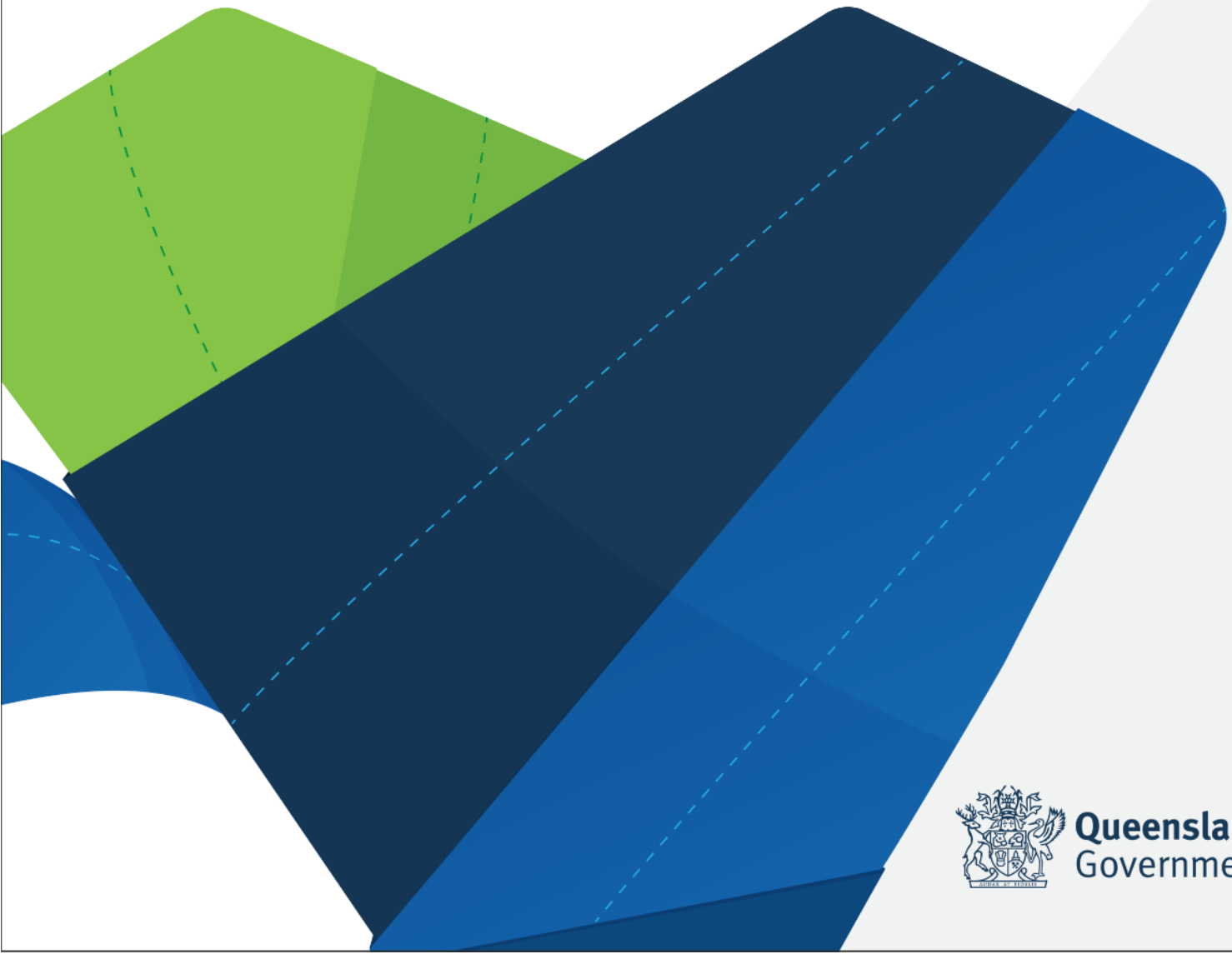
Local area needs assessment (LANA)

Wide Bay Hospital and Health Service

Priorities Summary Report

Submitted 30/06/2022



Queensland Government

Contents

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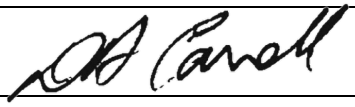
Signature	

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Acknowledgements

Executive Summary

The introduction of a Local Area Needs Assessment (LANA) across each region will enable a detailed assessment of health need, based on data analysis across multiple domains and consultation with local stakeholders, clinicians, consumers and health organisations. Hospital and Health Services (HHSs) providing services in Queensland have been requested to perform the LANA for their jurisdictions and publish a report on community health needs, service needs, gaps and priorities.

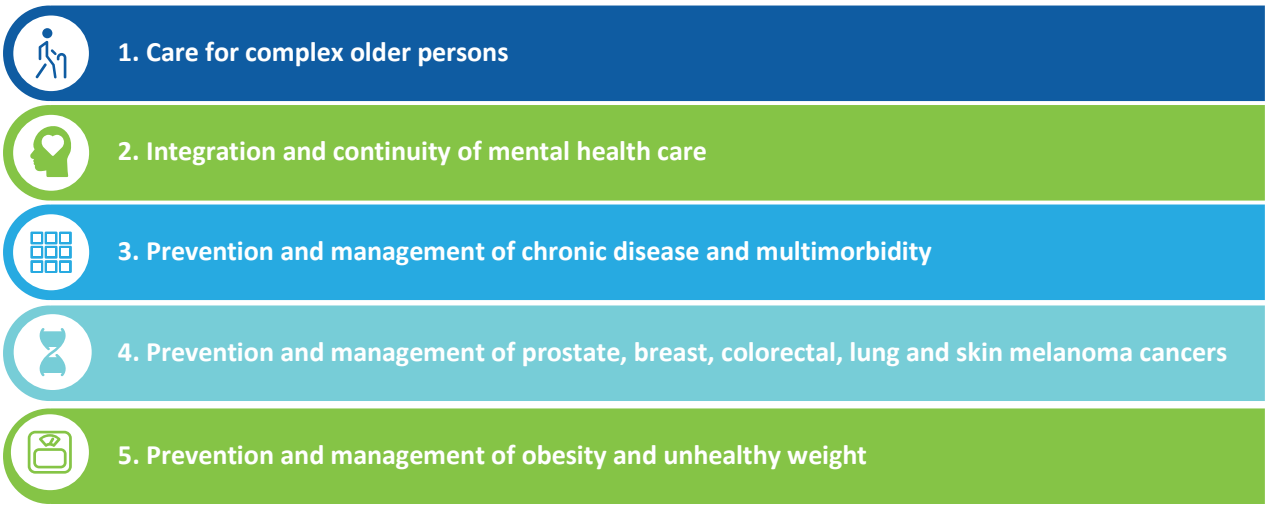
The purpose of this priorities summary report is to provide a synopsis of the Wide Bay Hospital and Health Service (WBHHS) key health service needs and priorities, identified throughout the development of the WBHHS LANA and new Health Service Plan (2022-2037). Service Priorities have been designed to 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.

Despite significant progress and service enhancements in recent years, WBHHS continues to face growing demand for health services, compounded by existing infrastructure and workforce capacity constraints. Key factors driving demand for health services, as identified by the LANA report findings, 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. Health care access for lower socioeconomic populations is compounded by the fact that 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 Queensland.
- Primary care capacity - The number of General Practitioners (GPs) per 1,000 population in Wide Bay is 0.7, compared to Queensland average of 1.1.

A short-list of Health needs were identified and validated, summarised below.

Figure 1. Identified health needs for WBHHS.



1 Introduction

Queensland Health aims to improve relative equity across the health system by transforming its approach to health service planning, models of care development and service commissioning, through utilisation of a comprehensive assessment of community health and service needs.

The introduction of a Local Area Needs Assessment (LANA) across each region will enable a detailed assessment of health need, based on data analysis across multiple domains and consultation with local stakeholders, clinicians, consumers and health organisations. Hospital and Health Services (HHSs) providing services in Queensland have been requested to perform the LANA for their jurisdictions and publish a report on community health needs, service needs, gaps and priorities.

This report has been developed by Wide Bay Hospital and Health Service to present a summary of regional priorities based on findings from the LANA.

2 Purpose of document

The purpose of this priorities summary report is to provide a synopsis of the Wide Bay Hospital and Health Service (WBHHS) key health service needs and priorities, identified throughout the development of the WBHHS LANA and new Health Service Plan (2022-2037).

3 Wide Bay Hospital and Health Service vision and priorities

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 staff to provide excellence in regional health services.

The process of completing the Wide Bay Local Area Needs Assessment (LANA) has provided the analysis and insights on the WBHHS population, service needs and opportunity areas. This has directly informed the development of the WBHHS Health Service Plan (2022-2037) which provides an ambitious roadmap of strategic service priorities over the next fifteen years. 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. A variety of service delivery challenges and opportunities were identified through extensive stakeholder consultation, from which corresponding service priority areas have been identified.

Figure 2. The five pillars of the WBHHS Health Service Plan (2022-2037).

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 & accessibility of care across our community

We will 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 & targeted service models

We will create a sustainable, future-focused health service through accelerating adoption of technology to enable 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 our 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.

4 Methods

4.1 Data analysis

The *LANA Framework* provides guidance on a minimum data set for analysis by all HHSs in development of its LANA. This minimum data set for population health is categorised by data based on the following:

- The region - geography and demography
- Health risks - social determinants, health determinants/behaviours
- Health status – morbidity and mortality
- Service access and availability – workforce, hospital and health system capability and capacity
- Service utilisation – primary care, NDIS, hospitalisations, residential aged care, non-admitted activity and health care planning
- Service profiling – service mapping, performance analysis and workforce mapping.

In addition to the above minimum dataset, WBHHSs has utilised additional data available that supports the priorities put forward for the region. In addition, qualitative data collected during the course of the assessment, through sources such as stakeholder consultation, consumer focus groups, or other methods, has been utilised to develop this report.

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 target priorities for the WBHHS community.

4.2 Consultation

A HSP and LANA project steering committee provided guidance and assurance over the approach to development of the WBHHS Health Service Plan and LANA development. Composition of this PSC included:

- Chief Executive
- Director of Infrastructure and Assets (Executive Sponsor)
- Executive Director Medical Services
- Executive Director Allied Health
- Executive Director Governance.

Extensive staff and community consultation was undertaken to validate and contextualise the evidence developed as part of the Health Service Plan and Local Area Needs Assessment. Consultation identified strategies, key enablers and implementation considerations and reached over 410 WBHHS stakeholders including:

- Online survey – receiving 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 Fraser Coast Regional Council, Bundaberg Regional Council, Central Queensland Wide Bay Sunshine Coast Primary Health Network (CQWBSC PHN), Discovery Coast Consumer Reference Group
- 38 focus groups across all facilities with clinical and operational staff reaching >150 staff.

4.3 Identification of community health needs

WBHHS defined 'health need' as a health outcome and/or the related conditions that contribute to a defined health need. Identification of population health needs was based on data analysis and consultation, including assessment of community health need, service gaps, and identification of health service needs to address those gaps.

Methods used to identify **community health needs** included analysis and stakeholder consultation on:

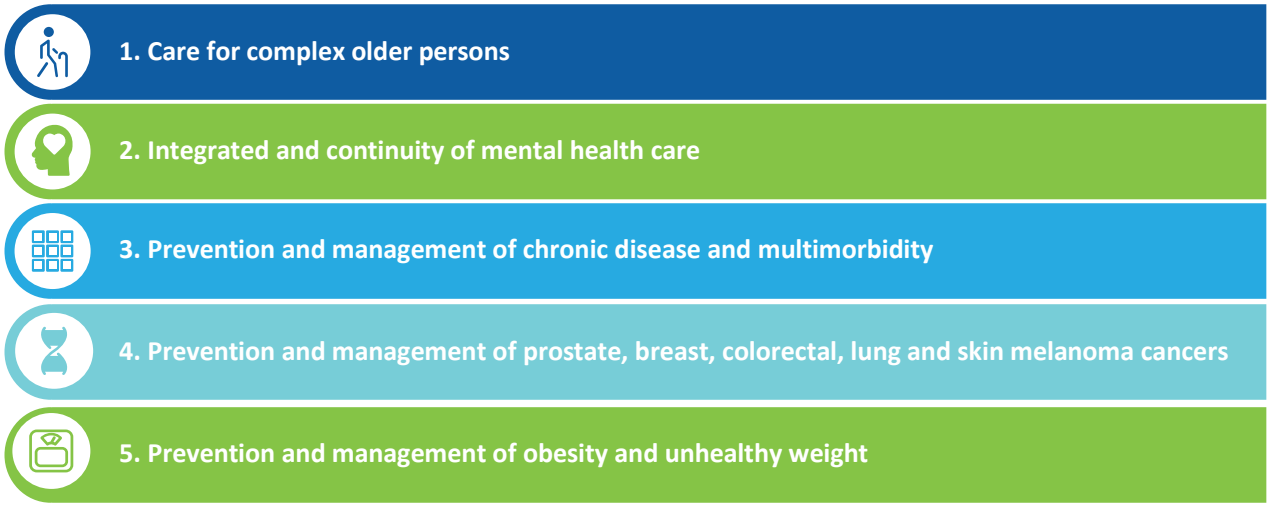
- **Population demographic profile** across the various planning regions to identify key areas of growth, where certain patient cohorts are expected to grow, and socio-economic profiles
- **Risk factors** across the population that are associated with poor health and impact on demand for services
- **Burden 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 the emergency department to understand potential future pressure areas
- **Patient flows** between services, including services for which WBHHS residents travel outside of the region, or within and between WBHHS facilities.

4.4 Prioritisation of community health needs

A structured approach to prioiritsation of **community health needs** was adopted. A Health needs prioiritsation 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. Membership of the PSC involved in the prioiritsation exercise, included the WBHHS Chief Executive, Director of Infrastructure and Assets (also the Executive Sponsor of the project), Executive Director of Medical Services, Executive Director of Allied Health and Executive Director of Governance.

A short-list of health needs were identified and presented to the PSC for validation, utilising the table and structure recommended within the LANA development framework (Section 5). Through this process, the following health needs were confirmed

Figure 2. Identified health needs for WBHHS.



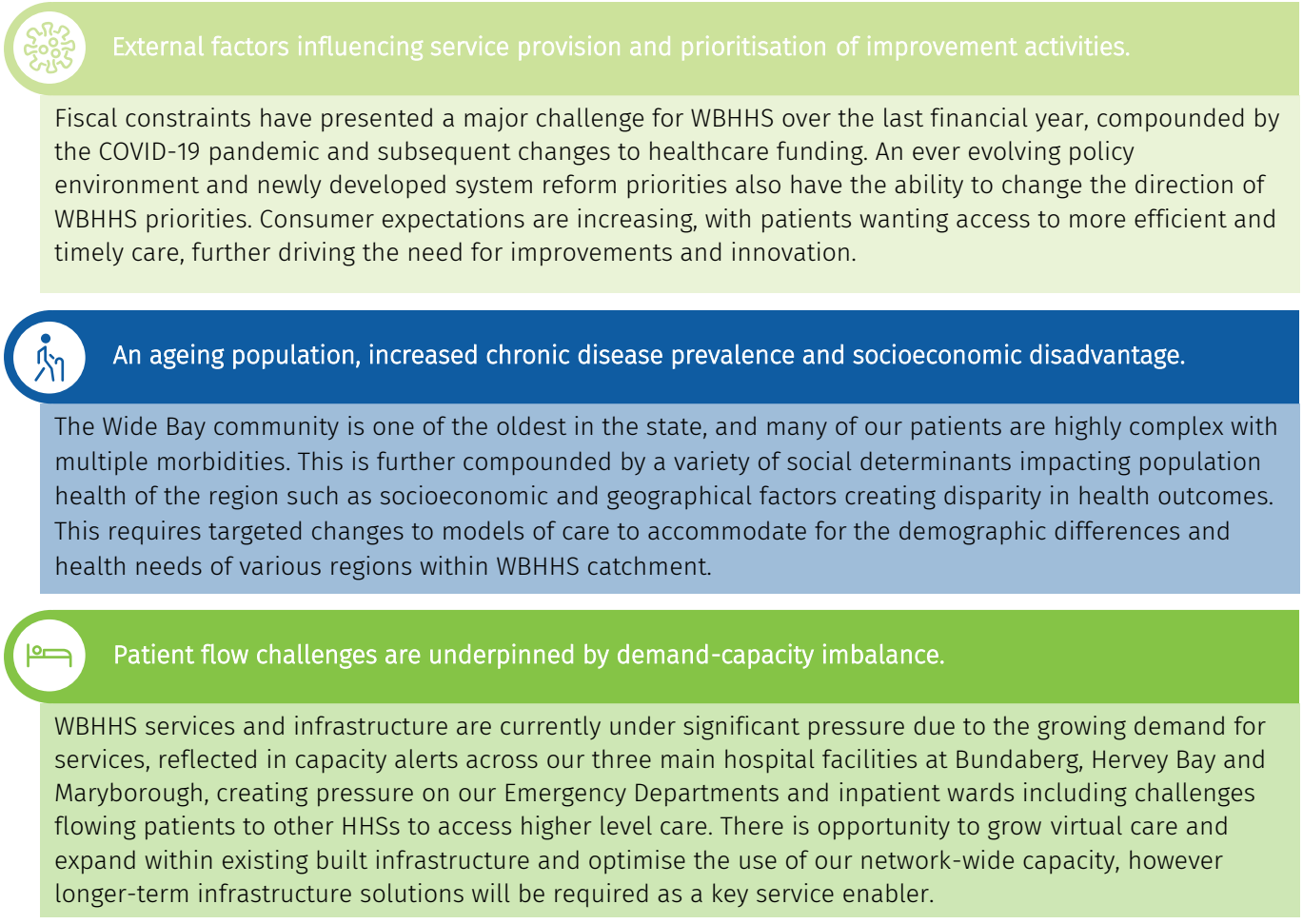
4.5 Identification of health needs

Similar to methods used to identify community health needs, methods used to identify **health needs** included analysis and stakeholder consultation on:

- **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 the emergency department to understand potential future pressure areas
- **Patient flows** between services, including services for which WBHHS residents travel outside of the region, or within and between WBHHS facilities.
- **Community service profile** including availability of primary health care services (General Practitioners, allied health, pharmacy), private hospital and other health services available locally.

The WBHHS Health Service Plan (2022-2037) was developed in conjunction the LANA to ensure an evidence based approach to formulating strategies that address community health needs and health service needs. As such, there are many interdependencies and strong alignment between identified community health needs (figure 3), health service needs (figure 4) and proposed Service priorities (figure 2).

Figure 4. Service delivery challenges and opportunities.



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.

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.

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.

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 Program is designed to grow our own junior medical workforce commencing 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).

4.6 Prioritisation of health service needs

A structured approach to prioiritsation 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. Membership of the PSC, involved in the prioritisation exercise, included the WBHHS Chief Executive, Director of Infrastructure and Assets (also the Executive Sponsor of the project), Executive Director of Medical Services, Executive Director of Allied Health and Executive Director of Governance. This developed criteria was aligned to the mandatory criteria to be used by all HHSs outlined in the Local Area Needs Assessment (LANA) Framework, developed by the Department of Health. Alignment to the mandatory criteria is outlined in the table below.

A short-list of Health needs and corresponding 'health service need/s' were presented, utilising the table and structure recommended within this LANA development framework. Each health need (and corresponding health service need/s) were assessed against key criteria - with the PSC collectively allocating an appropriate rating/score against each criteria. The rating system to assign a score to each criteria is outlined below.

Rating/Score	Rating description
3	Health need scores highly against criteria
2	Health need scores moderately against criteria
1	Health need scores least against criteria

Criteria and allocated weighting were agreed to by the PSC, and used to assess each health need/service need, as outlined below.

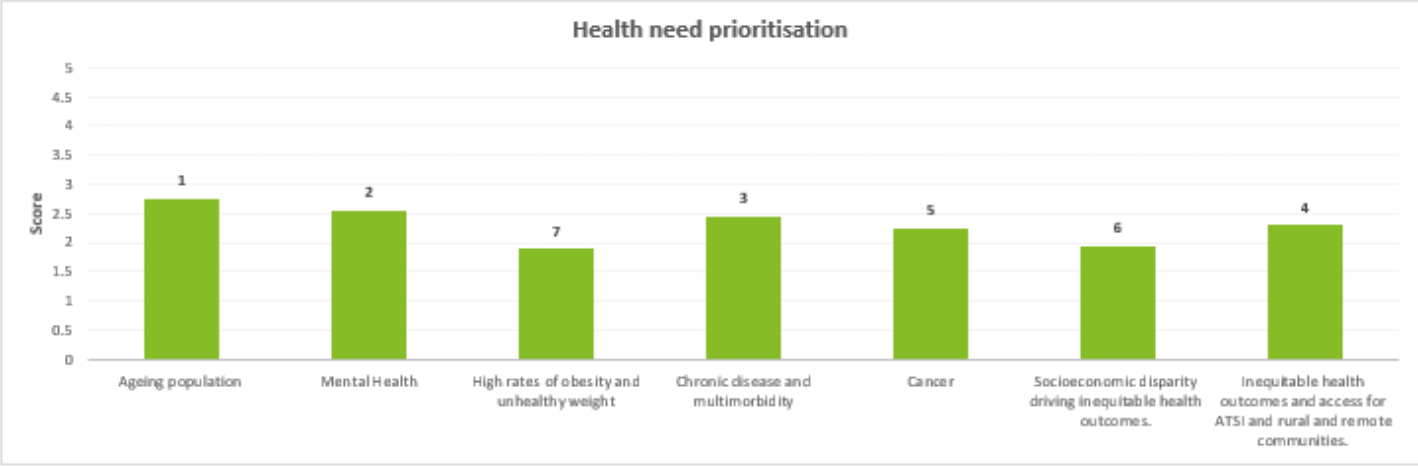
Department of Health Criteria	WBHHS Developed Criteria	Weighting
	Impact	75%
Validation of need - has the need been identified using more than one method (e.g. consultation, community profile, literature review, data analytics)?	**Size/severity** of the problem created by the health need/service gap – data validation	30%

Risk of unmet need - what are the potential consequences if the need is not addressed? For example, will existing health inequalities/inequities persist or exacerbate over time if not addressed?		
Validation of need - has the need been identified using more than one method (e.g. consultation, community profile, literature review, data analytics)?	Community and clinicians raised this health need as an issue in **consultation**	20%
Feasibility - can the potential solution for this need be implemented within available resources? Can it be implemented within the health system, geographical, political, social and financial conditions? Are there opportunities to collaborate with other agencies that would enhance feasibility?	Ability of Wide Bay HHS to **influence** outcomes	15%
Validation of need - has the need been identified using more than one method (e.g. consultation, community profile, literature review, data analytics)? **Risk of unmet need** - what are the potential consequences if the need is not addressed? For example, will existing health inequalities/inequities persist or exacerbate over time if not addressed?	**Proportion** of population impacted (whole population vs. subgroups)	10%
	Implementation	**25%**
Feasibility - can the potential solution for this need be implemented within available resources? Can it be implemented within the current financial conditions?	Level of **operational funding** required to implement proposed solutions *(What are the workforce impacts?)*	5%
Feasibility - can the potential solution for this need be implemented within available resources? Can it be implemented within the current financial conditions?	Level of **capital funding** required to implement proposed solutions *(How much additional infrastructure is required?)*	5%
Feasibility - can the potential solution for this need be implemented within available resources? Can it be implemented within the health system, political and social conditions? Are there opportunities to collaborate with other agencies that would enhance feasibility?	Level of **influence** Wide Bay HHS has over potential solutions *(Is this our core business?)*	10%

Government/Departmental direction - does the need align with government and departmental strategic directions, targets, election or other commitments or formal obligations contained within the HHS Service agreement?	Alignment with **strategic objectives** (*Does this align with our HHS or system strategy?)*	5%

As a result, WBHHS Health Needs were prioritised as follows:

	Impact				Implementation					
Criteria	Size and severity of the problem created by the health need/service gap	Community/clinicians raised this as an issue in consultation	Ability of Wide Bay HHS to influence outcomes	Proportion of population impacted (whole population vs. subgroups)	Level of operational funding required to implement proposed solutions	Level of capital funding required to implement proposed solutions	Level of influence Wide Bay HHS has over potential solutions	Alignment with HHS and system strategic objectives	Score	Rank
Criteria weighting	30%	20%	15%	10%	5%	5%	10%	5%		
Ageing population	3	3	3	2	1	2	3	3	2.75	1
Mental Health	3	2	2	3	2	2	3	3	2.55	2
High rates of obesity and unhealthy weight	2	2	1	3	2	1	2	2	1.9	7
Chronic disease and multimorbidity	2	3	2	3	2	2	3	3	2.45	3
Cancer	3	1	3	2	2	1	3	1	2.25	5
Socioeconomic disparity driving inequitable health outcomes.	2	3	1	2	3	1	1	2	1.95	6
Inequitable health outcomes and access for ATSI and rural and remote communities.	3	2	2	1	2	1	3	3	2.3	4



Note: Following consultation and feedback from DoH System Planning Branch, these health needs were shortlisted and prioritised further, as described in Section 4.4.

5 Identified priorities

Rank	Priority health need	Description of health need at local community geographical area and by population cohort	Health service gap	Evidence (present evidence for health need and service gap)	Health service need	Alignment to system priorities
1	Care for complex older persons	The Wide Bay community is one of the oldest in the state, with 25.9% of the population aged over 65 years (compared to Queensland average of 15.7%). Specific SA2 areas have more accelerated population aging growth rates.	The need to manage older patients (especially those with behavioural and memory loss issues or with complex medical comorbidities) is impacting capacity and performance. Additional staffing and general medical beds are required to care for complex older patients who typically have a longer length of hospital stay, require more rehabilitation and clinical resources.	More than 50% of WBHHS bed days attributable to persons aged over 65 years. 29.5% of WBHHS emergency department presentations attributable to persons aged over 65 years. 15.0% of the population in Wide Bay over 65 years live with a profound or severe disability in the community, compared to just 13.4% of over 65s in Queensland. Feedback from extensive consultation with over 410 WBHHS stakeholders, including HHS workforce, consumers and partners.	Healthy Ageing Strategies are imperative to ensure changing demand and needs of an older population are met. Partnerships with community care and RACF imperative to ensure care delivered in the right setting. Increase service capability locally to increase self-sufficiency.	Queensland Health System Outlook to 2026 Care 4 Qld Queensland Health System Priorities
2	Integration and continuity of mental health care	The age standardised rate (ASR) per 100,000 population for high levels odf psychological distress are varied across Wide Bay. The majority of SA2 areas have similar ASRs, similar to the Queensland average (ASR 13). Within the	Current services require greater integration with other acute, primary and community care for a seamless patient journey and greater access to care for individuals with a range of mental health conditions. Additional staffing and appropriate services	The incidence of **Mental and Behavioral problems** was highest in SA2 areas of Pialba-Eli Waters, Bundaberg and Bundaberg North-Gooburrum at a rate of 26.8 ASR per 100,000 people. Bundaberg had the highest volume of mental health practitioners (113) across Wide Bay. Total mental health practitioners across Wide Bay were predominantly made up of Mental Health Nurses (138), followed by Psychologists (109) and Psychiatrists	Increased partnerships to build capacity of community mental health services to prevent patient deterioration to the point of requiring crisis support and hospitalisation. Greater integration and consumer-focused approaches	Mental Health, Alcohol and Other Drugs Joint Regional Plan (Wide Bay 2020-25) Department of Health Fifth National Mental Health and Suicide Prevention Plan (2017)

Rank	Priority health need	Description of health need at local community geographical area and by population cohort	Health service gap	Evidence (present evidence for health need and service gap)	Health service need	Alignment to system priorities
		Maryborough area, regions of Granville, Burrum – Fraser and Maryborough Region – South have age standardised rates of 17.	are required to care for patients with mental illness who typically have comorbidities and increased risk of representation and readmission.	(12). Feedback from extensive consultation with over 410 WBHHS stakeholders, including HHS workforce, consumers and partners.	to co-planning, co-implementation and coordinated investment to promote better outcomes for people with mental illness and/or substance misuse.	Department of Health national Drug Strategy (2017-2026)
3	Prevention and management of chronic disease and multimorbidity	In 2017-2018, chronic disease incidence (Age Standardised Rates per 100,000 people) across the vast majority of Wide Bay SA2 areas was higher than the Queensland average for: • Arthritis, • Asthma, • Chronic Obstructive Pulmonary Disease, • Diabetes mellitus, • Cardiovascular disease and Stroke, • Osteoporosis and	The need to manage patients with multimorbidity and complex, chronic health needs is impacting capacity and performance. Additional staffing and general medical beds are required to care for complex patients who typically have a longer length of hospital stay and clinical resources. Access to specialist services within the WBHHS region is limited due to several subspecialty gaps. Workforce capacity constraints across both acute and primary care sectors throughout the Wide Bay region.	WBHHS has a higher age-standardised rate of PPH than the state-wide rate for both acute and chronic conditions. Of the fifteen HHSs in Queensland, WBHHS ranks sixth, with 4,307 potentially preventable hospitalisations per 100,000 people for acute and chronic conditions in 2016/17, compared to 3,695 per 100,000 people in Queensland. The number of General Practitioners (GPs) per 1,000 population in Wide Bay is 0.7, compared to Queensland average of 1.1. The number of GPs is highest in Hervey Bay (1 per 1,000 population), followed by Bundaberg (0.9) and Maryborough (0.5). The percentage of GPs over the age of 65 is higher in Wide Bay (18%) than Brisbane Inner region (14%). In Maryborough, the percentage of GPs over the age of 65 was particularly	Increase hospital avoidance by introducing new models of care and preventative measures. Work with partners to address service gaps and fragmentation along the patient's journey. Increase service capability locally to increase self-sufficiency at Wide Bay. Develop formal relationships, joint and shared service models and patient pathways to ensure seamless access to	Queensland Health System Outlook to 2026 Care 4 Qld Queensland Health System Priorities

Rank	Priority health need	Description of health need at local community geographical area and by population cohort	Health service gap	Evidence (present evidence for health need and service gap)	Health service need	Alignment to system priorities
		• Mental and Behavioural Problems.		high at 41%, followed by Bundaberg (15%). Feedback from extensive consultation with over 410 WBHHS stakeholders, including HHS workforce, consumers and partners.	care when needed from partners. Recruitment and retention workforce strategies.	
4	Prevention and management of prostate, breast, colorectal, lung and skin melanoma cancers	Cancer incidence in Wide Bay was generally slightly more than the Queensland average cancer incidence (590 Age Standardised Rate per 100,000 people) throughout 2010-2014. SA2 areas of Bundaberg, Bundaberg North-Gooburrum and Millbank-Avoca had the highest cancer incidence within Wide Bay at a rate of 717 ASR per 100,000 people.	The rising community demand for cancer care services requires health service alignment (services, workforce) to meeting this growing need.	The five most common types of cancer within Wide Bay throughout 2010-2014 were 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. Feedback from extensive consultation with over 410 WBHHS stakeholders, including HHS workforce, consumers and partners.	Work with partners to address service gaps and fragmentation along the patient's journey. 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. Promote Breast and other cancer screening services to enable early detection.	Queensland Health System Outlook to 2026
5	Prevention and management of obesity and	The Wide Bay region has higher rates of obesity and being overweight than Queensland and a	The need to manage patients with overweight and obesity is impacting capacity and performance, with	Larger proportion of adults who are **obese** in Wide Bay (31.2%) compared to Queensland (24.8%)	Increase hospital avoidance and preventative measures	Queensland Health System Outlook to 2026 Care 4 Qld

Rank	Priority health need	Description of health need at local community geographical area and by population cohort	Health service gap	Evidence (present evidence for health need and service gap)	Health service need	Alignment to system priorities
	unhealthy weight	corresponding lower proportion of the population that is a healthy weight or underweight.	care for complex patients with obesity and associated multi-morbidities typically requiring longer length of hospital stay. Access to specialist services within the WBHHS region is limited due to several subspecialty gaps. Workforce capacity constraints across both acute and primary care sectors through the region.	Higher proportion of adults who are overweight in Wide Bay (37.2%) compared to Queensland (35.3%). Feedback from extensive consultation with over 410 WBHHS stakeholders, including HHS workforce, consumers and partners.	Work with partners to address service gaps and fragmentation along the patient's journey. Increase service capability locally to increase self-sufficiency at Wide Bay. Recruitment and retention workforce strategies.	Queensland Health System Priorities
	Inequitable health outcomes and access for rural and remote communities, including our Aboriginal and Torres Strait Islander population.*	There are significant challenges for physically and socially isolated communities in accessing health care in WBHHS. Aboriginal and Torres Strait Islander people represent 4.2% of the WBHHS population and 6.64% of WBHHS bed days, with the largest populations in Bundaberg, North	Across WBHHS, the degree of technology adoption is inconsistent, and unreliable access to internet in some regions presents a unique set of challenges in providing integrated and timely care. Access to specialist services within the WBHHS region is	Rural and remote Australians have a higher burden of disease, mortality rate and more potentially avoidable deaths. 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 Queensland population (73.7 years). Furthermore, this population experiences 2.2x greater burden of disease. Virtual care accounts for 18% of services delivered within WBHHS. This	Develop the WBHHS Health Equity Plan by April 2022, and review on a three yearly cycle. Accelerate adoption of technology to update referral process, intra-facility access to medical reports, improve HHS-wide communication and primary care interfacing.	Queensland Government Making Tracks Investment Strategy Queensland Government Health Equity Strategy and legislative framework Queensland Health's Virtual

Rank	Priority health need	Description of health need at local community geographical area and by population cohort	Health service gap	Evidence (present evidence for health need and service gap)	Health service need	Alignment to system priorities
		Burnett, Monto-Eidsvold and Gayndah-Mundubbera areas.	limited due to several subspecialty gaps. Workforce capacity constraints across both acute and primary care sectors throughout the Wide Bay region, driving increased potentially preventable hospitalisations.	utilisation is comparable with the median across all HHS's (ranking 10th out of 16 HHSs in delivery as a percentage of total services). Feedback from extensive consultation with over 410 WBHHS stakeholders, including HHS workforce, consumers and partners.	Recruitment and retention workforce strategies.	Healthcare Strategy (2020) Queensland Health Telehealth Strategy (2021-26)
	Increase access to virtual care options and accessible transport to support equitable health outcomes for low socioeconomic populations in our region*	There are significant socioeconomic challenges for the Wide Bay population, compounding disparity in health care access and outcomes for some communities.	There are a variety of social determinants impacting population health of the region such as socioeconomic and geographical factors creating disparity in health outcomes.	Socio-Economic Indexes for Areas (SEIFA): Wide Bay population experiences **socio-economic disadvantage** at a rate higher than the Queensland average, with majority of SA2 areas having over 20% of the population within the 'most disadvantaged' quintile. 100% of the population in Bundaberg, Gin Gin, Point Vernon and Burrum – Fraser are within the bottom 2 quintiles, experiencing disadvantage at a higher level than the rest of the state population. Residents across the Wide Bay region experience **unemployment** at a higher rate than the Queensland average by 4 percentage points. Only 51% of the Wide Bay population participates in the labour force, compared to 66% of all Queenslanders	Targeted changes to models of care to accommodate for the demographic differences and health needs of various regions within WBHHS catchment (e.g. virtual care options to reduce need for travel). Considering cost as a barrier to health service access for some patients will increase health equity across the region. Provision of virtual modalities and accessible transport options will support patients to access care.	Queensland Health System Outlook to 2026 Care 4 Qld Queensland Health System Priorities

Rank	Priority health need	Description of health need at local community geographical area and by population cohort	Health service gap	Evidence (present evidence for health need and service gap)	Health service need	Alignment to system priorities
				Feedback from extensive consultation with over 410 WBHHS stakeholders, including HHS workforce, consumers and partners.		
Note: Following consultation and feedback from DoH System Planning Branch, these health needs were shortlisted and prioritised further, as described in Section 4.4.						

5.1 Priority 1 – Care for Complex Older Persons

Description of health need at local community geographic area and by population cohort

The Wide Bay community is one of the oldest in the state, with 25.9% of the population aged over 65 years (compared to Queensland average of 15.7%). Specific SA2 areas have more accelerated population ageing growth rates including Tinana, Booral-River Heads, Maryborough South, Craignish and North Bundaberg. More than 25% of the population is over the age of 65+ in SA2 areas:

- Bundaberg Region – South
- Bargara – Burnett Heads
- Bundaberg North – Gooburrum
- Millbank – Avoca
- Gin Gin
- Monto – Eidsvold
- North Burnett, Craignish - Dundowran Beach
- Pialba - Eli Waters
- Point Vernon
- Torquay - Scarness – Kawungan
- Tinana
- Burrum – Fraser
- Urangan - Wondounna
- Maryborough Region – South.

Health service gap

The need to manage older patients (especially those with behavioural and memory loss issues or with complex medical comorbidities) is impacting capacity and performance. Alternative models of care (including ambulatory care) is a key opportunity area. Additional staffing and general medical beds are required to care for complex older patients who typically have a longer length of hospital stay, require more rehabilitation and clinical resources.

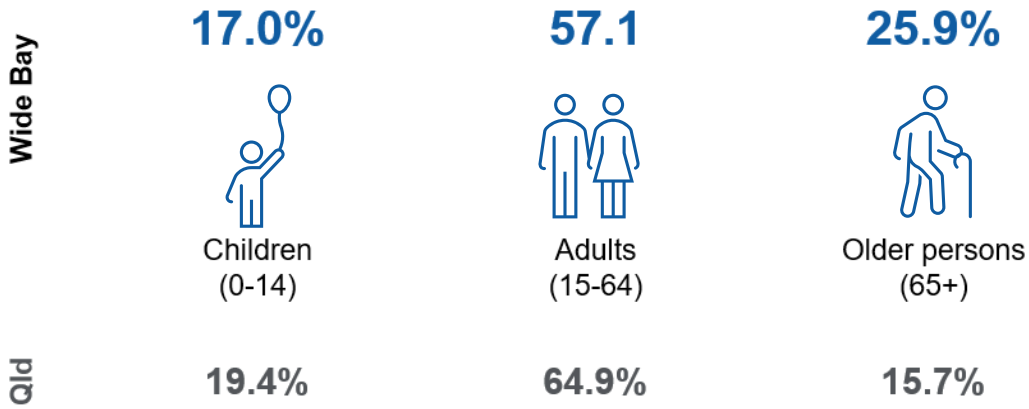
Evidence

Over 50% of WBHHS bed days attributable to persons aged over 65 years.

29.5% of WBHHS emergency department presentations attributable to persons aged over 65 years.

15.0% of the population in Wide Bay over 65 live with a profound or severe disability in the community, compared to just 13.4% of over 65s in Queensland.

Feedback from extensive consultation with over 410 WBHHS stakeholders, including HHS workforce, consumers and partners.



Health service need

Healthy Ageing Strategies are imperative to ensure changing demand and needs of an older population are met. Partnerships with community care and RACF is imperative to ensure care delivered in the right setting.

Alignment to system priorities

- Queensland Health System Outlook to 2026
- Care 4 Qld
- Queensland Health System Priorities

5.2 Priority 2 – Integration and continuity of Mental Health Care

Description of the health need at local community geographical area and by population cohort

The age standardised rate (ASR) per 100,000 population for high levels of psychological distress are varied across Wide Bay. The majority of SA2 areas have similar ASRs, similar to the Queensland average (ASR 13). Gympie region and Maryborough Region – South have scores significantly higher (ASR 30 and 33 respectively).

Health service gap

Require a shift 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.

Evidence

The incidence of Mental and Behavioural problems was highest in SA2 areas of Pialba-Eli Waters, Bundaberg and Bundaberg North-Gooburrum at a rate of 26.8 ASR per 100,000 people. SA2 areas of Bargara-Burnett Heads, Gayndah-Mundubbera, Urangan-Wondunna and Granville had the lowest incidence of mental and behvioural problems at 23.3 ASR per 100,000 people, (still higher than the Queensland average of 22.7).

Bundaberg had the highest volume of mental health practitioners (113) across Wide Bay. Total mental health practitioners across Wide Bay were predominantly made up of Mental Health Nurses (138), followed by Psychologists (109) and Psychiatrists (12).

Feedback from extensive consultation with over 410 WBHHS stakeholders, including HHS workforce, consumers and partners.

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.

Health service need

Increased partnerships to build capacity of community mental health services to prevent patient deterioration to the point of requiring crisis support and hospitalisation. Greater integration and consumer-focused approaches to co-planning, co-implementation and coordinated investment to promote better outcomes for people with mental illness and/or substance misuse. Additional staffing and appropriate services are required to care for patients with mental illness who typically have comorbidities and increased risk of representation and readmission.

Alignment to system priorities

- Mental Health, Alcohol and Other Drugs Joint Regional Plan (Wide Bay 2020-25)
- Department of Health Fifth National Mental Health and Suicide Prevention Plan (2017)
- Department of Health national Drug Strategy (2017-2026)

5.3 Priority 3 – Prevention and Management of Chronic Disease and Multimorbidity

Description of health need at local community geographical area and by population cohort

In 2017-2018, chronic disease incidence (Age Standardised Rates per 100,000 people) across the vast majority of Wide Bay SA2 areas was higher than the Queensland average for:

- Arthritis,
- Asthma,
- Chronic Obstructive Pulmonary Disease,
- Diabetes mellitus,
- Cardiovascular disease and Stroke,
- Osteoporosis; and
- Mental and Behavioural Problems.

Health service gap

The need to manage patients with multimorbidity and complex, chronic health needs is impacting capacity and performance. Additional staffing and general medical beds are required to care for complex patients who typically have a longer length of hospital stay and clinical resources. Access to specialist services within the WBHHS region is limited due to several subspecialty gaps.

Workforce capacity constraints across both acute and primary care sectors throughout the Wide Bay region further impact the service capacity to manage the demand curve.

Evidence

WBHHS has a higher age-standardised rate of PPH than the state-wide rate for both acute and chronic conditions. Of the fifteen HHSs in Queensland, WBHHS ranks sixth, with 4,307 potentially preventable hospitalisations per 100,000 people for acute and chronic conditions in 2017/18, compared to 3,695 per 100,000 people in Queensland. The largest contributors to PPH in WBHHS were diabetes complications, COPD, and urinary tract infections including pyelonephritis. Age Standardised Rate (ASR) per 100,000 for:

- Arthritis incidence was highest in Torquay - Scarness – Kawungan and Urangan - WondunnaBurrum-Fraser at an ASR of 17.4, (Queensland ASR 13.9).
- Asthma incidence was highest in SA2 area of Gympie Region at an ASR of 14.2, (Queensland ASR 11.8).
- Chronic Obstructive Pulmonary Disease incidence highest in SA2 areas Bundaberg, Bundaberg North-Gooburrum, Millbank – Avoca and Bundaberg at a rate of 4.2 ASR (Queensland 3.5 ASR).
- Diabetes Mellitus incidence highest in SA2 areas Gayndah – Mundubbera, Gin Gin, Monto – Eidsvold and North Burnett at an ASR of 6.0 (Queensland 4.7 ASR).
- Cardiovascular disease and stroke incidence highest in SA2 areas of Gayndah – Mundubbera, Gin Gin, Monto – Eidsvold and North Burnett at an ASR of 5.3 (Queensland 4.7 ASR).
- Compared to other chronic diseases, more SA2 areas within Wide Bay were at or below the Queensland average of 3.8 ASR per 100,000 rate for Osteoporosis.

The number of General Practitioners (GPs) per 1,000 population in Wide Bay is 0.7, compared to Queensland average of 1.1. The number of GPs is highest in Hervey Bay (1 per 1,000 population), followed by Bundaberg (0.9) and Maryborough (0.5). The percentage of GPs over the age of 65 is higher

in Wide Bay (18%) than Brisbane Inner region (14%). In Maryborough, the percentage of GPs over the age of 65 was particularly high at 41%, followed by Bundaberg (15%).

Feedback from extensive consultation with over 410 WBHHS stakeholders, including HHS workforce, consumers and partners.

Figure 4. Age standardised rates (per 100,000) for select chronic diseases in Wide Bay (median) and Qld (2010-2014).

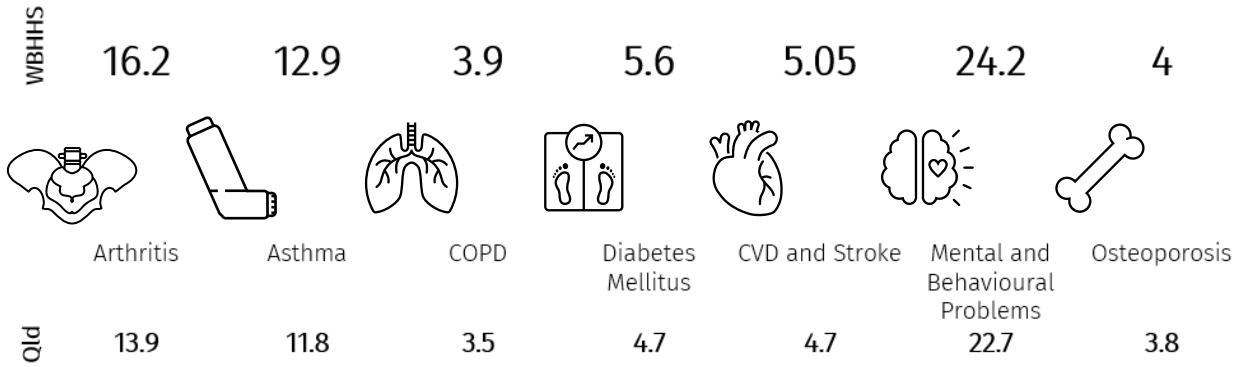
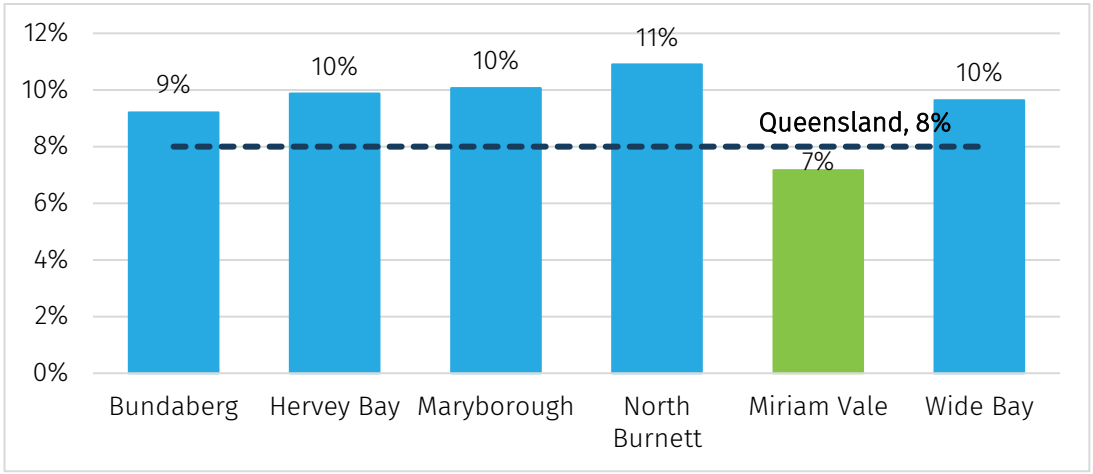


Figure 5. Potentially preventable hospitalisations as a percentage of total presentations (2021).



Wide Bay/region with higher cancer incidence than Queensland

Wide Bay/region with lower cancer incidence than Queensland

Health service need

Increased hospital avoidance and preventative measures is required, underpinned by strong partnerships with stakeholders of WBHHS to address service gaps and fragmentation along the patient's journey. This includes development of 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.

Increase service capability locally to increase self-sufficiency at Wide Bay HHS. This includes provision of new subspecialties, informed by demand analysis and projections of the proportion of our population requiring these services. 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.

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 (including providing 25% of all outpatient clinics via telehealth by 2036/37 and introduction of new technologies as they are adopted), best practice models of care and standardised procedures will be key to success. Recruitment and retention workforce strategies to maintain assurance of workforce capacity and pipeline to meet demand needs is required.

5.4 Priority 4 – Prevention and Management of Prostate, Breast, Colorectal, Lung and Skin Melanoma Cancers

Description of health need at local community geographic area and by population cohort

Cancer incidence in Wide Bay was slightly more than the Queensland average cancer incidence (590 Age Standardised Rate per 100,000 people) throughout 2010-2014. SA2 areas of Bundaberg, Bundaberg North-Gooburrum and Millbank-Avoca had the highest cancer incidence within Wide Bay at a rate of 717 ASR per 100,000 people.

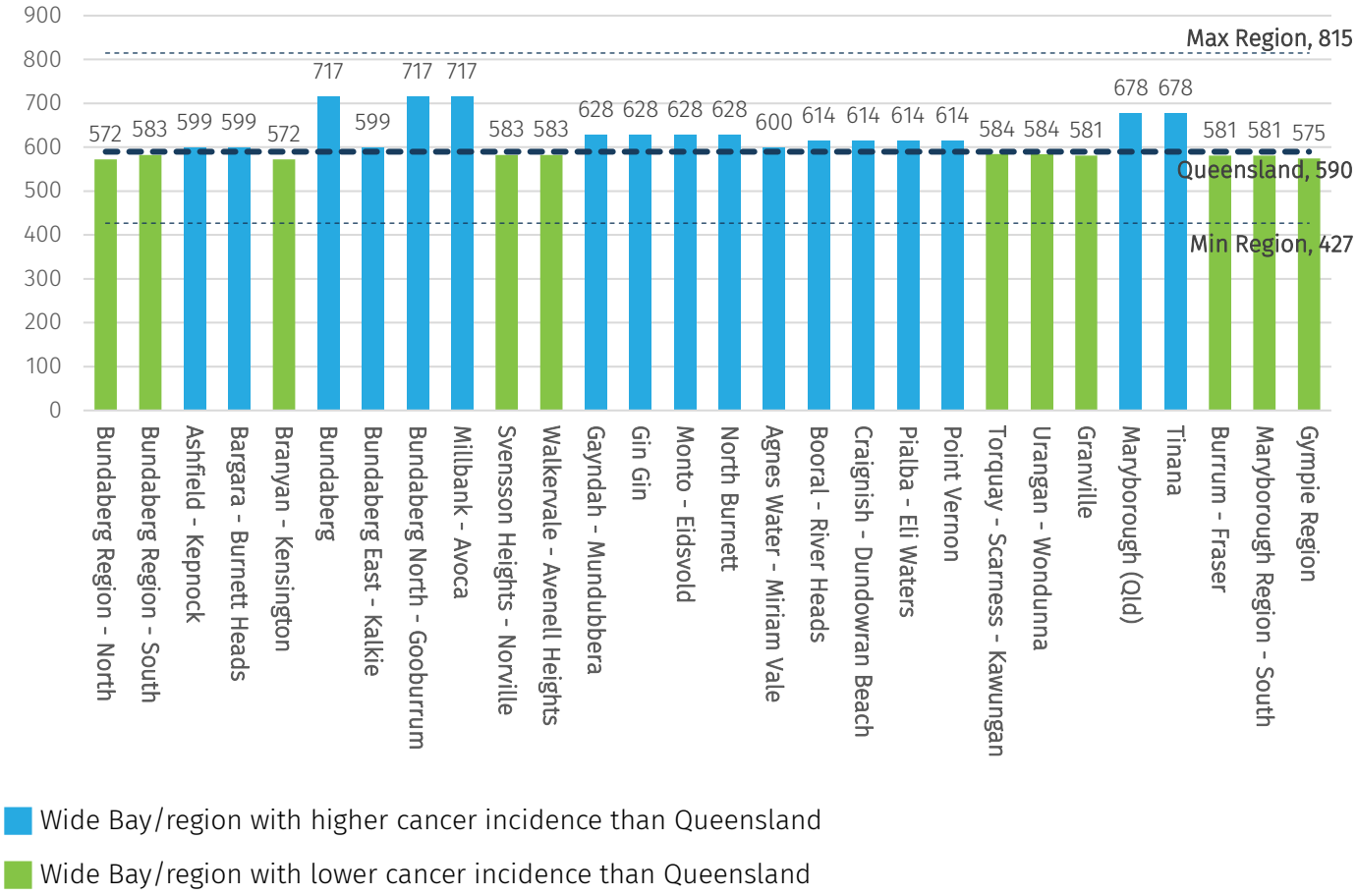
Health Service Gap

The rising community demand for cancer care services requires health service alignment (services, workforce) to meeting this growing need.

Evidence

The five most common types of cancer within Wide Bay throughout 2010-2014 were 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 6. Cancer incidence (ASR per 100,000 people) by SA2, 2010-2014.



Wide Bay/region with higher cancer incidence than Queensland

Wide Bay/region with lower cancer incidence than Queensland

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

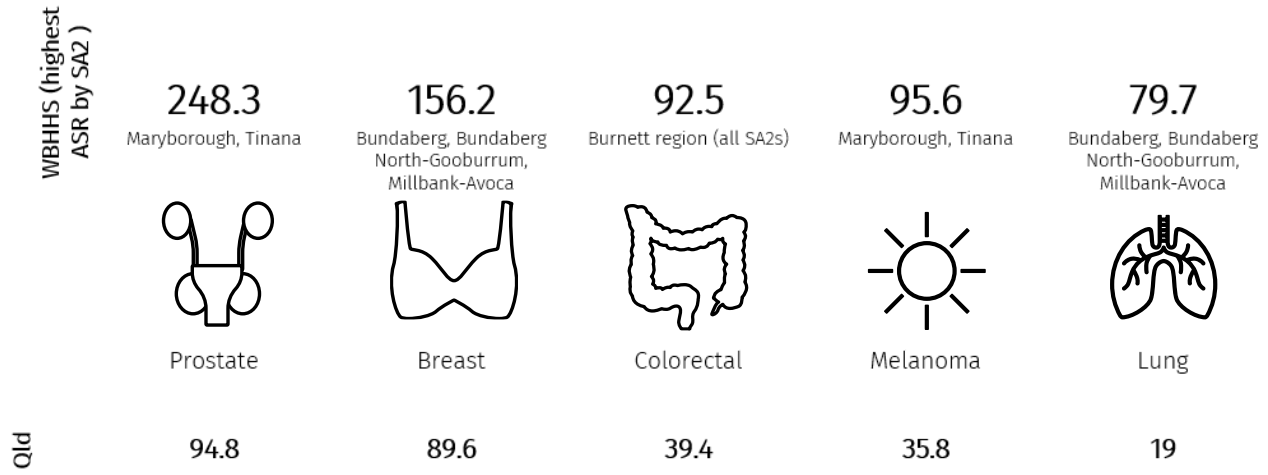
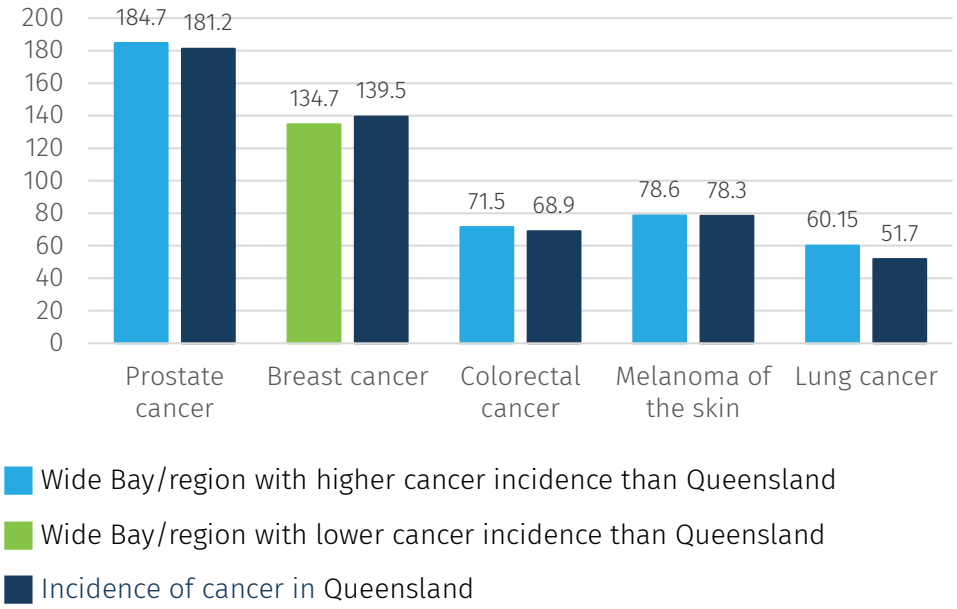


Figure 8. Median incidence of cancers (ASR per 100,000 people) in Wide Bay HHS compared to Queensland.



Screening

The proportion of the population (aged 50-74) who participate in breast cancer screening in Wide Bay is 58%, 3 percentage points above the Queensland average. Only the Gympie – Cooloola area is below the state level, albeit by 1 percentage point. Screening is highest in Bundaberg and Hervey Bay.

The proportion of the population who participate in bowel cancer screening in Wide Bay is 47%, 5 percentage points above the Queensland average (and highest in Maryborough and Hervey Bay). Only the Gladstone area (38%) is below the state level.

The proportion of the population (aged 25-74) who participate in cervical cancer screening in Wide Bay (42%) is lower than the Queensland average (46%).

Feedback from extensive consultation with over 410 WBHHS stakeholders, including HHS workforce, consumers and partners.

Health service need

WBHHS will work with partners to address service gaps and fragmentation along the patient's journey. This includes developing 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.

Increase service capability locally to increase self-sufficiency at Wide Bay.

Recruitment and retention workforce strategies.

Alignment to System Priorities

- Queensland Health System Outlook to 2026

5.5 Priority 5 – Prevention and Management of Obesity and Unhealthy Weight

Description of health need at local community geographical area and by population cohort

The Wide Bay region has higher rates of obesity and being overweight than Queensland and a corresponding lower proportion of the population that is a healthy weight or underweight. Only Maryborough and Burnett SA3s have lower rates of overweight adults than Queensland average, but all SA3s have higher rates of obesity than Queensland average.

Health service gap

The need to manage patients with overweight and obesity is impacting capacity and performance. Additional staffing and general medical beds are required to care for complex patients with obesity and associated multi-morbidities who typically have a longer length of hospital stay.

Access to specialist services within the WBHHS region is limited due to several subspecialty gaps.

Workforce capacity constraints across both acute and primary care sectors throughout the Wide Bay region, driving increased potentially preventable hospitalisations for this cohort.

Evidence

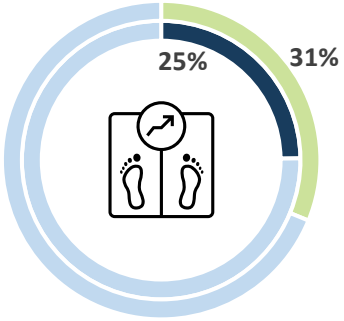
Larger proportion of adults who are obese in Wide Bay (31.2%) compared to Queensland (24.8%)

Higher proportion of adults who are overweight in Wide Bay (37.2%) compared to Queensland (35.3%).

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

Feedback from extensive consultation with over 410 WBHHS stakeholders, including HHS workforce, consumers and partners.

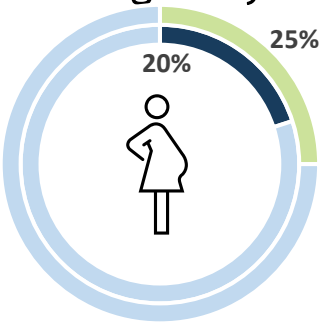
Obesity



WBHHS Queensland

31% of WBHHS adults were obese in 2017-18 compared to 25% for QLD

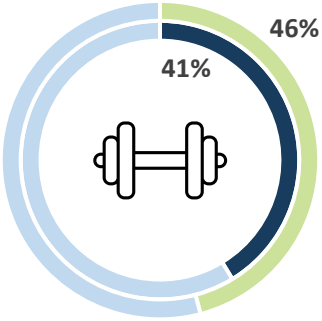
Obesity during Pregnancy



WBHHS Queensland

25% of WBHHS mothers were obese during pregnancy in 2017-18 compared to 20% for QLD

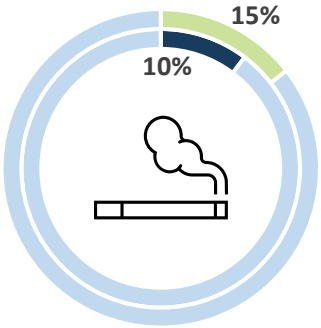
Physical activity



WBHHS Queensland

46% of WBHHS adults engaged in insufficient physical activity in 2017-18 compared to 41% for QLD

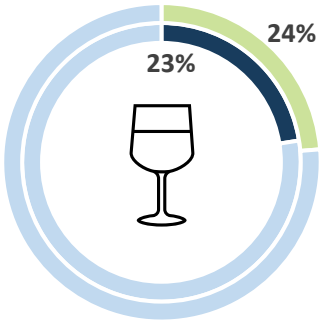
Tobacco



WBHHS Queensland

15% of WBHHS adults were daily smokers in 2017-18 compared to 10% for QLD

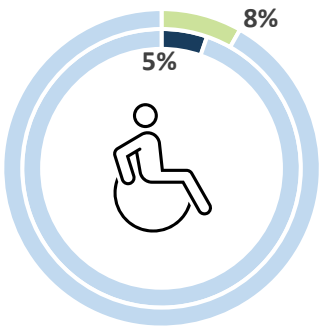
Alcohol



WBHHS Queensland

24% of WBHHS adults were risky drinkers in 2017-18 compared to 23% for QLD

Disability



WBHHS Queensland

8% of WBHHS residents were living with a profound disability in 2017-18 compared to 5% for QLD

Health service need

Increased hospital avoidance and preventative measures is required.

Work with partners to address service gaps and fragmentation along the patient's journey. This includes developing 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.

Increase service capability locally to increase self-sufficiency at Wide Bay.

Recruitment and retention workforce strategies.

Alignment to system priorities

- Queensland Health System Outlook to 2026
- Care 4 Qld
- Queensland Health System Priorities

Throughout the LANA development process, common health service needs and gaps were identified that spanned all the identified health needs.

a) Increase Access to Virtual Care Options and Accessible Transport to Support Equitable Health Outcomes for Low Socioeconomic Populations in our Region

Description of health need at local community geographical area and by population cohort

There are significant socioeconomic challenges for the Wide Bay population, compounding disparity in health care access and outcomes for some communities.

Health service gap

Greater consideration of cost as a barrier to health service access for some patients will increase health equity across the region. Provision of virtual modalities and accessible transport options will support patients to access care.

Evidence

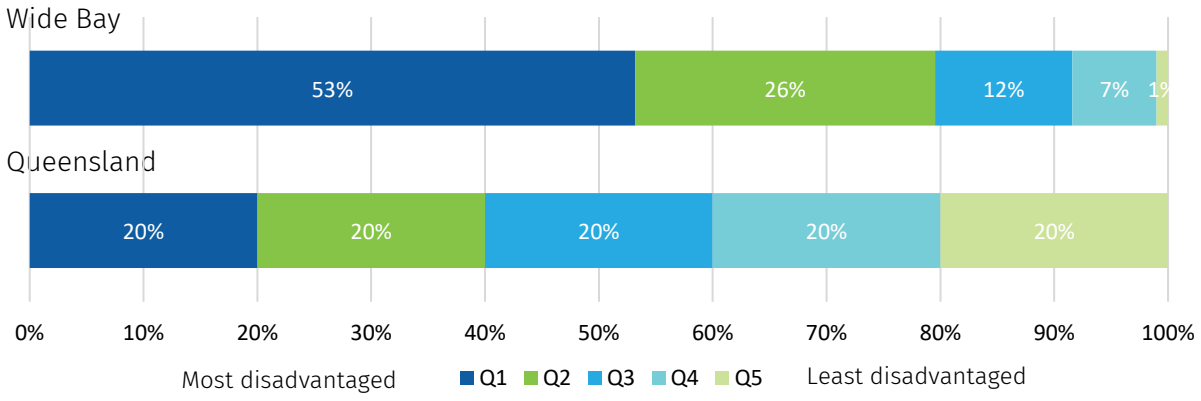
Wide Bay population experiences socio-economic disadvantage at a rate higher than the Queensland average, with majority of SA2 areas having over 20% of the population within the 'most disadvantaged' quintile (as per Socio-Economic Indexes for Areas (SEIFA)).

100% of the population in Bundaberg, Gin Gin, Point Vernon and Burrum – Fraser are within the bottom 2 quintiles, experiencing disadvantage at a higher level than the rest of the state population.

Residents across the Wide Bay region experience unemployment at a higher rate than the Queensland average by 4 percentage points. Only 51% of the Wide Bay population participates in the labour force, compared to 66% of all Queenslanders

Feedback from extensive consultation with over 410 WBHHS stakeholders, including HHS workforce, consumers and partners.

The Wide Bay region experiences far greater rates of socio-economic disadvantage in comparison the Queensland average. Over half of the population falls within the most disadvantaged quintile.



Across Wide Bay...

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

Rental stress is over 38% among low income households (Queensland, 28%)

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

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

Health service need

Targeted changes to models of care to accommodate for the demographic differences and health needs of various regions within WBHHS catchment (e.g. virtual care options to reduce need for travel) will be implemented.

Alignment to system priorities

- Queensland Health System Outlook to 2026
- Care 4 Qld
- Queensland Health System Priorities.

b) Increased access to healthcare services for rural and remote communities, including Aboriginal and Torres Strait Islander People

Description of the health need at local community geographical area and by population cohort

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 5.3% of the WBHHS population and 5.94% of WBHHS bed days, with the largest populations in Bundaberg and in particular, North Burnett, Monto-Eidsvold and Gayndah-Mundubbera areas (2021).

Health service gap

Across WBHHS, the degree of technology adoption is inconsistent, and unreliable access to internet in some regions presents a unique set of challenges in providing integrated and timely care.
Access to specialist services within the WBHHS region is limited due to several subspecialty gaps.
There are workforce capacity constraints across both acute and primary care sectors throughout the Wide Bay region, driving increased potentially preventable hospitalisations.
Consultation identified the need for greater focus on working with First Nations peoples, communities and organisations to design, deliver, monitor and review culturally safe health services.

Evidence

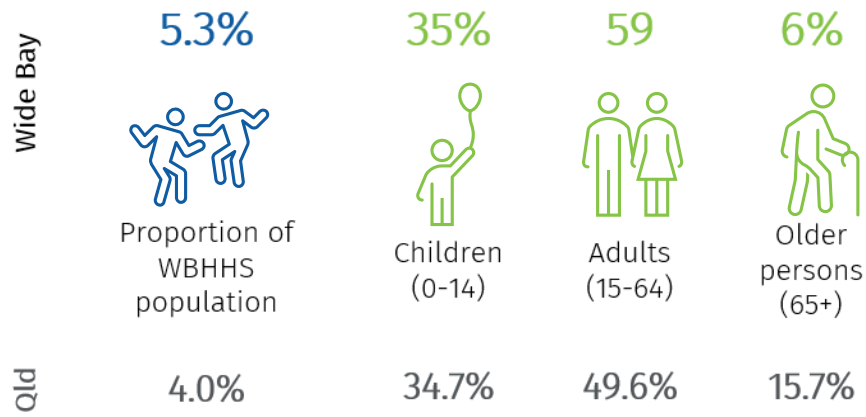
The Wide Bay HHS Aboriginal and Torres Strait Islander Closing the Gap Health Plan (2019) outlined a 12.2 year Health Adjusted Life Expectancy Gap of Aboriginal and Torres Strait Islander people (61.5 years) compared to Queensland population (73.7 years). Furthermore, this population experiences 2.2x greater burden of disease.

Aboriginal and Torres Strait Islander people represent 5.3% of the WBHHS population and 6.64% of WBHHS bed days, with the largest populations in Bundaberg, North Burnett, Monto-Eidsvold and Gayndah-Mundubbera areas. 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.

Feedback from extensive consultation with over 410 WBHHS stakeholders, including HHS workforce, consumers and partners.

Aboriginal and Torres Strait Islander Population



Health service need

Virtual care accounts for 18% of services delivered within WBHHS. This utilisation is comparable with the median across all HHS's (ranking 10th out of 16 HHS's in delivery as a percentage of total services).

WBHHS will increase equitable health outcomes and wellbeing of our Aboriginal and Torres Strait Islander community, in alignment with the WBHHS Health Equity Strategy 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 culturally safe, appropriate and accessible services for the Aboriginal and Torres Strait Islander population through all clinical service models.
- working with First Nations peoples, communities and organisations to design, deliver, monitor and review health services.

Alignment to system priorities

- Queensland Government Making Tracks Investment Strategy
- Queensland Government Health Equity Strategy and legislative framework
- Queensland Health's Virtual Healthcare Strategy (2020)
- Queensland Health Telehealth Strategy (2021-26).

6 Alignment to system priorities

Health needs and priorities align with many existing organisational, state, and federal government health policies and strategies, including:

- Queensland Health System Priorities outlined seven priorities, two of which are particularly relevant to the HHSs, and the development of this Plan. 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, growth of telehealth services, and improved cross-sector partnerships.

- Care4Queensland was initiated in 2021 aiming to support unprecedented demand in Queensland's 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. Currently, HHS' are required to report against Car4Qld metrics relating to HHS and QAS state-wide performance metrics.

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

- Health Equity Strategy has recently become a requirement of the HHSs. The strategy will outline mechanisms for the HHS to address how inequities in Aboriginal and Torres Strait Islander health outcomes in their region. This strategy will be completed in April 2022.
- 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. These focus on the two key priority areas of non-admitted referrals and chronic disease which both present a significant opportunity to reimagine healthcare pathways.

- Digital Strategy for Rural and Remote Healthcare (2022-2032) 10 year plan articulates a vision for putting in place the right digital infrastructure, systems and solutions to deliver better patient care for Queensland rural and remote patients and integrating that care across the health system.

- 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) which outlines a series of actions to improve the patient journey through public specialist outpatient services, resulting in state-wide investment in an electronic referral system (Smart Referrals), introduction of clinical decision support tools (Clinical Prioritisation Criteria) to standardise triaging of outpatient referrals across the state, and investment in developing new models of care.

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

- The COVID-19 pandemic has had a significant impact on the health system. Whilst the plan and LANA was written taking into consideration the changes in circumstances caused by the pandemic some data attained for FY20 and FY21 may be atypical.

- 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.

- 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 to provide more community nursing, expanded palliative care services in residential aged care facilities, and 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 Queensland Connecting care to recovery 2016–2021 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.

7 Other considerations

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 and readmissions.

COVID19 pandemic

Managing disruptions related to COVID19, including erratic workforce capacity due to isolation requirements.

Increased financial constraints

While there have been improvements in cost efficiencies and deployment 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. Telehealth) 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 toward population based allocation to support equitable funding distribution, including a shift to value and outcome versus traditional volume based funding models.

8 Next steps

The Wide Bay Health Service Plan (2022-37) and Wide Bay HHS Strategic Plan (2022-26) were developed in conjunction with the Local Area Needs Assessment (LANA). The integration of these important strategic documents will ensure alignment and clarity of focus as WBHHS targets priority areas to set to deliver contemporary, quality and sustainable services for the community. WBHHS is committed to delivering our service priorities and actions to ensure we are investing in initiatives that are effective and driving improved health outcomes for our community.

The WBHHS Health Service Plan strategies align to our Local Area Needs Assessment (LANA), and in particular, our identified Health Need priorities.
Summary Tables 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 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 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.						

Strategy	Complex older persons	Mental Health	Chronic disease	Cancer	Obesity
2. Ensure equity & 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 stepdown 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 by April 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.					

Strategy	Complex older persons	Mental Health	Chronic disease	Cancer	Obesity
2. Ensure equity & accessibility of care across our 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 Wide Bay Joint Regional Plan (2020-25)		✓			
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.		✓			

Strategy	Complex older persons	Mental Health	Chronic disease	Cancer	Obesity
3. Embed technology to bolster sustainable & 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.					

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					✓

Strategy	Complex older persons	Mental Health	Chronic disease	Cancer	Obesity
5. Nurture and future-proof our workforce					
5.1. Maximise 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 program.	✓	✓	✓	✓	✓
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.	✓	✓	✓	✓	✓

Acronyms

Abbreviation	Definition
ASR	Age-standardised rate
CAGR	Compound annual growth rate
CALD	Culturally and linguistically diverse
COPD	Chronic obstructive pulmonary disease
FTE	Full time equivalent
GP	General Practitioner
HHS	Hospital and Health Service
IRSD	Index of Relative Socioeconomic Disadvantage
LANA	Local area needs assessment
LGA	Local Government Area
NGO	Nongovernmental organisation
PHN	Primary Health Network
OBD	Occupied Bed Day
OOS	Occasion of service
SEIFA	Socio-Economic Indexes for Areas
SA2	Statistical Area Level Two
SA3	Statistical Area Level Three
SRG	Service Related Group

Glossary

Term	Definition
Acute care	A key service area for people experiencing an exacerbation of an existing condition or who may be experiencing the onset of a new illness or injury requiring hospitalisation or specialist services.
Ambulatory care	A key service area that includes emergency medical services, oral health services, public outpatient services including pre-admission, post-acute and other specialist services.
Burden of disease and injury	Assesses and compares the relative impact of different diseases and injuries on populations. It quantifies health loss due to disease/injury that remains after treatment, rehabilitation or prevention efforts of the health system and society generally.
Chronic disease	Diseases of long duration and generally slow progression. In this guide, chronic disease refers to all non-communicable disease and excludes injuries.
Clinical services capability framework	Minimum service requirements for health services, support services, staffing and safety standards in public and licensed private health facilities in Queensland.
Community	'Community' also refers to an inter-connected group of people who can influence one another's wellbeing - however, an individual's community is usually considered to be broader than the people with whom they live or have immediate family ties. Communities are commonly thought of as being groups of people living within particular geographical areas, such as cities or rural towns and their surrounding areas, but there is no particular geographic criteria that are widely used to set limits in defining a community
Diagnostic related group	Part of a data grouping classification scheme that provides a clinically meaningful way of relating the types of patients treated in a hospital to the resources required by the hospital.
Health inequality	Population-specific differences in the presence of disease, health outcomes or access to services. In other words, there are differences between populations on one or more measures of health.
Health inequity	The presence of systematic health inequalities between groups with different social advantage/disadvantage (e.g. wealth, power or prestige). It essentially refers to the social gradient of health.
Health need	A deficiency in health that requires health care. It can be subjectively determined (by an individual) or objectively determined (by a health professional or through scientific confirmation).
Health needs assessment	Systematic method for reviewing the health issues facing a defined population and identifying the specific health needs of a population.
Health service demand	Service activity that a catchment population can generate—that is, the amount of activity that a defined population uses regardless of where it is accessed.
Health service need	The gap between what services are currently provided to a given population and what will be required in the future to improve the health status of a community (and avoid a decline).
Health service supply	Service activity available to a catchment population—for example, the activity supplied by public sector health facilities in a particular HHS.
Healthcare need	A gap in a person's health state, which would benefit from an appropriate and effective care intervention, i.e. the capacity to benefit from services which may be health education, disease prevention, diagnosis, treatment, rehabilitation or palliative care.
Hospital separation	An episode of care that can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay ending in a change of status (e.g. from acute care to rehabilitation).
Incidence	Number of new health-related events (for example, illness or disease) in a defined population in a defined period of time.

Inpatient	A patient who undergoes a formal admission process to receive treatment and/or care from a hospital. Care may occur in a hospital or in the home. Also referred to as an 'admitted patient'.
Life expectancy	Average number of additional years a person of a given age and sex might expect to live if the age-specific death rates of the given period continue throughout his/her lifetime.
Local area	Geographic area ideally defined by SA3 or SA2 level boundaries (where data is available).
Local area needs assessment (LANA)	A detailed assessment of health need, based on an analysis of local level data across domains as well as community, clinician and service partner consultation
Mental health services	A key service area that provides alcohol, tobacco and other drug services, mental health promotion and prevention activities, acute services and extended treatment services.
Model of care	Outlines best practice care through the application of a set of service principles across services. It provides an overarching description of how care is managed, organised and delivered within the system.
Occasion of service	Any examination, consultation, treatment or other service provided to a non-admitted hospital patient in each functional unit of a health service facility on each occasion such service is provided.
Outpatient services	A hospital service in which patients receive treatment without being admitted.
Population growth	Average annual rate of population change.
Population projections	Population projections are illustrations of the change in population which would occur if the assumptions were to prevail over the projection period. The assumptions are based on demographic trends over the past decade and longer, both in Australia and internationally.
Prevalence	Measure of disease occurrence or frequency, often used to refer to the proportion of individuals in a population who have a disease or condition at a particular point of time.
Prevention, promotion and protection	A key service area that aims to prevent illness and injury, actively promote and protect the good health and wellbeing of people, and reduce the health status gap between the most and least advantaged in the community.
Primary healthcare	A key service area that addresses health problems or established risk factors of individuals and small targeted groups by providing curative, health promotion, preventative and rehabilitative services.
Service catchment	The geographic area for which a service is planned or the area in which most people accessing the service reside.
Service delivery model	An adaptation of an organisation's model of care that describes where and how work is carried out—developed to suit the local environment and to best meet organisational requirements.
Service directions	Describe clearly and succinctly the directions for the organisation to take to address the issues/needs that the health service planning is seeking to address.
Service enabler	In health service delivery, service enablers include assets (such as capital infrastructure), clinical support services, funding, information and communication technology and workforce.
Value	Value in health care is the measured improvement in a person's health outcomes divided by the cost of achieving that improvement.