Central Queensland Hospital and Health Service

Clinical Services Plan

2024–2029

Queensland Government

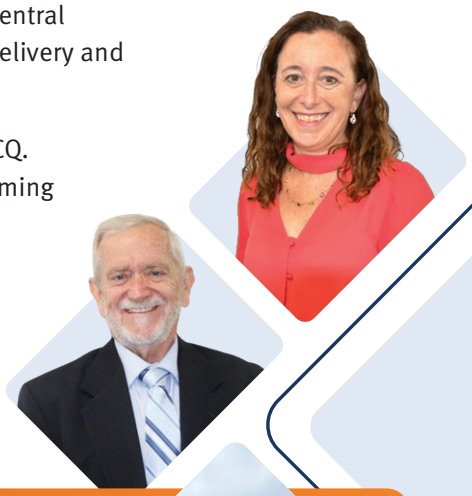
Welcome to the Plan

From the Board Chair and Health Service Chief Executive, Central Queensland Hospital and Health Service

We acknowledge the traditional custodians, across the lands which Central Queensland Hospital and Health Service (CQHHS) provides healthcare services and pay our respect to Elder's both past and present.

We are excited to launch the first Clinical Services Plan (2024–2029) for Central Queensland Hospital and Health Service.

We know this plan will pave the way for better access and improved health outcomes for Central Queenslanders now and into the future by focussing on contemporary models of service delivery and working in a networked approach.



This plan could not have been developed without our workforce and communities across CQ. We would like to acknowledge their significant contribution to building this plan and informing the services we will deliver over the next five years as we continue to work towards achieving our Destination 2030 vision to deliver Great Care for Central Queenslanders.

Paul Bell
Board Chair

Emma McCahon
Health Service Chief Executive

Acknowledgement of Country

We respect the collective cultures and traditions of the – recognised Aboriginal Traditional Owners and the Mura Kus Torres Strait Islander Descendants and Mura Kus communities of the Torres Strait Islanders living in Central Queensland – that are represented across the land, sea and river systems that connect and link our health services.

Darumbal, Woppaburra, Konomie, Byellee (Bailai), Gurang, Gooreng Gooreng, Taribelang Bunda, Gangulu/Gaangal, Ghungalu, Wulli Wulli, Western Kangoulu, Wadja, Kairi.

Please note for the purposes of consistency throughout this document, the term 'patient/s' represents the diverse range of stakeholders that access our health service including but not limited to, patients, consumers, clients, residents, etc.

Central Queensland Hospital and Health Service, Clinical Services Plan 2024–2029

Published by Central Queensland Hospital and Health Service, November, 2023

P2978 - Clinical Services Plan v1.0 | 16/11/2023

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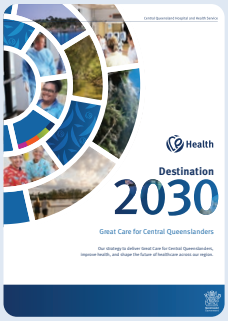
Our Clinical Services Plan

The Clinical Services Plan identifies the priority actions we need to take over the next five years (2024 to 2029) to provide safe and sustainable service models to meet the needs of the Central Queensland population, now and into the future. Through our collaborative new ways of working, we will deliver integrated and coordinated models of care that ensure patients and their families have access to culturally responsive and seamless care and support across their entire patient journey, closest to home.

Overarching Strategic Plan

Destination 2030 | Great care for Central Queenslanders

- **Great Care, Great Experience**
- **Great People, Great Place to Work**
- **Great Learning and Research**
- **Great Partnerships**
- **Sustainable Future**



Organisational core principles

Governance | **Culture** | **Health equity** | **Quality and safety**

Care closest to home

Our patients
Culturally responsive patient-centred care

Care in hospital

Organisational enablers

Models of service delivery (ways of working) | **Workforce wellbeing** | **Communication and engagement**

This plan will support our existing Destination 2030 Strategy to deliver great care for Central Queenslanders and contribute to achieving the HEALTHQ32 vision to create a healthier system for a healthier Queensland. It is underpinned by the organisational core principles of: Governance; Culture; Health equity; and Quality and safety. This will be achieved through our organisational enablers of: Models of service delivery; Workforce wellbeing; and Communication and engagement.

The priority for this plan is to focus on contemporary models of service delivery across all Central Queensland health service areas with the aim to deliver:

- Equitable health outcomes
- Improved access to quality and safe healthcare

In order to achieve these objectives, the initiatives identified within this plan embed care networks that focus on proactive care provision within the four care domains across the patient journey.

Key objectives

Contemporary models of service delivery

Equitable health outcomes | Improved access to quality and safe healthcare

Care domains

Care domain 1
Health protection, promotion and disease prevention

Better health and wellbeing for Central Queenslanders throughout all stages of life

Care domain 2
Ambulatory care and emergency department avoidance

Reduce unnecessary emergency department presentations and hospital admissions

Care domain 3
Acute care

The right care, for the right patient, in the right place, at the right time by the right care providers

Care domain 4
Care coordination and transitions

Coordinated and collaborative care for seamless transitions across the patient journey

Care networks

Aged and frail

- Establish Aged and Frail Care Network
- Optimise and expand teams that support out of hospital care including early discharge and transitions
- Expand geriatric service model
- Enhance support for residential aged care facilities with increased in reach and support

Chronic and complex

- Establish Chronic and Complex Care Network
- Establish sustainable, specialised chronic and complex disease service models
- Transform and optimise out of hospital care
- Streamline rapid access for known chronic disease patients

Mental health, alcohol and other drugs

- Deliver care in a single health service-wide 'networked' model
- Targeted services for vulnerable populations
- Expansion of community-based services, hospital avoidance and outreach programs

Perioperative

- Establish Perioperative Care Network
- Develop pathways that optimise perioperative patient experience and outcomes
- Increase self-sufficiency for sub-speciality care delivery for CQ patients closer to home
- Coordinated trauma service delivery

Women and children

- Establish networks for women's and children's care
- Optimise and standardise patient access to specialist obstetric services
- Build a collaborative care model for Aboriginal and Torres Strait Islander women and their families
- Standardise and streamline access for paediatric patients

The Clinical Services Plan is a key component of our Integrated Planning Framework, ensuring a consistent approach to planning to enable CQHHS to deliver safe, reliable and financially sustainable services. This will ensure we are investing in the resources, infrastructure and services that are most effective in meeting the health needs of Central Queenslanders and redirecting or scaling back those that are not.

The Integrated Planning Framework illustrates the relationship between our organisational strategies, plans, and frameworks in a proactive and integrated way. Each layer of planning helps organise and align activities by their role and function towards achieving our overarching vision and direction.

Overarching Strategic Plan

Destination 2030 | Great care for Central Queenslanders

- **Great Care, Great Experience**
- **Great People, Great Place to Work**
- **Great Learning and Research**
- **Great Partnerships**
- **Sustainable Future**

Supporting strategies and plans

- Health Equity Strategy 2022–2025
- Clinician Engagement Strategy 2022–2025
- Consumer and Community Engagement Strategy 2022–2025
- Local Area Needs Assessment (LANA) 2022
- Infrastructure Master Plan 2019
- Strategic Workforce Plan 2020–2030
- Clinical Services Plan 2024–2029

- Operational plans

Organisational core principles

Governance | Culture | Health equity | Quality and safety

Organisational enablers

Models of service delivery (ways of working) | Workforce wellbeing | Communication and engagement

Our demographic profile

Population: current and future

226,316 ▸ **279,470**

Current population of Central Queensland.

Estimated population by 2041. It is estimated that the population will grow by **0.8%** per year.

7.2%

of Central Queenslanders are of Aboriginal or Torres Strait Islander descent.

2.6% ▲

higher than the Queensland average.

Median age of people living in Central Queensland

38

Non-Aboriginal and Torres Strait Islander peoples.

21 ▼

Aboriginal and Torres Strait Islander peoples.

Birth rates

Birth rate of Central Queensland

2.04

per 1,000 live births

▲ **Higher than the Queensland birth rate.**

2.34

per 1,000 live births

Aboriginal and Torres Strait Islander peoples.

18%

Births at CQHHS occuring prior to 37weeks gestation.

▲ **7% higher than the Queensland average.**

13%

Aboriginal and Torres Strait Islander people born pre-term.

▲ **3% higher than the national average.**

27%

Low birthweight births at CQHHS that were Aboriginal and Torres Strait Islander births.

Ageing population

38

Current median age of people living in Central Queensland.

41

Projected median age by 2041.

3.72%

Estimated increase in Central Queenslanders aged greater than 65 years by 2036.

Social determinants of health

53%

Percentage of Central Queenslanders with the highest level of schooling of Year 11 or 12 (or equivalent), ▼ **10% lower than the Queensland state average.**

44.7

per 10,000 persons

Homelessness in Central Queensland is higher than the Queensland state average. Central Highlands having the highest rate of homelessness.

5.1%

Percentage of Central Queenslanders living in crowded dwellings. **This increases to 15% for Aboriginal and Torres Strait Islander peoples.**

7.4%

Percentage of Central Queenslanders classed as 'low-income earners', with 28.9% of residents classified in the most disadvantaged Socio-Economic Indexes for Areas (SEIFA) quintile.

Our service delivery profile

CQHHS delivers a broad range of public health services including emergency, medical, surgical, obstetrics, paediatrics, mental health, critical care, outpatients, oral health, aged care, community and clinical support services.

Services are provided from 12 hospitals, multipurpose health services, outpatient clinics and standalone aged care facilities. The network spreads across a diverse geographical area from the Queensland central coast to outer regional and remote towns.

Rockhampton Hospital is the major referral hospital for the region providing a range of speciality services at Clinical Service Capability Framework (CSCF) levels 4 and 5. Residents mey be required to travel to Brisbane for services such as cardiac surgery, maxillo-facial surgery, plastic surgery, vascular surgery, neurosurgery, neurology, endocrinology, dermatology, chronic pain, and interventional cardiology. Regional and rural facilities that provide a range of specialty services at CSCF level 2-3 are located at Gladstone, Emerald, and Biloela. Multipurpose health services and outpatient clinics located throughout the health service provide services such as emergency, medical, primary health care, and aged care services (some facilities) at CSCF levels 1-2.

Rockhampton Hospital

Gladstone Hospital

Emerald Hospital

Biloela Hospital

Mount Morgan
Multipurpose Health Service

Capricorn Coast
Hospital and Health Service

Baralaba
Multipurpose Health Service

Moura
Multipurpose Health Service

Theodore
Multipurpose Health Service

Blackwater
Hospital and Health Service

Springsure
Multipurpose Health Service

Woorabinda
Multipurpose Health Service

Community Health

Mental Health, Alcohol and
Other Drugs Service

Public Health Unit

Oral health Services

Breast Screening Service

Offender health

Eventide Home - Rockhampton

North Rockhampton Nursing Centre

Self-sufficiency

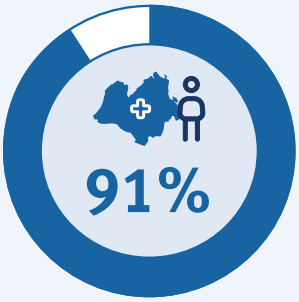
Self-sufficiency refers to the proportion of Central Queenslanders that receive the care they need locally, without need to be treated outside the region.

Services that are not available locally in CQ are delivered in tertiary Brisbane facilities including the Royal Brisbane and Women's Hospital, Prince Charles Hospital, Princess Alexandra Hospital and the Queensland Children's Hospital where they receive tertiary and quaternary care that is not available within Central Queensland.

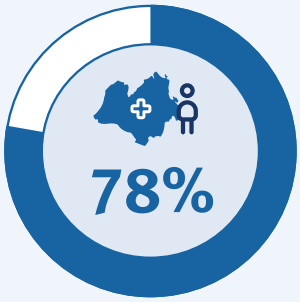
Adult self-sufficiency

Adult self-sufficiency within CQHHS

Highest outflows to Metro North HHS for obstetrics, vascular surgery, ophthalmology, and neurosurgery.



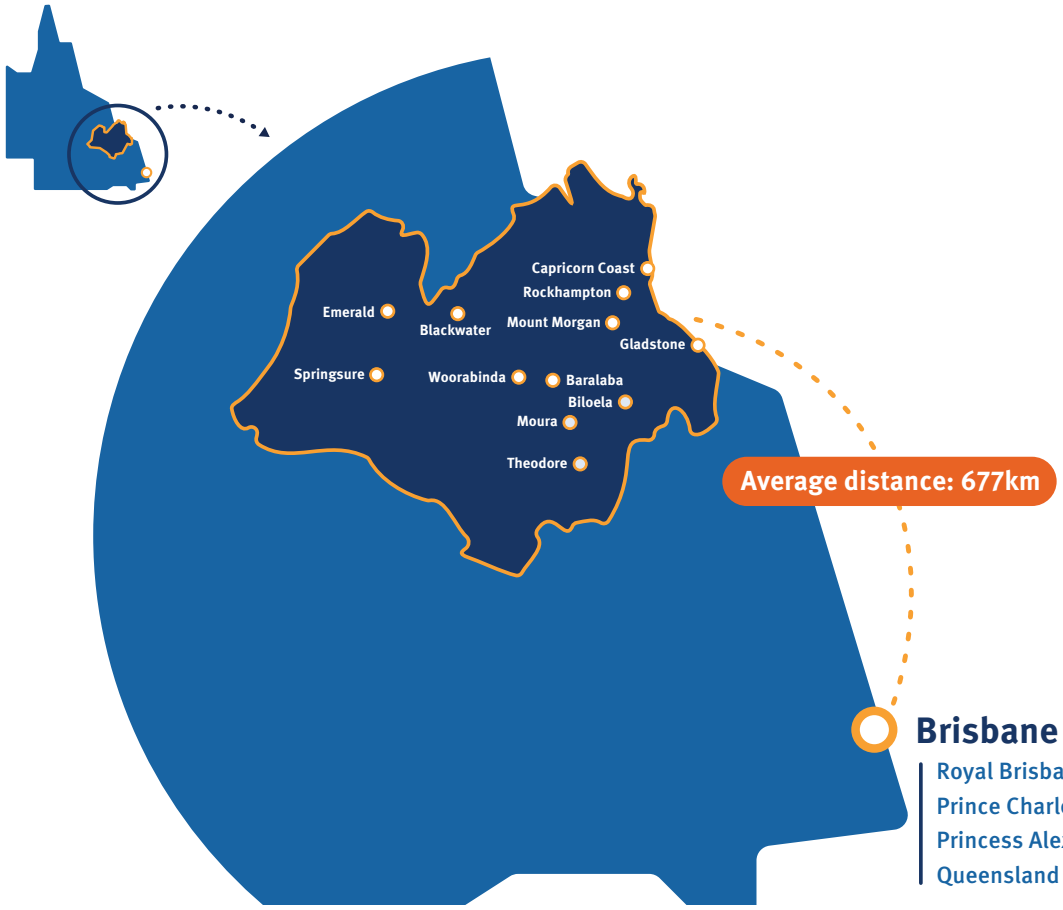
Child self-sufficiency



Child self-sufficiency within CQHHS

Highest outflows to Queensland Children's Hospital for rehabilitation, chemotherapy, orthopaedics, neurology, and thoracic medicine.

- A key strategy is to deliver care 'closer to home' to improve access and mitigate the travel burden for Central Queenslanders
- The Clinical Services Plan identifies gaps in the local service delivery and opportunities to further enhance services so that our residents can receive care in Central Queensland. This may involve the whole patient episode being able to be managed locally or alternatively the facilitation of an earlier transfer back to a local facility.



Our service activity and demand

The following section provides a high-level snapshot of the current and projected activity and demand data across Central Queensland Hospital and Health Service.

	Past Where we were 2017-18	Present Where we are now 2020-21/2021-22	Future Where we are projected to be by 2026-27
Emergency Department			
Emergency presentations	125,441	148,700	185,538
Inpatient services			
Inpatient acute separations	45,905	47,334	63,139
Inpatient sub-acute separations	2,013	1,805	2,533
Inpatient mental health acute separations	1,270	1,153	1,415
Inpatient overnight beddays	109,318	115,678	146,482
Inpatient same day beddays	19,534	21,062	29,815
Average length of stay	2.69 days	2.78 days	2.68 days
Hospital in the Home days	6,932	6,012	8,100
Critical care			
Intensive Care Unit beddays	1,834	2,111	2,299
Cardiac (Coronary) Unit beddays	1,515	3,891	3,633
Special Care Nursery beddays	1,844	1,829	3,076
Procedures (admitted/non-admitted)			
Endoscopy separations	4,571	5,412	7,221
Facility haemodialysis separations	10,826	14,043	16,834
Chemotherapy separations	4,079	5,827	6,331
Outpatient services			
Outpatient occasions of service	279,754	254,687	381,774
Oral health completed courses of care	31,734	26,167	Not Available

Community and outpatient

Outpatient occasions of service (OOS)

OOS have decreased by 9% since 2019-20 due to the impact of COVID

OOS consultation types 2019–20

Percentage of OOS for primary health care and community health services

Top providers of outpatient OOS since 2019–20

- Midwifery and maternity
- Child and youth community health services
- Orthopaedics clinics

Emergency department activity

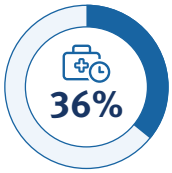
Total emergency department presentations

2017–18
125,441

2021–22
148,700
+19% from 2017–18
CAGR 4.3%

Of the total presentations, adults (aged 15+ years) accounted for approximately 80%

Emergency department presentations occurring outside usual business hours



Emergency presentation growth

From 2017–18 to 2020–21, there has been growth in emergency presentations, especially for semi and non-urgent conditions, older residents, and Aboriginal and Torres Strait Islander peoples living in Central Queensland:

Total emergency presentations that are triage category 4 and 5

Category 5 presentations grew by 27% (6% CAGR)

CAGR in emergency presentations since 2017–18

9%
People aged 70+

14%
Aboriginal and Torres Strait Islander people

6%
Non-Aboriginal and Torres Strait Islander people

Emergency presentations will continue to grow

74% The projected growth in emergency presentations for Central Queensland facilities between 2020–21 and 2036–37. Reflecting a steady compound annual growth of 3.5%.

Table 2 - Projected emergency department presentations at CQHHS facilities, by triage category, all ages, 2020-21 to 2036-37

Age	Triage category	2020–21 base year ^	2026–27	2031–32	2036–37	Growth	CAGR%
Adult (15+)	Triage 1	543	757	817	873	▲ 330 (61%)	3.0%
	Triage 2	16,781	22,776	27,088	31,321	▲ 14,540 (87%)	4.0%
	Triage 3	45,450	65,410	82,143	99,137	▲ 53,687 (118%)	5.0%
	Triage 4	39,561	47,616	53,977	60,124	▲ 20,563 (52%)	2.7%
	Triage 5	13,566	17,597	19,270	20,816	▲ 7,250 (53%)	2.7%
	Total adult	**115,901**	**154,156**	**183,295**	**212,271**	**▲ 96,370 (83%)**	**3.9%**
Child (0–14)	Triage 1	66	82	87	91	▲ 25 (38%)	2.0%
	Triage 2	2,097	2,455	2,573	2,725	▲ 628 (30%	1.7%
	Triage 3	11,167	12,443	13,635	15,128	▲ 3,961 (35%)	1.9%
	Triage 4	12,120	13,429	14,898	16,599	▲ 4,479 (37%)	2.0%
	Triage 5	2,807	2,973	3,149	3,401	▲ 594 (21%)	1.2%
	Total child	**282,57**	**31,382**	**34,342**	**37,944**	**▲ 9,687 (34%)**	**1.9%**
Total CQHHS		**144,158**	**185,538**	**217,637**	**250,215**	**▲ 106,057 (74%)**	**3.5%**

^Base year is 2020–21 however projection methodology considers historical trends derived from 5 years of data (2016-17 to 2020-21). Non-emergency COVID activity (such as fever clinics) have been excluded from 2019–20 and 2020–21 data sets.

Data source: Projections of Health Service Activity, Emergency Department Projections 2022 (Base year 2020–21). Published October 2022.

Inpatient activity

CQHHS public inpatient separations
(excluding mental health)

2020–21
47,986

2036–37 (projected)
88,300
+ 40,314 (84%)
CAGR 3.9%

Residents aged 70+

Separations for CQHHS residents **aged 70+ years** are expected to **increase by 174%** (CAGR 6%) by 2036-37 and consume 39% of resident demand while **beddays will increase by 127%** (5% CAGR) and consume **51% of total bedday demand**.

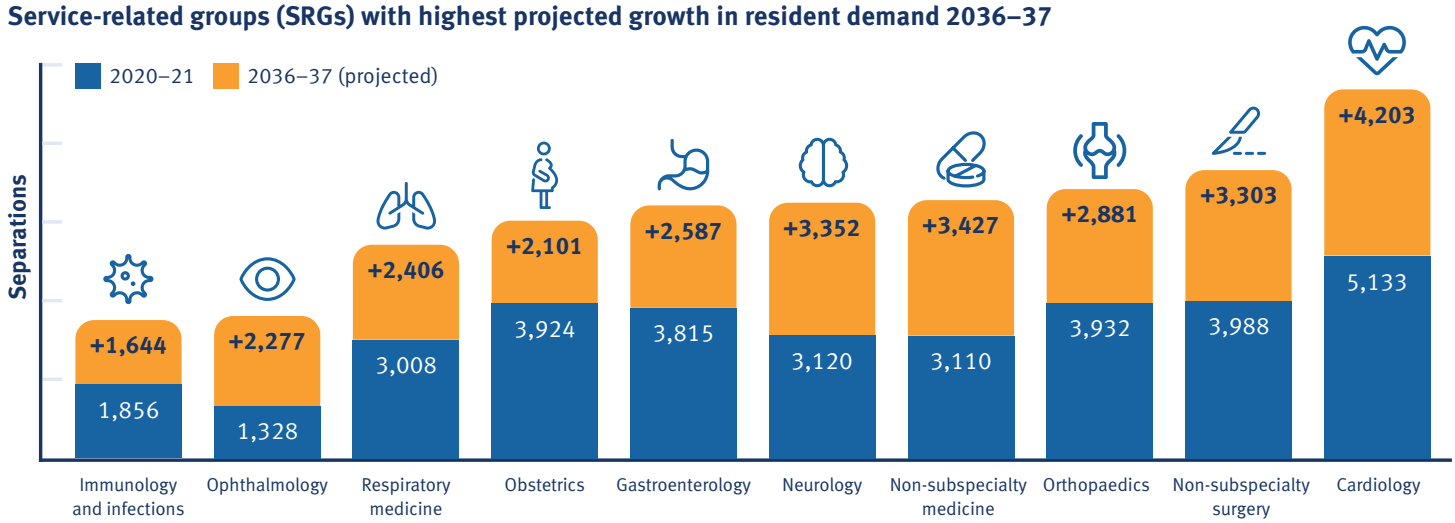
The highest growth in beddays across all age groups is for those aged 70-84 years (40,552 more beddays by 2036-37).

Refer to Table 3.

Table 3 - Projected CQHHS resident inpatient demand (separations and beddays), by age group, 2020-21 to 2036-37

	Age group	2020–21	2026–27	2031–32	2036–37	% of total (2036–37)	Growth # (2020–21 to 2036–37)
Separations	0-4 years	3,133	3,780	4,246	4,647	5.0%	1,514
	5-14 years	2,107	2,450	2,628	2,819	3.0%	712
	15-44 years	16,008	20,229	23,111	24,997	26.8%	8,989
	45-69 years	16,256	19,993	22,805	24,798	26.6%	8,542
	70-84 years	10,008	15,974	21,180	24,761	26.5%	14,753
	85+ years	3,170	5,569	7,974	11,282	12.1%	8,112
	Total separations	**50,682**	**67,995**	**81,944**	**93,305**	**100.0%**	**42,623**
Beddays	0-4 years	10,407	11,322	13,063	14,530	5.9%	4,123
	5-14 years	4,004	4,173	4,377	4,630	1.9%	626
	15-44 years	29,644	35,307	39,166	41,750	16.8%	12,106
	45-69 years	46,719	52,291	57,277	61,214	24.7%	14,495
	70-84 years	40,349	55,770	70,389	80,901	32.6%	40,552
	85+ years	15,067	22,708	31,672	44,778	18.1%	29,711
	Total beddays	**146,190**	**181,573**	**215,945**	**247,802**	**100.0%**	**101,612**

Service-related groups (SRGs) with highest projected growth in resident demand 2036–37



Data source: Projections of Future Health Service Activity, Base Case – Inpatient Projections (Base Year 2020-21, ASGS 2016), Published by the State of Queensland (Queensland Health), 2022.

Our partnerships

In order to meet the health care needs of our Central Queensland community now and into the future, our Clinical Service Plan considers what care we have self-sufficiency to deliver. It also identifies where we need to strengthen partnerships to ensure integrated, seamless, coordinated, culturally responsive, and specialist care in all patient flows across the hospital setting, in the community, and at home.

We have worked to establish collaborative service agreements with the two Aboriginal Community Controlled Health Organisations that operate within our health service catchment. These agreements with Bidgerdii Community Health Service and Nhulundu Health Service provide the foundation for improved care collaboration and coordination between our organisations.

We work collaboratively with other hospital and health services within a networked health care system to streamline and better coordinate access to services locally. This is part of a broader regional health network, with Metro North Hospital and Health Service, Queensland Children's Hospital, Metro South Hospital and Health Service, Mackay Hospital and Health Service, Sunshine Coast Hospital and Health Service, and Wide Bay Hospital and Health Service. These relationships are central to our commitment to reducing duplication, clinical and non-clinical variation, improving self-sufficiency, service sustainability, care coordination and providing the best possible care closer to home and country as possible.

We also have strong partnership with our 'Country to Coast' Primary Health Network to ensure a collaborative partnership approach to identifying and addressing regional health needs and planning for seamless healthcare transitions.

We will continue working closely with private care providers, non-government organisations, and our two private hospitals, Mater Private Hospital Rockhampton and Hillcrest Rockhampton Private Hospital, within our Central Queensland region to reduce pressure on our facilities.

The Clinical Services Plan project has been delivered in partnership between CQHHS and the Department of Health's Systems Planning Branch (SPB) between April and October 2023, with oversight from a project steering group inclusive of clinical and clinical support workforce representatives.

High-level project milestones

	April 2023	May 2023	June 2023	July 2023	August 2023	September–October 2023
Process	**(Background analysis)** Review LANA priorities Develop background papers (demography, strategic context, service profile, activity profile (historical and projected)	**Consultation with key stakeholders** Targeted stakeholder engagement to identify needs and issues and preliminary service delivery options	**Options development** Identify health service delivery options via scenario modeling and continued targeted consultation	**Broad, extensive consultation** Broad consultation across the health service	**Recommendations** Develop recommendations for service options based on consultation outcomes Draft options for the Plan Seek feedback on draft Clinical Services Plan	**Clinical Services Plan** Integrate stakeholder feedback into draft Clinical Services Plan Finalise Clinical Services Plan
Deliverables	**Background papers to inform consultation project collateral**	**Phase 1** Consultation summary	**Service options paper / Clinical Services Plan showcase**	**Phase 2** Consultation summary	**Draft Clinical Services Plan**	**Final Clinical Services Plan**
Governance and leadership	CQHHS and SPB partnership formed (weekly) Project Steering Group (PSG) established	- Robust governance structure for decision-making and risk management - Clinical lead to provide ongoing leadership and engagement with clinical and clinical support stakeholders PSG 1	PSG 2	PSG 3	PSG 4 PSG 5	PSG 6 PSG 7
Communication and engagement	Communication and engagement plan developed CE Engage 1	Engagement with key health service representatives and groups Electronic feedback form CE Engage 2	Targeted consultation to clarify priorities	Showcase event CE Engage 3	Draft Clinical Services Plan circulated for feedback to key health service representatives CE Engage 4	**Clinical Services Plan launch** CE Engage 5

The methodology applied

The priorities identified in this plan have been based on the input of multiple qualitative and quantitative datasets to ensure that the health needs of the community are best managed by using a deliberate and evidence-based strategy that makes the most effective use of physical and human resources. It has taken into account the current and future service demands, workforce requirements, advances in health technologies and innovative models of service delivery that we will use to deliver care to our local population both in, and out, of a hospital setting.

The voices of our community

External stakeholder engagement undertaken as part of the 2022 CQHHS Local Area Needs Assessment (LANA) to identify community health care needs through community and consumer advisory groups, community surveys and community and key stakeholder workshops.

The voices of our workforce

Extensive internal consultation with our workforce regarding service gaps and opportunities.

Scenario planning and modelling through use of historical data and trend analysis including statistical and data analysis of service use, community health indicators, population characteristics and changes (needs and gaps).

Data analytics

Identified risks and issues across the health service through understanding of local services' challenges and community feedback to identify service gaps, opportunities and priorities.

Known strategic risks and issues

Communication and engagement

The Clinical Services Plan has been developed through extensive consultation and engagement with staff. This approach has included a range of methodologies and approaches to ensure staff had visibility and transparency of progress and opportunities to participate in building our Clinical Services Plan across the project lifecycle.

0 Phase 0
Communication and engagement

Regular and timely updates across a number of platforms to ensure transparency and visibility of progress across the entire project including:

- Development of an intranet page, frequently asked questions and feedback form

1 Phase 1
Consultation
525 pieces of feedback

Broad stakeholder engagement to identify current strengths, opportunities and priorities through:

- CE virtual townhall
- CE Engage
- Virtual showcase feedback
- Targeted engagement with key stakeholder groups

2 Phase 2
Consultation
1,456 pieces of feedback

Broad stakeholder engagement to gain feedback on priorities, strategies and framework through:

- Clinical Services Plan summit
- Virtual showcase feedback

3 Phase 3
Consultation
Over 100 photos submitted

Final review of Clinical Services Plan:

- Targeted engagement on draft Clinical Services Plan
- Photo and artwork submission process

Consultation summary

Over 2,000
Pieces of feedback collected throughout the development of the plan

Over 80
Entries in the communication and engagement register

Our known commitments

There are a number of commitments already in the pipeline for the next five years that have been identified during the development of the Clinical Services Plan.

Known infrastructure commitments

Emerald Emergency Department expansion and associated works

Rockhampton Cardiac Catheterisation Lab

Woorabinda Aged Care expansion

Blackwater Multipurpose Health Service

Capricorn Coast (Yeppoon) Renal Unit

Rockhampton Mental Health Unit

Moura Multipurpose Health Service Aged Care expansion

CQHHS Central Sterilising Department AS4187 compliance works

Biloela Hospital

Known service delivery commitments

Cardiology service expansion

Provide expanded Cardiology Service that are evidence based, innovative, high quality, timely, and high value to the Central Queensland region.

Key services to be delivered

- The new Cardiac Catheterisation Lab will establish a diagnostic and interventional cardiology service, enhancing the range of cardiovascular procedures available in Central Queensland.
- Expansion of Cardiac Investigation Unit to increase the capacity of non-invasive cardiac imaging service.
- Extension of cardiology acute inpatient services.
- Implement integrated and coordinated network cardiology outreach service to provide culturally sensitive and care closer to home.
- Contemporary cardiology ambulatory service delivering multidisciplinary rapid diagnostic & chronic care services.

Palliative Care Reform Program

The Queensland Government has committed to additional funds to:

- Develop and implement a new Palliative and End-of-Life Care Strategy.
- Grow and invest in Queensland's specialist palliative care workforce through a Queensland Health Specialist Palliative Care Workforce Plan.
- Invest in community-based services to improve and promote choice for care at end of life through increased home-based and after-hours care, focusing on regional, rural and remote service provision outside of South-East Queensland.
- Enhance digital and telehealth solutions for consumers.
- Deliver 24/7 secondary consultation for palliative care practitioners through PallConsult.
- Provide education and advocacy about dying, death and advanced care planning.

Offender health

- Planning and implementation of Prisoner Electronic Medical Records (PeMR).
- Establishment and recruitment of Aboriginal and Torres Strait Islander Health Worker positions to provide culturally appropriate and safe care delivery to First Nations' men.
- Enhance telehealth services: Innovation through Virtual Clinics.

Integrated Workforce Management (IWFM) electronic rostering project

IWFM will roll out the existing state-wide enterprise rostering solution (known as Workbrain), a new business operating model supported by local Roster Support Officers, standardised roster to pay business processes and a capability uplift program to enhance workforcemanagement across the health system.

State-Wide Management Information System (SWMIS)

The new SWMIS solution, SystemView, will combine near real-time data in a read-only platform across outpatients, surgery, emergency department and inpatients from existing source systems into a single place, making it easier to view and understand hospital operations in near real-time.

Organisational core design principles

The organisational core design principles are the permanent, unchanging and universal components of the Clinical Services Plan. They will act as a reference point to guide decision making across our organisation. These include:

Governance

Governance structures and processes that clearly establish authority and accountability for decision making and pathways for escalation.

Governance in action

- Expectations, accountabilities and responsibilities are clearly set for all levels and roles across the organisation.
- Decision making and delegations are clearly articulated for staff empowerment and autonomy.
- Performance and outcomes are tracked and measured.
- Alignment with our Destination 2030 strategic vision.

Culture

Every staff member (clinical and clinical support) is valued for their unique and vital contribution to the delivery of care.

Culture in action

- A focus on caring for our people to care for Central Queenslanders.
- Living our values.
- Empowering and developing our leaders.
- Pathways to promote a diverse, inclusive and culturally capable workforce.
- A culture of teamwork that supports workforce well-being.

Health equity

Provide all Central Queenslanders with the opportunity to achieve their best possible health, the tools they need to manage their own health and equitable access to care.

Health equity in action

- Remove barriers to accessing healthcare and improving health outcomes.
- Actively eliminate racial discrimination and institutional racism.
- Culturally safe and responsive services.
- Work with the community to design and review health services.

Quality and safety

Deliver on our commitment to provide safe and quality healthcare that supports Central Queenslanders to achieve better health outcomes.

Quality and safety in action

- Strong clinical governance framework to support clinical decision making.
- The consumer is at the centre of all we do.
- Communicate effectively across the entire patient journey.
- Provide consistency in care.
- Embed quality and safety as routine practice.
    - Undertake continuous learning and quality improvement cycles.

Integrated care approach

With our patients at the centre, the integrated care approach ensures coordinated transitions and continuity of care in and out of hospital across the entire care journey and as close to home as possible. It focusses on delivering culturally responsive and patient centred care, where our services wrap around our patients in a seamless way.

Organisational enablers

The organisational enablers are the people, strategies, technologies and processes that will enable the Clinical Services Plan to be possible and successful. These include:

Models of service delivery (ways of working)

How our people and systems work together to deliver safe and quality care including models of care, clinical support and corporate functions, infrastructure and technology.

- Clearly defining our models across our health service to ensure they are contemporary, proactive and put our patients at the centre.
- Focus on breaking down service silos, and work collaboratively to deliver integrated and coordinated models of care.
- Collaborate through care networks, to integrate our workforce, our systems and our service delivery across the whole patient journey.
- Leverage alternative care modalities, including telehealth, visiting outreach services, in-home care, and potential for public-private partnerships.
- Explore alternative workforce models including generalist and higher-scope workforce models.
- Establish clear decision-making frameworks that support flexible utilisation of current workforce and budget.

Workforce wellbeing

Caring for our people from recruitment to retirement: personal wellness, professional development, leadership and growth, and physical and psychologically safe workplaces.

- Develop flexible workforce models that support retention, provide rotational, upskilling and skill-sharing opportunities.
- Invest in our staff with professional development pathways that ‘grow our own’ workforce and support succession planning.
- Focus on improving our workplace culture, effectively communicating across all levels of staff, demonstrating strong leadership and effective governance, and ensuring safe work environments for our people.
- Establish a health service wide recruitment framework that streamlines processes to attract and retain the right people for sustainable service delivery.
- Review our workforce models to optimise the capability of our staff and ensure the appropriate resource and skill allocation to reduce burnout.

Communication and engagement

Consistent and proactive communication and engagement for collaborative relationships and partnerships that are based on trust and respect.

- Authentic engagement with our consumers and community.
- Visible leadership and engagement that ensures effective and transparent communication and engagement across all levels of the organisation.
    - Build on meaningful and effective partnerships with primary care and private providers.
        - Set clear expectations and ensuring well defined business processes.

Section 5

Our priorities and care domains

To achieve the key objectives of equitable health outcomes and improved access to quality and safe healthcare, the priority for this Clinical Services Plan is to focus on contemporary models of service delivery. This will ensure we are investing in the resources, infrastructure and services that are most effective in meeting the health needs of Central Queenslanders and redirecting or scaling back those that are not.

Key objectives

Contemporary models of service delivery

Equitable health outcomes | Improved access to quality and safe healthcare

The four care domains summarise the types of care that we will focus on across the patient journey, both in and out of hospital, and identify the key outcomes and initiatives required to achieve our key objectives:

Care domains

Care domain 1	Care domain 2	Care domain 3	Care domain 4
Health protection, promotion and disease prevention	Ambulatory care and emergency department avoidance	Acute care	Care coordination and transitions
Better health and wellbeing for Central Queenslanders throughout all stages of life	Reduce unnecessary emergency department presentations and hospital admissions	The right care, for the right patient, in the right place, at the right time by the right care providers	Coordinated and collaborative care for seamless transitions across the patient journey

Care domain 1 Health protection, promotion and disease prevention

Reduce health inequalities and improve health outcomes for Central Queenslanders throughout all stages of life.

We are committed to delivering improved health outcomes and access for our region. Health and wellbeing are a complex combination of a person's physical, mental, emotional, social and environmental health factors. We will work collaboratively to support the health and wellbeing of our staff and the community, empowering people to live healthy and well.

We will take a coordinated approach to health protection, promotion and disease prevention by reorienting our existing health promotion programs. We will embed a culture of health promotion across our health services to prioritise and implement initiatives to keep our population healthy and living free from preventable diseases and their complications. We will work collaboratively with service delivery partners across our region to improve health outcomes for our communities, reduce duplication and address service delivery gaps, in particular for our priority care areas of antenatal care, chronic disease management, mental health, and surgical outpatients.

Measures of success

- Equitable access to services for improved health and wellbeing outcomes.
- Individuals are empowered and engaged to navigate through their care journey with a range of high-quality services available.
- Active engagement in community screening and health promotion programs for improved health behaviours and a healthier community.
- Improved collaborative partnerships with residential aged care facilities, general practitioners and community care providers.
- Improved health outcomes for our Aboriginal and Torres Strait Islander women and their families.
- Individuals have more equitable access to consistent and standardised early assessment and intervention services across Central Queensland.
- Reduced presentations to emergency departments due to avoidable chronic diseases and conditions.

Initiatives

- Build a collaborative care model for Aboriginal and Torres Strait Islander expectant mothers and their families.
- Coordinate and expand health promotion services and initiatives to keep our community healthy. For example, residential aged care facilities surveillance network, SMS-precall for increased immunisation uptake and timeliness, proposed Healthy Ageing Network, 10,000 lives smoking cessation, skin cancer prevention and early detection.
- Develop targeted mental health, alcohol and other drug service models for vulnerable populations, including suicide prevention programs.
- Establish mental health crisis response services in our communities to better support the needs of people with mental illness.
- Expand the delivery of mobile dental services to residential aged care facilities.

Care domain 2 Ambulatory care and emergency department avoidance

Improved access to care models that reduce unplanned presentations and hospital admissions.

We will coordinate our service delivery and care teams to focus on contemporary ambulatory and emergency department avoidance models. This will support our community to receive proactive and timely care closest to home and where possible, in their place of usual residence, to improve self-management and prevent unnecessary hospitalisations.

We will transform and optimise our services and establish comprehensive pathways that refocus how, where, when and who provides care. We will embed contemporary service models that improve equity of access for our community, in particular our most vulnerable population groups.

Measures of success

- Our patients have increased access to services in the community and in their home.
- Patients are empowered with knowledge of escalation points in times of crisis or disease exacerbation.
- There is a reduction in emergency department presentations and potentially preventable hospitalisations, through service optimisation and improved utilisation of hospital diversion pathways.
- We have improved partnerships with care providers to deliver care closer to home and in a safe and timely manner.
- We have clear and comprehensive pathways that improve coordination and supports patient transitions across the health service, including virtual care modalities.

Initiatives

- Streamline rapid access to supportive interventions closer to home for known chronic disease patients.
- Optimise and mobilise out of hospital care.
- Enhance support for residential aged care facilities with increased in-reach services.
- Establish model for early and proactive care for complex, frail and aged patients to avoid reaching crisis point.
- Expand virtual care modalities and technologies to empower self-management of chronic disease.
- Expansion of mental health, alcohol and other drug community-based, hospital avoidance and outreach programs.
- Expansion of our mental health co-responder model to other Central Queensland communities.

Care domain 3 Acute care

Deliver high quality, safe and timely care, for the right patient, in the right place, at the right time by the right care providers.

We will provide a consistent acute service model that provides more care closer to home for our communities. We will optimise patient flow by providing safe, timely and coordinated care across our services and settings. We will deliver contemporary evidence-based care and better connect services, facilities and patients.

We will deliver a standardised approach to service delivery, maximising use of all of our resources and facilities by leveraging technology and new models of care to support more timely access to services.

Measures of success

- Patients have improved outcomes and experiences, with less hospital acquired complications and appropriate length of stays.
- Efficient and effective resource allocation and utilisation, in alignment with service demand and patient needs.
- Improved management of hospital demand, including improved lengths of stays in emergency and inpatients beds and improved wait times for outpatients and surgery.
- Increased capacity to deliver more high acuity care in the community or our patients place of usual residence.

Initiatives

- Establish sustainable specialised integrated service models for chronic and complex and geriatric cohorts that provide acute intervention and de-escalation.
- Increased self-sufficiency for perioperative sub-speciality care. Including urology, vascular, ophthalmology, ear, nose and throat and gastroenterology.
- Develop pathways that optimise perioperative patient experience and outcomes.
- Standardise and streamline access to specialist obstetric and acute paediatric services.
- Build collaborative partnerships with internal and external providers that improve access to specialist services.
- Expand hospital in the home models to include a broader range of chronic and complex conditions and care for paediatric patients.

Care domain 4 Care coordination and transitions

Coordinated and collaborative care for seamless transitions across the patient journey.

We will work collaboratively to deliver integrated healthcare across our geographically diverse health service. We will broaden and strengthen partnerships that are productive and support a shared commitment to health outcomes. We will focus on cultivating an outcome-driven culture to support patient centred care and collaborative decision making across care teams.

We will develop contemporary service delivery models that leverage innovative technology and facilitate the best and highest use of our workforce. We will standardise and simplify our engagement approaches with all key stakeholders to support the delivery of integrated and seamless care transitions and support our patients to navigate our complex health system.

Measures of success

- Multidisciplinary clinical and clinical support workforces operating to top of scope, and where appropriate advanced scope.
- Coordinated service delivery across the health service that optimises resources and manages demand through a consistent, proactive approach to planning, resource allocation and quality service delivery.
- Interconnected services that create continuity in patient care and fill critical service gaps.
- Improved collaborative relationships and shared responsibility for health outcomes.
- Improved understanding of available services, both internal and external to the health service, to support the navigation of patients through their healthcare journey.

Initiatives

- Establish care networks for the key clinical areas of chronic and complex, aged and frail, maternity, children, and perioperative services.
- Expand 7-day service models for more equitable access and to facilitate earlier transitions back to the community or place of usual residence.
- Explore ‘discharge to assess’ models that support patient discharges as soon as they are ‘medically fit’, with assessment for longer-term care and support needs undertaken in the most appropriate setting and at the right time.

Section 6

6 Our care networks and initiatives

A number of priority initiatives were identified through the stakeholder engagement process which underpinned the development of this plan which fall into specific speciality areas as detailed in the following section.

Actions relating to short term operational issues, workforce planning, information system resources have not been included in the Clinical Services Plan and will need to be considered as part of the Integrated Planning Framework and the supporting strategies and operational plans.

Care networks

Aged and frail

- Establish Aged and Frail Care Network
- Optimise and expand teams that support out of hospital care including early discharge and transitions
- Expand geriatric service model
- Enhance support for residential aged care facilities with increased in reach and support

Chronic and complex

- Establish Chronic and Complex Care Network
- Establish sustainable, specialised chronic and complex disease service models
- Transform and optimise out of hospital care
- Streamline rapid access for known chronic disease patients

Mental health, alcohol and other drugs

- Deliver care in a single health service-wide 'networked' model
- Targeted services for vulnerable populations
- Expansion of community-based services, hospital avoidance and outreach programs

Perioperative

- Establish Perioperative Care Network
- Develop pathways that optimise perioperative patient experience and outcomes
- Increase self-sufficiency for sub-speciality care delivery for CQ patients closer to home
- Coordinated trauma service delivery

Women and children

- Establish networks for women's and children's care
- Optimise and standardise patient access to specialist obstetric services
- Build a collaborative care model for Aboriginal and Torres Strait Islander women and their families
- Standardise and streamline access for paediatric patients

Aged and frail care network

Initiatives	Components	Horizon				
		2024	2025	2026	2027	2028
Establish Aged and Frail Care Network	Establish networked model for aged and frail services to adopt a consistent approach to planning, resource allocation and quality service delivery.	✓				
Optimise and expand teams that support out of hospital care including early discharge and transitions	Optimise care delivery teams with expansion to a 7-day a week service early intervention for patients at risk of a long hospital length of stay and facilitate early discharge and transitions back to the community (or into a nursing home).	✓				
	Expand the existing hospital in the home model to include a Geriatric Evaluation and Management (GEMITH) and Rehabilitation (RITH) in the home.		✓			
	Establish model for early and proactive care in the patient's usual place of residence to prevent patient decline and avoid reaching crisis point.			✓		
Expand geriatric service model	Expand geriatrician service model to provide timely and responsive access to specialist geriatric services to prevent secondary complications associated with medical co-morbidities of high-risk elderly patients.	✓				
	Establish comprehensive patient pathways that enable early identification of patient trajectory (discharge home or nursing home placement) and standardises coordinated care processes.			✓		
Enhance support for residential aged care facilities with increased in reach and support	Build partnerships and better coordination of general practitioner care with residential aged care facilities.	✓				
	Optimise virtual care options for residential aged care facilities.				✓	
	Increase residential aged care facility in-reach services to reduce avoidable presentations to emergency department.				✓	
	Deliver mobile dental service to residential aged care facility residents in their home.		✓			

Key outcomes

- Improved patient outcomes including hospital acquired complications.
- Reduced number of long stay (over 30 days) aged and frail patients.
- Reduced length of stay for aged and frail patients.
- Care in the right setting to support improved patient experience and outcomes.
- Improved collaborative partnerships with residential aged care facilities, general practitioners and community care providers.

Chronic and complex care network

Initiatives	Components	Horizons				
		2024	2025	2026	2027	2028
Establish Chronic and Complex Care Network	Establish networked model for chronic and complex services to adopt a consistent approach to planning, resource allocation and quality service delivery.	✓				
Establish sustainable specialised chronic and complex disease service models	Define specialist service models for patients for prevention, early intervention, reduction of complications and timely access close to home for patients.	✓				
	Expand to a 7-day a week service models where it enables equitable access and facilitation of early discharge and transitions back to the community.		✓			
	Optimise existing interdisciplinary services and partnerships to deliver specialised chronic and complex care models for example specialist wound care, chronic pain and diabetes services.			✓		
Transform and optimise out of hospital care	Expand health promotion services, including the 10,000 lives programs, to keep our community well.	✓				
	Develop clear and comprehensive pathways that improve coordination and supports patient transitions across the health service, including virtual care modalities.	✓				
	Optimise and mobilise out of hospital care teams to deliver coordinated and seamless care that supports early detection, hospital avoidance and care transitions.		✓			
	Expand Hospital in the Home models to include a broader range of chronic and complex conditions to support care at home.			✓		
	Explore 'discharge to assess' models that support patient discharges as soon as they are 'medically fit', with assessment for longer-term care and support needs undertaken in the most appropriate setting and at the right time.	✓				
	Expand virtual care modalities and technologies to empower self-management of chronic disease.		✓			
Streamline rapid access for known chronic disease patients	Apply the proven Rapid Access Services model to other chronic disease cohorts across the health service, which includes pathways to access same day care and support for chronic disease exacerbations that don't require a hospital presentation for example:					
	• Renal	✓				
	• Diabetes		✓			
	• Cancer care			✓		

Key outcomes

- Improved patient self-management and experience.
- Care in the right setting to support improved hospital flow.
- Reduction in potentially preventable hospitalisations.
- Reduction in potentially preventable emergency department presentations.
- Reduced number of emergency department and inpatient length of stay.
- Reduced admission conversions from emergency department.
- Comprehensive 7-day service for medical and allied health.
- Continue to work towards improving health outcomes for chronic and complex patients.

Mental health, alcohol and other drugs care network

Initiatives	Components	Horizons				
		2024	2025	2026	2027	2028
Deliver care in a single health service wide 'networked' model	Work collaboratively to adopt a consistent approach to planning, resource allocation and quality service delivery to create continuity in patient care and fill critical service gaps.	✓				
Targeted services for vulnerable populations	Increase the Aboriginal and Torres Strait Islander mental health services to address the cultural needs of our communities.	✓				
	Addressing the mental health needs for our population of pregnant women perinatal and infant mental health.	✓				
	Expanded programs for older persons mental health.		✓			
	Expanded youth services such as the assertive mobile youth outreach services, adolescent day programs and clinical in-reach for new and existing headspace sites.		✓			
	New crisis support spaces and services that provide an alternative or adjunct to emergency departments.			✓		
Expansion of community-based services, hospital avoidance and outreach programs	Build productive partnerships with the Primary Health Network and non-government organisations to improve awareness and utilisation of suicide prevention and intervention programs.	✓				
	Enhance and improve access to specialist alcohol and other drugs services in the community.		✓			
	Grow existing community forensic outreach services.		✓			
	Expand mental health services in adult correctional settings.	✓				
	Expansion of the 1300 mental health call centre.	✓				
	Scale and spread the co-responder model to other communities within the health service.	✓				
	Lived experience (peer) and clinical support in home-like settings.		✓			

Key outcomes

Successful implementation of the Better Care Together initiatives including:

- Individuals, families and carers have improved health and wellbeing outcomes.
- Individuals can access and navigate their care pathway with a range of high-quality services available.
- Services individually tailored, coordinated with partners, and delivered close to home and in a safe and timely manner.
- Multidisciplinary mental health, alcohol and other drug clinical and clinical support workforces operating at full scope of practice in collaboration with partners.

Perioperative care network

Initiatives	Components	Horizons				
		2024	2025	2026	2027	2028
Establish Perioperative Care Network	Establish networked model for perioperative services to adopt a consistent approach to planning, resource allocation and quality service delivery.	✓				
	Health service wide coordination of perioperative services to ensure consistent processes and governance, and optimal use of resources within facilities across Central Queensland.		✓			
	Robust data management systems and support to create transparency.			✓		
Develop pathways that optimise perioperative patient experience and outcomes	Expand the use of virtual care across preoperative, intraoperative and postoperative pathways.			✓		
	Establish pre-habilitation service pathways that ensure patients 'wait well' for surgery.		✓			
	Optimise post-surgical pathways that supports seamless post-operative care requirements and rehabilitation.			✓		
	Establish dedicated orthopaedic trauma list.		✓			
Increase self-sufficiency for sub-speciality care delivery for CQ patients closest to home	Optimise service delivery for sub-speciality areas across Central Queensland, and partner with other hospital and health services to delivery cluster model for subspeciality service delivery including:					
	• Gastroenterology		✓			
	• Urology			✓		
	• Opthamology				✓	
	• Ear, nose and throat				✓	
	Provide a virtual care platform for theatres to support speciality services across Central Queensland and tertiary level services, to provide real time assistance into operating theatre.					✓
Coordinated trauma service delivery	Undertake feasibility assessment and scoping requirements for accreditation as a level 3 trauma centre at Rockhampton Hospital.			✓		
	Build stronger relationships, pathways and protocols in conjunction with level 1 trauma service (Royal Brisbane and Women's Hospital and Princess Alexandra Hospital) to ensure consistent care of and seamless transitions for CQ patients.				✓	

Key outcomes

- Decreased median wait time across all categories.
- Data to predict demand and best utilisation of resources.
- Increased self-sufficiency.
- Improved patient outcomes and reduced hospital-acquired complications.
- Reduced patient travel.
- Emergency surgery patients treated in time.
- Reduced cases performed out of hours (by category).
- Reduced day of surgery cancellations.
- Reduced percentage of elective session time occupied by emergency cases.

Women and children care network

Initiatives	Components	Horizons				
		2024	2025	2026	2027	2028
Establish care networks for Women's and Children's Care	Embed existing networked model for maternity care services.	✓				
	Establish networked model for children's services to adopt a consistent approach to planning, resource allocation and quality service delivery.		✓			
Optimise and standardise patient access to specialist obstetric services	Build on partnership models with other hospital and health services to deliver specialist care for women across their care journey for example chronic pain teams, endometriosis services and Ultrasound Specialist (MFM).		✓			
	Develop standardised care pathways for diabetes in pregnancy with improved access to endocrinologist specialist support.			✓		
	Improve access to community-based perinatal and infant mental health (PIMH) treatment, care and support for new parents and infants across Central Queensland.			✓		
	Establish comprehensive women's health physiotherapy service for antenatal and postnatal care.				✓	
Build a collaborative care model for Aboriginal and Torres Strait Islander women and their families	Implement a contemporary and comprehensive maternal and child health model that delivers clinically safe services through all phases of the pregnancy journey and for the first 2000 days following birth.		✓			
	Create a safe and welcoming environment for patients, their families and staff inclusive of culturally appropriate spaces within our hospital premises.			✓		
	Expand access to courses of oral health care in partnerships with Aboriginal Community Controlled Health Organisations (ACHHOs).				✓	
Standardise and streamline access for paediatric patients	Expand our existing Hospital in the Home model to provide acute care for low-risk paediatric patients.	✓				
	Standardise a direct admission pathway for paediatric patients to receive timely care in the most appropriate care environment.		✓			
	Implement integrated Central Queensland wide child development services.	✓				
	Build collaborative partnerships with internal and external providers that enhance family's access to support services.		✓			
	Standardise pathways to support seamless and timely repatriation of neonates.			✓		

Key outcomes

- Improve outcomes for Aboriginal and Torres Strait Islander Women and their families.
- Improved access for women to specialist care.
- More babies born of healthy birthweight.
- Improved neonate repatriation and management.
- More equitable access to child development services across Central Queensland.

7 Section 7
What does success look like

We are committed to delivering on the priorities and initiatives identified within the Clinical Services Plan, in order to realise our strategic vision and achieve our key outcomes of:

- Improved access to quality and safe healthcare
- Equitable health outcomes

Key objectives

Contemporary models of service delivery

Equitable health outcomes | Improved access to quality and safe healthcare

Care domains

Care domain 1	Care domain 2	Care domain 3	Care domain 4
Health protection, promotion and disease prevention	Ambulatory care and emergency department avoidance	Acute care	Care coordination and transitions
Better health and wellbeing for Central Queenslanders throughout all stages of life	Reduce unnecessary emergency department presentations and hospital admissions	The right care, for the right patient, in the right place, at the right time by the right care providers	Coordinated and collaborative care for seamless transitions across the patient journey

Care networks

Aged and frail

Establish Aged and Frail Care Network | Optimise and expand teams that support out of hospital care including early discharge and transitions | Expand geriatric service model | Enhance support for residential aged care facilities with increased in reach and support

Chronic and complex

Establish Chronic and Complex Care Network | Establish sustainable, specialised chronic and complex disease service models | Transform and optimise out of hospital care | Streamline rapid access for known chronic disease patients

Mental health, alcohol and other drugs

Deliver care in a single health service-wide 'networked' model | Targeted services for vulnerable populations | Expansion of community-based services, hospital avoidance and outreach programs

Perioperative

Establish Perioperative Care Network | Develop pathways that optimise perioperative patient experience and outcomes | Increase self-sufficiency for sub-speciality care delivery for CQ patients closer to home | Coordinated trauma service delivery

Women and children

Establish networks for women's and children's care | Optimise and standardise patient access to specialist obstetric services | Build a collaborative care model for Aboriginal and Torres Strait Islander women and their families | Standardise and streamline access for paediatric patients

Integrated Planning Framework

Overarching Strategic Plan

Destination 2030 | Great care for Central Queenslanders

Great Care, Great Experience | Great People, Great Place to Work | Great Learning and Research | Great Partnerships | Sustainable Future

Supporting strategies and plans

- Health Equity Strategy 2022–2025
- Clinician Engagement Strategy 2022–2025
- Consumer and Community Engagement Strategy 2022–2025
- Local Area Needs Assessment (LANA) 2022
- Infrastructure Master Plan 2019
- Strategic Workforce Plan 2020–2030
- Clinical Services Plan 2024–2029

Operational plans

Organisational core principles

Governance | Culture | Health equity | Quality and safety

Organisational enablers

Models of service delivery (ways of working) | Workforce wellbeing | Communication and engagement

The following CQHHS enabling strategies and plans will be reviewed to ensure appropriate resources and enablers are in place to achieve the objectives of the plan:

Health Equity Strategy 2022–2025

Supports our commitment to placing Aboriginal and Torres Strait Islander peoples and voices at the centre of healthcare.

Clinician Engagement Strategy 2022–2025

Defines how we will engage our clinical workforce to delivery high-value, patient-centred care.

Consumer and Community Engagement Strategy 2022-2025

Explains how we work with our community to provide opportunities for patients, carers and consumers to have a say on our health care services.

Local Area Needs Assessment (LANA) 2022

Identifies Central Queensland's health and service needs and priorities.

Infrastructure Master Plan 2019

Assesses current state and determines future infrastructure requirements.

Strategic Workforce Plan 2020-2030

Outlines guiding principles for a sustainable and highly capable workforce who are committed to improving the health of Central Queenslanders.

Clinical Services Plan 2024-2029

Informs the prioritisation and strategic phasing of initiatives balancing available resources with the ability to achieve the greatest possible impact.

This suite of plans will be supported by annual operational plans that articulate how the priorities and initiatives identified in the Clinical Services Plan will be actioned, monitored and evaluated.

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Internal stakeholders who provided feedback and input

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- CQHHS Executive Leadership Team
- CQHHS Senior Leadership Team
- CQHHS Clinical Directors Group
- CQHHS Nursing Directors and Directors of Nursing
- CQHHS Allied Health Directors Council
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