,045	1,214	1,354	13.8%
Childers MPHS	2,469	2,592	3,162	13.2%
Eidsvold MPHS	523	461	494	-2.8%
Gayndah Hospital	1,101	1,263	1,741	25.7%
Gin Gin Hospital	3,243	3,105	3,080	-2.5%
Monto Hospital	1,206	1,369	1,378	6.9%
Mundubbera MPHS	902	1,015	843	-3.3%
Total	**121,529**	**122,889**	**131,251**	**3.9%**

Figure 7. Total WBHHS Emergency Department presentations from 2019 to 2021 by triage category (1-5).



Demand pressures

WBHHS is experiencing ongoing capacity challenges, with ongoing increase in health service demand.

Care4Qld

The State Government's Care4Queensland (C4Q) Strategy aims to improve emergency access and patient flow through measuring a number of key metrics relating to QAS and HHS state-wide measures.

During October 2021, Maryborough Hospital reported the best overall performance against C4Q measures. Hervey Bay reported less than 70% of patients moved off stretchers in the recommended time, and less than 60% of patients seen within recommended times. Admissions were delayed by an average of 3.5 hours. Whilst POST and delayed admission metrics were slightly better at Bundaberg, just over half of patients were seen in recommended times, and three quarters of patients off stretcher within the recommended times.

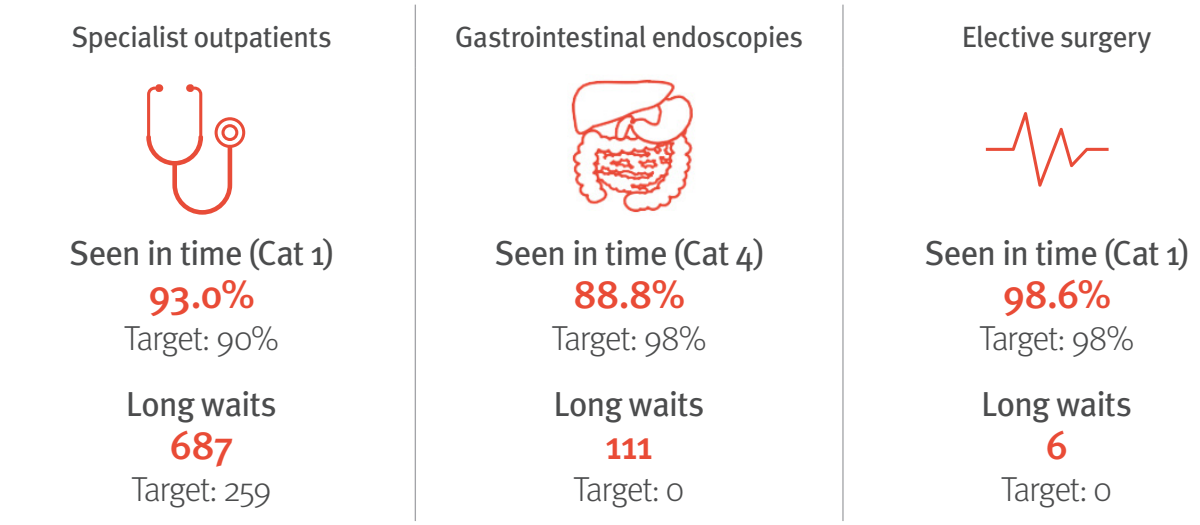
Table 7. Care4Qld Emergency Department performance metrics (October 2021).

	Target	Maryborough	Hervey Bay	Bundaberg
Patients off stretcher within recommended times (POST) (ramp 1 measure)	90%	84.8%	65.7%	74.95%
Patients seen within recommended times (ramp 2 measure)	100%	57.8%	57.4%	52.5%
Delayed admission hours (ramp 3 measure)	-	1.23	3.5	1.83

Wait times

Demand pressures are not isolated to the emergency department, with WBHHS experiencing increasing numbers of long waits for specialist outpatient, gastrointestinal endoscopies and elective surgeries. Whilst the percentage of patients seen in time for Category 1 specialist outpatient and elective surgeries was above target, both had long wait numbers above target. 88.8% of gastrointestinal endoscopies (category 4) were seen in time, below the 98% target, with 111 long waits.

Figure 8. WBHHS wait times and performance metrics (October 2021).



Data source: Wide Bay HHS Performance Report Jan 2022. Specialist Outpatients is based on FYTD Oct 21, Gastrointestinal Endoscopies and Elective Surgery are based on FYTD Dec 21, extracted from SPR.

Demand pressures

WBHHS is experiencing capacity challenges, with ongoing increase in health service demand.

WBHHS is currently experiencing increasing demand pressures due to various factors, including physical infrastructure constraints, funded bed constraints, a growing and ageing local population and limited primary care services. These demand pressures are being compounded by the presence of COVID-19 impacting patient complexity, workforce capacity and delays to some elective services.

Capacity alerts

From February to December 2021 WBHHS facilities experienced 50% of days at capacity alert levels. Capacity levels peaked in June when the health service spent 92% of the month on alert, with 13% of this time at code yellow.

Since June, capacity alerts have been consistent, affecting approximately 63% of the month. In this period, Bundaberg Hospital reached code yellow capacity on 4 days, representing 1.2% of the period, whereas Hervey Bay reached code yellow capacity 23 days, 6.9% of the time. Hospital-wide capacity pressures have directly impacted end to end patient flow (e.g. delayed admission from Emergency Department), impacting patient outcomes and experience.

Table 8. Capacity alert summary (Feb-Dec 2021).

Bundaberg Hospital	Hervey Bay Hospital
4/334 (1.2%) days spent at code yellow (DEM inclusive)	23/334 (6.9%) days spent at code yellow

Figure 9. Percent of month spent at capacity alerts at Hervey Bay Hospital from February to December 2021.

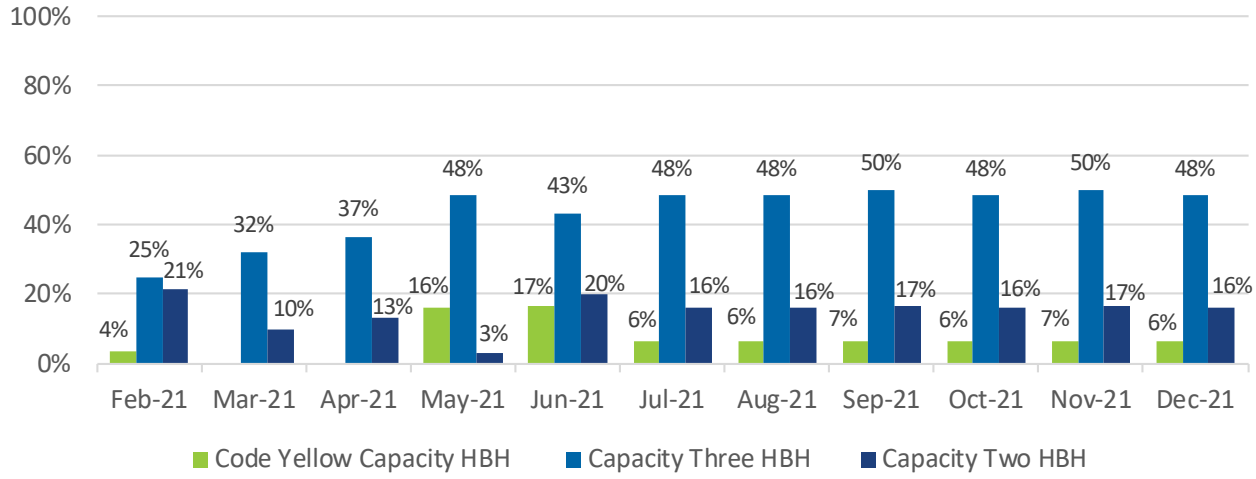
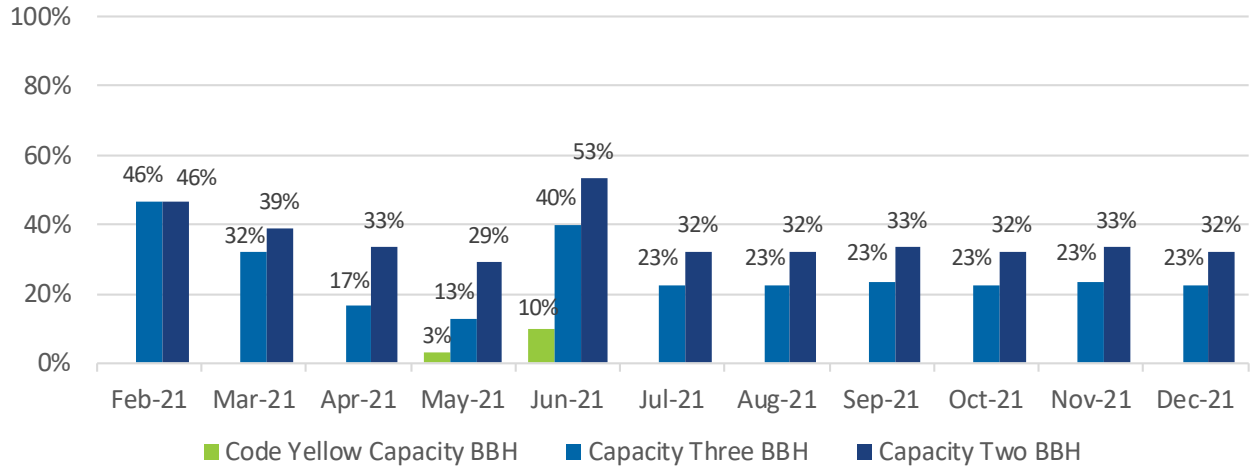


Figure 10. Percent of month spent at capacity alerts at Bundaberg Hospital from February to December 2021.



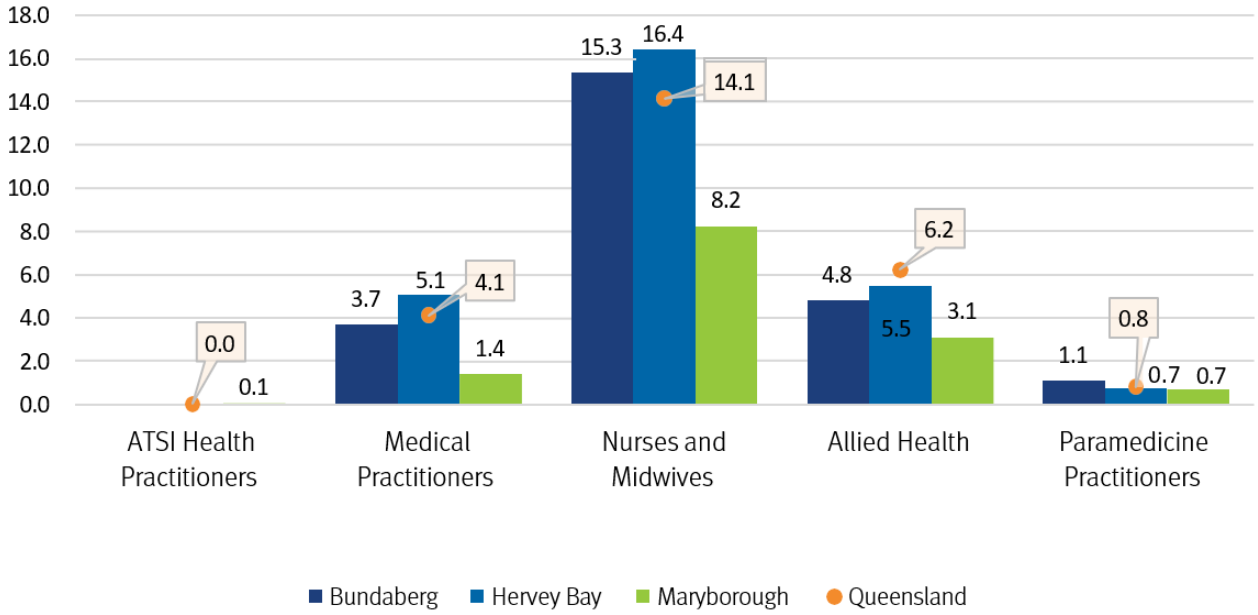
Note that code yellow processes are newly introduced and still being integrated into business as usual processes. Capacity alerts can be in effect concurrently, and are not always mutually exclusive, whereby Level 2 equates to being at capacity and using Flex beds, Level 3 all Flex beds are full and Code Yellow is using over Census beds.

Service access and availability

Workforce and service capacity constraints across the region (including aged, primary, community and acute care), result in missed opportunities for hospital avoidance and preventative measures, and suboptimal service continuity along the patient's journey.

Workforce

Figure 11. Wide Bay workforce per 1,000 population by profession.

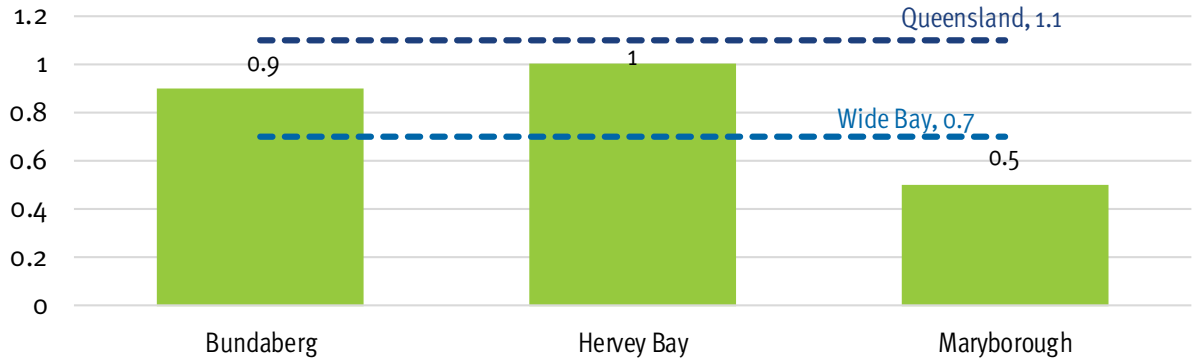


General Practitioners

18% of GPs in Wide Bay are **over the age of 65 years.** This issue is worse in **Maryborough** where **41%** of GPs are **over 65 years.**

Wide Bay has fewer GPs per capita than the required DPA Australian Government benchmark (with the exception of Hervey Bay).

Figure 12. GPs per 1,000 population by SA3.



**Burnett GP figures are recorded within Darling Downs HHS and as such have been excluded from WBHHS totals. *Data sources: Open Data Portal - Commonwealth Department of Health: National Health Workforce Dataset (NHWDS), 2019. Data extracted and prepared March 2021 by Department of Health, Workforce Strategy Branch, WBHHS Infrastructure Data (2021), Department of Health Infrastructure and Planning Guidelines.*

Service needs and issues

Service challenges and opportunities

A variety of service delivery challenges were identified through the Local Area Needs

An ageing population, increased chronic disease prevalence and socioeconomic disadvantage

The Wide Bay community is one of the oldest in the state, and many of our patients are highly complex with multiple morbidities. This is further compounded by a variety of social determinants impacting population health of the region such as socioeconomic and geographical factors creating disparity in health outcomes. This requires targeted changes to models of care to accommodate for the demographic differences and health needs of various regions within WBHHS catchment.

Patient flow challenges are underpinned by demand capacity imbalance

WBHHS services and infrastructure are currently under significant pressure due to the growing demand for services, reflected in capacity alerts across our three main hospital facilities at Bundaberg, Hervey Bay and Maryborough, creating pressure on our Emergency Departments and inpatient wards including challenges flowing patients to other HHSs to access higher level care. There is opportunity to grow virtual care and expand within existing built infrastructure and optimise the use of our network-wide capacity, however longer-term infrastructure solutions will be required as a key service enabler.

Siloed services and disjointed planning require improved coordination across Wide Bay

The large geographic area of WBHHS presents a challenge for providing services closer to home. An appropriate balance needs to be found between providing access to local services and centralising services to ensure quality and sustainability through more cohesive service delivery. There is an opportunity to redirect additional activity from the Bundaberg, Hervey Bay and Maryborough Hospitals to the rural facilities, allowing patients to receive care closer to home. This would, however, require greater coordination and integration of specialist and support services across WBHHS.

Mental health services are under significant demand pressure

There are a variety of social determinants of health influencing our populations risk of developing mental health issues and alcohol and substance abuse. Current services require greater integration with other acute, primary and community care for a seamless patient journey. Our role in supporting and working with partners is integral in building capacity of community mental health services to prevent patient deterioration to the point of requiring crisis support and hospitalisation.

Self-sufficiency is limited and many residents travel long distances to access services

Access to specialist services within the WBHHS region is limited due to several subspecialty gaps, resulting in many patients needing to travel long distances to receive care. For residents who live in North Burnett and the Discovery Coast, accessing care in Bundaberg can be a three hour round trip. There is an unrealised opportunity to grow service capability locally, develop formal relationships, joint and shared service models and patient pathways to ensure seamless access to care when needed from larger tertiary facilities and HHS partners.

Service challenges and opportunities

A variety of service delivery challenges were identified through the Local Area Needs Assessment, stakeholder consultations and data analysis.

Primary and community care service gaps impact WBHHS demand

There are many instances of a siloed approach between primary care, acute care and community services. This leads to missed opportunities for hospital avoidance and preventative measures, and suboptimal service continuity along the patient's journey. Furthermore, workforce and service capacity constraints across the region (including aged, primary, community and acute care), result in WBHHS stepping in to fill the gaps.

Need for greater digital capabilities across the spectrum of service delivery

Across WBHHS, the degree of technology adoption is inconsistent, with no electronic medical records and unreliable access to internet in some regions presenting a unique set of challenges in providing integrated and timely care. There is an opportunity to accelerate adoption of technology to update referral process, intra-facility access to medical reports, improve HHS-wide communication and primary care interfacing, as well as enhance our visibility of real-time performance.

Workforce capacity constraints requiring targeted effort to build assurance on workforce pipeline and sustainability

Recruitment and retention of workforce are major challenges, and are critically important to providing sustainable and specialised services to our community. At rural sites it is difficult to fill fractional staff roles, and workforce capacity constraints limit opportunities for staff upskilling. The capacity to manage patients with behavioural and memory loss issues is limited, with additional staffing required to care for complex patients. Further, the ability to achieve assurance of workforce pipeline is limited as the majority of medical training programs are dependent on SEQ determined rotations. The Regional Medical Pathway is designed to grow our own junior medical workforce, with the first intake of medical students starting in March 2022.

Providing more care in the most appropriate setting

The lack of allied health, nursing and medical workforce providing community-based services significantly limits the potential for patients to have their care provided in a community-based setting rather than a hospital setting. Access to models of care that substitute inpatient subacute care for home-based alternatives are limited by eligibility criteria and the funded places available (e.g. TCP, community palliative care). Furthermore, WBHHS patient flow challenges sometimes impact our ability to support patients in the right environment as part of their treatment and recovery (e.g. flex bed utilisation and medical outliers).

External factors influencing service provision and prioritisation of improvement activities

Fiscal constraints have presented a major challenge for WBHHS over the last financial year, compounded by the COVID-19 pandemic and subsequent changes to healthcare funding. An ever evolving policy environment and newly developed system reform priorities also have the ability to change the direction of WBHHS priorities. Consumer expectations are increasing, with patients wanting access to more efficient and timely care, further driving the need for improvements and innovation.

Operating context - health trends

In addition to our local service needs, there is a range of trends in health care nationally and globally that will continue to inform our planning and service delivery.

Optimisation of current assets

There is a strong focus on ensuring that existing infrastructure assets are optimised in order to delay or stage significant capital investment and also align with the changing consumer expectations of being able to access care outside of the hospital setting.

Acceleration of the digital landscape

New technologies are now available at a fraction of the cost, enabling delivery of new models of care in alternative settings and use of automation and artificial intelligence to achieve efficiencies to deliver high value care.

Demand increase exceeding population growth across the system

The burden of disease and health care utilisation continues to out-pace population growth, requiring targeted action to influence the demand curve. Chronic, complex morbidities and mental illness contribute to service utilisation, reflected in frequent presentations

COVID-19 pandemic

Managing disruptions related to COVID-19, including erratic workforce capacity due to isolation requirements.

Increased financial constraints

While there have been improvements in cost efficiencies and development of targeted financial initiatives, the overall rate of growth in health care spending has been unsustainable across the health care system generally.

Changing consumer expectations

There has been a significant shift to consumer centred and co-designed care models. Consumer preferences have changed, particularly with the use of technology for the convenience of care closer to home.

Climate change

The environment and health care are inextricably linked - with environmental factors impacting population health (e.g., asthma, infectious diseases) and health service operations impacting the environment (e.g., waste management). Opportunities to deliver care in ways that minimise environmental impact without compromising patient safety (e.g., telehelath) should be a priority.

Regulatory and policy requirements

Funding, policy and regulatory requirements from a diverse array of commonwealth and state agencies need to be considered (e.g., National Disability Insurance Agency, Royal Commission into Aged Care Quality and Safety). Additionally, there is evolution of funding towards population based allocation to support equitable funding distribution, including a shift to value and outcome versus traditional volume based funding models.

Our existing service responses to address demand pressures and health need

WBHHS is continuing to implement a range of service transformation and optimisation initiatives.

Bringing Virtual Care to Life	Increasing the use of telecommunications technology across WBHHS, improving access to care and improving sustainability of services.
Outpatient Optimisation	Reviewing and implementing a sustainable and consistent model of care in SOPDs.
Right Patient, Right Place, Right Time	Ensuring early and accurate patient-needs assessment on admission through developing and implementing effective discharge planning processes, optimising patient outcomes and patient flow efficiency.
Choosing Wisely	Reducing low value care practices across the HHS through management of demand and reduction of unnecessary tests, procedures and treatments to patients and expedite patient flow.
Theatre Optimisation	Ensuring flow through theatres is optimised, decreasing delays, starting on time and reducing day of surgery cancellations and increased bed days.
GP Liaison Officer	Working with GPs to ensure that care is received in the most appropriate place, close to home when safe and appropriate to do so.
Renal Nurse Practitioner	Speciality nurse case managing patients with chronic kidney disease and providing outpatient clinic consultations, reducing the need for regular hospital admission.
Optimise Utilisation of Allied Health and Nursing to Expedite Patient Discharge	Supporting the timely and safe discharge of patients using an evidence based and multidisciplinary approach to coordinate patient's inpatient journey, improve equity of access and reduce length of stay.
Healthy Ageing Collaborative	Development of initiatives in partnership with the PHN, local government and NGOs to promote health and wellbeing and injury prevention in the aged population.
First One Thousand Days of Life	Working in partnership with primary and community health organisations to support the foundations for optimum health, growth and development across a person's lifespan and ultimately keeping them out of hospital.
Residential Aged Care Facilities Acute Care Support Service (RaSS)	Delivering options for site of care delivery for Residential Aged Care Facility residents with acute care issues to reduce unnecessary hospital presentations for older persons.
Paving the Way - Cognitive Impairment Model of Care Initiative	Providing a multidisciplinary approach to inpatient care to facilitate hospital avoidance strategies.
Front End Care (Admission Avoidance) Initiative	Increasing front ending of patient care within the ED to optimise patient flow and reduce hospital admissions where safe and suitable to do so.
Aboriginal and Torres Strait Islander People Health Outcomes	Improving health outcomes for our Aboriginal and Torres Strait people through implementation of the *WBHHS Closing the Gap Health Plan*.
Geriatric Emergency Department Intervention (GEDI)	Maximising and fast tracking multidisciplinary decision making for older people with complex needs.
PHN Management of Chronic Disease Cohort	Ensuring patients receive management in the community without having to attend hospital for acute admission.
Integrated Care Alliance Strategic Plan	Facilitating and progressing integrated health care within the Wide Bay for priority populations including avoidance initiatives for people with chronic and complex conditions.
PHN and Mental Health Collaborative	Enhanced management of patients with mental health conditions in the community to reduce the need for inpatient acute beds.

Looking forward

Health system reform and policy context

The HSP has been developed within the broader context of previous planning work undertaken by WBHHS and State and Federal Governments.

The HSP aligns with existing organisational, state, and federal government health policies and strategies, including:

Queensland Health System Priorities, including two which are particularly relevant to the HHSs and the development of the HSP. These are (1) the implementation of rapid access clinics to provide direct access to specialised care, reducing ED attendances and enabling discharge from admitted care, and (2) high-impact patient flow changes using a collaborative approach to optimise length of stay, reduce ED delays and improve inpatient bed access.

Queensland Health System Outlook to 2026 contains strategies to *transform*, *optimise* and *grow* Queensland health services. *Transform* strategies include better support for non-hospital care especially for the frail and elderly, expanded investment in nurse navigators to improve care coordination, an increase in delivery of appropriate care in home and community settings, and improved telehealth access. *Optimise* strategies include innovation in models of care that extend partnerships across the care continuum and strategies to standardise care and reduce variation. *Grow* strategies include optimising the use of rural and remote infrastructure to meet community need, expanding home/community-based services especially for palliative care and rehabilitation, and improved cross-sector partnerships.

Care4Queensland was initiated in 2021 aiming to support unprecedented demand in public hospitals. This included funding for additional bed capacity and deployment of patient flow strategies such as post-acute services, long stay patient discharge and co-responder models.

Queensland Government Making Tracks Investment Strategy provides funds to close the gap in health outcomes for First Nations Australians. The strategy is aligned to the targets outlined in the national Closing the Gap agenda.

Health Equity Strategy has recently become a legislated requirement of the HHSs. The strategy will outline mechanisms for the HHS to address inequities in Aboriginal and Torres Strait Islander health outcomes in their region. This strategy will be completed in 2022.

Digital Strategy for Rural and Remote Healthcare 10 year plan articulates a vision for putting in place the right digital infrastructure, systems and solutions to deliver better patient care for Queensalnd rural and remote patients and integrating that care across the health system.

Queensland Health's Virtual Healthcare Strategy (2020) presents a vision for the way that consumers and providers will access and interact through virtual health care initiatives. Two key priority areas include non-admitted referrals and chronic disease which both present a significant opportunity to reimagine healthcare pathways.

Queensland Health Telehealth Strategy (2021-26) has been jointly developed by Clinical Excellence Queensland (CEQ) and eHealth Queensland, and aims to provide every Queenslander with the opportunity to access healthcare via Telehealth.

Queensland Health's Specialist Outpatient Strategy (2016) outlines actions to improve the patient journey through public specialist outpatient services. The strategy has resulted in state-wide investment in an electronic referral system (Smart Referrals), introduction of clinical decision support tools (Clinical Prioritisation Criteria), and investment in new models of care.

The National Medical Workforce Strategy (2021–2031) guides long-term medical workforce planning across Australia. This strategy identifies achievable, practical actions to build a sustainable highly trained medical workforce.

Health system reform and policy context

The COVID-19 pandemic has had a significant impact on the health system as a whole. Whilst the plan was written taking into consideration the changes in circumstances caused by the pandemic some of the data attained for FY20 and FY21 may be atypical due to the pandemic's impact on clinical service activity.

The Reform Planning Group was established to prepare advice for the Director-General and the then Deputy Premier and Minister for Health and Minister for Ambulance Services on how best to harness the opportunities arising from the COVID-19 pandemic response to support the best possible health and healthcare for Queenslanders. As a result, the **Unleashing Potential Report** was released in February 2022 outlining 17 recommendations focused on key areas to accelerate health system transformation.

Queensland Government implementation of the **National Disability Insurance Scheme (NDIS)** from 2018 added another layer of complexity to a health and disability support system already fragmented by Commonwealth and State funding. Currently, there remains a cohort of patients with complex care needs unable to find adequate service provision in the relatively immature NDIS marketplace. WBHHS subacute services are experiencing difficulties coordinating discharges due to delays in assessment and inflexible system requirements which can delay access to community support.

The Royal Commission into Aged Care Quality and Safety has identified a set of recommendations aimed at improving the consistency and access to aged care services, with a specific focus on greater integration between the Commonwealth and State provided services.

An increased focus on community service provision in the aged care space has led successive Commonwealth governments to expand community support packages accessed through **MyAgedCare.** This has allowed more people to remain at home for longer, with implications for discharge planning for WBHHS and increased transition care requirements as well as flow-on impacts to the acuity of older people accessing residential aged care.

Changing models of care and recognition that many people would prefer to receive palliative care at home led to development of the **National Palliative Care Strategy 2018**. Initiatives include funding to Primary Health Networks (PHNs) to provide more community nursing, funding to provide expanded palliative care services in residential aged care facilities, and development of a national workforce development framework.

Mental Health, Alcohol and Other Drugs Joint Regional Plan (2020-25) combines the resources and knowledge of the local PHN, HHSs (including WBHHS), NGOs, private health providers and consumer representatives. The plan commits to working together in a planned and integrated way to address the region's critical need for services that focus on mental health and alcohol and other drugs.

The Department of Health Fifth National Mental Health and Suicide Prevention Plan (2017) and the corresponding **Department of Health National Drug Strategy (2017-2026)** seek to reform and improve services delivered by HHSs and community agencies for mental health, alcohol and other drug services.

The Qld Connecting care to recovery 2016–2021 plan builds on the vision of **My health, Queensland's future: Advancing health 2026** through supporting the mental, alcohol and other drug system to work better for individuals, their families and communities by strengthening collaboration and more effective integration.

Table 9. WBHHS activity projections

WBHHS	Actual	Baseline projection				Scenario projection			
	2020 / 2021	2026 / 2027	2031 / 2031	2036 / 2037	CAGR (2036/2037)	2026 / 2027	2031 / 2031	2036 / 2037	CAGR (2036/2037)
Inpatient	55,549	75,894	88,131	99,357	3.7%	78,863	97,563	113,842	4.6%
Medical imaging	117,196	131,774	146,126	162,787	2.1%	140,373	163,653	191,407	3.1%
Chemotherapy	4,845	9,239	10,120	10,890	5.2%	9,597	10,763	11,844	5.7%
Dialysis	17,236	22,940	25,573	26,879	2.8%	23,831	27,197	29,235	3.4%
Endoscopy	2,812	9,117	9,727	10,289	8.4%	9,471	10,346	11,196	9.0%
Interventional cardiology	704	1,458	1,586	1,712	5.7%	1,515	1,687	1,862	6.3%
Emergency	131,251	158,156	182,559	205,362	2.8%	164,297	194,155	223,360	3.4%
Outpatient	378,231	276,808	321,666	360,119	-0.3%	443,806	513,708	594,293	2.9%
Mental health	45,572	49,355			8.3%				

Bundaberg Hospital

Current Services

Bundaberg Hospital has 249* beds and bed alternatives excluding ED treatment spaces/beds. It provides CSCF Level 4/5 inpatient, specialist outpatient, and 24-hour emergency department.

Services to Bundaberg, North Burnett and Discovery Coast. The hospital has an ICU/coronary care unit, services in obstetrics, orthopaedics, paediatrics, general medicine, endoscopy, oncology, general surgery, gynaecology, mental health, rehabilitation, palliative care, and renal medicine (including dialysis and surgery). The hospital is supported by onsite medical imaging and pathology services.

Vision

A detailed business case was submitted in 2021 to investigate the delivery of a new Bundaberg Hospital on a new site, to increase capacity and service capability, including an expanded range of services and additional CSCF Level 5 services, and improve operational efficiencies.

Specialist services will provide outreach from Bundaberg to the rest of the HHS, and improve Wide Bay's overall self-sufficiency as well as access to care close to home.

Future Services

Bundaberg Hospital project will invest in subspecialities to increase capacity across WBHHS to deliver services where our community currently has limited or no access.

** as at July 2022.*

Hervey Bay Hospital

Current Services

Hervey Bay Hospital is the largest acute facility in the Fraser Coast region, operating at CSCF Level 4/5 capability with 209* bed and bed alternatives excluding ED treatment spaces and beds. It provides inpatient, outpatient, and 24-hour emergency department services to the Fraser Coast community. The hospital has an ICU/coronary care unit, services in obstetrics, orthopaedics, paediatrics, general medicine, endoscopy oncology, general surgery, gynaecology, community mental health, rehabilitation, and renal medicine (including dialysis and surgery). The hospital is supported by onsite medical imaging (X-ray) and pathology services.

Vision

Hervey Bay Hospital will be the main referral centre for services in the Fraser Coast and over time there will be planning for increased service capacity and capability including planning for any identified future CSCF level 5 services.

Future Services

The shell space above the new emergency department provides the facility with room to expand with a Detailed Business Case under development (2022) to accommodate 35 beds (medical and intensive care).

** as at July 2022.*

Maryborough Hospital

Current Services

Maryborough Hospital has 97* bed and bed alternatives, excluding ED treatment spaces and beds, it operates at CSCF Level 3 capability with some Level 4 services. It provides inpatient services (especially sub-acute services including palliative care and rehabilitation), surgical services, endoscopy services, acute inpatient mental health services, outpatient services, and a 24-hour emergency department. A satellite renal dialysis unit provides dialysis services. Overnight medical cover will increase capacity for acute activity.

There are also a range of community health services in the Maryborough area.

Vision

Maryborough is developed as a Centre of Excellence for geriatric care and leads WBHHS in the provision of geriatrics, rehabilitation, and palliative care.

Future Services

Specialist geriatrics services will include an expanded geriatrics service, psychogeriatric service, rehabilitation service with expertise in providing rehabilitation to older patients, and consideration of expanding the existing palliative care service.

** as at July 2022.*

Rural facilities

Current Services

WBHHS rural facilities currently provide local inpatient, emergency and outpatient services. The regional facilities mostly operate at a CSCF level 2.

Vision

The regional facilities will continue to support larger hospitals in WBHHS by providing local care to residents in the west of the HHS.

Expansion virtual care modalities will allow these residents to be treated closer to home for longer.

Future Services

The services available at the regional facilities will be supported by clear guidelines and models of care that allow these facilities to look after more patients for longer, reducing interfacility transfers. Expanded virtual models of care will allow more pre-admission and outpatient clinics to be delivered locally.

A detailed service plan and infrastructure business case for Agnes Water will be developed. This includes investigating the most appropriate service mix and model to be delivered at Agnes Water (considering MPHS, Community Health Centre and Satellite Hospital options).

Location	Current services	Bed numbers
Biggenden MPHS	Multipurpose facility providing acute, aged care, 24 hour emergency department, community and allied health services to the Biggenden community and surrounding area. Clinical support services include radiology (X-ray) and pathology.	18
Childers MPHS	Multipurpose facility that provides acute hospital services include inpatient, outpatient and 24 hour emergency department services, as well as long stay aged care to Childers and surrounding communities. Clinical support services include radiology (X-ray) and pathology	20
Eidsvold MPHS	Small rural health service which provides acute services including 24 hour emergency department, inpatient, and outpatient services, as well as aged care services. Clinical support services include radiology (X-ray) and pathology.	11
Gayndah Hospital	Outpatients, 24 hour emergency department, inpatient, respite care and palliative care services. Clinical support services include radiology (X-ray) and pathology.	10
Gin Gin Hospital	Acute 6 bed facility which provides outpatient, 24 hour emergency, pharmacy, general medicine and palliative care services. Clinical support services include radiology (X-ray) and pathology.	6
Monto Hospital	24 hour emergency, outpatients, acute and aged care, paediatrics, palliative care, general medicine, radiology and pathology services to the local community. Clinical support services include radiology (X-ray) and pathology.	14
Mount Perry Health Centre	Health centre that provides health promotion, chronic disease management, outpatient and emergency department services to the local community from 8am – 4:30 pm, Monday to Friday. Clinical support services include pathology.	
Mundubbera MPHS	Multipurpose facility that provides acute inpatient, 24 hour emergency department services, outpatients, general medicine, community care and aged care services to Mundubbera and the surrounding community. Clinical support services include radiology (X-ray) and pathology	18
Discovery Coast	The Discovery Coast community has access to minimal community based services through outreach services WBHHS provides via the Agnes Water and Miriam Vale Community Centres.	

Mental Health

Current mental health services

Acute, subacute and community-based mental health services are currently provided across Wide Bay, with inpatient capacity provided at Bundaberg Hospital (12 beds) and Maryborough Hospital (12 beds.)

A Step Up Step Down Unit (short-term sub-acute residential service) and Wide Bay Community Care Unit (supported residential care for rehabilitation) are located in Bundaberg but provide support to consumers across Wide Bay

Future mental health services

- Construction is underway on a new 22-bed acute mental health inpatient unit at Hervey Bay Hospital.
- Once the new acute inpatient unit is complete, the existing mental health unit at Maryborough Hospital will undergo a refurbishment to provide subacute specialist older persons mental health capacity (10 beds).
- The new Bundaberg Hospital will include an expansion of existing mental health capacity in Bundaberg, with 8 additional acute inpatient beds.

Wide Bay Public Health

Vision

The Wide Bay Public Health Unit will provide health protection services throughout Wide Bay, adapting to future trends, needs and risks. This will include a strong focus on and leadership for building a culture and environment of health promotion across WBHHS.

Future services

Future services may include a WBHHS health promotion plan, prevention and education services, training programs to build skills, public health expertise for internal programs and advocacy, and improved engagement with the community sector.

Facility	Current Services
WBHHS Public Health Unit	Services include but are not limited to: • Pandemic response activities • Implementation of evidence based control strategies • Monitoring and reporting on notifiable conditions • Supporting the provision of immunisation programs • Monitoring existing and identify new public health risks • Collaborating with state-wide partners to maintain a consistent evidence base, deploy initiatives to surge capacity and enforce / achieve compliance with legislation.

Service priorities

1. Strengthen foundations to optimise and transform

We recognise it is critical to address immediate demand and capacity pressures at WBHHS that are limiting our ability to optimise and transform services across the network of facilities.

1.1. Identify alternative service delivery models and settings for subacute patients, to increase bed capacity and provide care closer to home.

We will configure and coordinate our hospital substitution services to provide safe and viable alternatives to institutional care. This includes exploring short term opportunities to increase bed capacity in the WBHHS region for subacute patients that will provide greater flexibility for Hervey Bay and Bundaberg Hospitals. A public/private partnership may provide an opportunity for the delivery of day or overnight hospital type services through flexible and innovative model of care options.

1.2. Review our interim demand and bed management strategy to ensure we meet the needs of the community, whilst we are at capacity and awaiting new infrastructure.

1.3. Clearly define the roles and purpose of each facility within WBHHS to optimise the existing service network capacity (including shifting services between facilities, strengthening interface points, and rural site optimisation).

1.4. Pursuit of 'Best and most effective use' of our rural facilities and services to provide care closer to home.

- Develop a comprehensive rural health strategy, which recognises unique rural health challenges, and specific infrastructure requirements.
- Increase reverse flows from major Hospitals to rural facilities for ongoing care. Supporting growth in services within current rural facility CSCF levels will focus on: General Medicine, Subacute services, Dementia appropriate spaces
- Define a consistent model of care that is flexible to the needs of each of our rural facilities, including step-down rehabilitation services.
- Apply for commonwealth funding to increase number of aged care beds in our MPHSs in line with population growth and federal planning guidelines.

1.5. Implement an end-to-end patient flow optimisation strategy

We will implement a Patient Access and Clinical Effectiveness (PACE) service focussed on centralising and optimising patient flow spanning from point of entry through to discharge and will encompass transportation and hospital-community interface.
This will streamline patient transition across services and sectors, including coordination with MPHSs. The service will be comprised of:

- Clinical Informatics
- Nurse Managers for Patient Flow & Coordination (including Flex Bed Unit)
- Transit Lounge
- Nurse Navigators
- Discharge Planners
- Allied health services.

In FY20, some ESRGs had significant bed day opportunities based on their current Average Length of Stay (ALOS), relative to the corresponding national benchmark ALOS. Patient flow strategies to reduce overall bed days and infrastructure requirements should be prioritised based on ALOS benchmarking, with initial focus on the following specialties:

- Neurology
- Orthopaedics
- Cardiology
- Non Subspecialty Medicine and Surgery
- Qualified neonate
- Respiratory Medicine
- Rheumatology
- Surgical

1.6. Improve communication, coordination, and integration between Bundaberg, Hervey Bay, Maryborough Hospitals and Rural facilities.

Increased information sharing between WBHHS facilities aims to bridge silos and enhance interfacility collaboration. This includes adoption of a centralised approach to patient flow and referrals, and greater coordination of interhospital transfers and patient transport.

1.7. Develop clear and standardised clinical pathways across WBHHS services, including protocols for direct admission and criteria led discharge. Specific areas for focus include:

- Orthopaedics
- Surgical and Medical
- Maternity
- Long stay patients clinically ready for discharge (e.g. Aged Care placement and NDIS patients).

1. Strengthen foundations to optimise and transform

In order to reap the full benefits of transformation and optimisation strategies, we need to address fundamental capacity challenges that limits full adoption of new models of care and integration across the health continuum.

1.8. Develop targeted hospital pathways for NDIS eligible patients to facilitate discharge when clinically appropriate that reduces unnecessary prolonged hospital length of stay.

- We will establish NDIS coordinator positions
- Develop hospital pathways to support early identification of supported independent living, home modifications, specialist disability accommodation and/or specialist equipment requirements for our NDIS eligible patients. This will enable discharge planning and identification of options for interim accommodation and supports while patients are awaiting final discharge destination. This includes patients with special care needs e.g. tracheostomy care, Acquired Brain Injury related behavioural challenges.

1.9. Develop and keep updated an Infectious Diseases Outbreak Management Plan and associated supporting materials to ensure WBHHS is well prepared to deal with this on an ongoing basis.

This is particularly important in the context of COVID-19 management and is an immediate priority. This will ensure we are well prepared with a detailed tiered response for outbreak management (including the prioritising of access to urgent care, and the recovery phase to address backlogs of non-urgent and planned care).

1.10. Develop and implement strategies that target reduction in our high volume of hospital readmissions.

Across the WBHHS network, patient readmissions within 30 days accounted for 14% of 2021 separations. Models of care to address this readmission challenge should be prioritised to large opportunity areas, including:

- Older patients (over 70)
- Gastroenterology
- Neurology
- Cardiology
- Haematology
- Non Subspecialty Medicine
- Respiratory Medicine

Ongoing long term WBHHS infrastructure planning, that considers the range of infrastructure needs and priorities across the health service for the next 15 years is imperative.

1.11. Review the WBHHS existing built capacity to identify what spaces can be configured to provide additional bed capacity across the network.

This includes conversion of spare office space to ward space for patient 'chairs' versus beds (e.g. chemotherapy and renal).

1.12. Continue to plan and invest in future infrastructure, focusing on sustainable growth of existing capacity to deliver quality services locally.

We need to continue to invest in the right number and mix of clinical and non-clinical spaces and contemporary infrastructure to meet the changing demographics and needs of our region, aligning with expanded services and new models of care. As such, future infrastructure planning needs to consider:

- Cohort specific adaptations, including capacity and spaces equipped to care for older patients, mental health services, cultural diversity, obesity.
- Multipurpose spaces for flexible service delivery.
- Digital enabled virtual models of care.

1.13. Complete a detailed business case for the design, construction, and fit-out of the cold shell in Hervey Bay Hospital Level 2 (Emergency Building).

This seeks to address a shortage of acute beds within the Fraser Coast region and will deliver up to 35 beds.

1.14. Undertake forward planning aligned with the WBHHS Master Plan through development of strategic asset master plans for all facilities.

This includes working in partnership with Maryborough Correctional Services to support improved health facility infrastructure and services.

1.15. Continue the planning process for a new Bundaberg Hospital which will also be critically important to achieving an uplift in acuity of services provided for Wide Bay.

1.16. Prepare a detailed service plan and infrastructure business case for Agnes Water.

We will investigate the most appropriate service mix and model to be delivered at Agnes Water (considering MPHS, Community Health Centre and Satellite Hospital options). This will address key local needs including recent accelerated population growth (comparative to WBHHS average) and a highly transient population including long-term tourists.

2. Ensure equity and accessibility of care across our community

There are a variety of social determinants of health that are particularly relevant in the Wide Bay region, with areas of the WBHHS catchment experiencing lower socioeconomic status proportionally (specifically Bundaberg, Svensson Heights-Norville, Maryborough, Granville and Gin Gin). Furthermore, our widely distributed remote populations have reduced opportunity to access health care locally.

Our ability to provide patients with timely access to care is challenged by existing WBHHS physical capacity constraints which limits significant growth in inpatient bed capacity in the medium-term. This presents an opportunity to significantly expand and invest in alternative models of care to transform and optimise the way we work to reduce disparities in health outcomes for our population, realise service efficiencies and ensure we provide timely access to appropriate care for our entire community.

We recognise the importance of meeting requirements of the *Human Rights Act 2019* (Qld), which highlights a patient's right to access health services without discrimination, and the right to not be refused emergency medical treatment for life saving and to prevent serious impairment. As such, this Service Priority seeks to systematically and proactively address barriers to equitable access of care across our entire community, aspiring to provide care closer to home.

2.1. Improve our patients' experience in navigating health services at WBHHS, including at interface points with home and community care.

The broad mix of providers and settings across Wide Bay makes service navigation challenging, especially for patients with multiple health conditions or complex needs. Key actions will include:

- Embedding performance reporting processes that reflect the patient experience (Patient Reported Experience Measures and Patient Reported Outcomes Measures).
- Engage with internal and external health care and community providers to plan, lead and coordinate interdependent resources to facilitate provision of high quality person centred care. This includes leveraging the skills of Nurse Navigators.

2.2. Introduce new medical subspecialties to increase the self-sufficiency of WBHHS to facilitate care closer to home.

The provision of new subspecialties will be informed by demand analysis and projections of the proportion of our population requiring these services. We will develop a WBHHS consistent service model to better connect services and allow us to safely increase our self-sufficiency and provide acute services closer to home. We recognise that use of technology, best practice models of care and standardised procedures will be key to success.

Based on extensive consultation and volume analysis, targeted subspecialties include:

- Cardiology (incl. interventional cardiology)
- Urology
- Gastroenterology
- Interventional Radiology/procedural services
- Neurology
- Rheumatology
- Geriatrics
- Respiratory
- Endocrinology
- Local ophthalmology services to manage low acuity surgery (e.g. pterygium and cataracts) and medical condition management including macular degeneration and glaucoma.

2.3. Develop a formal strategy for visiting outreach services to improve coordination and access across our communities.

The strategy will outline clear and consistent time frames for when services visit, standardise processes for care and increase capacity to support outreach clinics in rural facilities. The strategy will be designed to optimise integration with existing local services and ensure a demand-driven rationale for prioritisation. It will also consider alternative delivery models, leveraging Service Priority 3 in expanding virtual care modalities to provide outreach specialist services.

Services of focus for increased outreach capacity:

- Oral health services
- Mental health
- General Medicine to WBHHS rural facilities
- Endocrinology
- Nephrology
- Geriatric evaluation and management
- Tertiary Cardiology.

The recent success of the WBHHS partnership with Metro North HHS in the delivery of a Rheumatology Outreach Model should be emulated, scaling this approach to models with high referral volumes.

2. Ensure equity and accessibility of care across our community

Many of our patients have multiple morbidities and require a more integrated team approach to care. Further, with increased patient complexity the delineation between acute and subacute care is narrowing, whereby subacute support often forms part of acute patient recovery. This directly influences whole-of-hospital patient flow and our ability to support patients in the right environment as part of their treatment and recovery.

2.4. Provide consistent subacute care closer to home for all of our WBHHS residents, especially residents who live outside of Bundaberg and Hervey Bay. This strategy is multifaceted, requiring:

- Assessment of sub-acute service expansion options across our network of facilities, especially in regions with an ageing population, increasing complexity of care, and socioeconomic disparity greater than that of Wide Bay.
- Development of community-based service models to reduce need for patient travel to Bundaberg or Hervey Bay to access services.
- Rural generalist allied health services will be scaled up to enable safe, equitable sub-acute care closer to home for local patients according to the *Queensland Health Allied Health Rural and Remote Sub-Acute Service Framework*. This includes expedited transfer from a regional/tertiary hospital to a rural facility or discharged directly home with follow up care as an outpatient or in the community.
- Integration with the principles of Service Priority 1, Strategy 1.4. Pursuit of 'Best and most effective use' of our rural facilities to provide care closer to home.

2.5. Standardise our approach to step down services across WBHHS.

- Surgical model – pre admission clinics run locally at all facilities, with surgery conducted in Bundaberg, Hervey Bay or Maryborough. This includes step down into Maryborough, rural facilities or community for rehabilitation.
- Cancer care – where possible and safe, our oncology patients currently step down to our rural facilities as part of chemotherapy treatment, with telehealth support from oncologists. We will continue this model into the future and look for opportunities to grow this service.

2.6. Proactively shift health services to ambulatory settings where clinically appropriate.

This strategy will be enabled by expanded and new speciality services across WBHHS. Central coordination and planning of ambulatory care services will create more cohesive patient-centred services, especially for our patients with chronic disease and complex needs. This will consider the need for overarching governance, without compromising current operational and professional management of diverse models of care.

2.7. Scale our Hospital in the Home (HiTH) service

Additional services to be investigated include 'Rehabilitation in the Home' to meet expected growth in subacute activity and 'Hospital in the Nursing Home' to support step down of aged care patients into nursing homes and the community to complete recovery and rehabilitation. HiTH amenable DRGs where WBHHS could target greater increase in HiTH include:

- Septic arthritis
- Osteomyelitis
- Venous thrombosis
- Digestive malignancy
- Infective endocarditis
- Other follow-up after surgery or medical care
- Chemotherapy and dialysis services

2.8. Improve chronic disease management, including prevention and education, through scaling of the integrated care service model.

We will work to build capacity and ability to address obesity, chronic disease and complex conditions that will require additional nurse navigator and complex care coordinator support. This includes exploring future state options for how nurse navigator service is provided (including integration with virtual wards). This will be an important initiative to minimise unnecessary inpatient admissions, as well as the ALOS of admitted patients and empower our patients toward self-management.

2.9. Develop partnerships across the system to adopt a rigorous and comprehensive approach to strategic evaluation of models of care.

Collaborative partnerships across the system will boost our ability to stress test the efficacy of services, including translational university research to trial new evidence-based models of care.

This will enhance our ability to prioritise resources (including workforce, infrastructure and funding), to where it will provide the greatest return on investment and ensure sustainability and provision of high value care.

2. Ensure equity and accessibility of care across our community

The Wide Bay community is one of the oldest in the state, with 26.5% of our population aged over 65 years (10.4% greater than Queensland average). Specific SA2 areas have more accelerated population ageing growth rates including Tinana, Booral-River Heads, Maryborough South, Craignish and North Bundaberg. This requires targeted changes to models of care to accommodate for the demographic differences and health needs of various regions within WBHHS catchment.

Healthy Ageing Strategies are imperative to ensure we meet changing demand and needs of our community, drive service sustainability, and provide equitable access to care. With 60.9% of WBHHS bed days and 29.5% of WBHHS emergency department presentations attributable to persons aged over 65 years – providing appropriate care for older patients should form a core part of our business.

As such, we will strive for excellence in meeting the needs of older persons and aspire to be a leading HHS within the state in the delivery of best practice, contemporary and innovative models of care for this cohort.

2.10. Implement a Geriatrician led team focusing on all presentations from aged care facilities as well as older people from the community who are identified as frail.

This will facilitate earlier discharge, or fast-track referral and admission when required, to optimise patient outcomes and minimise hospital acquired complications such as cognitive decline and delirium.

2.11. Extend the Geriatric Evaluation and Management model of care to include person enablement and rehabilitation for complex health conditions (OPEN ARCH).

This will facilitate a direct path from GPs to a community-based geriatrician for comprehensive interdisciplinary assessment and care management. This model facilitates timely access to the most appropriate and early care in the community, enabling the older person's health to be supported such that they do not require hospital attendance.

2.12. Introduce a Geriatric evaluation and management in the home (GiTH) service to deliver care packages at home and support elderly patients in returning home sooner.

This will require integration with local care providers, including GPs, to increase workforce capacity across the service for greater collaboration and management of patients locally.

2.13. Increase transitional care packages (TCP) available to provide short term care to optimise the functioning and independence of older people following hospital discharge.

We are committed to support our older patients' capacity to return to independent living where possible, and recognise TCP plays a critical role in making his happen. TCP services are designed to meet a client's daily care needs (e.g. showering, wound care, shopping) and provide additional rehabilitation to maintain and improve physical, cognitive and psychological functioning.

We will prioritise support for the Aged Care Assessment Team (ACAT) to enable timely assessment of eligibility and streamlined applications for residential care (permanent and respite) and community aged care packages. The multidisciplinary team provides advice to elderly people in order to assist them in making informed decisions about care services.

2.14.Implement a specialist palliative care rural telehealth service

This service will support clinicians caring for patients across the entire region, enabling patients located in rural and remote areas to arrange a consultation with a palliative care specialist via telehealth and providing access to advice for their GP.

2.15. Adopt a consistent approach to palliative and end of life care that is close to home.

We will deliver local and community based palliative care services including advanced care planning and End of Life care across the HHS with support from our NGO sector and GPs.

2. Ensure equity and accessibility of care across our community

There are significant challenges for physically and socially isolated communities in accessing health care in WBHHS. This includes Aboriginal and Torres Strait Islander people, representing 4.2% of the WBHHS population and 6.64% of WBHHS bed days, with the largest populations in Bundaberg and in particular, North Burnett, Monto-Eidsvold and Gayndah-Mundubbera areas.

Rural and remote Australians have a higher burden of disease, mortality rate and more potentially avoidable deaths. Health inequalities have manifested as a gap in life expectancy between Indigenous and non-Indigenous Australians. In Wide Bay, there is a 12.2 year Health Adjusted Life Expectancy Gap of Aboriginal and Torres Strait Islander people (61.5 years) compared to Qld population (73.7 years). Furthermore, this population experiences 2.2x greater burden of disease.

We are committed to equitable health outcomes and wellbeing of our Aboriginal and Torres Strait Islander community.

2.16. Develop and implement the WBHHS Health Equity Strategy in 2022, and review on a three yearly cycle going forward.

The Strategy will be completed in 2022 and will be co-designed, co-owned and co-implemented in accordance with legislated requirements outlined in the Hospital and Health Boards Regulation 2012.

This Strategy will outline mechanisms for WBHHS to address inequities in Aboriginal and Torres Strait Islander health and wellbeing outcomes in our region through:

- actively eliminating racial discrimination and institutional racism within the service
- increasing access to healthcare services
- influencing the social, cultural and economic determinants of health
- delivering sustainable, culturally safe and responsive healthcare services
- working with First Nations peoples, communities and organisations to design, deliver, monitor and review health services.

2.17. Develop targeted culturally appropriate responses to address high burden of disease in the Aboriginal and Torres Strait Islander community.

We aim to deliver culturally safe, appropriate and accessible services for the Aboriginal and Torres Strait Islander population through all clinical service models. Based on the greatest percentage of admitted patient separations for Aboriginal and Torres Strait Islander people in WBHHS, areas of focus include:

- Renal Dialysis (29.74%)
- Non Subspecialty Surgery (5.84%)
- Obstetrics (5.49%)
- Orthopaedics (4.86%)
- Cardiology (4.84%)
- Mental health, suicide prevention, AOD services

Other strategies targeting equitable access to care our entire population

2.18. Increase access to child development services for children in WBHHS in partnership with primary health and community service providers.

This includes perinatal and infant mental health services, child and adolescent mental health crisis support, and assertive community outreach.

2.19. Undertake a review of our paediatric outpatient clinic service ability to meet local demand.

2.20. Implement targeted care coordination initiatives to enable our patients with a disability to have equitable access and participation in their own healthcare journey.

This includes working with other agencies and community providers to reduce unnecessary length of stay, inappropriate admission and improve patient and carer experience and outcomes.

2. Ensure equity and accessibility of care across our community

We are committed to shifting from episodic care to more comprehensive, continuous and person-centred care to promote better outcomes for our patients living with mental illness and/or substance misuse. This will require addressing fragmentation in mental health and alcohol and other drug (AOD) services through more genuinely integrated and consumer-focused approaches to co-planning, co-implementation and coordinated investment.

2.21. Act on Wide Bay Mental Health, suicide prevention and alcohol and other drugs Joint Regional Plan (2020-25).

This plan represents a commitment by CQWBSCPHN and its three partner HHSs to work together to address the region's need for mental health, suicide and AOD services. It supports evidence-based co-planning, coordinated investment and integrated service delivery to promote better outcomes. The Wide Bay MHAOD Operational Group will target 3 focus areas:

- developing the regional mental health, suicide prevention and drug and alcohol service system.
- developing and supporting an integrated, skilled workforce to deliver consumer-centred services.
- changes needed in governance, gathering evidence, and co-design to deliver on the Plan

2.22. Implement initiatives of Mental Health Alcohol and Other Drugs 5 year Plan within the region.

This includes models of care to support youth in the community and in crisis including drug and alcohol issues, meeting services gaps, and expansion of forensic and prison services.

2.23. Implement the priorities of the Fifth National Mental Health and Suicide Prevention Plan and the National Drug Strategy within the region.

This includes a commitment to addressing fragmentation through integrated and consumer- focused approaches to planning, implementation and development, and a review of mental health and drug and alcohol services. Once released, we will pursue strategies that align with the National Mental Health Service Planning Framework.

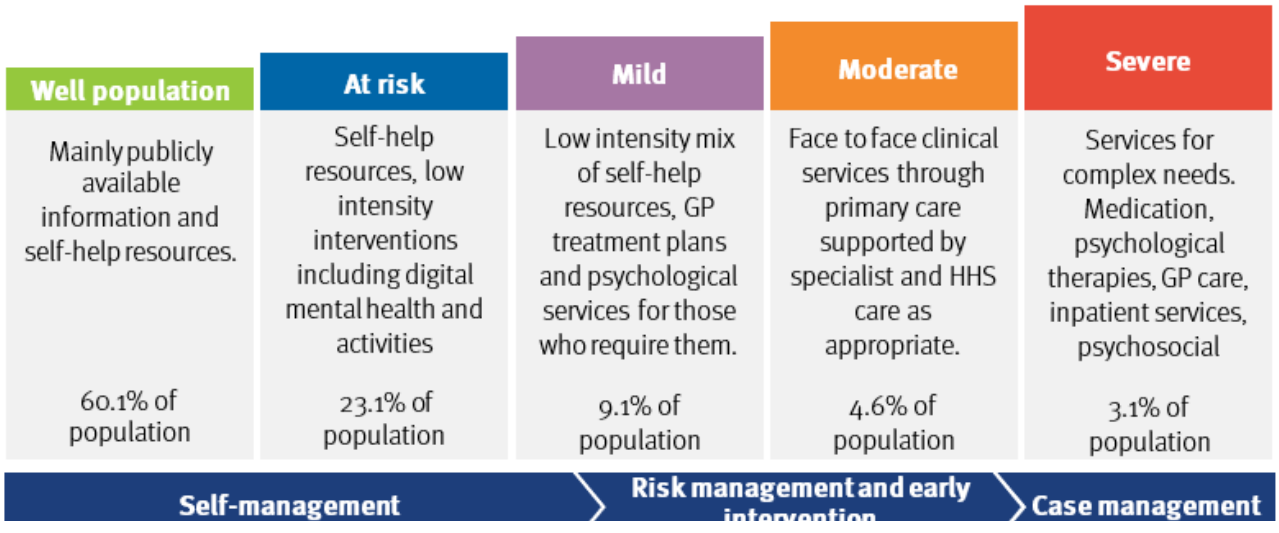
2.24. Plan and implement mental health and suicide prevention services within a stepped care framework.

Key areas of focus in the delivery of a stepped care approach include:

- actively pursing integration and collaboration across services, including with community-based mental health step up/step down services, to support our patients in accessing care closer to their personal support systems (including RACF outreach mental health support, utilisation of the Crisis Peer Support model with clinical assessment, and eating disorder brief intervention models).
- planning services to provide a spectrum of interventions that suits a patient's need. People will enter the system at any level, based on current need, and as needs change individuals may step up/down the support hierarchy.

Our approach will align with the principles of the Qld Mental Health Commission plan.

Figure 13. Mental health stepped care approach (adapted from the Joint Regional Plan 2020-2025).



3. Embed technology to bolster sustainable and targeted service models

Future health service models and delivery will be unrecognisable to the one we know today.

Advancements in technology and digital solutions are bridging siloed working across the health system, delivering personalised healthcare, and shifting the focus from illness to wellbeing.

Virtual care accounts for 18% of services delivered within WBHHS. Whilst this utilisation is comparable with the median across all HHSs (ranking 10th out of 16 HHS's in delivery as a percentage of total services), our ambition is to accelerate uptake service-wide.

In order to optimise the opportunities afforded by technology, we have committed to proactively engage and adopt emerging technologies and embed these within our ways of working now to deliver faster and enhanced services for our patients.

Our virtual ambition seeks to benefit:

1. **Our Healthcare Partners:**
   Improved collaboration and enhanced continuity of care through active participation in specialist consults

2. **Our Patients and consumers:**
   Improved experiences of our health service access and options to receive high quality care closer to home

3. **Our Workforce:**
   Increased peer support, professional development opportunities and collaboration for our staff to deliver high quality care

4. **Our Services:**
   Enhanced efficiency and effectiveness through optimised physical capacity and workforce capability

3.1. Leverage the opportunities presented by technology advancements system-wide, and modernise for a digital hospital.

The focus of the digital hospital will be improvement in safety and quality and as an enabler to delivering new and innovative models of care, with priorities including:

- Implement an electronic medical record before the end of this Plan to improve safety, efficiency and quality in clinical work flow processes at WBHHS.
- Phased implementation of Smart Referrals by 2023 to enable faster, streamlined management of referrals within WBHHS and to our partners.

3.2. Develop an ambitious virtual care agenda that aligns with the Queensland Health Virtual Healthcare Strategy (2020).

WBHHS will expand virtual horizons and aspirations beyond videoconferencing.

- We will embrace the variety of functional and secure technology enabled models of care supported by Queensland Health including, e-consult, remote patient monitoring and clinical video conferencing.
- We will invest in digital platforms, analytics and AI to drive personalisation of healthcare treatment and outcomes along with new operating models.
- In alignment with the QH Virtual Healthcare Strategy, we will prioritise virtual initiatives relating to non-admitted referrals and chronic disease which both present a significant opportunity to reimagine healthcare pathways

3.3. Systematically address key barriers to technology adoption by WBHHS staff, our patients and key stakeholders.

This includes:

- Implementation of a comprehensive digital strategy, architecture and plan.
- Targeted actions to enhance digital literacy of users, including providers, recipients and consumer/carers. Additional training will be provided to clinicians in delivery of virtual consultations to ensure it remains an efficient, low-risk modality.
- Advocate to relevant government agencies to promote improved internet connectivity, that will reduce digital disadvantage in remote locations.
- Provide clarity and delineate the roles of various software based collaboration tools that has led to clinician confusion over what services to use.

3. Embed technology to bolster sustainable and targeted service models

Telehealth has long represented an opportunity for WBHHS to address the challenges of its geography, with a large catchment area and dispersed population. Furthermore, it is an evidence-based solution to support a reduction in physical capacity pressures across WBHHS. The radical expansion of telehealth adoption throughout COVID-19 means now, more than ever, the enablers of infrastructure requirements and cultural shift are in place to support lasting expansion of telehealth services.

Despite the rapid acceleration of the adoption of telehealth and technology-enabled ambulatory care throughout the COVID-19 response, some services have returned to former models of service delivery rather than permanently embedding changes in telehealth use. In contrast, some specialties remain leaders in telehealth, and existing successful models of care (e.g. tele-oncology model).

In 2021, WBHHS delivered 16% of outpatient occasions of service via telephone or telehealth. **Our goal is that 30% of all outpatient activity will be delivered via telehealth by 2037. Our ambition is that telehealth will be recognised at WBHHS as a sustainable and effective mode of care delivery, and becomes the default choice for clinicians and our patients where clinically appropriate.**

3.4. Define a WBHHS model of care for telehealth that is regularly reviewed and aligns with the Qld Telehealth Strategy (2021-26)

Redefine specific care pathways through a standardised and defined telehealth model of care that adopts best-practice standards for telehealth implementation and delivery. This will require evolving our ways of working and rethinking how patients and providers access and interact across healthcare journeys at Wide Bay.

We will develop a single, coordinated hub and spoke telehealth model, with defined roles and responsibilities and clinical governance, that can be managed centrally (or via an alternative virtual health hub).

This model will enable:

- Greater coordination of appointment scheduling to increase local virtual service delivery capacity (e.g. outpatient preadmissions, external HHS). This includes introducing a single fully integrated portal to support scheduling of telehealth services.
- Leveraging finite resources for telehealth administration and coordination functions.

3.5. Identify priority Tier 2 clinics and other services for immediate expansion of telehealth models where clinically appropriate.

Clinics where WBHHS delivers significantly lower volume of activity via Telehealth than the median telehealth per cent of all HHSs include:

- Genetics
- Aged care assessment
- Geriatric evaluation and management
- Haematology and immunology
- Community health – palliative care
- Specialist mental health
- Cognition and memory

Throughout engagement with WBHHS stakeholders, additional telehealth adoption and/or scaling opportunity areas were identified, including:

- Tele-Cardiac Stress testing
- Pre-admission clinics
- Post-surgical reviews
- Virtual ward rounds including TeleHandover
- Orthopaedics / fracture clinics
- Rehabilitation services

Australian hospital services have successfully adopted a variety of Telehealth models:

- TeleTrauma
- Telehealth Emergency Management Support
- Burns eConsultation
- Prison health
- TelePharmacy
- TeleStroke
- Dermatology eConsult
- Collaborative case conferencing
- Remote breast screening
- Diabetic retinopathy screening
- Patient education

3. Embed technology to bolster sustainable and targeted service models

3.6. Establish Virtual Emergency Department and virtual ward models of care.

These models will provide both primary healthcare providers and WBHHS rural facilities with access to specialist and/or emergency physician advice as appropriate, by telephone or video conferencing. This safe, fast alternative pathway will reduce avoidable ED presentations, and ensure patients receive care in the right setting.

3.7. Optimise communication between WBHHS and our health and human service partners through interoperable digital platforms.

- Increase utilisation of **e-consultation** to provide electronic transmission, receipt, storage, retrieval, and assessment of digitised clinical data between WBHHS and other healthcare providers (without the need for patient to be present). This will enable us to continue managing patients locally by having the ability to access timely specialist advice, will support continuity of care for our patients, and drive reduction of unnecessary referrals.
- Enhance use of existing digital communication systems at our disposal to streamline patient care (e.g. Health Pathways web-based portal for clinical management and referral advice into local services).
- Targeted actions to enhance the user experience and confidence in navigating virtual care models, through consideration of the end to end service experience and interoperability to support clinical decision making (including improved handover and communications).

3.8. Uplift business intelligence through accurate and predictive performance insights and data analytics.

- Establish one data source of truth, supported by appropriate data governance, to foster data driven insights, benchmarking, early intervention and accountability to enhance organisational performance.
- Utilise hospital systems and databases to predict and manage demand and monitor and manage health service key performance and access targets (e.g. Care4Qld metrics).

Case study: Virtual Outpatient Integration for Chronic Disease (VOICeD) Program

Virtual Outpatient Integration for Chronic Disease (VOICeD) Program focusses on reducing the life burden of healthcare for chronic disease patients. The model allows a person who would usually require numerous specialist appointments and associated travel to see multiple healthcare providers at one appointment via telehealth.

The model has been trialled as a VOICeD Diabetes- Renal-Cardiac multi-specialist clinic in partnership with Cairns and Hinterland Hospital and Health Service, State-wide Diabetes, Renal and Cardiac Clinical Networks (HIU), and Queensland University of Technology (QUT) Design Lab. Improvements have been identified relating to overall wellness and co-ordination of care for patients, and is anticipated to be adaptable for specialist, nurse, or allied health led care. The most benefit is anticipated for patients in rural and remote locations, where patients cannot easily travel for care.

Case study: West Moreton health MeCare virtual care program

West Moreton Health established MeCare to support collaboration among specialists and general practitioners who attend to patients with complex chronic conditions.

The program is designed to use remote monitoring technology and video conferencing to help patients manage their own health from home. As a result, when COVID-19 arrived, West Moreton Health was able to rapidly set up a virtual “hospital in the home” service to deliver high-quality care remotely.

By 2019, within three years of setting up MeCare, West Moreton Health had seen a 35% reduction in preventable hospital visits within the program and improvement in Patient-reported experience measures (PREMs).

The Australian Centre for Health Services Innovation found that the MeCare program delivers a median cost saving of $1,201 per participant per month for a cohort size of 300.

4. Foster genuine partnerships to drive seamless service integration

The delivery of services across the patient's care continuum is the responsibility of different levels of government, involving multiple providers and different funding sources. This complexity can lead to service fragmentation and barriers to timely access to appropriate care across the health system.

Although there are instances of coordinated service delivery between WBHHS and our partners, this is not consistent across all regions and services.

Fragmentation and non-standardised pathways and models of care have led to some duplication of services and resources and difficulties accessing the right care. Fragmentation exacerbates existing patient flow challenges across WBHHS (including discharge delays and avoidable hospitalisation) and results in service gaps across the broader health service ecosystem.

Partnerships are critical to driving improved health outcomes for our community, ensuring seamless access to timely, appropriate care in the right setting for patients. Embracing an approach of co-design and co-delivery with our partners can ensure the most efficient and effective allocation of resources to promote sustainability of health services.

Advancements in technology and workforce, alongside growing WBHHS capability and self-sufficiency provide an opportunity to work with our partners to transform and optimise our services. We will continue to develop and invest in a more targeted and coordinated approach across our partnerships to improve transition between settings and providers and address service delivery gaps. We will use our influence and other levers at our disposal to develop additional capacity to care for our community.

Our ambition is to realign resources and deliver care in a more coordinated and integrated way, improving health outcomes, and the efficiency and effectiveness of the local health system itself.

Celebrating our successes: Healthy Ageing Collaborative

The Fraser Coast Falls Prevention Service is a collaboration between CQWBSCPHN, WBHHS, QAS and Hervey Bay Neighbourhood Centre. An initiative of this Service, the Lifestyle Café, launched at the Hervey Bay Neighbourhood Centre late 2021 for seniors over 65 and Aboriginal and Torres Strait Islander people over 50. This café-based healthcare concept is helping Hervey Bay seniors who have recently experienced a fall, regain their confidence and strength to reduce their falls risk while promoting social connections.

4.1. Strengthen existing partnerships to reduce duplication and address service delivery gaps through targeted investment in local health priorities. This includes working with:

HHS peers: to improve care pathways, communication and timeliness of service access

Joint Consortia in the CQWBSC PHN region (USC, CQU, CQHHS, WBHHS, SCHHS, CQWBSC PHN): to improve access, promotion, prevention and early intervention across the region. Specific priorities include: Healthy ageing, Telehealth, Maternal and child health, Mental health

CQWBSC PHN: to increase alignment of planning and needs assessment cycles (including the WBHHS LANA and PHN HNA), commissioning and data integration.

Local private sector: to facilitate sharing of services and workforce to reduce demand pressures in the hospital setting. This will build on our interim care beds strategy to enhance service capacity .

Primary care partners: to improve information sharing, including greater clarity on roles and responsibilities throughout the patient journey. This includes targeted focus on referral pathways and joint models of care to minimise duplication and ensure care is delivered in the right setting.

Community service partners:

- to develop initiatives that support early intervention for at risk mothers and families, recognising the importance of the first 1,000 days in setting the foundations for optimum health across a person's lifespan. For example, supporting GP follow up of mothers with gestational diabetes who are at greater risk of developing diabetes later in life.
- build capacity of community services to provide the package of care required to facilitate timely discharge for NDIS eligible patients.

4.2. Develop and implement a strategy to enhance health literacy of patients and carers to support prevention and self management.

We will empower consumers as active care partners, whilst managing consumer expectations on their experience within WBHHS.

4. Foster genuine partnerships to drive seamless service integration

4.3. Leverage partnerships to develop joint, future-focussed, translational research strategy.

We will work with our partners to establish research partnerships that adopt a systematic approach to research pursuits. A focus on translational research will support design of evidence-based models of care and strengthen business cases for investment to support delivery of these models of care

4.4. Implement integrated models of governing and commissioning our region's services to deliver better results with existing resources.

Explore opportunities with our partners to co-fund and co-deliver services, using a larger pool of resources to create scale of service provision and sustainability. Target cohorts based on shared care responsibilities and funding sources include:

- young people, including those with severe mental illness
- psychosocial support and clinical services for people with severe and complex mental illness
- rural and remote areas of Wide Bay region
- Aboriginal and Torres Strait Islanders.

Develop a co-commissioning agenda with local Primary Health Network (CQWBSC PHN) that prioritises patient cohort and service delivery areas that align with:

- Joint Regional Plan (2020-2025) (spanning First Nations health, chronic disease prevention/ management, maternal and child health, palliative care, alcohol and other drugs, mental health, practice support and data analytics
- First 2000 days' (early 2022)
- 'Healthy Ageing Strategy' (2022-2037)

4.5. Develop effective partnerships to support our aging population.

There are increasing transfers from RACF facilities to our Emergency Departments for the management of complex patients that trigger often long stays in hospital and possible decline in patient's condition.

- Expand partnerships with RACFs to increase capability, provide care closer to home, provision of in-reach services to include both in person and telehealth consultation services.
- Engage with local GPs to create capacity for intervention and support to RACF staff in management of complex patients. This will be enabled by a WBHHS standardised approach to timely discharge summary completion and visibility of local community services.
- Identify a RACF partner that will work with HHS and other partners to develop the case for the establishment of a specialist dementia unit collocated with the RACF for the management and support of dementia patients and patients with challenging behaviours closer to home.

4.6. Scale effective partnership models to other priority cohorts, targeting hospital avoidance

The Fraser Coast Healthy Ageing Collaborative is an example of an effective multi-partner multi-sector partnership model aimed at optimising service access and health outcomes of older people.

The 'Falls initiative' partnership between WBHHS, QAS, NGOs utilises nurse navigator and allied health to reduce avoidable ED presentations following a fall. This model can be expanded to other cohorts such as heart failure, COPD, diabetic foot ulcers.

Case study: Hospital Admission Risk Program (HARP) at Ballarat Health Service

The Hospital Admission Risk Program (HARP) is a Health Independence Program (HIP), which provides care coordination for people with complex medical and/or psychosocial issues at Bendigo Health. This includes people with a chronic disease, conditions of ageing (including falls) or psychosocial needs.

The HARP Program was able to achieve significant reductions in hospital admissions and non-significant reduction in emergency department presentations and length of stay.

Effective partnership models implemented in other regions: Brisbane North Health Alliance

The Health Alliance provides a space for individuals and organisations from across the system to come together to develop a shared understanding of the problems and develop shared solutions that are good for people, and for the system itself.

A joint committee of the boards of Metro North Health and Brisbane North PHN provides the strategic direction of the Health Alliance. The Alliance builds relationships across the sector to support innovation and a learning environment grounded in local experience. The Health Alliance have led co-commissioning services including maternal and child health in Caboolture.

5. Nurture and future-proof our workforce

COVID-19 has highlighted Queensland's reliance on interstate locum medical officers with the State border closures and the need to build a pool of qualified, available medical workforce within our own State boundaries to scale up when required (HWQ, 2021). In Wide Bay, this challenge is further compounded by the limited number of eligible International Medical Graduates (IMGs), shortages of General Practitioners and primary care workforce, and the persistent challenge of workforce attraction and retention.

The primary care sector remains vulnerable in remote and rural Qld with growing prevalence of market failure and legislative barriers restricting entry to workforce programs designed to support critical workforce shortages (HWQ, 2020). The knock-on effect of workforce maldistribution have seen practice closures, increased patient wait times, and increased pressure on hospital capacity.

In the face of these pressures, health practitioners have embraced virtual care modalities and have showcased unwavering commitment in delivering care for our patients. However, this has not come without a cost - with workforce shortages across the region increasing the burden on both the WBHHS and primary care workforce, increasing risk of disengagement and burnout.

Our people are the drivers of all that we do. Our workforce is imperative to the ongoing delivery of quality and sustainable clinical care as close to our communities as possible. Our workforce strategies target 3 key priority areas, spanning across our entire network of facilities and categorised as follows:

Quality – Building a skilled local workforce, empowered to work to their full scope of practice to optimise staff engagement and meet community care needs.

Access – Improving access to essential care.

Sustainability – Growing the sustainability of the local health workforce, including assurance of our pipeline of qualified staff, as well as supporting agility and flexibility to bridge service gaps.

Quality

5.1.Maximise the individual potential of our staff through providing opportunities for learning, development and career progression.

Prioritising accessible, quality professional development opportunities for our workforce is important to ensure sustainable and specialised services. This will require quarantining clinician time to undertake professional development activities in amongst clinical workloads and supporting staff to work to top of skill level and scope of practice. Furthermore, leveraging partnerships with providers and agencies (e.g. NDIA) to develop shared training and employment models will bolster rural workforce development through student training, clinical placement networks and early career professional support.

5.2. Adopt multidisciplinary team based workforce models with a focus on enhanced integration of the allied health workforce.

The value of multidisciplinary based team care is undisputed. This includes the allied health workforce, which requires greater integration and capacity building across WBHHS clinical care models. We will bridge clinical silos and improve access to allied health across our network of services through:

- providing greater clarity of allied health roles and responsibilities within clinical care teams
- adopt contemporary best practice workforce models that support extended and expanded scope of practice of allied health practitioners.
- expand allied health rural generalist pathway
- increase inclusion in bed side MDT meetings, criteria led discharge, and HiTH.

5.3. Pursue partnerships with universities locally, elsewhere in Australia and worldwide.

Providing opportunities for research and education through partnerships with universities and education providers, will enrich the breadth of experience of our workforce, this includes:

- opportunities to contribute to health focused research trials and embed into service delivery.
- developing a framework and governance to support research development and funding.

5.4 Review of fractional staff positions at rural sites.

We will identify opportunities to pool full time equivalent across positions or facilities to minimise fractional FTE that will enable attraction of staff.

5. Nurture and future-proof our workforce

Access

5.5. Target and grow workforce capabilities aligned with areas of emerging demand and retention strategies to sustain subspecialty models.

Attraction and retention challenges were consistently identified throughout consultation. This strategy aims to align with the National Medical Workforce Strategy 2021–2031 which seeks to address many of these issues through better medical workforce planning. We will secure and retain clinical staff required for the development of new medical subspecialties and Level 5 services within WBHHS, imperative to the delivery of many strategies within this HSP.

5.6. Adopt creative approaches to use limited workforce, including workforce sharing or co-commissioning models.

Greater flexibility in workforce models for the remote and rural area of Wide Bay is required to attract and support capable and culturally responsive health professionals. Developing innovative workforce models will support increase workforce capacity to meet community need.

5.7. Build HHS workforce capacity and capabilities to meet needs of specific target cohorts.

- Supporting people with lived experience who enter the workforce, including addressing stigma through de-stigmatisation training utilising Queensland Mental Health Commission resources.
- Leverage our pool of peer support workers and volunteers to fully draw upon capacity and capability of region.
- Invest in cultural sensitivity training to build capacity to meet needs of our Non-English speaking background (NESB) patients and Aboriginal and Torres Strait Islander patients.
- Develop workforce strategies to increase the proportion of local Aboriginal and Torres Strait Islander people and people living with disability engaged. This includes working with secondary and tertiary education facilities to increase career pathways into health service roles, facilitating connection with appropriate mentors, clinical supervisors and leaders.
- Better utilise the Aboriginal and Torres Strait Islander health practitioner role to complement Indigenous Health Worker activities
- Support commissioning of providers that embed cultural orientation training in their organisation

Sustainability

5.8. Adopt a system-wide focus to support the viability of the health workforce across Wide Bay.

Supporting the viability of our partners is required not only in our role as a good corporate citizen, but to mitigate potential demand surge on WBHHS. We will identify opportunities to co-commission services and support private/public business mix.

5.9. Strengthen existing partnerships with local education providers to support increased workforce training and immersive placements.

- Identify and support students with a genuine interest in rural health practice and prioritise for long term rural placements
- Implement our memorandum of understanding with CQU and UQ for medical programs and ongoing focus on our Regional Medical Pathway.
- Provide training and practicum opportunities (e.g. AIN, AHA, Phlebotomy) to increase student linkage to the Wide Bay community
- Support rural school visits to foster interest in rural health careers

5.10. Support succession planning to ensure a continuous pipeline of strong clinical leaders.

- Develop and implement WBHHS leadership and management framework
- Develop and implement strategies to ensure Aboriginal and Torres Strait Islander representation in positions of leadership

5.11. Create a culture where all of our staff feel safe and supported to deliver patient centred care.

- Deliver WBHHS employee engagement strategy
- Identify meaningful and sustained employee
- Engagement activities, to boost staff engagement
- Develop a staff wellbeing program that supports an environment and culture where all staff feel supported and have the opportunity to flourish.

5.12. Establish a regular cycle of WBHHS workforce planning with targeted strategies.

Workforce planning will consider not only the quantity and profiles of the workforce, but also encompass:

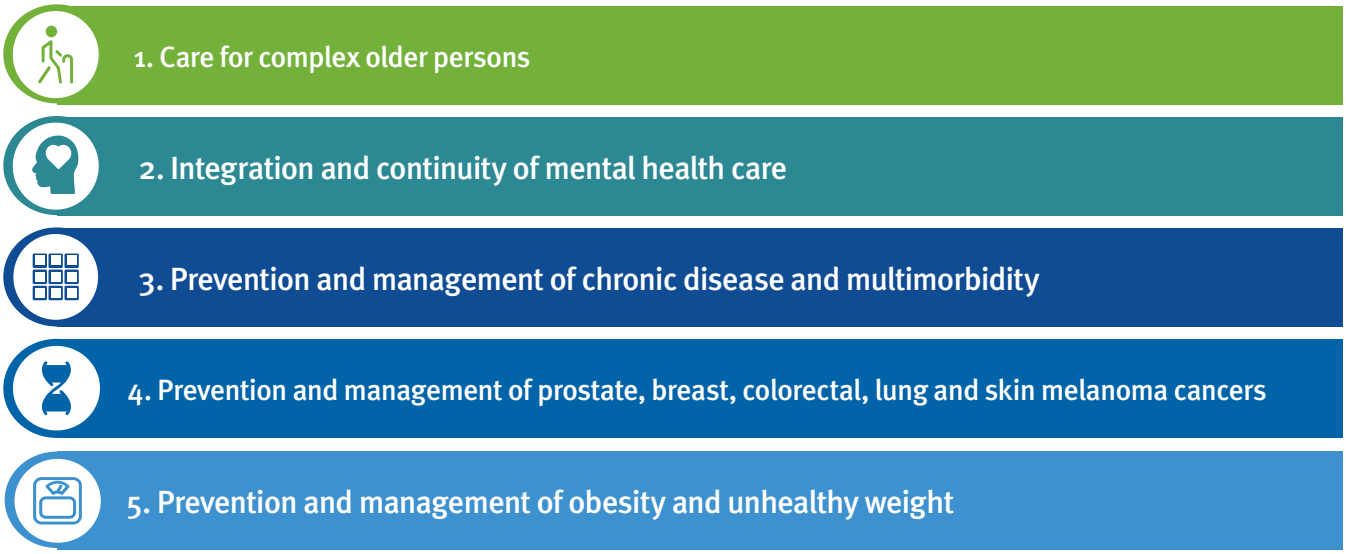
- training and development (including research)
- contemporary and innovative workforce models
- attraction and retention (e.g. recruitment processes and accommodation barriers).

Local Area Needs Analysis (LANA) integration

The HSP has been developed in conjunction with our Local Area Needs Analysis

Service Priorities have been designed to address the specific burden of disease and community needs within the region now and into the future, and uphold WBHHS' ongoing commitment to contemporary, quality and sustainable services for our community.

Throughout the Local Area Needs Assessment (LANA) development process, 5 key health needs were identified based on data analysis and consultation, including assessment of community health need, service gaps, and identification of health service needs to address those gaps. WBHHS defined health need as a health outcome and/or the related conditions that contribute to a defined health need, as summarised below.



The HSP has been developed in conjunction with our Local Area Needs Analysis

HSP strategies align to our Local Area Needs Assessment (LANA) and, in particular, our identified Health Need priorities.

Table 10: Summary of all of the strategies according to the five identified health needs within the LANA.

Strategy	Complex older persons	Mental health	Chronic disease	Cancer	Obesity
1. Strengthen foundations to transform and optimise					
1.1. Identify alternative service delivery settings for subacute patients, to increase bed capacity and provide care closer to home.	✓	✓	✓		
1.2. Review our interim demand and bed management strategy to ensure we meet the needs of the community, whilst we are at capacity and awaiting new infrastructure.	✓		✓		
1.3. Clearly define the roles and purpose of each facility within WBHHS to optimise the existing service network capacity (including shifting services between facilities, strengthening interface points, and rural site optimisation).					
1.4. Pursuit of 'Best and most effective use' of our rural facilities and services to provide care closer to home.					
1.5. Implement an end-to-end patient flow optimisation strategy.					
1.6. Improve communication, coordination, and integration between Bundaberg, Hervey Bay, Maryborough Hospitals and rural facilities.					
1.7. Develop clear and standardised clinical pathways across WBHHS services, including protocols for direct admission and criteria led discharge.	✓	✓	✓	✓	✓
1.8. Develop targeted hospital pathways for NDIS eligible patients to facilitate discharge when clinically appropriate that reduces unnecessary prolonged hospital length of stay.			✓		
1.9. Develop and keep updated an *Infectious Diseases Outbreak Management Plan* and associated supporting materials to ensure WBHHS is well prepared to deal with this on an ongoing basis.					
1.10. Develop and implement strategies that target reduction in our high volume of hospital readmissions.	✓	✓	✓		✓
1.11. Review the WBHHS existing built capacity to identify what spaces can be configured to provide additional bed capacity across the network.					
1.12. Continue to plan and invest in future infrastructure, focusing on sustainable growth of existing capacity to deliver quality services locally.					
1.13. Complete a detailed business case for complete design, construction, and fit-out of the cold shell in Hervey Bay Hospital Level 2 (Emergency Building).	✓	✓	✓	✓	✓
1.14. Undertake forward planning aligned with the *WBHHS Master Plan* through development of strategic asset master plans for all facilities.	✓	✓	✓	✓	✓
1.15. Continue the planning process for a new Bundaberg Hospital which will also be critically important to achieving an uplift in acuity of services provided for Wide Bay.	✓	✓	✓	✓	✓
1.16. Prepare a detailed service plan and infrastructure business case for Agnes Water.					

The HSP has been developed in conjunction with our Local Area Needs Analysis

HSP strategies align to our Local Area Needs Assessment (LANA) and, in particular, our identified Health Need priorities.

Table 11: Summary of all of the strategies according to the five identified health needs within the LANA.

Strategy	Complex older persons	Mental health	Chronic disease	Cancer	Obesity
2. Ensure equity and accessibility of care across our community					
2.1. Improve our patients' experience in navigating health services at WBHHS, including at interface points with home and community care.	✓	✓	✓	✓	✓
2.2. Introduce new medical subspecialties to increase the self-sufficiency of WBHHS to facilitate care closer to home.	✓		✓		✓
2.3. Develop a formal strategy for visiting outreach services to improve coordination and access across our communities.	✓		✓		
2.4. Provide consistent subacute care closer to home for all of our WBHHS residents, especially residents who live outside of Bundaberg and Hervey Bay.	✓		✓		
2.5. Standardise our approach to step down services across WBHHS.		✓	✓		
2.6. Proactively shift health services to ambulatory settings where clinically appropriate.	✓	✓	✓		
2.7. Scale our Hospital in the Home (HiTH) service.			✓		
2.8. Improve chronic disease management through scaling of the integrated care service model.			✓		
2.9. Develop partnerships across the system to adopt a rigorous and comprehensive approach to strategic evaluation of models of care.	✓	✓	✓	✓	✓
2.10. Implement geriatrician led team focusing on all presentations from aged care facilities as well as older people from the community who are identified as frail.	✓				
2.11. Extend the Geriatric Evaluation and Management model of care to include person enablement and rehabilitation for complex health conditions (OPEN ARCH).	✓				
2.12. Introduce a Geriatric Evaluation and Management in the home (GiTH) service to deliver care packages at home and support elderly patients in returning home sooner.	✓				
2.13. Increase transitional care packages available to provide short term care to optimise functioning and independence of older people following hospital discharge.	✓				
2.14. Implement a specialist palliative care rural telehealth service.	✓		✓		
2.15. Adopt consistent approach to palliative and end of life care close to home.	✓		✓		
2.16. Develop and implement the *WBHHS Health Equity Strategy* in 2022, and review on a three yearly cycle going forward.					

The HSP has been developed in conjunction with our Local Area Needs Analysis

HSP strategies align to our Local Area Needs Assessment (LANA) and, in particular, our identified Health Need priorities.

Table 11: Summary of all of the strategies according to the five identified health needs within the LANA.

Strategy	Complex older persons	Mental health	Chronic disease	Cancer	Obesity
2. Ensure equity and accessibility of care across our community					
2.17. Develop targeted culturally appropriate responses to address high burden of disease in the Aboriginal and Torres Strait Islander community.					
2.18. Increase access to child development services for children in WBHHS in partnership with primary health and community service providers.					
2.19. Undertake a review of our paediatric outpatient clinic service ability to meet local demand.					
2.20. Implement targeted care coordination initiatives to enable patients with a disability to have equitable access and participation in their healthcare journey.					
2.21. Act on mental health, suicide prevention and alcohol and other drugs *Wide Bay Joint Regional Plan 2020-2025*.		✓			
2.22. Implement initiatives of the Mental Health Alcohol and Other Drugs 5 year Plan within the region.		✓			
2.23. Implement the priorities of the *Fifth National Mental Health and Suicide Prevention Plan* and the *National Drug Strategy* within the region.		✓			
2.24. Plan and implement mental health and suicide prevention services within a stepped care framework.		✓			

The HSP has been developed in conjunction with our Local Area Needs Analysis

HSP strategies align to our Local Area Needs Assessment (LANA) and, in particular, our identified Health Need priorities.

Table 12: Summary of all of the strategies according to the five identified health needs within the LANA

Strategy	Complex older persons	Mental health	Chronic disease	Cancer	Obesity
3. Embed technology to bolster sustainable and targeted service models					
3.1. Develop an ambitious virtual care agenda that aligns with the *Queensland Health Virtual Healthcare Strategy (2020)*.	✓	✓	✓	✓	✓
3.2. Leverage the opportunities presented by technology advancements system-wide, and modernise for a digital hospital.	✓	✓	✓	✓	✓
3.3. Systematically address key barriers to technology adoption by WBHHS staff, our patients and key stakeholders.					
3.4. Define a WBHHS model of care for telehealth that is regularly reviewed and aligns with the *Qld Telehealth Strategy (2021-26)*.	✓	✓	✓	✓	✓
3.5. Identify priority Tier 2 clinics and other services for immediate expansion of telehealth models where clinically appropriate.	✓	✓	✓	✓	✓
3.6. Establish Virtual Emergency Department and virtual ward models of care.	✓	✓	✓	✓	
3.7. Optimise communication between WBHHS and our health and human service partners through interoperable digital platforms.					
3.8. Uplift business intelligence through accurate and predictive performance insights.					

The HSP has been developed in conjunction with our Local Area Needs Analysis

HSP strategies align to our Local Area Needs Assessment (LANA) and, in particular, our identified Health Need priorities.

Table 13: Summary of all of the strategies according to the five identified health needs within the LANA.

Strategy	Complex older persons	Mental health	Chronic disease	Cancer	Obesity
4. Foster genuine partnerships to drive seamless service integration					
4.1. Strengthen existing partnerships to reduce duplication and address service delivery gaps through targeted investment in local health priorities.	✓	✓	✓	✓	✓
4.2. Develop and implement a strategy to enhance health literacy of patients and carers to support self management.					
4.3. Leverage partnerships to develop joint, future-focussed, translational research strategy.	✓	✓	✓	✓	✓
4.4. Implement integrated models of governing and commissioning our region's services to deliver better results with existing resources.	✓	✓	✓	✓	✓
4.5. Develop effective partnerships to support our aging population.	✓				
4.6. Scale effective partnership models to other priority cohorts, targeting hospital avoidance.					✓

The HSP has been developed in conjunction with our Local Area Needs Analysis

HSP strategies align to our Local Area Needs Assessment (LANA) and, in particular, our identified Health Need priorities.

Table 14: Summary of all of the strategies according to the five identified health needs within the LANA.

Strategy	Complex older persons	Mental health	Chronic disease	Cancer	Obesity
5. Nurture and future-proof workforce					
5.1. Maximise the individual potential of our staff through providing opportunities for learning, development and career progression.	✓	✓	✓	✓	✓
5.2. Adopt multidisciplinary team based workforce models with a focus on enhanced integration of the allied health workforce.	✓	✓	✓	✓	✓
5.3. Pursue partnerships with universities locally, elsewhere in Australia and worldwide.	✓	✓	✓	✓	✓
5.4. Review of fractional staff positions at rural sites.	✓	✓	✓	✓	✓
5.5. Target and grow workforce capabilities aligned with areas of emerging demand and retention strategies to sustain subspecialty models.			✓		
5.6. Adopt creative approaches to use limited workforce, including workforce sharing or co-commissioning models.					
5.7. Build HHS workforce capacity and capabilities to meet needs of specific target cohorts.	✓	✓	✓	✓	✓
5.8. Adopt a system-wide focus to support the viability of the health workforce across Wide Bay.					
5.9. Strengthen existing partnerships with local education providers to support increased workforce training and immersive placements, including the Regional Medical Pathway.	✓	✓	✓	✓	✓
5.10. Support succession planning to ensure a continuous pipeline of strong clinical leaders.					
5.11. Create a culture where all of our staff feel safe and supported to deliver patient centred care.	✓	✓	✓	✓	✓
5.12. Establish a regular cycle of WBHHS workforce planning with targeted strategies.	✓	✓	✓	✓	✓

Making it work - our plan for implementation

Making it work - our plan for implementation

We will set WBHHS up for success to pursue the strategies outlined in this Plan.

A significant program of work and detailed project planning is required to operationalise these strategies, and support the transition to our ambitious future state over the next 15 years.

Figure 14. Key considerations for effective implementation of the Health Service Plan.

- WBHHS implementation plan to support HSP
- Assignment of Executive responsibility to each of the priorities and strategies
- Prioritisation and agreement on when planning should commence for each of the strategies
- Consideration of how existing resources could be utilised to undertake the planning and business case development required
- Consideration of how to embed planning, business cases and implementation of the HSP into annual operational planning - both at divisional and WBHHS levels

Roles and responsibilities

The Health Service Plan Project Steering Committee will oversee the implementation of this Strategy through regular reviews of progress. Progress reports at the end of each financial year will provide a summary of achievements against pre-determined KPIs for consideration of the WBHHS Executive and Board.

We will work with our partners to plan and design services that are complementary, avoid duplication and bridge gaps between primary, secondary and tertiary care. This will include co-design, co-planning and co-implementation to ensure long-lasting implementation of strategies within this Plan.

Funding considerations

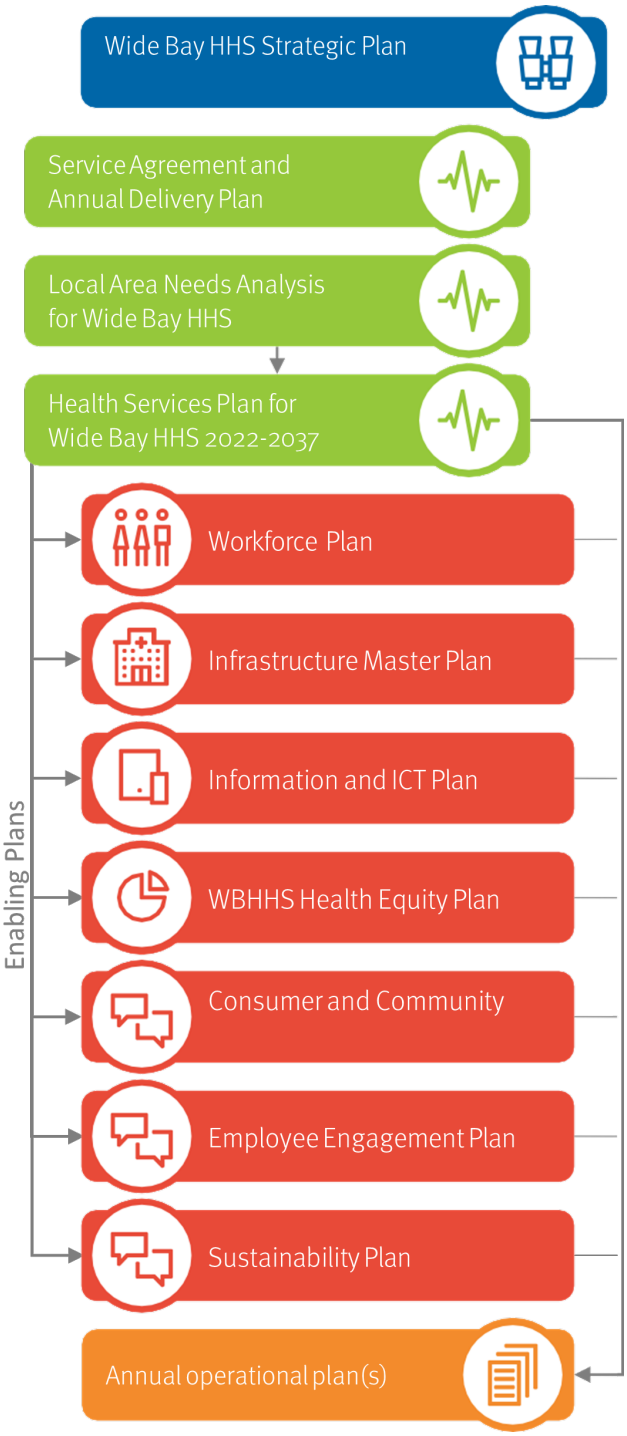
We will undertake purposeful investment in services that address identified regional needs and priorities outlined in this Plan. However, additional funding will be required to support implementation as many of these strategies are currently unfunded. Key actions to optimise the funding lever for implementation include:

- Adopt a rigorous approach to prioritisation and strategic phasing of initiatives, and direct resources at our disposal to focus on these key priorities to achieve the greatest possible impact.
- Integrate implementation into annual operational planning and budget cycles to inform the prioritisation of WBHHS initiatives. Some initiatives still require targeted planning and investment for effective implementation.
- A plan for transitioning services from pilot projects into BAU supported by recurrent funding.
- Build an evidence base for proposed or newly implemented models of care to support the review of existing and pipeline funding mechanisms both at WBHHS and at system-level.
- Engage the Department of Health as part of implementation planning to identify opportunities for investment into alternative models of care and consideration to funding outside of the traditional model.
- Engage with Clinical Excellence Queensland and other key stakeholders across the system to access resources and funding to evaluate innovative models of care that can be scaled and adapted into other jurisdictions.

Making it work - our plan for implementation

Development of a robust evaluation framework will help to monitor progress and engender a unified commitment to implementation across WBHHS.

Figure 15. Key considerations for effective implementation of the Health Service Plan.



Measuring progress

The development of a robust monitoring and evaluation framework to assess the Plan's impact is critical. This evaluation should be supported by evidence, measurable Key Performance Indicators (KPIs) and be informed by our partnerships with key stakeholders. KPIs will be developed and monitored in line with WBHHS performance and accountability processes. This will increase visibility of implementation progress (including acting as a supportive early warning mechanism for deviations from project milestones, time frames), to support informed decision making and corrective actions. A continuous improvement approach will be adopted to account for changes in health needs or service developments throughout implementation (e.g. Census data release), and inform adjustments to that will ensure lasting implementation success.

Core markers of success

Improved health outcomes
Improving the health and wellbeing of target populations, including Aboriginal and Torres Strait Islander people.

Sustainable services
Developing, linking and delivering services to make efficient, effective and environmentally responsible use of limited resources.

Accessible services
Delivering safe and connected services as close to home as possible.

Culturally appropriate services
Considering cultural diversity in communities and the health needs of specific groups

Safe services
Providing consistently safe and appropriately supported health services

Person focused services
Integrating services across the health service to facilitate continuity of care

Quality value based care
Promoting models of service delivery consistent with good clinical practice

Making it work - our plan for implementation

A phased approach to implementation is needed which allows time for the building blocks of initiative integration to be put in place. A more detailed implementation plan will be developed to guide this process.

1. Act now

There are a number of immediate priorities that will require focus and implementation within the first year of the time horizon for the HSP. These priorities are a result of the significant pressures being experienced by the health system arising from the COVID-19 pandemic, as well as a number of state-wide priority areas, WBHHS Strategic Plan and Health Equity Plan.

2. Optimise

Optimise strategies aim to ensure the best use of existing resources and infrastructure, to deliver services that are contemporary best practice, focused on outcomes and as close to home as possible. This provides a significant opportunity to ensure WBHHS appropriately configures our services across our network of facilities, including appropriate bed mix and bed substitution models to optimise capacity with existing resources.

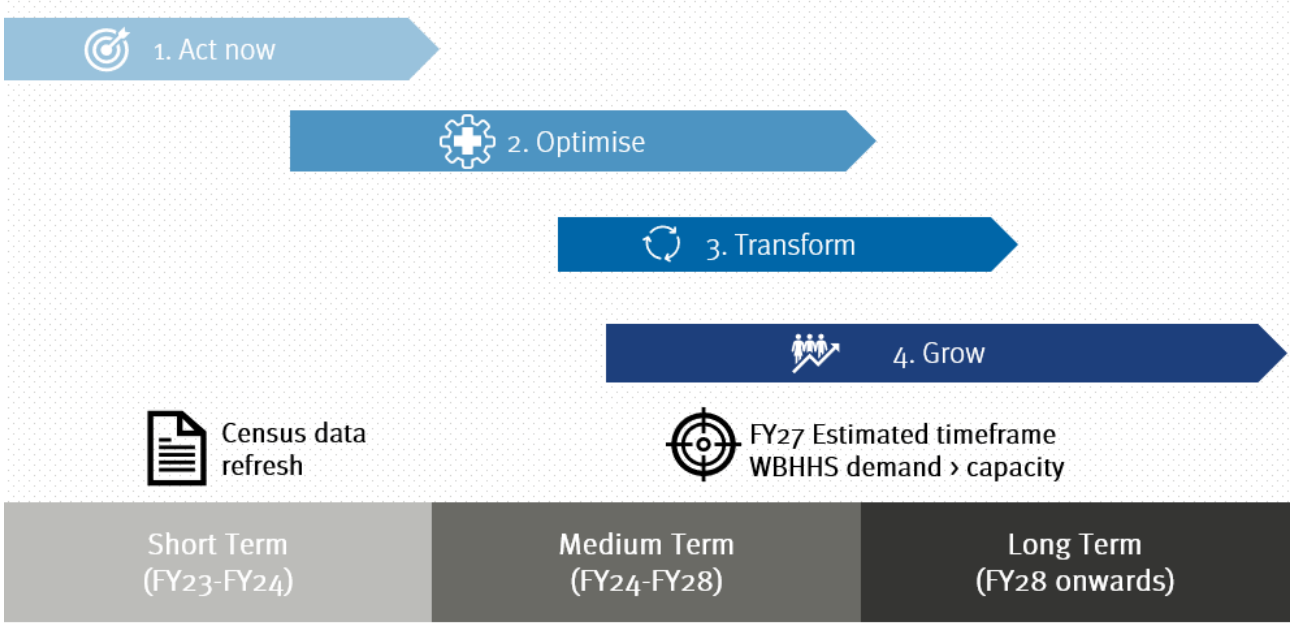
3. Transform

These strategies transform how and where we deliver health care for better patient outcomes and sustainable services. The objective of these strategies is to grow service capability and capacity. Capability will be uplifted by providing more advanced services concentrated where our population needs it most. Meanwhile, capacity will be uplifted across the health service in areas where there is a forecast demand increase.

4. Grow

We recognise that the challenges and opportunities we face today will be vastly different toward the end of the time envelope of this Plan. Grow strategies reflect both local and more global health trends to ensure we remain on the front foot in providing sustainable, quality services for our community.

Figure 16. Suggested timeframe for implementation of strategy priority groups.



Integration with WBHHS Strategic Plan

The *Wide Bay Strategic Plan 2022-2026 'Care, connection, compassion for all' describes key strategic directions for WBHHS* that support the overarching purpose to compassionately care and connect with the Wide Bay community and our staff to provide excellence in regional health services.

The strategic plan and initiatives detail 'Act Now' and 'Optimise' priorities that complement and align with the HSP. The table below shows the direct relationship of each health service priority in this plan to specific strategies within the WBHHS Strategic Plan. Some priorities support more than one strategic direction, and the service priorities also rely on each other.

Service priority	'Act now' and 'Optimise' strategies
Strengthen foundations to transform and optimise	Establish contemporary patient flow models which ensures the community receives appropriate care, within clinically recommended time frames, in locations close to home where possible.
	Improve wait time indicators for all elective surgery, specialist outpatients, endoscopy and emergency care to support best care provision.
	Optimise WBHHS service network capacity to support interfacility collaboration for best patient outcomes, and infrastructure solutions to support sustainable service delivery.
Ensure equity and accessibility of care across our community	Continue to engage with our community to improve understanding of sustainable service delivery model.
	Expand availability of subspeciality services within budget allocation to meet local need and access for patients.
	Enhance holistic and coordinated heath care delivery to provide evidence-based multidisciplinary care models which optimally manages chronic and acute health conditions.
	Expand and scale Hospital in the Home and virtual care service offerings to meet community needs, enhance patient experience and outcomes , and support service sustainability.
	Development and implementation of WBHHS Health Equity Strategy.
Embed technology to bolster sustainable and targeted service models	Scale use of technology and virtual care models (where clinically appropriate) to facilitate care closer to home.
	Optimise technology to support improved organisational performance and decision making.
	Develop a virtual care agenda that aligns with Qld Health virtual healthcare and telehealth strategies.
	Redefine care pathways to improve service access and clinical decision making through virtual care health care initiatives.
Foster genuine partnerships to drive seamless service integration	Implement collaborative co-designed community-based services with stakeholders to improve patient care.
	Pursue mutually beneficial partnerships with private, PHN and non government sector to optimise regional capacity to meet demand pressures.
	Development and implementation of a meaningful Health Literacy program to empower consumer self- management of their health care needs.
	Leverage partnerships to progress a future-focussed and translational research strategy, including university and TAFE partnerships
Nurture and future-proof workforce	Create a culture where staff feel their physical, social, emotional and psychological wellbeing is cared for, ensuring a culturally safe and responsive workplace.
	Enable people with lived experiences to enter and remain within the workforce, providing specific support for target groups
	Target and grow workforce capabilities, focussing on the pursuit of partnerships with education providers.
	Foster a continuous improvement and learning environment to expand our staff's delivery of high quality, patient-centred care.
	Effectively manage the workforce to met service demand needs.

Critical enablers for success

Each of these key enablers requires targeted support to ensure successful realisation of HSP strategies

Workforce Planning

New models of care, including expansion of telehealth and virtual care, will require updated workforce planning. This needs to outline future workforce requirements, including planning to provide increased assurance on workforce sustainability. Areas of focus include:

- Align appropriate human resource profiles to organisational priority areas (including operational staff support)
- Support growth in clinics at rural sites to enable the rural workforce to upskill and work to full scope of practice.
- Identify clinical governance requirements

Digital

Digital solutions and infrastructure that support communication and coordinated planning are essential in implementation. Areas of focus include:

- Map the complex hierarchy and relationships between current ICT systems and identify any foundational uplift needed.
- Support greater interoperability.
- Develop a Virtual Health Strategy, as outlined in Service Priority 3, with a focus on: accelerating adoption of digital systems, developing tools to support timely clinical and business intelligence and communication

Partnerships

WBHHS will strengthen partnerships across our region, as a critical enabler for the delivery of many proposed Health Service Plan Strategies. These partnerships will span public and private across health and human service sector, including local Private Hospitals, primary health care and general practice, neighbouring HHS's, the Department of Health, Residential Aged Care Facilities and NGOs.

Physical Infrastructure

A review of the required infrastructure must be undertaken as part of the operational planning component of strategy implementation. Key service-related priorities should inform future infrastructure priorities, which will need to be subject to standard, ongoing infrastructure planning processes as determined by the Department of Health and WBHHS. This includes future Strategic Asset Management Plans for the WBHHS, and bids for infrastructure project funding in line with the Investment Management Framework.

Research

An evidence-based approach underpins everything we do. We will work with our partners to establish research partnerships that adopt a systematic approach to research pursuits. A focus on translational research will support design of evidence-based models of care and strengthen business cases for investment to support delivery of these models of care.

Health Equity Plan

Development of the WBHHS Health Equity Plan will be complete in April 2022. The Health Equity Plan will align with the priorities and actions articulated in this HSP, relevant for Aboriginal and Torres Strait islander people.

Appendix

References

Resources accessed and referenced throughout the Health Service Plan

WBHHS Resources

Strategic Plan 2022-2026

Service Agreement and Annual Delivery Plan

Local Area Needs Analysis for Wide Bay HHS

Health Services Plan for Wide Bay HHS (this document)

Workforce Plan

Infrastructure Master Plan

Information and ICT Plan

Health Equity Strategy 2022-2025

Consumer and Community Engagement Strategy

Employee Engagement Plan

Sustainability Plan

Business Case for Change

Inpatient Activity Data FY19-21

Outpatient Activity Data FY19-21

Emergency Department Activity Data Fy19-21

Capacity Alert Data, October 2021

Additional Resources

Patient Experiences in Australia: Summary of Findings, Australian Bureau of Statistics, 2021

System Priorities, Queensland Health System Outlook to 2026, Queensland Health

Making Tracks Investment Strategy, Queensland Government

Health Equity Strategy, Queensland Government

Telehealth Strategy (2021-26), Queensland Health

Virtual Healthcare Strategy (2020), Queensland Health

Specialist Outpatient Strategy (2016),Queensland Health

Royal Commission into Aged Care Quality and Safety (2018)

MyAgedCare, Australian Government

National Palliative Care Strategy 2018, Australian Government

National Drug Strategy (2017-2026), Department of Health

Qld Connecting care to recovery 2016–2021, Queensland Health

My health, Queensland's future: Advancing health 2026, Queensland Health

The Department of Health Fifth National Mental Health and Suicide Prevention Plan (2017)

The Mental Health, Alcohol and Other Drugs Joint Regional Plan 2020-2025, Central Queensland, Wide Bay and Sunshine Coast PHN

Maternal Health and First 2000 Days/Women's Health initiative 2022, Queensland Health

Healthy Ageing Strategy 2019, Queensland Health

The Fraser Coast Healthy Ageing Collaborative, Fraser Coast Regional Council

The Health Alliance, Metro North Health and Brisbane North PHN

MeCare Virtual Care Program, West Moreton Health

Virtual Outpatient Integration for Chronic Disease (VOICeD) Program, University of Queensland

Hospital Admission Risk Program (HARP), Ballarat Health Services

National Medical Workforce Strategy 2021-2031, Department of Health

The Fraser Coast Falls Prevention Service, CQWBSCPHN, WBHHS, QAS and Hervey Bay Neighbourhood Centre

Care4Qld Strategy, Queensland Health

Smart Referrals, Queensland Health

Digital Health Strategic Vision for Queensland 2026, Queensland Health

The Shifting minds: Queensland Mental Health Alcohol and Other Drugs Strategic Plan 2018-2023, Queensland Health

Preliminary Business Case for Hervey Bay Hospital Emergency Department Expansion

WBHHS Service and Infrastructure Plan Update 2018-2037, Johnstaff

Chief Health Officer Report and Datasets 2018, 2020, Queensland Health

Australian Institute of Health and Welfare Datasets

Population and Housing Data, Australian Bureau of Statistics

Medicare Benefits Scheme Activity Data

Glossary

Abbreviation	Definition
ABS	Australian Bureau of Statistics
AEDC	Australian Early Development Census
AIHW	Australian Institute of Health and Welfare
ASR	Age-standardised rate
ATS	Australasian Triage Scale
ATSICHHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
BMI	Body Mass Index
CAGR	Compound annual growth rate
CARE	Collaboration, Accountability, Respect and Excellence
CALD	Culturally and linguistically diverse
CAOHS	Child and adolescent oral health services
CI	Confidence interval
COPD	Chronic obstructive pulmonary disease
DWS	District of workforce shortage
ESRG	Enhanced service related group
FTE	Full time equivalent
GP	General Practitioner
HHS	Hospital and Health Service
ICD	International Classification of Disease
IDR	Insufficient data recorded
IRSD	Index of Relative Socioeconomic Disadvantage
LANA	Local area needs assessment
LGA	Local Government Area
LGBTIQ+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer people
MAC	Monthly Activity Collection
MBS	Medicare Benefits Schedule
NGO	Nongovernmental organisation
PHN	Primary Health Network
OBD	Occupied Bed Day
OOS	Occasion of service
PHIDU	Public Health Information Development Unit
PHN	Primary Health Network
QAS	Queensland Ambulance Service
QHAPDC	Queensland Health Admitted Patient Data Collection
QHNAPDC	Queensland Health Non-admitted Patient Data Collection
Qld	Queensland
QPHU	Queensland Preventive Health Survey
SEIFA	Socio-Economic Indexes for Areas
SA2	Statistical Area Level Two
SA3	Statistical Area Level Three
SRG	Service Related Group
STI	Sexually Transmitted Infections
TAFE	Technical and Further Education
WBHHS	Wide Bay Hospital and Health Service

Wide Bay Hospital and Health Service

Queensland Government