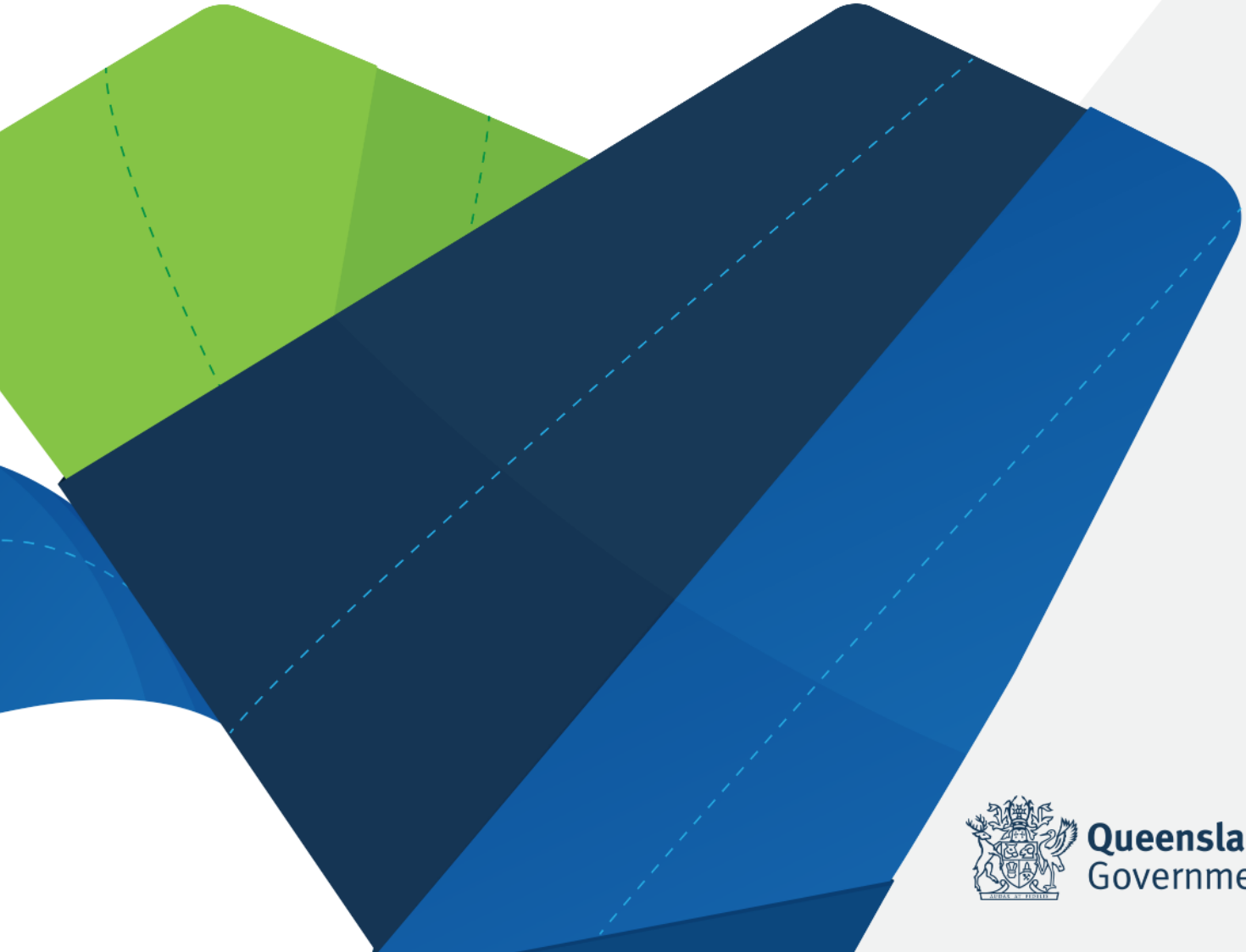
CQHHS Local Area Needs Assessment (LANA)

Central Queensland Hospital and Health Service

LANA summary report

Submitted 09/11/2022



Queensland Government

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Endorsement

Hospital and Health Service details	
Hospital and Health Service	Central Queensland
Name of primary contact for this LANA report	Colin Bartlem, Manager Health Planning and Performance
Address	Rockhampton Hospital Campus, Canning Street, Rockhampton, Qld 4700
Phone	4920 7367
Email	Colin.Bartlem@health.qld.gov.au

HSCE Endorsement	
Name	Dr Emma McCahon
Signature	
Date	/ /
Phone	4920 6282
Email	Emma.McCahon@health.qld.gov.au

Acknowledgements

Central Queensland Hospital and Health Service pays respect to the traditional custodians of the lands on which we walk, work, talk and live. We also acknowledge and pay our respect to Aboriginal and Torres Strait Islander Elders past, present and future.

CQHHS wishes to thank all stakeholders, staff and community members that participated in the engagement process to inform development of the CQHHS LANA. The data analysis report for this LANA was compiled by CQHHS, with key contributions from the CQHHS LANA Project Lead and Senior Project Officer, the Department of Health's System Planning Branch, and at a later stage, Deloitte.

A CQHHS LANA project steering committee (PSC) provided guidance and assurance over the development of the LANA. Composition of this PSC included:

CQHHS LANA Project Steering Committee

Emma McCahon, Chair, Health Service Chief Executive

Lisa Caffery, Deputy Chair, CQHHS Board

Colin Bartlem, Manager Health Planning, CQHHS

Colin Weeks, Chief Financial Officer, CQHHS

Gulam Khandaker, Director Public Health, CQHHS

Donna Cruickshank, Executive Director Aboriginal & Torres Strait Islander Health & Wellbeing, CQHHS

Ross Atu, Health Equity Framework Project Officer, CQHHS

Angela Carberry, Health Planner, Central Qld Wide Bay Sunshine Coast Primary Health Network

Geoff Higgins, Representative, Consumer and Community Advisory Committee (CACC)

Nathan Costin, Director, System Planning Branch, Queensland Health

Steven Gall, A/Director Project Management Office, CQHHS

Hannah Gardner, Senior Project Officer, CQHHS

Abbreviations and terminology

ASR	Age-Standardised Rate
CAGR	Compound Annual Growth Rate
CSCF	Clinical Services Capability Framework
COPD	Chronic Obstructive Pulmonary Disease
CYMHS	Child And Youth Mental Health Service
ED	Emergency Department
FTE	Full Time Equivalent
HHS	Hospital And Health Service
A&TSIHLO	Aboriginal and Torres Strait Islander Hospital Liaison Officer
A&TSIHW	Aboriginal and Torres Strait Islander Health Worker
LANA	Local Area Needs Assessment
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation
PHN	Primary Health Network
PPH	Potentially Preventable Hospitalisations
PSC	Project Steering Committee
RACF	Residential Aged Care Facilities
RSD	Respiratory System Diseases
SEIFA	Socio-Economic Indexes For Areas
SA2	Statistical Area Level Two
SA3	Statistical Area Level Three
SAGE	Subacute Geriatric Evaluation Ward
SRG	Service-Related Group

Executive Summary

The Local Area Needs Assessment (LANA) for CQHHS is a detailed assessment of health and service need in the region based on data analysis across multiple domains, supported by consultation with local stakeholders, clinicians, consumers, and health organisations. Queensland Hospital and Health Services (HHSs) have been required to complete a LANA for their jurisdictions and a public report on community health needs, service gaps and priorities.

This LANA Summary Report provides a synopsis of the Central Queensland Hospital and Health Service (CQHHS) key health service needs and priorities, identified throughout the development of the CQHHS LANA. High level solutions have been proposed to address the ten health needs and service gaps identified and prioritised for the Central Queensland community.

Figure 1: CQHHS prioritised health needs

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 undertake the LANA for their jurisdictions and publish a report on community health needs, service needs, gaps, and priorities.

2. Purpose of document

The purpose of this LANA Summary report is to outline the qualitative and quantitative evidence supporting the health needs and service needs prioritised during the development of the LANA.

Methods used to identify and validate health and service needs include quantitative analysis of key data elements (including geographic and demographic profile, risk factors, health status and service utilisation) and stakeholder consultation.

3. HHS vision and priorities

CQHHS's strategic plan, *Destination 2030: Great Care for Central Queenslanders* describes key strategic directions for CQHHS that support the overarching goals of improving the health of Central Queenslanders and to shape the future of hospital and healthcare across the region.

The five key objectives of *Destination 2030* are described in Figure 2 and drive the improvement that will deliver Great Care for Central Queenslanders.

Figure 2: CQHHS five key strategic objectives in *Destination 2030*

Great Care, Great Experience	Great People, Great Place to Work	Great Learning and Research	Great Partnerships	Sustainable Future
Safe, compassionate care, delivered to the highest standards, close to home, with consumers at the heart of all we do	*Great staff working in great teams with a culture of supporting and investing in our people's future.*	*Great place to learn, research and shape the future of healthcare*	*Working collaboratively with our partners to deliver great care and improve the health of Central Queenslanders*	*Securing the future of great healthcare with efficient, effective, affordable, and sustainable services*

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.

Detailed data analysis that supported the identification and evidencing of the health needs outlined in this report can be found in the Local Area Needs Assessment (LANA) Data Analysis report.

In addition to the above minimum dataset, CQHHS has utilised additional data available that supports the priorities put forward for the region including qualitative data collected as part of the assessment. Qualitative data was sourced from stakeholder consultation, an online consumer survey, an online survey of non-HHS service providers in the Central Queensland region and a CQHHS staff survey. Detailed consultation methodology and findings are summarised in the Qualitative Data Analysis report.

4.2. Consultation

Extensive consultations were undertaken with CQHHS staff, external stakeholders, and community groups and members to gather and validate evidence on the health and service needs of the community as part of the development of CQHHS LANA.

CQHHS LANA consultation engagement reached over 1,482 CQHHS stakeholders (156 consumers, 112 staff and 1,214 external stakeholders) through:

- 287 online survey responses, with 156 responses from consumers, 78 responses from staff and 53 from external stakeholders and partners
- 57 focus groups and meetings across all facilities with clinical and operational staff (mix of in person and virtual)
- Showcases at Rockhampton Hospital, Gladstone Hospital, Emerald Hospital and Biloela Hospital
- Targeted engagements with external stakeholders including Central Queensland Wide Bay Sunshine Coast Primary Health Network (CQWBSC PHN), Consumer and Community Advisory Committee (CACC), universities, schools, Aboriginal and Torres Strait Islander organisations and community-controlled health services, aged care providers and private hospitals.

Online surveys were prepared as a key method of seeking input from community groups and members. Surveys were also used to capture feedback from CQHHS staff and external stakeholders that were unable to attend consultations or preferred to provide feedback online. The surveys were designed to gain an understanding of:

- health needs of local populations within CQHHS
- drivers for population health needs and barriers to accessing health care
- service needs and gaps in the region.

Surveys had a wide reach across the region. Of the 287 respondents, 54% were consumers, 27% were CQHHS staff and 19% were external stakeholders (see Figure 3). Completed surveys were received from all major CQHHS regions and cities, with 51% of responses from Rockhampton, 22% from Gladstone and 12% from Emerald (see Figure 4).

Figure 3: Distribution of responses by stakeholder type (consumers, staff, and external stakeholders)

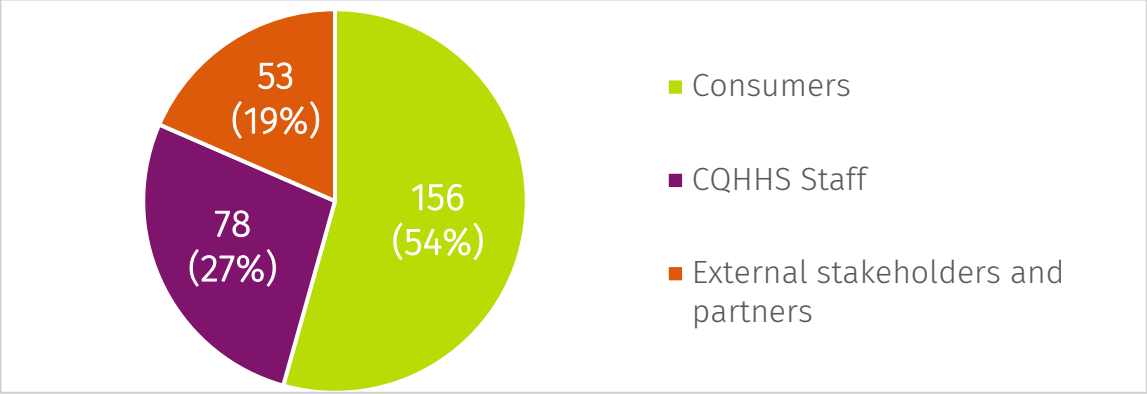
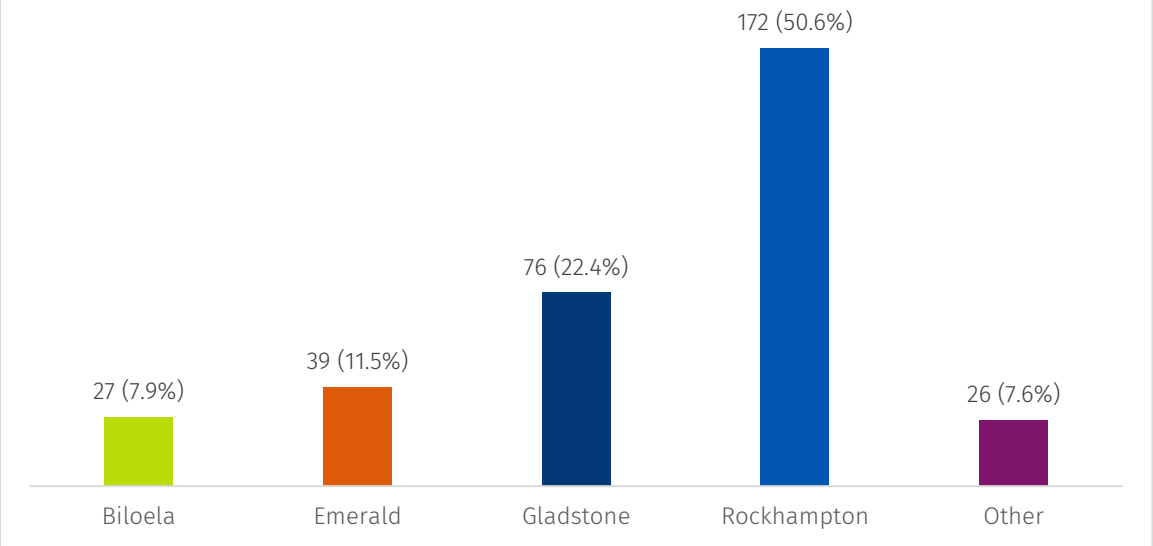


Figure 4: Distribution of responses by Central Queensland region where consumers accessed care



Note: The total number of selected regions (340) is greater than the total number of completed surveys (287) since respondents had the ability to select more than one region from which they accessed health care services. Other regions primarily constituted of Yeppoon and Boyne Island within CQHHS, Mackay, Bundaberg, Maryborough and Hervey Bay regions..

4.3. Identification of community health needs

As per the LANA framework, 'health need' has been defined as a health outcome and/or the related conditions that contribute to a defined health need. Methods used to identify and validate health needs included quantitative analysis and stakeholder consultation.

The LANA Framework provides guidance on a minimum data set for analysis by all Hospital and Health Services to guide the development of a Local Area Needs Assessment (LANA). As a result, key data elements were identified to inform prioritised health needs:

- The region: geographic and demographic profile across Central Queensland planning regions to identify areas of growth, where certain patient cohorts are expected to increase, and socio-economic profiles
- Risk factors across the population that are associated with poor health and impact on demand for services
- Health status and burden of disease reflected through the profile of chronic disease and admission rates for key conditions across each planning region
- Service utilisation – primary, secondary, and tertiary care - hospitalisations and non-admitted service activity, residential aged care, national disability insurance scheme utilisation.

4.4. Prioritisation of community health needs

A structured approach to prioritisation of health needs was adopted. A health needs prioritisation survey, supplemented with an interactive workshop, was conducted with the CQHHS Project Steering Committee (PSC) who were tasked with overseeing the development of the LANA.

Assessment criteria and allocated weighting were agreed to by the PSC, and used to assess each health need, as outlined in Figure 5.

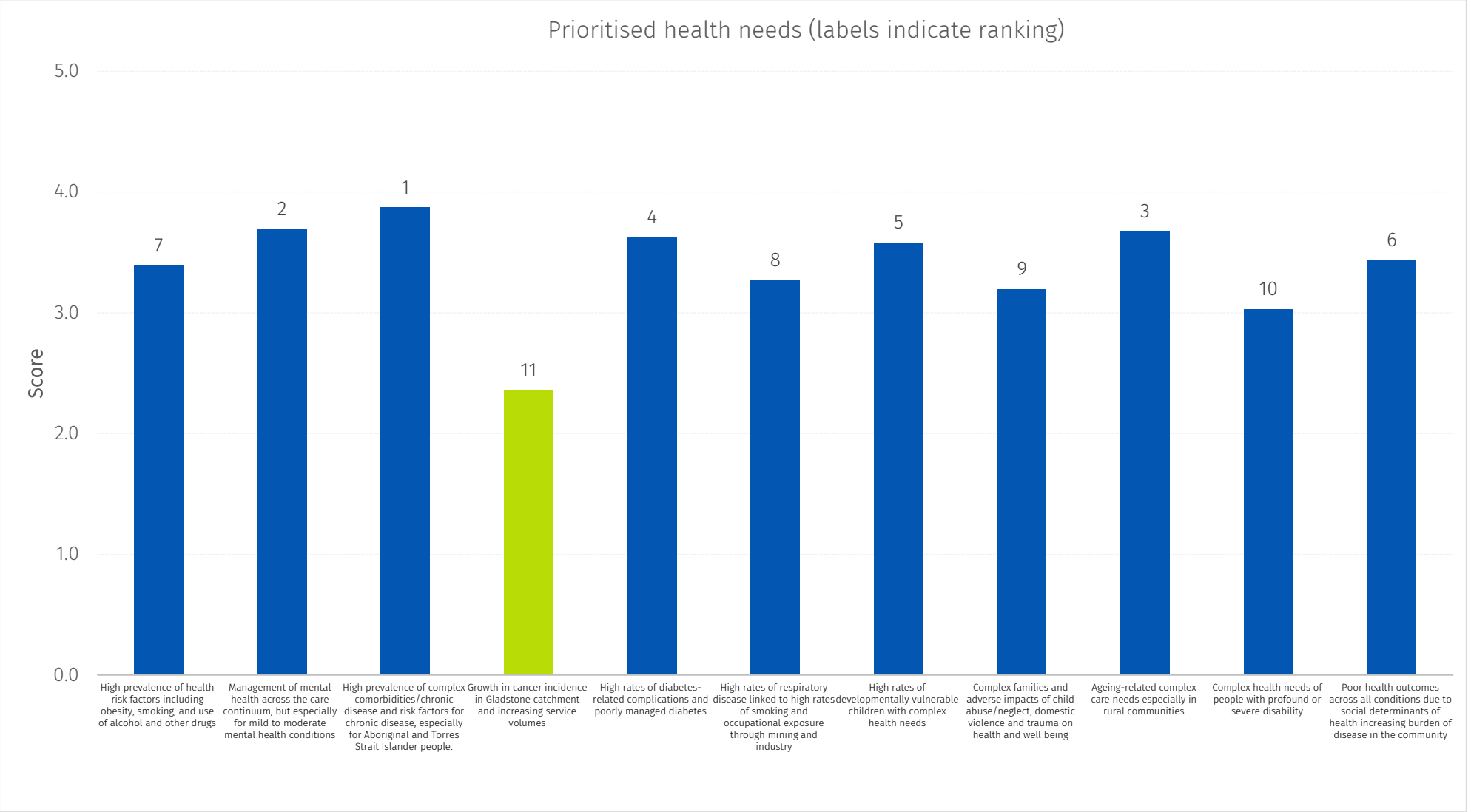
Figure 5: Endorsed Criteria and Weighting utilised to prioritise health needs

Criteria	Description	Weighting
Governmental & 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?	20%
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?	20%
Magnitude of need	How widespread is/what is the extent of the need? Is it associated with the greatest historical service activity growth?	15%
Validation of need	Community and clinicians raised this health need as an issue in consultation	15%

Criteria	Description	Weighting
Validation of need	Size/severity of the problem created by the health need/service gap - data validation	10%
Feasibility - Internal	Internally dependent factors: Can the potential solution for this need be implemented within available resources?	10%
Feasibility - external	Externally dependent factors: 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?	10%

Figure 6 indicates the ranking of CQHHS Health Needs following the prioritisation exercise with the PSC. Based on the scoring, the top 10 health needs were adopted as priorities for CQHHS, and details of these health needs (evidence, service gaps related to the health needs, and proposed solutions) are outlined in this report.

Figure 6: Summary ranking of prioritised health needs (following survey completion and interactive workshop with PSC)



4.5. Identification of service needs and gaps

Service profiling and identification of service gaps related to the prioritised health needs was undertaken through a process based on a combination of data analysis and stakeholder consultation.

Data analysis focussed on CQHHS activity data and waitlist data, existing service profiles developed as part of previous service planning, and CQHHS' current Clinical Services Capability Framework (CSCF) and CSCF outlook to 2026.

Data analysis was supported and validated by findings from stakeholder consultation, survey responses, and PSC feedback.

4.6. Prioritisation of service needs and gaps

The Project Steering Committee reviewed the prioritised health needs in the context of the identified service needs and gap analysis.

Following discussion of the service gaps identified, no updates were made to the ranking and prioritisation of the health needs.

5. Identified priorities for population health needs and service gaps

Table 1 summarises the outcome of the LANA process and provides an overview of the prioritised health needs, service gaps and proposed high level solutions for CQHHS.

Some high level solutions have been listed to target the service gaps related to each of the 10 prioritised health needs. Given many of the identified health needs and service gaps span both the HHS and primary care sector's responsibility, we have adopted a strong focus on extending partnerships with primary care, CQWBSC Primary Health Network (PHN), Commonwealth and NGO providers. We recognise the important role and responsibility of these stakeholders in addressing many of the underlying drivers contributing to service gaps in the region. The role of local PHN, Commonwealth, NGOs, and other service delivery partners in building primary care capacity and residential aged care facility capacity will ensure our community is provided care in the right place, right setting and at the right time.

We also recognise that additional, multifaceted strategies will be required to effectively address the prioritised health needs of our population. Further detailed planning beyond the scope and purpose the LANA will be considered as part of further additional CQHHS planning processes.

Table 1: Priorities table in order of highest to lowest health need and service gaps priority

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
Priority 1: High prevalence of complex comorbidities/chronic disease and risk factors for chronic disease, especially for Aboriginal and Torres Strait Islander people					
High prevalence of complex and chronic diseases across Central Queensland region was frequently raised in consultation, with chronic disease incidence (Age Standardised Rates per 100 people) higher than the Queensland average for Arthritis, Asthma and Diabetes.	In 2017-18, chronic disease incidence (ASR per 100) across the majority of Central Queensland SA2 areas was higher than the Queensland average for arthritis, asthma, and diabetes mellitus. In 2019-20, potentially preventable hospitalisations (PPHs) relating to chronic conditions represented 57% (5,067) of all CQHHS PPHs. In 2019-20, PPHs related to diabetes complications were the most common chronic PPH condition throughout CQHHS, for both Aboriginal and Torres Strait Islander people and non-Aboriginal and Torres Strait Islander people.	CQHHS services focused on support for chronic disease management including care co-ordination and hospital avoidance require additional capacity, given the prevalence of chronic disease. All services could also better embed early intervention, screening, and health promotion into existing models of care.	In FY21 and FY22, 31% of all inpatient separations across CQHHS were for primary diagnoses associated with chronic disease. Consultations identified a gap in care co-ordination, in particular the nurse navigator service.	• Work with service delivery partners to address service gaps and fragmentation. • Increase hospital avoidance by introducing new models of care and preventative initiatives. For chronic disease patients, consider the Rapid Access Service model for ED avoidance (expanding beyond existing Respiratory Rapid Access model to other conditions). • Accelerate adoption of technology to update referral processes, provide intra-facility access to medical reports, improve HHS-wide	• Queensland Health System Priorities • Unleashing the potential: an open and equitable health system • My health, Queensland's future: Advancing health 2026 (Advancing health 2026) • Care 4 Qld • Digital Health 2031 - A digital vision for Queensland's health system

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
				communication and primary care interfacing. • Consider possibility of remote digital monitoring/ virtual care models for chronic disease.	

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
		Aboriginal and Torres Strait Islander people experience a significant gap in culturally appropriate services for chronic disease management. There are limited Aboriginal and Torres Strait Islander Healthcare Workers and Aboriginal and Torres Strait Islander Hospital Liaison Officers in the Central Highlands and Biloela regions which are required to assist in coordinating care and navigating the system for First Nations people.	In FY21 and FY22, 42% of all inpatient episodes of care for Aboriginal and Torres Strait Islander people were for patients with a primary diagnosis associated with a chronic condition One of the factors influencing access to care and the cultural appropriateness of care is ongoing recruitment and retention challenges in the identified workforce. As at 10 August 2022, 13.2 FTE of 33.6 Approved FTE is currently vacant for positions in the Aboriginal and Torres Strait Islander Workers' stream in the CQHHS workforce. Delivery of outpatient services by Aboriginal and Torres Strait Islander Health Workers is lowest in the Gladstone SA3.	• Recruitment and retention workforce strategies particularly for Aboriginal and Torres Strait Islander health workers. (Consider links with health equity strategy.) • Review models of care, patient journey and workforce models for areas of care highly utilised by Aboriginal and Torres Strait Islander patients with chronic illnesses (renal dialysis, rheumatic heart disease, heart failure, COPD and asthma) with a focus on increasing cultural safety and access to care. This should include consideration of the best setting for delivery of culturally safe care and delivery of care	• National Medical Workforce Strategy (2021–2031) • Queensland Government Making Tracks Investment Strategy Queensland Government Health Equity Strategy and legislative framework • Queensland Health, Health Equity Framework • 2021 Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2026

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
				outside traditional hospital or healthcare settings.	

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
Priority 2: Management of mental health across the care continuum, especially for mild to moderate mental health conditions					
There are significant risk factors for mental illness and high prevalence of mental health conditions across Central Queensland, with 14 SA2 areas in the HHS experiencing greater rates of mental health and behavioural problems than the Queensland average. Of particular concern are reported suicide rates within Rockhampton, Gladstone, and Central Highlands (Qld) SA3s which are significantly higher than both Queensland and Australian rates. The Aboriginal and Torres Strait Islander population in Central Queensland has a higher prevalence of mental health	Mental and behavioural problems incidence was 21-32 ASR per 100, this is higher than the Queensland rate of 23 ASR per 100. During 2016-20, reported suicide ASRs within CQHHS were statistically higher than the Queensland ASR rate. In 2019-20, 3.7% of emergency department presentations were for mental and behavioural disorders, with majority of presentations being for people aged 15-44 years. According to 2021 census data, Aboriginal and Torres Strait Islander populations in the Banana, Central Capricorn, Gladstone, and Rockhampton/Yeppoon Indigenous areas (IARE	Community-based and outpatient mental health services, particularly for people who require support but not hospitalisation, are a service gap for Central Queensland – especially in light of increasing demand for services. This service gap includes accessible and culturally appropriate mental health services for First Nations people as outlined in the Health Equity Strategy (currently being finalised).	Consultation identified that there is a gap in mental health support services available to individuals and their family and carers, without large co-payments. 18.3% of CQHHS residents currently waiting for mental health related outpatient services identified as First Nations people. This is 11.0% higher than the region's First Nations population share (7.3%).	• Strengthen partnerships with primary care partners and Central Queensland, Wide Bay, Sunshine Coast Primary Health Network (CQWBSC PHN) to better integrate services across the care continuum, undertake joint planning for services across the HHS and build capacity in the community sector for prevention and early intervention. • As part of joint planning across the region with other providers, consider expansion of community mental health services, better data sharing with primary care	• Mental Health, Alcohol and Other Drugs Joint Regional Plan (2020- 25) • Department of Health Fifth National Mental Health and Suicide Prevention Plan (2017) • Department of Health national Drug Strategy (2017-2026) • Unleashing the potential: an open and equitable health system • My health, Queensland's future: Advancing health 2026 (Advancing health 2026)

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
conditions, compared to the region's non-Indigenous population.	2021) reported greater incidence (ASR per 100) of mental health conditions, when compared to these areas' non-Indigenous population.[1]			providers and across CQHHS services, and models for ED avoidance for crisis presentations. • As part of joint planning with other providers, ensure local models of care for accessing mental health services are responsive to the specific needs of First Nations people to improve access to culturally appropriate care. • As part of joint planning with other providers, ensure there are safe spaces for gender diverse people to access mental health support across CQHHS.	

[1] Statistical boundaries of the Rockhampton – Yeppoon, Banana, Central Capricorn and Gladstone Indigenous areas (IARE 2021) correspond to the Rockhampton, Biloela, Central Highlands and Gladstone SA3 areas, as confirmed using ABS mapping tools.

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
		Mental health services across the HHS are not able to meet increasing demand as evidenced by long waits for specialist outpatient services and workforce recruitment and retention challenges.	Of 115 CQHHS residents currently waiting for Mental Health outpatient clinics, 82.6% are currently classed as long-waits. One of the drivers exacerbating the access to existing services is a high staff vacancy rate – mental health services across CQHHS have vacant positions totalling 50.2FTE, at a vacancy rate of 16.0%. In particular, CYMHS have 3.0FTE of vacant positions, at a vacancy rate of 20.7%[2].	• Develop recruitment and retention strategies for the mental health workforce with a focus on a sustainable workforce model, especially in rural parts of CQHHS. • Further embed network wide service models across CQHHS facilities. Build upon existing staffing models and initiatives enabling both face-to-face and telehealth delivery, supporting care across CQHHS and improving access to services for young people in regional and rural parts of the health service.	

[2] **True Substantive Vacancy:** True substantive vacancy is calculated as approved FTE that is not filled by permanently appointed FTE, or filled by a temporary/backfilling employee.

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
		There are limited mental health and trauma indicators embedded into patient care pathways.	Consultation with a youth reference group raised a lack of embedded screening for underlying mental health issues and trauma in standard care pathways.	• Consider use of peer workers in emergency departments to support crisis management of related presentations	

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
		Acute inpatient services are only accessible in Rockhampton, which results in patients from other SA3s having to travel outside of their communities to access care. These patients may require additional support to access transport and local follow up care/community supports on discharge. This is also a consideration for patients accessing acute inpatient treatment from other HHSs (Central West).	For CQHHS residents, Rockhampton Hospital provided 25.7% of its total inpatient mental health separations for CQHHS residents to residents outside the Rockhampton SA3.	• Build on newly established HHS-wide patient flow team to coordinate patient flows for acute mental health scare across CQHHS. • Work with HHS services and primary care partners in regional SA3s to ensure these patients that travel to access care are supported in their local communities after discharge. • Consider the appropriateness of acute inpatient infrastructure across CQHHS for providing high quality care, given the age and condition of the existing mental health unit. • Maximise use of telehealth and virtual models to	

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
				support patients in their local communities where safe to do so.	

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
 Priority 3: Ageing-related complex care needs especially in rural communities					
Ageing related conditions were identified as key health needs, particularly cognitive decline and impairment, dementia, frailty, functional decline, falls/injuries in the home, delirium, behavioural and memory loss issues and degenerative diseases and complex and chronic medical conditions. Furthermore, the population of Central Queensland residents aged 65 years and older is projected to increase significantly, experiencing the fastest rate of growth across all age groups in CQHHS by 2041.	The Central Queensland community has a significant proportion of older persons, with 15% of the population over the age of 65 years in 2019-20, with a projected growth of 4.3% compound annual growth rate by 2031. In 2016-17, CQHHS had significantly higher ASR mortality rates from dementia (33.9 per 100,000) compared to Queensland rate of 28.9 per 100,000. 18.0% of people over the age of 65 years in Central Queensland lived with a profound or severe disability, higher than the Queensland rate of 16.8%.	The availability of acute care for ageing-related complex conditions (including dementia) is limited to Rockhampton Hospital, contributing to high demand and capacity issues for this service.	The Rockhampton Hospital SAGE (Subacute Geriatric Evaluation Ward) operated at an average annual occupancy of 99% in FY22. (Note: this may be attributed to multiple factors such as demand, model of care and discharge processes) 12% of discharges from the SAGE and OPMHU wards in FY22 were for residents of the Gladstone, Central Highlands or Biloela SA3s. Of 104 CQHHS residents currently waiting for Ageing-Related Complex Care clinics, 64.4% are currently classed as long-waits.	• Explore and adopt contemporary models of care to support our older patients including those with cognitive decline, frailty, dementia (and associated comorbidities). • Strengthen partnerships with community care and RACF to ensure care is delivered in the right setting. This includes expanding HHS in reach to local RACF for patients that would otherwise use hospital services (e.g. consider establishing a HITH in RACF model for appropriate patients.)	• Royal Commission into Aged Care Quality and Safety • National Palliative Care Strategy 2018 • Healthy Ageing: A strategy for older Queenslanders • Unleashing the potential: an open and equitable health system • My health, Queensland's future: Advancing health 2026 (Advancing health 2026)

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
				• As part of service planning, consider access to subacute beds across the HHS, including hospice beds. • Continue to support work toward high quality palliative care across Central Queensland.	

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
		There is a lack of aged care beds and community-based services to support this patient cohort, including dementia care. This is a particular issue in rural communities, including Woorabinda. This contributes to a lack of care co-ordination, more frequent hospitalisations among this cohort, and increasing demand for specialised inpatient care. There are limited numbers of dementia care places available within CQHHS and these are not geographically distributed (located only in Rockhampton and Gracemere).	Consultation in Central Highlands identified that there is no secure dementia care available locally, with patients having to be placed in outside their local communities (in Longreach, Gracemere or Rockhampton.) As at 06 October 2022, 37 patients across the HHS with a maintenance care type were identified as occupying acute beds, with the majority (20) of these at Rockhampton Hospital. In FY22, CQHHS discharged 593 patients under this care type with an Average Length of Stay (ALOS) of 29.6 days, compared to an ALOS of 3.2 for all admitted patients.[3]	• Engage with the Commonwealth and private sector to support and assist advocacy of expansion of local RACF capacity and adequate primary care capacity to provide care at home and in the community. • As part of this process, or as part of ongoing service planning, develop a longer term plan for dementia services across the HHS. • Explore partnerships with stakeholders that have a key responsibility in supporting and building primary health care capacity (e.g. the CQWBSC PHN has an emerging focus on	

[3] Figures relating to the number of maintenance care type inpatients occupying acute beds are based on point-in-time data provided on 06 October 2022. ALOS of all admitted patients is based on HBCIS Admitted Inpatient Activity Data Extracts, FY21-FY22 (provided by Central Queensland HHS 08 August 2022).

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
				older persons health initiatives in the community)	

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
 Priority 4: High rates of diabetes-related complications and poorly managed diabetes					
There is a high prevalence of diabetes in the community, and in particular type 2 diabetes and gestational diabetes. Diabetes related complications and comorbidities, particularly cardiovascular and renal disease, further add complexity to the health needs of this patient cohort and a disproportionate impact on the Aboriginal and Torres Strait Islander population is evident.	In 2017-18, the incidence in Central Queensland for Diabetes Mellitus was 4-6 ASR per 100, compared to Queensland ASR of 5 per 100. In 2016-17, CQHHS ASR per 100,000 for mortality rates relating to Diabetes was 18.42, compared to Queensland 15.11. In 2019-20, CQHHS had a 111% relative utilisation for public Endocrinology services and 68% for private Endocrinology services. According to 2021 census data, Aboriginal and Torres Strait Islander populations in the Banana, Central Capricorn, Gladstone and	There is limited support available to patients living with diabetes in the community in terms of access to contemporary, case-managed care, exacerbating the prevalence of diabetes-related complications.	CQHHS staff identified that there is a need for clinical guidelines for care of diabetes patients and specialist oversight in the form of an employed endocrinologist to ensure safe, appropriate, and consistent management of diabetes.	• Explore and adopt contemporary models of care to support our patients with diabetes (and associated comorbidities). This includes supporting patient health literacy and self-management strategies to help reduce avoidable condition deterioration whilst in the community.	• National Medical Workforce Strategy (2021–2031) • Unleashing the potential: an open and equitable health system • My health, Queensland's future: Advancing health 2026 (Advancing health 2026)

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
	Rockhampton/Yeppoon Indigenous areas (IARE 2021) reported greater incidence (ASR per 100) of diabetes (excluding gestational diabetes), when compared to these areas' non-Indigenous population.	There is insufficient capacity to meet current demand for outpatient services relating to diabetes.	Outpatient clinics for treatment of Diabetes-related conditions currently have 403 persons waiting across CQHHS, with 250 of these being classed as long waits (62.0%).	• Develop a diabetes workforce strategy for recruitment and retention. Consider the right multidisciplinary workforce model for CQHHS' local including medical workforce, appropriate allied health supports and dedicated nursing positions. • Expand partnerships with local providers and partners to increase awareness of community based diabetes education and support services, particularly in rural settings (e.g. pharmacy-based diabetes education services).	

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
		First Nations people in the CQHHS region are more likely to be waiting for diabetes care, and are less likely to receive care within clinically recommended timeframes.	Of 403 CQHHS residents waiting for treatment of Diabetes-related conditions, 263 (65.3%) are persons identifying as First Nations people. This is greater than the region's First Nations population share (7.3%). 69.6% of First Nations people waiting for these clinics are classed as long-waits, compared to 47.9% for non-Indigenous persons.	• Given the increased prevalence of diabetes in the First Nations community, consider inclusion of identified workforce positions in the overall model of care to support these patients. • Explore opportunities for partnership with the primary care sector and local ACCHOs to ensure seamless support for First Nations diabetics across primary and specialist care.	

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
 Priority 5: High rates of developmentally vulnerable children with complex health needs					
There are significant health needs for the Central Queensland child and youth population in relation to developmental delays and behavioural challenges. Specifically, this included fetal alcohol syndrome disorder, child development, speech and communication issues, mental health risks and conditions, and learning disorders.	Children between the age of 0 and 14 years make up a significant proportion of the Central Queensland population (22%), greater than the Queensland average (20%). 27.2% of CQHHS children identified as developmentally vulnerable in one or more domains, higher than the state rate (25.87%). 14.67% of CQHHS children identified as developmentally vulnerable in two or more domains, higher than the state rate (13.88%).	For high risk children, current child development services are not integrated across CQHHS, with very few patients having coordinated care and follow through to adulthood.	Community Health Rockhampton staff identified that pathways should be developed for high-risk children to coordinate care and follow through to adulthood. Woorabinda Hospital's paediatric clinic currently has the most long-waits (135 long waits, 86.0% of all waits) of any CQHHS outpatient clinic relating to child development services.	• Continue to develop partnerships with education and NGO sector to support high risk children through to adulthood. This includes partnering with the CQWBSC PHN that plays a key responsibility in supporting and building primary health care capacity - including an emerging focus on this cohort. • Identify contemporary models of care to support our high-end, complex child and youth patients – including transition of their care to more appropriate settings and community-based care. This includes	• National Medical Workforce Strategy (2021–2031) • Unleashing the potential: an open and equitable health system • My health, Queensland's future: Advancing health 2026 (Advancing health 2026)

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
		There is limited access to community-based child and youth health clinics. Strict eligibility criteria are further preventing patients from being able to access the services that are available.	Services in Gladstone and Emerald have very strict eligibility criteria, which does not allow children aged above 8 years of age to access services. 60.5% of CQHHS residents waiting for outpatient clinics relating to child development are classed as long-waits.	consideration of alternative workforce models. • Expand delivery of child health clinics and consider the need for a child behavioural service for targeted interventions for children with behavioural needs. This could be considered as part of a partnership model with education, the primary health and NGO sector/local NDIS providers.	

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
		The Gladstone and Central Highlands areas have limited speech therapy and early intervention services available in the region.	Central Highlands SA3 children have the highest percentage (73.9%) of long-waits for speech pathology services. Gladstone has the largest number of children waiting to access speech pathology services with 34 children waiting outside clinically recommended timeframes.	• Develop a workforce strategy for allied health across CQHHS to address vacancies, particularly in regional SA3s. This should also consider extended and expanded scope of practice strategies to optimise utilisation of the existing allied health professional workforce. • Review of models of care to maximise care available locally – consider telehealth models where local services cannot be provided in person. • Models of care should be inclusive of First Nations children and support identification and support of vulnerable First	

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
				Nations children in a culturally appropriate way, closer to home and within the family unit.	

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
Priority 6: Poor health outcomes across all conditions due to social determinants of health increasing burden of disease in the community					
There is significant influence of social determinants on health throughout the Central Queensland population, creating disparity in health status and outcomes for some communities and individuals.	The population of Central Queensland experiences socio-economic disadvantage at a rate significantly higher than the Queensland average. In 2016, approximately 35% of CQHHS was categorised in SEIFA deciles 1-4 (most disadvantaged) and 64% in the SEIFA deciles 5-6. 36% of CQHHS Aboriginal and Torres Strait Islander people completed school at year 12, lower than the CQHHS non-Aboriginal and Torres Strait Islander rate of 47%. CQHHS residents have a lower life expectancy compared to Queensland.	Access to health services is limited by access to non-health services like public transport and social housing. Demand for CQHHS services is impacted by a lack of low cost primary care (e.g. The Gemfields is a highly disadvantaged area within CQHHS with limited access to low cost primary care influencing early treatment and prevention for these residents).	Consultations identified that homelessness and a lack of access to transport is exacerbating poor health outcomes, with many people delaying health checks, appointments, and treatments.	• Make targeted changes to models of care to accommodate for the socioeconomic factors that influence access to health care across CQHHS. (For example, providing outpatient clinics for at risk cohorts in more accessible settings to reduce the reliance on transport for access to care.) • Advocate for primary health services in CQHHS in partnership with CQWBSC PHN. Leverage off the first 2,000 days initiative. • Ensure our highly skilled workforce, including A&TSIHW and A&TSIHLOs, are	• Queensland Health's Virtual Healthcare Strategy (2020) • Queensland Health Telehealth Strategy (2021-26) • Digital Strategy for Rural and Remote Healthcare (2022-2032) • Unleashing the potential: an open and equitable health system • My health, Queensland's future: Advancing health 2026 (Advancing health 2026) • Digital Health 2031 - A digital vision for Queensland's health system

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
				working to the top of their scope - and appropriate alternative resources or tactics are engaged to support with logistics/admin support for vulnerable patients. • Continue to develop and strengthen existing partnerships with CQU and universities, CQWBSC PHN, other primary care providers and the NGO sector to address social determinants of health. • Cooperate across government to ensure CQHHS has the right local relationships to help patients that require access to social housing.	
		CQHHS has limited partnerships with CQWBSC PHN, universities and other organisations, which provide opportunities to improve social determinants of health across the community.	In consultation, many individual programs or partnerships were mentioned (E.g., Gladstone Region Together) but opportunities exist to broaden and strengthen these partnerships.		

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
 Priority 7: High prevalence of health risk factors including obesity, smoking, and use of alcohol and other drugs					
There is a high prevalence of modifiable health risk factors throughout the Central Queensland population, including high rates of obesity, smoking and use of alcohol and other drugs. These health risk factors were identified across all communities, but particularly in young adults and Aboriginal and Torres Strait Islander people.	When compared to Queensland, Central Queensland region has a higher prevalence of health risk factors including obesity, smoking, and use of alcohol and other drugs. Central Highlands- East and Mount Morgan SA2 areas had the highest prevalence of adult daily smoking (22%).	CQHHS services could better embed screening for modifiable health risk factors and implement early intervention strategies to reduce the prevalence of smoking, improve diet, and reduce use of alcohol and other drugs.	Consultations identified that greater health literacy education and prevention initiatives are needed with the aim of reducing the prevalence of health risk factors. In the age range of 50-74, CQHHS rate of bowel cancer screening participation is 41%, 1% below the state rate (42%). Of the 145 total waits for drug & alcohol outpatient services, 89 (61.4%) are classed as long-waits.	• Promote cancer screening services to enable early detection. • Review outpatient processes and identify opportunities to increase timely access to care for drug and alcohol outpatient services. • Embed health literacy and patient education (secondary promotion and prevention) into acute models of care.	• Prevention Strategic Framework 2017 to 2026 • My health, Queensland's future: Advancing health 2026 (Advancing health 2026) • Cancer Screening Strategic Framework 2019 to 2026 • Digital Health 2031 - A digital vision for Queensland's health system

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
		The uptake of health promotion and prevention activities is underutilised by populations with a higher prevalence of health risk factors.	There is a lower representation of Aboriginal and Torres Strait Islander individuals accessing outpatient clinics for health risk factor related services.	• Explore strategic partnerships with local universities, public health unit, and organisations such as *CQShines*, to embed hospital avoidance, prevention and health promotion initiatives across the community, targeting high risk or vulnerable people. • For First Nations people, this should include partnerships with local ACCHOs and First Nations service providers to engage the community in health promotion and prevention activities.	

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
 Priority 8: High rates of respiratory disease linked to high rates of smoking and occupational exposure through mining and industry					
Respiratory conditions of both chronic nature (chronic obstructive pulmonary disease, chronic bronchitis, occupational asthma, lung cancer) and acute nature (shortness of breath, chest pain) are a key health need of the Central Queensland community. Both industry and occupational factors, as well as other risk factors including lifestyle behaviours and environmental influence in some areas (silicosis and PM2.5 air pollution) were identified as key causative factors throughout engagement.	In 2016-17, CQHHS age standardised mortality rates (ASR per 100,000) from diseases of respiratory system and chronic obstructive pulmonary disease were statistically higher than Queensland rates. During 2014-18, 21 SA2s within CQHHS were estimated to have higher ASRs of premature deaths from respiratory system diseases (RSD) than the estimated Queensland ASR (16.64 per 100,000). According to 2021 census data, Aboriginal and Torres Strait Islander populations in the Banana, Central Capricorn, Gladstone and Rockhampton/Yeppoon Indigenous areas (IARE 2021) reported greater	Local access to contemporary, case-managed respiratory care is limited, especially outside of Rockhampton.	CQHHS staff highlighted that there are no respiratory physicians working in the HHS. 57.1% of patients waiting for outpatient clinics relating to Respiratory Disease are classed as long-waits. This is concentrated for residents of the Central Highlands SA3, with most of these residents waiting for services at Woorabinda. For outpatient service events related to treatment of respiratory disease, 98% of all service events were provided to residents of the Rockhampton SA3.	• Build a multidisciplinary respiratory service for CQHHS including medical workforce, nursing, and allied health. • Improve access to both planned and unplanned care for respiratory conditions with a focus on alternatives to ED and admitted inpatient care. • Work with local industries to ensure education and screening processes are in place for their workers.	• Unleashing the potential: an open and equitable health system • My health, Queensland's future: Advancing health 2026 (Advancing health 2026) • Prevention Strategic Framework 2017 to 2026 • Digital Health 2031 - A digital vision for Queensland's health system

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
	incidence (ASR per 100) of both lung conditions and asthma (specifically), when compared to these areas' non-Indigenous population.	First Nations people in the CQHHS region are more likely to be waiting for respiratory disease care, and are less likely to receive care within clinically recommended timeframes.	Of 112 CQHHS residents currently waiting for specialist outpatient services related to the treatment of respiratory disease, 52 (46.4%) identify as First Nations people. This is 39.2% greater than the region's First Nations population share (7.3%). Of First Nations people currently waiting, 71.2% are classed as long-waits. This compares to 45.0% for non-Indigenous persons currently waiting.	• As part of developing an appropriate workforce model, consider inclusion of Aboriginal and Torres Strait Islander-identified workforce positions. • Explore opportunities for partnership with the primary care sector and local ACCHOs to ensure seamless support for First Nations patients requiring ongoing support for chronic respiratory conditions.	• Queensland Health, Health Equity Framework 2021

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
 Priority 9: Vulnerable families and adverse impacts of child abuse/neglect, domestic violence and trauma on health and wellbeing					
Health needs related to the adverse impacts of child abuse and neglect, domestic violence, and trauma are evident throughout the Central Queensland region.	In 2018-20, CQHHS reported offence rate (all offences) per 100,000 persons was higher than Queensland rate and breach of domestic violence protection order was the third highest offence reported in CQHHS.	Additional social worker workforce is required to provide support for vulnerable families and at risk children, and address current waitlist and capacity requirements. This is an ongoing recruitment and retention challenge. A lack of understanding of Aboriginal and Torres Strait Islander family structures and relationships impacts the provision of culturally appropriate support.	Social worker positions in CQHHS have a vacancy rate of 17.9% (7.8 FTE vacant), higher than the average vacancy rate for CQHHS (12.5%). Outpatient services delivered by social workers for Central Highlands residents have decreased by 43% in FY22 compared to FY21. Gumbi Gumbi identified that multigenerational trauma impacts on the health of the Aboriginal and Torres Strait Islander community. Services need to be responsive to the needs	• Include social worker workforce in a workforce strategy for allied health across CQHHS to address vacancies, particularly in regional SA3s. • Consider telehealth models and partnerships with other government agencies and NGOs to support vulnerable families, particularly in Central Highlands and regional areas. • As for Priority 2, recruitment, and retention workforce strategies for Aboriginal and Torres Strait Islander identified positions and Aboriginal and Torres Strait	• Unleashing the potential: an open and equitable health system • My health, Queensland's future: Advancing health 2026 (Advancing health 2026) • Queensland Health, Health Equity Framework 2021 • Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2026 (the Framework)

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
			of individual families, community, and culture.	Islander health workers should be considered.	
		There are limited services and support available in the community sector for the at-risk youth cohort (including homeless, in-out-of-home care, and LGBTQI youth.)	External service providers highlighted the lack of counselling and support offered to people experienced domestic and family violence, and other traumas.	• Support and participate in an interjurisdictional approach with key government departments and stakeholders to better support at-risk youth (e.g., Develop partnerships with education providers and NGOs -See Priority 5.)	

Health need	Evidence for health need	Service Gap	Evidence for Service Gap	Proposed potential solution (high level)	Alignment to system priorities
Priority 10: Complex health needs of people with profound or severe disability					
Incidence of profound or severe disability across Central Queensland community was highlighted in stakeholder consultation, and quantitative evidence further validated significant rates of profound or severe disability, particularly for people over the age of 65 years.	In 2016, CQHHS rate of profound or severe disability was 5.06%, lower than Queensland average of 5.29%. However, there was a higher estimated rate of persons with profound or severe disability over the age of 65 years (17.97%) than the estimated state average (16.80%). In December 2019, there were approximately 4,410 NDIS participants in Central Queensland. This is projected to increase to 6,000 NDIS participants by 2023.	Access to in-home NDIS supports is limited outside of Rockhampton, particularly in Woorabinda.	Consultation in Woorabinda identified the gap in NDIS service provision. The requirement of persons in the Rockhampton NDIS service district[4] to access NDIS services is projected to increase from 4,410 participants in December 2019, to 6,000 in 2023.	• Develop formal relationships, joint and shared service models, and patient pathways with NDIS providers to ensure timely access to care when needed from partners. Consider capacity for HHS to provide education to increase the maturity and skills of the local disability service providers for relevant patient cohorts.	• National Disability Insurance Agency operational plan to improve hospital discharge for NDIS patients. • Queensland Health, Health Equity Framework 2021

[4] NDIS service districts do not align with Queensland HHS boundaries. Thse Rockhampton service district incorporates some areas that are in CQHHS' neighbouring HHSs, primarily Central West.

5.1 Priority #1: High prevalence of complex comorbidities, chronic disease, and risk factors for chronic disease, especially for Aboriginal and Torres Strait Islander people

Description of health needs

High prevalence of complex and chronic diseases across Central Queensland region was frequently raised in consultation as a key health need for the region. Chronic diseases include Arthritis, Asthma, Diabetes, Heart, Stroke and Vascular Disease, Chronic Obstructive Pulmonary Disease and Osteoarthritis. These health needs were reported as significant challenges by Aboriginal and Torres Strait Islander communities

Evidence of health needs

In 2017-18, chronic disease incidence (ASR per 100) across the majority of Central Queensland SA2 areas was higher than the Queensland average for arthritis, asthma, and diabetes mellitus (see Figure 7). Other chronic conditions including cardiovascular disease and stroke, osteoporosis and chronic obstructive pulmonary disease were similar to the Queensland average.

Figure 7: Chronic disease incidence, 2017-18

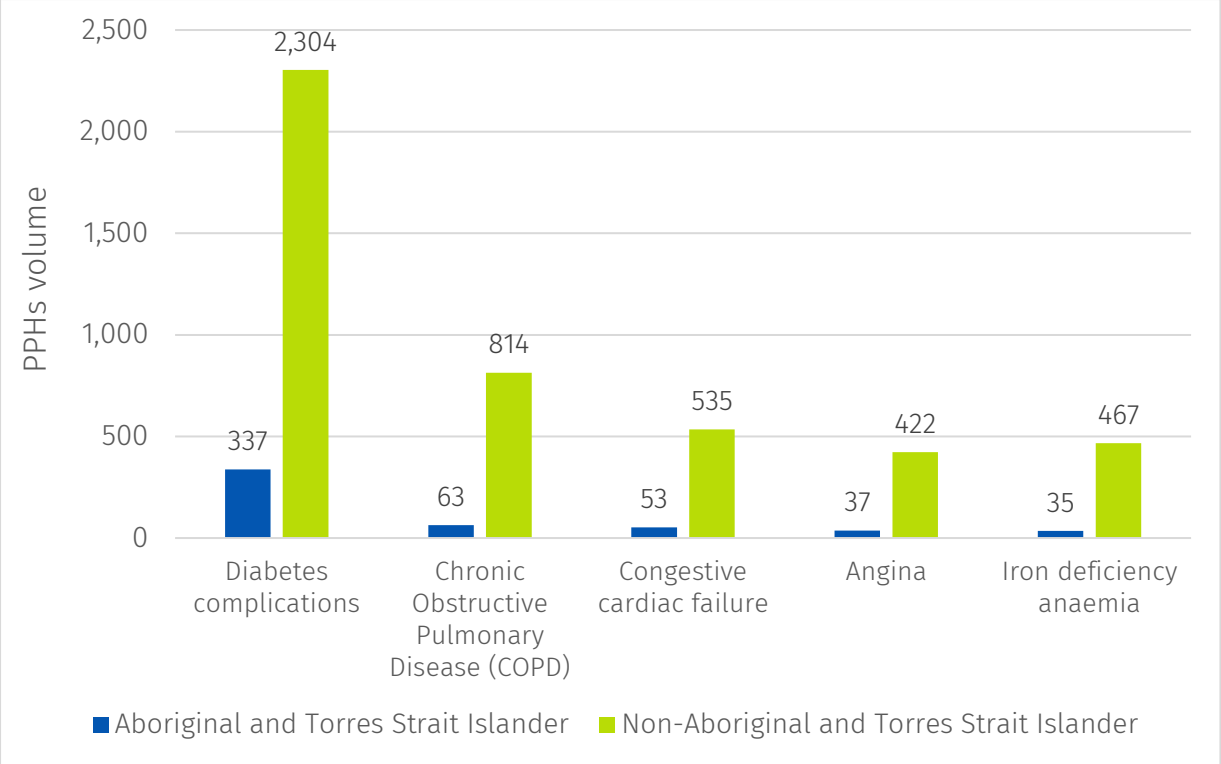
	CQHHS	QLD
Arthritis 10 SA2s with rates of 16 ASR per 100, totalling 11,564 residents (5.2% of total CQHHS population). Highest burden of disease for Yeppoon (3,519 persons suffering). 30,201 residents suffering with Arthritis across Central Queensland (13.7% of total CQHHS population).	13-16 per 100	14 per 100
Asthma 10 SA2s with rates of 14 ASR per 100, totalling 7,776 residents (3.5% of total CQHHS population). 26,881 residents with Asthma across Central Queensland (12.2% of total CQHHS population).	11-14 per 100	12 per 100
Diabetes mellitus Eight SA2s with rates of 6 ASR per 100, totalling 2,529 residents (1.1% of total CQHHS population). 10,048 residents suffering with Diabetes mellitus across Central Queensland (4.5% of total CQHHS population).	4-6 per 100	5 per 100
Heart, Stroke and Vascular Disease 10,048 persons suffered from heart, stroke, and vascular diseases (4.5% of total CQHHS population)	5 per 100	5 per 100
Chronic Obstructive Pulmonary Disease (COPD) 7,888 residents living with COPD (3.6% of total CQHHS population)	3-4 per 100	4 per 100
Osteoporosis 7,232 persons living with osteoporosis (3.3% of total CQHHS population)	2-4 per 100	4 per 100

In 2019-20, potentially preventable hospitalisations (PPHs) relating to chronic conditions represented 57% (5,067 separations) of all CQHHS PPHs, with 43% (3,761 separations) being acute PPHs.

The term PPH does not mean that a patient admitted for that condition did not need to be hospitalised at the time of admission, rather the hospitalisation could have potentially been prevented through the provision of appropriate preventative health interventions and early disease management in primary care and community-based care settings. This includes services provided by general practitioners, medical specialists, dentists, nurses, and allied health professionals. PPH rates are indicators of the effectiveness of non-hospital care. The rate of PPH in a local area may reflect access to primary health care, as well as sociodemographic factors and health behaviours (AIHW, 2022).

In 2019-20, diabetes complications was the most common chronic PPH condition throughout CQHHS, for both Aboriginal and Torres Strait Islander people and non-Aboriginal and Torres Strait Islander people (see Figure 8).

Figure 8: CQHHS chronic potentially preventable hospitalisations by condition, 2019-20



Data source: Queensland Hospital Admitted Patient Data Collection (QHAPDC), Statistical Services Branch, Queensland. Prepared by Statistical Reporting and Coordination, Statistical Services Branch, Queensland Health.

Description and evidence of service needs and gaps

Existing models of care

Given the prevalence of chronic disease, CQHHS services focused on support for chronic disease management including care co-ordination and hospital avoidance require additional capacity. All clinical services could also better embed early intervention, screening, and health promotion into existing models of care.

Chronic disease patients are a large cohort accessing CQHHS' inpatient services. In FY21 and FY22, 31% of all inpatient separations across CQHHS were for primary diagnoses associated with chronic disease. Many more patients admitted for care will have comorbidity. Care co-ordination for these patients, who often have a need for multidisciplinary care, was a service gap identified in CQHHS' services. In community survey responses, patients reported feeling ignored by the health care system and that accessing the right care in the right setting for their chronic illness was difficult. Staff consultation identified the number of existing nurse navigator positions as being inadequate to cover demand for the service.

Key subspecialty services are not provided widely across the CQHHS region, and gaps in these services result in delayed diagnosis and treatment. There is also a substantial burden on patients and their families who have to travel outside of CQHHS to access care.

Increased hospital avoidance and preventative measures, underpinned by strong partnerships and integration with primary and community care, will assist to address fragmentation along the patient's care journey. Examples included establishing chronic disease management teams to provide coordinated and integrated care for patients.

Aboriginal and Torres Strait Islander cohort

In FY21 and FY22, 42% of all inpatient episodes of care for Aboriginal and Torres Strait Islander people were for patients with a primary diagnosis associated with a chronic condition (compared to 29% of all episodes of care for non-Aboriginal and Torres Strait Islander people.) Despite greater health need and higher rates of chronic disease, Aboriginal and Torres Strait Islander people experience a significant gap in culturally appropriate service.

Fragmentation in service provision was reported by stakeholders as a significant challenge for Aboriginal and Torres Strait Islander patients, who experience greater barriers to access than the non-Aboriginal and Torres Strait Islander population. Stakeholders suggested that a case conferencing model of care with the consumer would work better especially for Aboriginal and Torres Strait Islander patients with complex medical needs, as this model allows patients to see multiple specialists on the same day.

To support the lifestyle modifications required to manage many chronic diseases, identified workforce who understand the cultural barriers to these changes were also identified as an important service gap. This is evident in CQHHS' workforce data, where 13.2 of 33.6 Approved FTE is currently vacant for positions in the Aboriginal and Torres Strait Islander Workers across the HHS. Services in Woorabinda and Rockhampton have the largest vacancy rate. There are also limited Aboriginal and Torres Strait Islander Health Workers (A&TSIHW) and Aboriginal and Torres Strait Islander Health Liaison Officer (A&TSIHLO) positions in Central Highlands and Biloela. These positions are important in coordinating care and helping Aboriginal and Torres Strait Islander patients navigate the health system.

Delivery of services by Aboriginal and Torres Strait Islander Health Workers is lowest in the Gladstone SA3, with 2.4% of service events across the HHS being delivered to residents of the Gladstone region; 60.3% of these services were delivered in-person (compared to 91.0% across CQHHS).

These workforce challenges also impact primary care services, with Bidgerdii Community Health stakeholders reporting that the lack of a stable chronic disease nurse workforce makes it difficult for Aboriginal and Torres Strait Islander patients to develop the trust and relationships required to sustain lifestyle changes.

Gaps in non-HHS health services

Across Central Queensland, there is a lack of community / general practitioner (GP) follow up on hospital discharge due to limited access to GPs and low number of bulk-billing GPs deterring patients and limiting access to primary health care and community based chronic disease services.

Over 18% of consumer survey responses identified that the community is lacking an adequate number of GPs. A large majority (89%) of consumers identified that health service access (timeliness and ease of access) needs to be improved across Central Queensland, particularly in the primary care setting.

Proposed potential solution (high level)

- Work with service delivery partners to address service gaps and fragmentation.
- Increase hospital avoidance by introducing new models of care and preventative initiatives. For chronic disease patients, consider the Rapid Access Service model for ED avoidance (expanding beyond existing Respiratory Rapid Access model to other conditions).

- Accelerate adoption of technology to update referral processes, provide intra-facility access to medical reports, improve HHS-wide communication and primary care interfacing.
- Consider possibility of remote digital monitoring/ virtual care models for chronic disease.
- Recruitment and retention workforce strategies particularly for Aboriginal and Torres Strait Islander health workers. (Consider links with health equity strategy.)
- Review models of care, patient journey and workforce models for areas of care highly utilised by Aboriginal and Torres Strait Islander patients with chronic illnesses (renal dialysis, rheumatic heart disease, heart failure, COPD and asthma) with a focus on increasing cultural safety and access to care.

Alignment to system priorities

- Queensland Health System Priorities
- Unleashing the potential: an open and equitable health system
- My health, Queensland's future: Advancing health 2026 (Advancing health 2026)
- Care 4 Qld
- Digital Health 2031 - A digital vision for Queensland’s health system
- National Medical Workforce Strategy (2021–2031)
- Queensland Government Making Tracks Investment Strategy Queensland Government Health Equity Strategy and legislative framework
- Queensland Health, Health Equity Framework 2021
- Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2026

5.2 Priority #2: Management of mental health across the care continuum, but especially for mild to moderate mental health conditions

Description of health needs

Stakeholders emphasised significant risk factors and high prevalence of mental health conditions within the Central Queensland community and the need for management of mental health across the care continuum. Mental health related needs were raised by 42% of external stakeholders and 34% of staff when asked about the highest health needs of the community. Stakeholders frequently raised high prevalence of mental health issues including suicide, depression, and anxiety with significant current and emerging needs for adolescents and young adults.

Central Queensland experiences mental and behavioural problems at a higher rate than Queensland, with 14 out of 32 SA2 areas having ASR rates above Queensland rates. The Aboriginal and Torres Strait Islander population in Central Queensland also has a higher

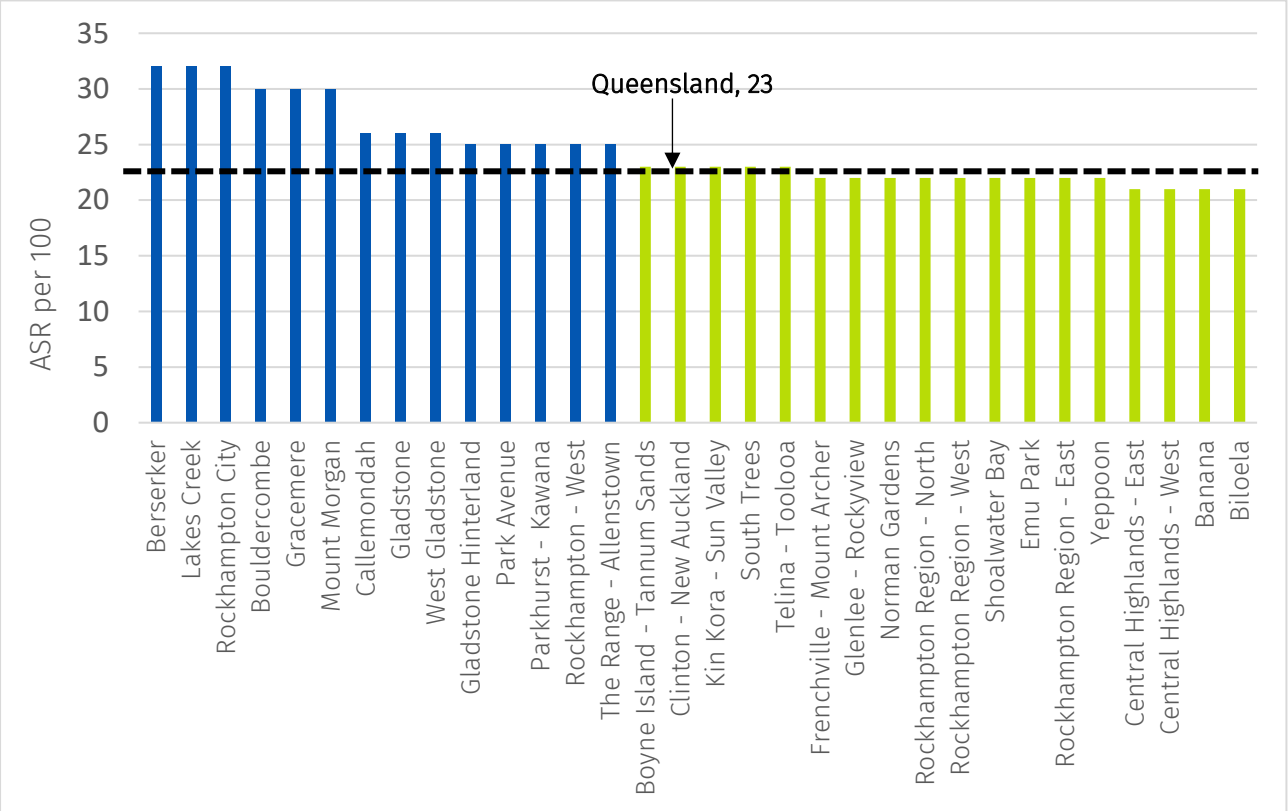
prevalence of mental health conditions, compared to the region's non-Indigenous population. Similarly, Central Queensland has a higher incidence of suicide deaths than Queensland and Australian rates across Rockhampton, Gladstone, and Central Highlands (Qld) SA3s.

Evidence of health needs

In 2017-18, the incidence of mental and behavioural problems (ASR per 100) across the majority of Central Queensland SA2 areas was significantly higher (21-32) than the Queensland average (23). Most notably, Berserker, Lakes Creek and Rockhampton City SA2s, with 32 persons per 100 living with mental illness and behavioural problems. According to 2021 census data, Aboriginal and Torres Strait Islander populations in the Banana, Central Capricorn, Gladstone and Rockhampton/Yeppoon Indigenous areas (IARE 2021) reported greater incidence (ASR per 100) of mental health conditions, when compared to these areas' non-Indigenous population.

Nineteen Central Queensland SA2 areas had significantly higher and/or comparable rates of mental and behavioural problems than the Queensland average. Most notably, Berserker, Lakes Creek and Rockhampton City SA2s, with 32 per 100 persons living with mental illness and behavioural problems (see Figure 9).

Figure 9: Mental health and behaviour problems by CQHHS SA2, all persons, 2017-18



Data source: Public Health Information Development Unit (PHIDU) material from : Social Health Atlas of Australia: Population Health Areas. Prepared by System Planning Branch, Planning Portal.

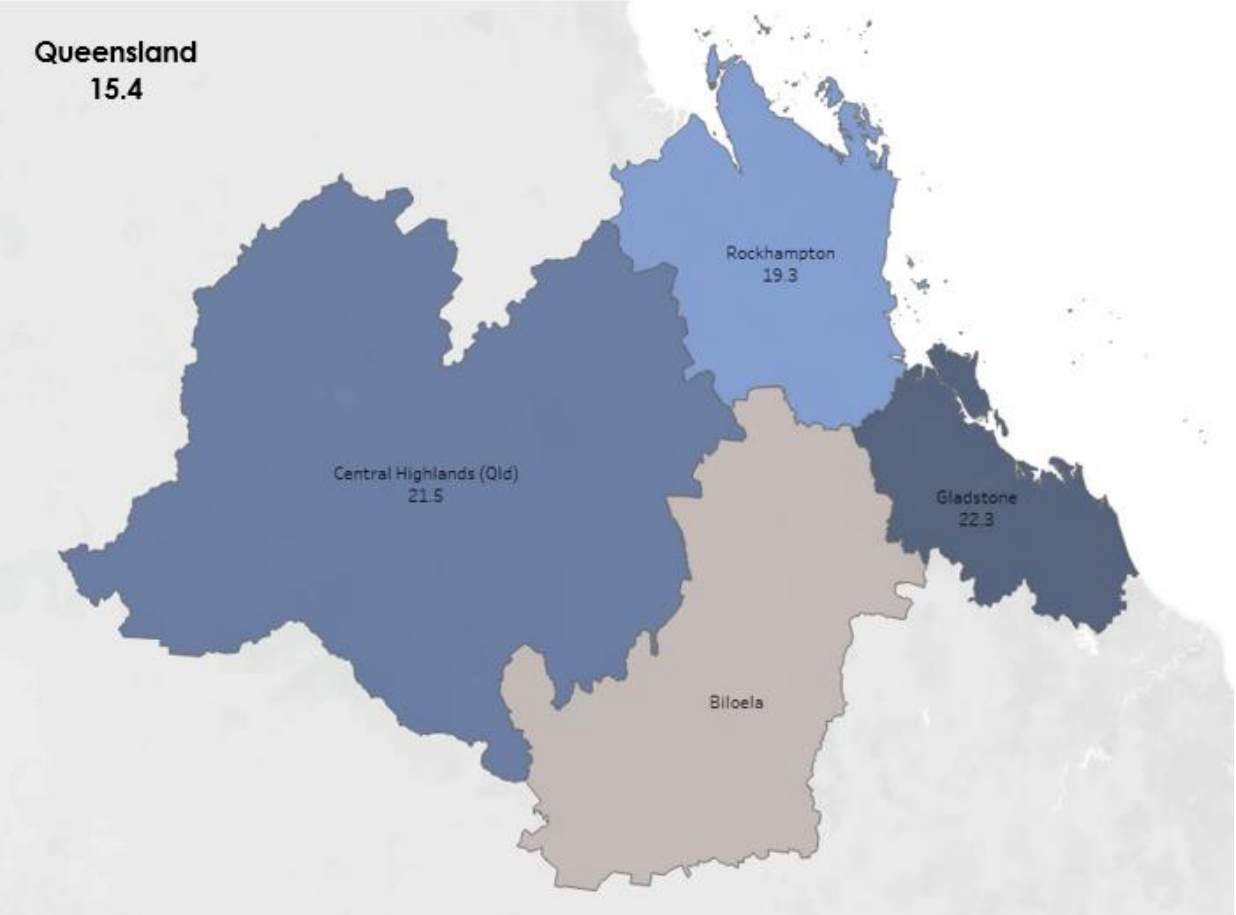
Between 2014-15 to 2018-19, hospital admissions for patients with a mental health Service Related Group (SRG) increased by a compound annual growth rate of 2.2%. Over this same period, admitted hospitalisation for Aboriginal and Torres Strait Islander people with a mental health SRG increased by a compound annual growth rate of 6.4%.

In 2019-20, 3.7% of emergency department presentations were for mental and behavioural disorders. Over half of those presentations (2.1% of all presentations) were for people aged 15-44 years.

During 2016-20, reported suicide ASRs within CQHHS were significantly higher than the Queensland ASR rate (15.4 per 100,000), see Figure 10:

- Rockhampton (19.3 per 100,000)
- Gladstone (22.3 per 100,000)
- Central Highlands (Qld) (21.5 per 100,000)

Figure 10: CQHHS suicide death rates, ASR per 100,000, all persons, 2016-20



Data source: Australian Institute of Health and Welfare (AIHW) 20212. National mortality database (NMD) statistical area level 3 (SA3), 2015-2019. Canberra: AIHW. Published on June 26, 2021.
** Data for Biloela SA3 has been suppressed due to data limitations*
** Scale colouring has been applied to represent incidence of suicide death rates in each SA3 (i.e., lightest to darkest represent least to most incidence)*

Description and evidence of service needs and gaps

Support services

Community-based and outpatient mental health services, particularly for people who require support but not hospitalisation is a service gap for CQHHS, especially in light of increasing demand for these services.

This service gap was evident in community survey responses. CQHHS staff also identified the urgent need for mental health support across Central Queensland for children and adults, without large co-payments.

"We need mental health support for individuals in the community and support for their family and carers. We need greater education to reduce stigma around mental health and reduce the intergenerational trauma and cycle of abuse."

- ***CQHHS community member***

Workforce challenges

Mental Health services have workforce vacancies which impact on their ability to provide the required level of service across the HHS. Mental Health services across CQHHS have vacant positions totalling 50.2FTE, at a vacancy rate[5] of 16.0%. In particular, CYMHS services currently have a true substantive vacancy rate of 20.7%, with 3.0FTE of vacant positions.

Growth in demand for CYMHS services was raised in multiple consultation sessions including sessions with a youth reference group and with local education providers, though this is not currently reflected in CQHHS' activity data. The adequacy of the current approved workforce profile of the service should also be considered in the context of growing demand.

Patient care pathways

There are limited mental health and trauma indicators embedded into patient care pathways.

Consultation with a youth reference group raised a lack of embedded screening for underlying mental health issues and trauma in standard care pathways.

Accessibility of services

Acute services are only accessible in Rockhampton, which results in patients from other SA3s having to travel outside of their communities to access care. For CQHHS residents, Rockhampton Hospital provided 25.7% of its total inpatient mental health separations (132 separations in FY22) to residents outside the Rockhampton SA3. This is 12.3% higher than the rate of out-of-SA3 separations that Rockhampton Hospital treats across all SRG. CQHHS also provides out-of-HHS care for acute inpatients from Central West HHS, and these patients travel large distances to access services.

These patients may require additional support to access transport and local follow up care/community supports on discharge. Consultation identified that these patients often have difficulties accessing transport back to their place of residence given the broader transport challenges within the HHS, and that post-discharge follow up in regional areas can be limited by capacity of the mental health services in these areas.

Access to Care for First Nations people

18.3% of CQHHS residents currently waiting for mental health related outpatient services identified as First Nations people. This is 11.0% higher than the region's First Nations population share (7.3%).

[5] **True Substantive Vacancy:** True substantive vacancy is calculated as approved FTE that is not filled by permanently appointed FTE, or filled by a temporary/backfilling employee.

Gaps in non-HHS health services

The engagement process identified service gaps whereby mild to moderate mental health needs and conditions require greater earlier intervention and / or subacute care to prevent crisis presentations both to emergency departments and primary care clinics. Respondents frequently described a lack of services available in the community across the care continuum and difficulty accessing multidisciplinary models with required allied health support (particularly social work support services).

Proposed potential solution (high level)

- Strengthen partnerships with primary care partners and Central Queensland, Wide Bay, Sunshine Coast Primary Health Network (CQWBSC PHN) to better integrate services across the care continuum, undertake joint planning for services across the HHS and build capacity in the community sector for prevention and early intervention.
- As part of joint planning across the region with other providers, consider expansion of community mental health services, better data sharing with primary care providers and across CQHHS services, and models for ED avoidance for crisis presentations.
- As part of joint planning with other providers, ensure local models of care for accessing mental health services are responsive to the specific needs of First Nations people to improve access to culturally appropriate care.
- As part of joint planning with other providers, ensure there are safe spaces for gender diverse people to access mental health support across CQHHS.
- Develop recruitment and retention strategies for the mental health workforce with a focus on a sustainable workforce model, especially in Emerald and rural parts of CQHHS.
- Further embed network wide service models across CQHHS facilities. Build upon existing staffing models and initiatives enabling both face-to-face and telehealth delivery, supporting care across CQHHS and improving access to services for young people in regional and rural parts of the health service.
- Consider use of peer workers in emergency departments to support crisis management of related presentations.
- Build on newly established HHS-wide patient flow team to coordinate patient flows for acute mental health scare across CQHHS.
- Work with HHS services and primary care partners in regional SA3s to ensure these patients that travel to access care are supported in their local communities after discharge.
- Consider the appropriateness of acute inpatient infrastructure across CQHHS for providing high quality care, given the age and condition of the existing mental health unit.
- Maximise use of telehealth and virtual models to support patients in their local communities where safe to do so.

Alignment to system priorities

- Mental Health, Alcohol and Other Drugs Joint Regional Plan (2020- 25)
- Department of Health Fifth National Mental Health and Suicide Prevention Plan (2017)
- Department of Health national Drug Strategy (2017-2026)
- Unleashing the potential: an open and equitable health system

- My health, Queensland's future: Advancing health 2026 (Advancing health 2026).

5.3 Priority #3: Ageing-related complex care needs especially in rural communities

Description of health needs

Ageing related conditions were identified as key health needs, particularly cognitive decline and impairment, dementia, frailty, functional decline, falls/injuries in the home, delirium, behavioural and memory loss issues and degenerative diseases and complex and chronic medical conditions. Furthermore, the population of Central Queensland residents aged 65 years and older is projected to increase significantly, experiencing the fastest rate of growth across all age groups in CQHHS by 2041.

Across all stakeholder groups, older people were identified as a population cohort increasing in size, but often not receiving the care they need to optimise their quality of life and wellbeing. For older community members, social isolation and loneliness were frequently linked with cognitive decline, mental illness, and accelerated physical deconditioning and mobility issues.

Evidence of health needs

The proportion of the Central Queensland over the age of 65 years in 2019-20 is consistent with Queensland at 15%, see Figure 11.

Figure 11: CQHHS age structure breakdown, 2019-20

	Children (0-14)	Adults (15-64)	Older persons (65+)
Central Queensland	22%	63%	15%
QLD	20%	64%	16%

By 2031, the projected number of residents aged 65 years and over is projected to increase from 31,273 (2020 ERP) to 49,675 which represents a 4.3% compound annual growth rate (CAGR), see Figure 12.

Figure 12: CQHHS projected population of people aged 65 years and over, 2019-20 to 2030-31

Specific SA3 areas have more accelerated projected population growth rates for residents aged 85 years and over by 2031 including Central Highlands (7.01% p.a.), Gladstone (6.59 p.a.), Rockhampton (6.29% p.a.). and Biloela (5.41% p.a.).

More than 15% of the population is over the age of 65 years in the following SA2 areas:

- Banana (18.4%)
- Berserker (16.6%)
- Bouldercombe (18.6%)
- Callemondah (70%)
- Central Highlands – West (16.7%)
- Emu Park (24.3%)
- Frenchville-Mount Archer (16.8%)
- Mount Morgan (27.9%)
- Park Avenue (18.7%)
- Rockhampton – West (17.6%)
- Rockhampton City (18.7%)
- Rockhampton Region – East (23.0%)
- Rockhampton Region – North (20.4%)
- Rockhampton Region – West (18.6%)
- Shoalwater Bay (68.8%)
- The Range – Allenstown (15.5%)
- West Gladstone (16.3%)
- Yeppoon (19.7%)

In 2016-17, CQHHS had significantly higher ASR mortality rates from dementia (33.89 per 100,000) compared to Queensland rate of 28.97 per 100,000.

In 2016, 17.97% of people over the age of 65 years in Central Queensland lived with a profound or severe disability, higher than the Queensland rate of 16.80%, with the highest rate being in Rockhampton SA3 (19.35%).

Adults over the age of 70 years represent 12% of total Emergency Department presentations, this is the lowest percentage of all age brackets.

Description and evidence of service needs and gaps

Availability of care

The availability of acute care for ageing-related complex conditions (including dementia) is limited to Rockhampton Hospital, contributing to high demand and capacity issues for this service. Stakeholders identified the need for alternative models of care (including ambulatory care), and 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.

Indicators of the availability of care in CQHHS' activity data include:

- The Rockhampton Hospital Subacute Geriatric Evaluation Ward operated at an average occupancy of 99% in FY22 (Note:this may be attributed to multiple factors such as demand, model of care and discharge processes).
- Residents of Gladstone, Central Highlands and Biloela SA3s accounted for 12% of discharges from the Subacute Geriatric Evaluation Ward and OPMHU wards in FY22 – patients have to travel to Rockhampton Hospital to access this service, and access at rates below their population share suggesting travel is a barrier to access.
- Of 104 CQHHS residents currently waiting for Ageing-Related Complex Care clinics, 64.4% are currently classed as long-waits.
- Of 14,043 outpatient service events delivered for Ageing Related Complex Care Clinics in FY22, 76.0% of service events were delivered to residents of the Rockhampton SA3 region, compared to this region's 62.8% share of the CQHHS over 60 population. Delivery of outpatient service events in regional areas is limited.

Aged-care beds and support

There is a lack of aged care beds and community-based services to support this patient cohort, including dementia care. This is a particular issue in rural communities, including Woorabinda. This contributes to a lack of care co-ordination, more frequent hospitalisations among this cohort, and increasing demand for specialised inpatient care. As at 06 October 2022, 37 patients across the HHS with a maintenance care type were identified as occupying acute beds, with the majority (20) of these at Rockhampton Hospital. In FY22, CQHHS discharged 593 patients under this care type with an average LOS of 29.6 days, compared to an ALOS of 3.0 for all admitted patients[6].

Central Highlands staff identified that "there is no secure dementia care available locally, with many patients having to be placed in Longreach or Gracemere". Aged care providers highlighted the need to better educate their own staff on how to adequately manage dementia patients.

The Residential Aged Care Facilities (RACF) in Central Queensland service a large geographical area, contributing to service access challenges for residents. There are limited numbers of dementia care places available within CQHHS an these are not geographically distributed

[6] Figures relating to the number of maintenance care type inpatients occupying acute beds is based on point-in-time data provided on 06 October 2022. ALOS of all admitted patients is based on HBCIS Admitted Inpatient Activity Data Extracts, FY21-FY22 (provided by Central Queensland HHS 08 August 2022).

(located only in Rockhampton and Gracemere. In particular, the Central Highlands region has no aged care facilities with capacity to care for residents with dementia.

Gaps in non-HHS health services

Respondents also identified service needs for appropriate workforce capacity and capability building to deliver care in community as a key measure to meet increasing demand for end-of-life care and palliation in the home. Respondents also identified service needs for appropriate workforce capacity and capability building to deliver care in community as a key measure to meet increasing demand for end-of-life care and palliation in the home. This was particularly the case for Aboriginal and Torres Strait Islander stakeholders, with the cultural significance and value placed on receiving 'care on country'.

Proposed potential solution (high level)

- Explore and adopt contemporary models of care to support our older patients including those with cognitive decline, frailty, dementia (and associated comorbidities).
- Strengthen partnerships with community care and RACF to ensure care is delivered in the right setting. This includes expanding HHS in reach to local RACF for patients that would otherwise use hospital services (e.g., consider establishing a HITH in RACF model for appropriate patients.)
- As part of service planning, consider access to subacute beds across the HHS.
- Engage with the Commonwealth and private sector to support and assist advocacy of expansion of local RACF capacity and adequate primary care (medical, nursing and allied health) capacity to provide care at home and in the community.
- As part of this process, or as part of ongoing service planning, develop a longer-term plan for dementia services across the HHS.
- Explore partnerships with stakeholders that have a key responsibility in supporting and building primary health care capacity (e.g. the CQWBSC PHN has an emerging focus on older persons health initiatives in the community)

Alignment to system priorities

- Royal Commission into Aged Care Quality and Safety
- National Palliative Care Strategy 2018
- Healthy Ageing: A strategy for older Queenslanders
- Unleashing the potential: an open and equitable health system
- My health, Queensland's future: Advancing health 2026 (Advancing health 2026)

5.4 Priority #4: High rates of diabetes-related complications and poorly managed diabetes

Description of health needs

A key theme of consultation feedback related to high prevalence of diabetes in the community, and in particular type 2 diabetes and gestational diabetes. Diabetes related complications and comorbidities, particularly cardiovascular and renal disease, further adds complexity to the health needs of this patient cohort and a disproportionate impact on the Aboriginal and Torres Strait Islander population is evident.

Evidence of health needs

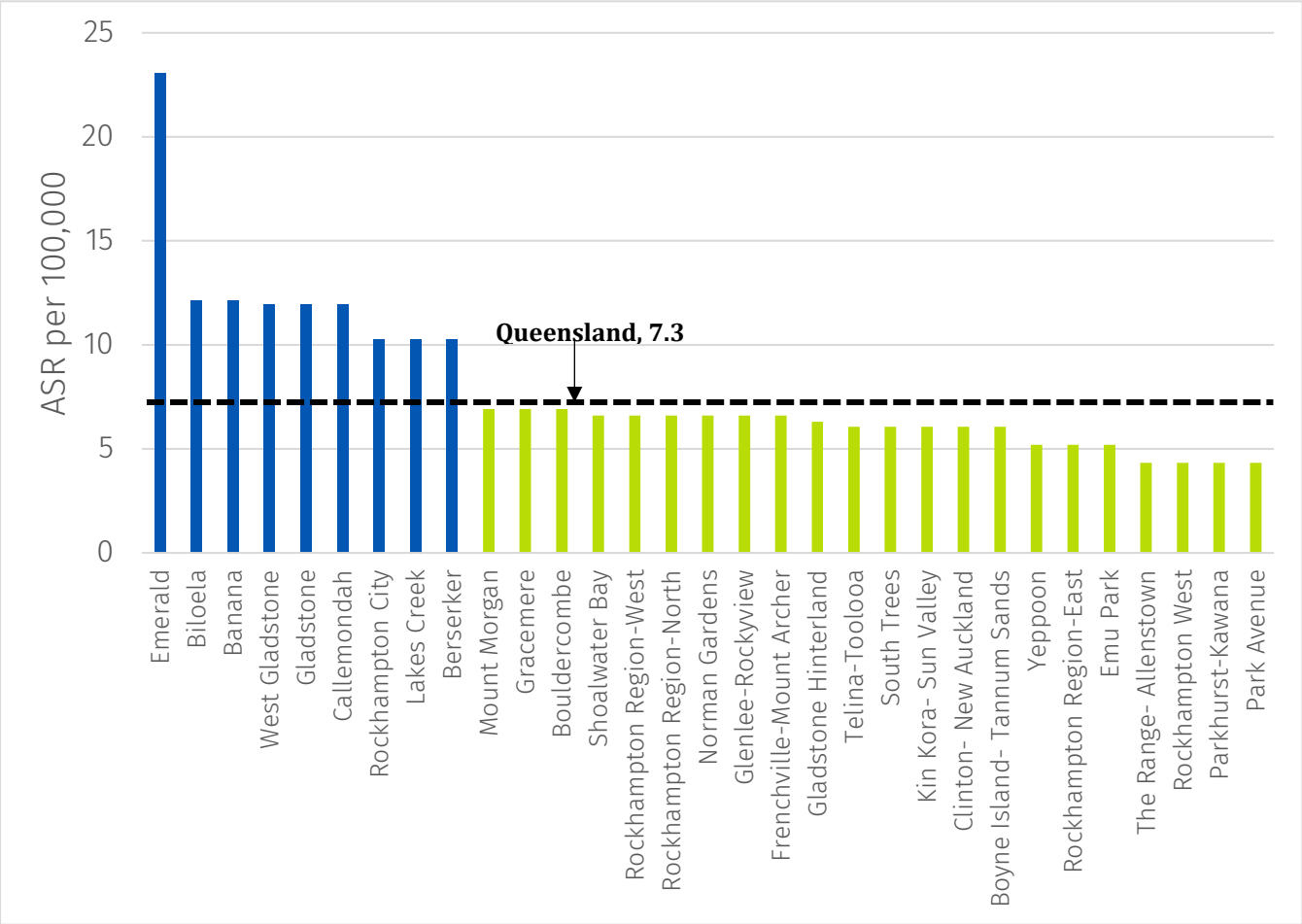
Incidence and mortality related to Diabetes Mellitus in CQHHS is higher than statewide rates. In 2017-18, the incidence in Central Queensland for Diabetes Mellitus was 4-6 ASR per 100, compared to Queensland ASR of 5 per 100. Eight SA2 areas experienced ASRs of 6 per 100. In 2016-17, CQHHS ASR per 100,000 for mortality rates relating to Diabetes was 18.42, compared to Queensland 15.11. According to 2021 census data, Aboriginal and Torres Strait Islander populations in the Banana, Central Capricorn, Gladstone and Rockhampton/Yeppoon Indigenous areas (IARE 2021) reported greater incidence (ASR per 100) of diabetes (excluding gestational diabetes), when compared to these areas' non-Indigenous population.

During 2014-18, nine SA2 areas within CQHHS were estimated to have higher ASRs of premature deaths from diabetes than the estimated Queensland ASR (7.25 per 100,000), see Figure 13. Emerald SA2 experienced the highest ASR of premature death from diabetes (23.04 per 100,000) which was more than triple the Queensland ASR.

Linking to health need #1, stakeholders emphasised significant community need for complex and multi-morbidity chronic disease management frequently occurring in conjunction with a diagnosis of Type 2 Diabetes (particularly cardiovascular and renal disease). This also included need for the patients to access support services in relation to management of diabetes related complications such as wound management and in-home dialysis.

Stakeholders frequently described Central Queensland having a high prevalence of gestational obesity, yet current maternity services in remote areas of Central Queensland do not have the capability to appropriately treat these patients, with pregnant women with a certain Body Mass Index and/or associated risk factors, having to relocate to Rockhampton to birth.

Figure 13: CQHHS premature deaths from diabetes, SA2, persons aged <75 years, 2014-18



Data source: Public Health Information Development Unit (PHIDU) material from: School Health Atlas of Australian: Population Health Areas Note: No estimates were available for Central Highlands-West and Central Highlands-East due to suppressed data

In 2019-20, CQHHS had a 111% relative utilisation for public Endocrinology services and 68% for private Endocrinology services. This indicates that CQHHS patients are more reliant on the public sector for admitted services in relation to diabetes.

Description and evidence of service needs and gaps

Availability of support services

There is limited support available to patients living with diabetes in the community in terms of access to contemporary case-managed care. There is limited specialist diabetes support locally in terms of management and supervision of ongoing care. Endocrinology services offered across CQHHS are limited, exacerbating the prevalence of diabetes-related complications.

CQHHS staff identified that there is a need for clinical guidelines for care of diabetes patients and specialist oversight in the form of an employed endocrinologist to ensure safe, appropriate, and consistent management of diabetes (including use of insulin pumps). Nhulundu Health Service emphasised that patients living with diabetes are a complex medical cohort that require integrated and coordinated care which is difficult to provide in the current system.

Insufficient capacity

There is insufficient capacity to meet current demand for outpatient services relating to diabetes (and related conditions). This is evidenced by:

- Waitlists for diabetes-related outpatient clinics: outpatient clinics for treatment of Diabetes-related conditions currently have 403 persons waiting across CQHHS, with 250 of these being classed as long waits (62.0%). Residents in the Central Highlands SA3 comprise 71% of all patients waiting, with 69.2% of these being classed as long-waits.

First Nations populations' access to care

First Nations people in the CQHHS region are more likely to be waiting for diabetes care[7], and are less likely to receive care within clinically recommended timeframes.

Of 403 CQHHS residents waiting for treatment of Diabetes-related conditions, 263 (65.3%) are persons identifying as First Nations people. This is 58.0% greater than the region's First Nations population share (7.3%).

69.6% of First Nations people waiting for these clinics are currently classed as long-waits, compared to 47.9% for non-Indigenous persons.

Proposed potential solution (high level)

- Explore and adopt contemporary models of care to support our patients with diabetes (and associated comorbidities). This includes supporting patient health literacy and self-management strategies to help reduce avoidable condition deterioration whilst in the community.
- Develop a diabetes workforce strategy for recruitment and retention. Consider the right multidisciplinary workforce model for CQHHS' local including medical workforce, appropriate allied health supports and dedicated nursing positions.
- Expand partnerships with local providers and partners to increase awareness of community based diabetes education and support services, particularly in rural settings (e.g. pharmacy-based diabetes education services).
- Given the increased prevalence of diabetes in the First Nations community, consider inclusion of identified workforce positions in the overall model of care to support these patients.
- Explore opportunities for partnership with the primary care sector and local ACCHOs to ensure seamless support for First Nations diabetics across primary and specialist care.

Alignment to system priorities

- National Medical Workforce Strategy (2021–2031)
- Unleashing the potential: an open and equitable health system
- My health, Queensland's future: Advancing health 2026 (Advancing health 2026).

[7] Waitlist figures are based on a point-in-time extract of the CQHHS specialist outpatients waitlist as at 24 August 2022 (provided by Central Queensland HHS, 24 August 2022)

5.5 Priority #5: High rates of developmentally vulnerable children with complex health needs

Description of health needs

Engagement identified health needs for children with developmental delays and/or behavioural challenges. Specifically, this included needs relating to fetal alcohol syndrome, child health and development, speech and communication issues, mental health concerns, early diagnosis, and learning disorders.

The Australian Early Development Census (AEDC) is an Australian Government initiative to measure five areas, or domains, of early childhood development that form the foundations for later good health, education, and social outcomes. The five developmental domains include:

- Physical health and wellbeing
- Social competence
- Emotional maturity
- Language and cognitive skills (school-based)
- Communication skills and general knowledge.

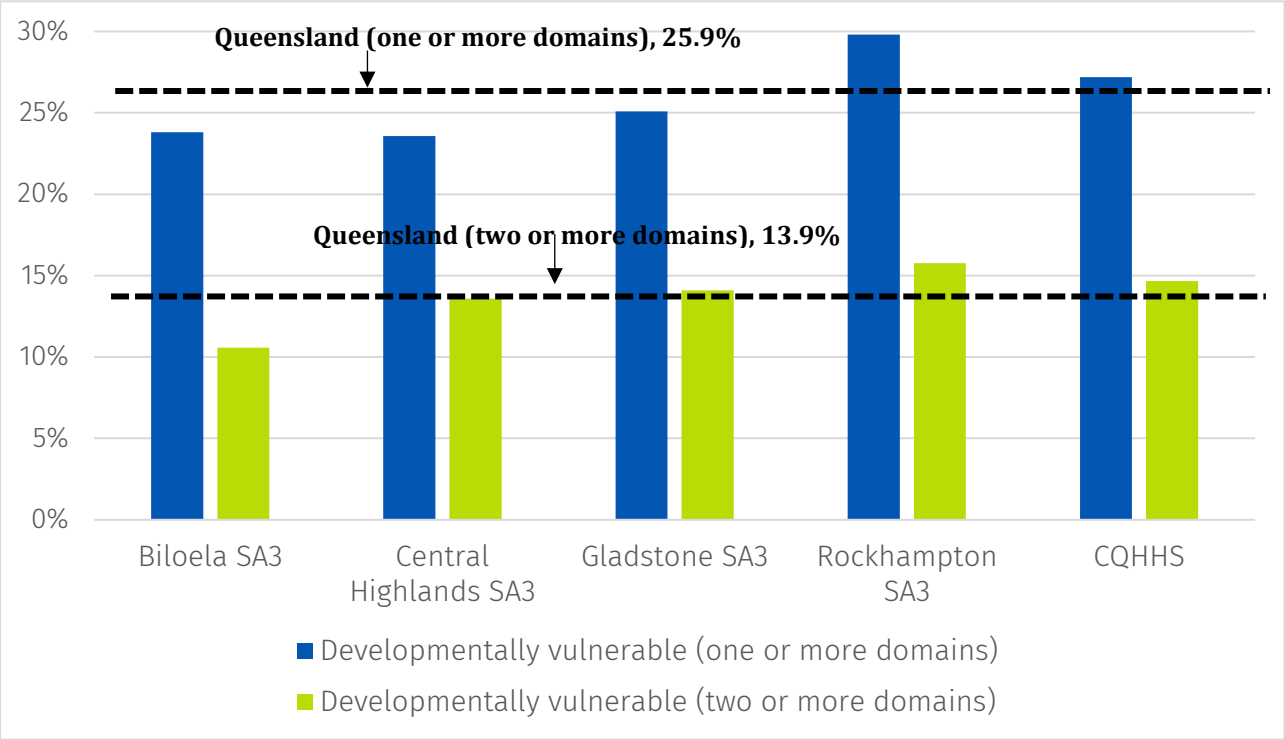
Children considered “developmentally vulnerable” are those who score in the lowest 10 % of the national population, based on a teacher-completed instrument.

Evidence of health needs

In 2018:

- 27.2% of CQHHS children were identified as developmentally vulnerable in one or more domains, higher than the state rate (25.87%), see Figure 14.
- 14.67% of CQHHS children were identified as developmentally vulnerable in two or more domains, higher than the state rate (13.88%).
- Rockhampton SA3 had the highest rates of developmentally vulnerable in both one or more domains (29.81%) and two or more domains (15.77%).

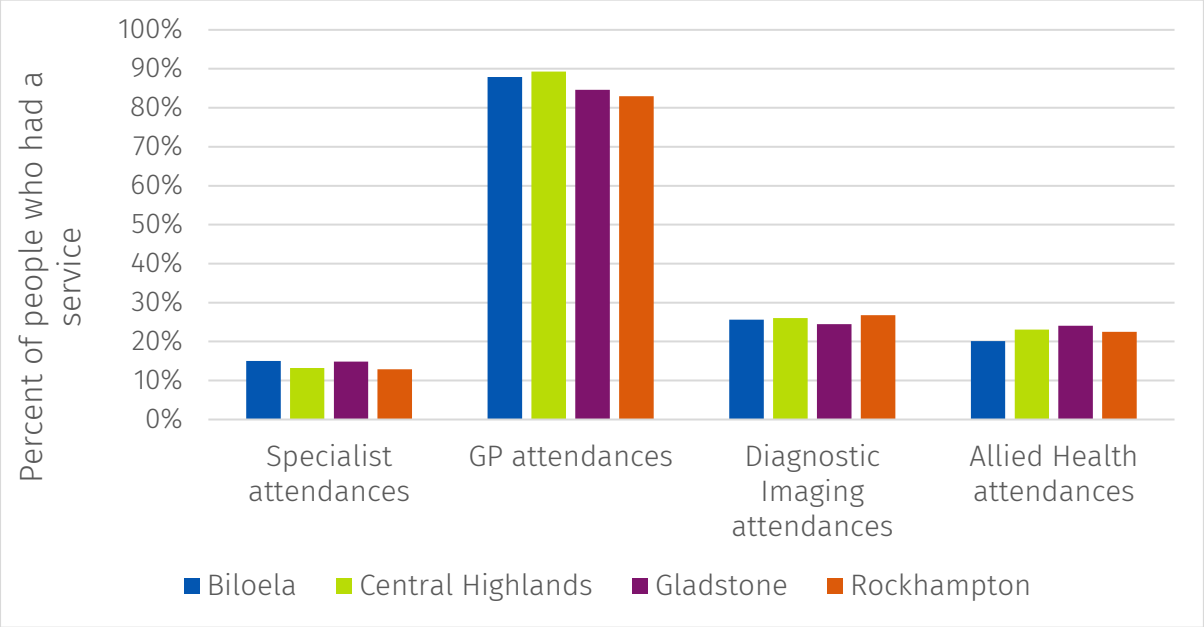
Figure 14: CQHHS children deemed developmentally vulnerable by SA3, 2018



Data source: Public Health Information Development Unit (PHIDU) material from Social Health Atlas of Australia: Population Health Areas. Derived from Australian Early Development Census (AEDC): Developmentally Vulnerable, Developmentally on track, Developmentally at Risk (2018).

Whilst data on Queensland average GP service utilisation was not available, it is clear by service volumes that GP attendances as a proportion of the population is high in CQHHS for people aged 0-24 years, including supportive diagnostic, allied health and specialist needs of patients (see Figure 15).

Figure 15: Services delivered by General Practitioner clinics to people 0-24 years across Central Queensland, 2018-19



Data source: Planning Portal, MBS Summary – By Age Group (2018-2019)

Furthermore, children between the age of 0 and 14 years make up a significant proportion of the Central Queensland population (22%), greater than the Queensland average (20%), see Figure 16.

Figure 16: CQHHS age structure breakdown, 2019-20

	Children (0-14)	Adults (15-64)	Older persons (65+)
Central Queensland	22%	63%	15%
QLD	20%	64%	16%

By 2031, the number of children between the age of 0 and 14 years is projected to decrease from 48,528 (2020 ERP) to 47,572 which represents a -0.18% compound annual growth rate (CAGR), see Figure 17.

Figure 17: CQHHS projected population of children between the age of 0 and 14 years, 2019-20 to 2030-31

By 2031, CQHHS SA3 areas are projected to have varying population growth rates for children between the age of 0- and 14-years, with Rockhampton being the only SA3 area projected to have a positive paediatric population growth of 0.15% p.a. Other SA3 areas in Central Queensland are projected to experience negative growth including Gladstone (-0.08% p.a.), Central Highlands (-0.93% p.a.) and Biloela (-1.68% p.a.).

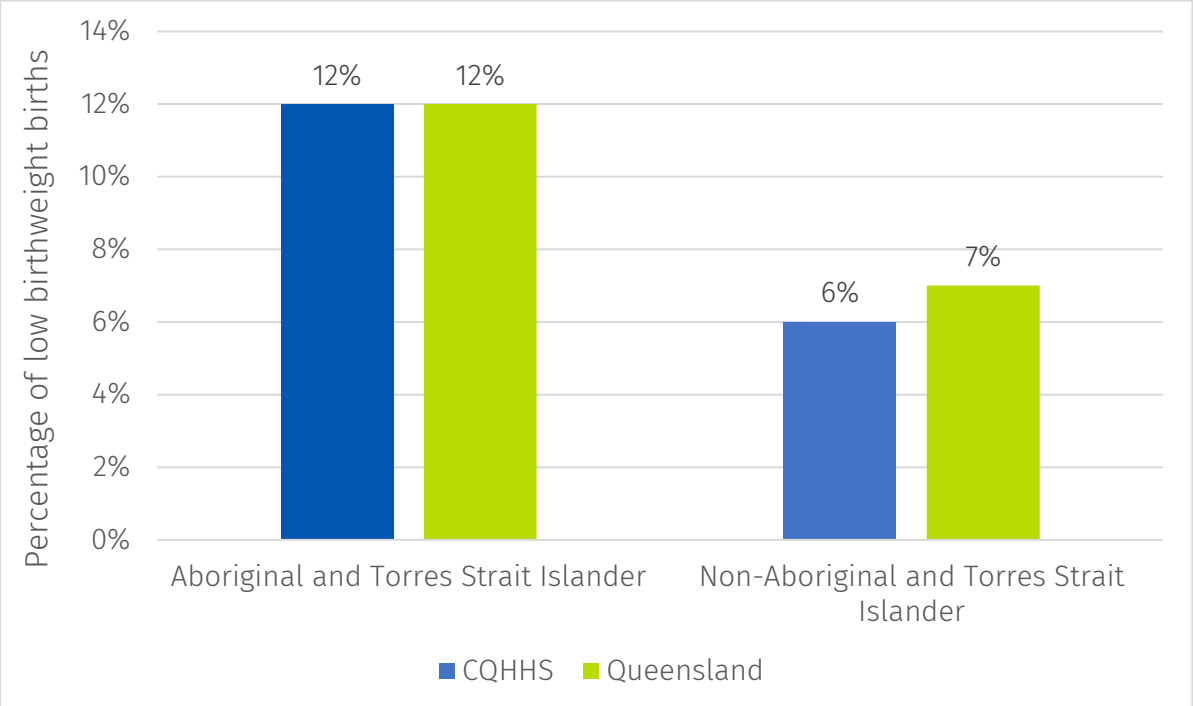
20% or more of the population is between the age of 0 and 14 years in the following SA2 areas:

- Banana (21.3%)
- Biloela (23.0%)
- Boyne Island- Tannum Sands (23.4%)
- Central Highlands - East (26.2%)
- Central Highlands-West (22.7%)
- Clinton-New Auckland (26.4%)
- Emerald (26.3%)

- Emu Park (20.0%)
- Frenchville-Mount Archer
- Gladstone Hinterland (25.2%)
- Gracemere (26.2%)
- Kin Kora- Sun Valley (22.5%)
- Lakes Creek (22.5%)
- Norman Gardens (20.9%)
- Park Avenue (20.7%)
- Parkhurst-Kawana (22.4%)
- Rockhampton City (20.0%)
- Telina- Toolooa (25.3%)

In 2019, CQHHS Aboriginal and Torres Strait Islander people had 12% of babies born with a low birthweight which is similar to the Queensland Aboriginal and Torres Strait Islander rate. In the same period, CQHHS non-Aboriginal and Torres Strait Islander people had 6% of babies born with a low birthweight, which is lower than the Queensland rate of 7% for non-Aboriginal and Torres Strait Islander people (see Figure 18).

Figure 18: CQHHS low birthweight birth rates, CQHHS, 2019



Data source: Queensland Perinatal Data Collection (QPDC), Statistical Services Branch, Queensland Health. Prepared by Statistical Reporting and Coordination. (HNA_LANA_Perinatal_Fertility - Power BI) Small patient numbers makes it difficult to analyse some data. Prepared by System Planning Branch, Planning Portal

Description and evidence of service needs and gaps

Integration services across CQHHS

For high-risk children, current child development services are not integrated across CQHHS, with very few patients having coordinated care and follow through to adulthood.

Community Health Rockhampton staff identified that pathways should be developed for high-risk children to coordinate care and follow through to adulthood. Current services have gaps for adolescents/young adults.

Eligibility criteria

There is limited access to community-based child and youth health clinics. Strict eligibility criteria are further inhibiting patients from being able to access the services that are available.

Services in Gladstone and Emerald have very strict eligibility criteria, which does not allow children aged above 8 years of age to access services.

Waiting times for outpatient clinics related to child development are also long, with 60.5% of CQHHS residents waiting for outpatient services classed as long waits (1,024 total waits). CQHHS residents requiring the Emerald Child & Family Health Service clinic (130 long-waits, 73.0% of total waits) and the Woorabinda Paediatric Clinic (135 long waits, 86.0% of total waits) have the largest number of long-waits.

Limited speech therapy and early intervention services

The Gladstone and Central Highlands areas have limited speech therapy and early intervention services available in the region.

For the CQHHS under 18 cohort waiting for speech pathology services (a total of 140 patients waiting, 38.6% are long-waits), Gladstone SA3 (53.1%) and Central Highlands SA3 (73.9%) residents have the highest percentage of long-waits.

Respondents emphasised service needs for increasing assessment and early intervention through improved referral pathways, increased social work availability to increase service integration, improve communication and liaison between services across the continuum of care, and building capacity of allied health community services that provide paediatric behavioural support services and interventions.

Proposed potential solution (high level)

- Continue to develop partnerships with education and NGO sector to support high risk children through to adulthood. This includes partnering with the CQWBSC PHN that plays a key responsibility in supporting and building primary health care capacity - including an emerging focus on this particular cohort.
- Identify contemporary models of care to support our high-end, complex child and youth patients – including discharge processes into the community. This includes consideration of alternative workforce models.
- Expand delivery of child health clinics and consider the need for a child behavioural service for targeted interventions for children with behavioural needs. This could be considered as part of a partnership model with education, the primary health and NGO sector/local NDIS providers.
- Develop a workforce strategy for allied health across CQHHS to address vacancies, particularly in regional SA3s. This should also consider extended and expanded scope of practice strategies to optimise utilisation of the existing allied health professional workforce.
- Review of models of care to maximise care available locally – consider telehealth models where local services cannot be provided in person.

- Models of care should be inclusive of First Nations children and support identification and support of vulnerable First Nations children in a culturally appropriate way, closer to home and within the family unit.

Alignment to system priorities

- National Medical Workforce Strategy (2021–2031)
- Unleashing the potential: an open and equitable health system
- My health, Queensland's future: Advancing health 2026 (Advancing health 2026).

5.6 Priority #6: Poor health outcomes across all conditions due to social determinants of health increasing burden of disease in the community.

Description of health needs

Stakeholders emphasised the impact of broader social determinants of health contributing to burden of disease or poor health outcomes in the community. Specifically, issues relating to homelessness, rising cost of living and impact on housing affordability, higher levels of unemployment rate, increasing number of families in financial and mortgage stress and lower educational attainment were regularly raised as contributing factors to poor health literacy, health behaviours and engagement with the health system. Low socioeconomic and remote/very remote communities within Central Queensland appear to have higher rates of complexity and adversity for families relating to these broader social determinants of health.

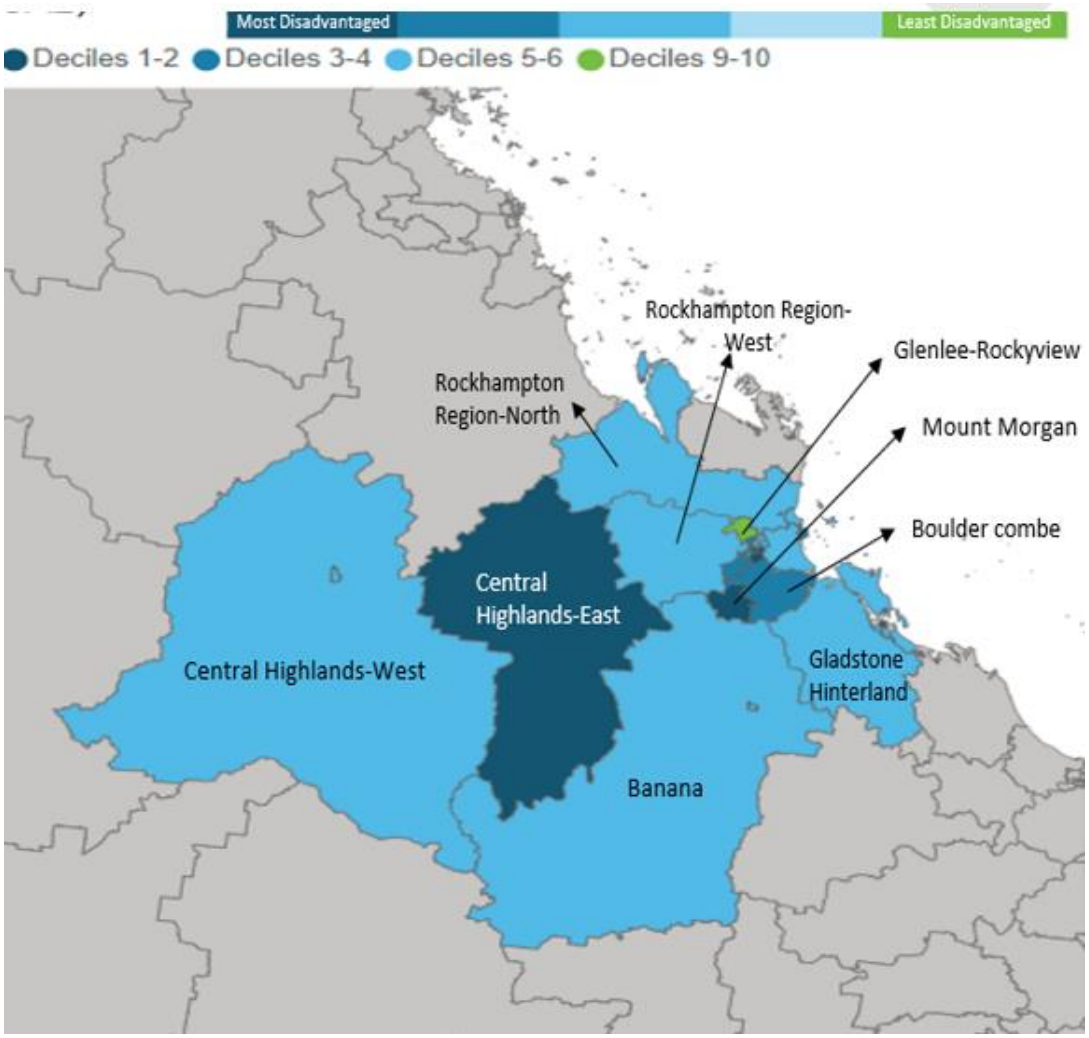
Additionally, patients with chronic and complex disease and from low socioeconomic families were more likely to experience adverse health outcomes and deterioration due to displacement and difficulties in engaging with local health services (associated with affordability barriers).

Evidence of health needs

The Socio-Economic Indexes for Areas (SEIFA) comprise a set of 4 indices that can be used for modelling scenarios to predict the impact of policy, strategy, or service delivery initiatives. The population of Central Queensland experiences socio-economic disadvantage at a rate significantly higher than the Queensland average.

In 2016, approximately 35% of CQHHS was categorised in SEIFA deciles 1-4 (most disadvantaged) and 64% in the SEIFA deciles 5-6 (see Figure 19). Over 50% of the population in the SA2 areas of Mount Morgan, Lakes Creek, Park Avenue, Gladstone and Berserker fall within the most disadvantaged quintile (deciles 1-2).

Figure 19: CQHHS Socio-Economic Indexes for Areas (SEIFA) by deciles, 2016



Data Source: Australian Statistical Geography Standard (ASGS 2016) and Australian Bureau of Statistics, 20330.55001 Socio-Economic Indexes for Australian (SEIFA)2016. Prepared by System Planning Branch, Planning Portal

In 2016:

- 10% of CQHHS Aboriginal and Torres Strait Islander people completed school at year 11, higher than the CQHHS non-Aboriginal and Torres Strait Islander rate of 8%.
- 36% of CQHHS Aboriginal and Torres Strait Islander people completed school at year 12, lower than the CQHHS non-Aboriginal and Torres Strait Islander rate of 47%.
- 47% of CQHHS non-Aboriginal and Torres Strait Islander people completed school at year 12, lower than the Queensland rate of 56%.

Education and health are intrinsically linked, with the level of educational attainment strongly associated with life expectancy, morbidity, and health behaviours. Figure 20 and Figure 21 indicate that CQHHS residents have a lower life expectancy compared to Queensland.

Figure 20: CQHHS life expectancy, 2017-19

Data source: Australian Bureau of Statistics (ABS), Tables 2.1 Life tables, Statistical Area Level 4 - 2010-12 to 2017-19, System Planning Branch prepared data June 2021 from ABS website, accessed 22 June 2021.

Figure 21: CQHHS median age at death, 2013-15

Aboriginal and Torres Strait Islander people median age at death

Central Queensland: 58 years

QLD: 60 years

Data source: Australian Bureau of Statistics (ABS), Tables 2.1 Life tables, Statistical Area Level 4 - 2010-12 to 2017-19, System Planning Branch prepared data June 2021 from ABS website, accessed 22 June 2021.

Description and evidence of service needs and gaps

Contributing factors to poor health outcomes

Access to health services is limited by access to non-health services like public transport and social housing. Demand for CQHHS services is impacted by a lack of low cost primary care (e.g. The Gemfields is a highly disadvantaged area within CQHHS with limited access to low cost primary care influencing early treatment and prevention for these residents).

Community Health Rockhampton staff identified that homelessness and a lack of access to transport is exacerbating poor health outcomes, and that socioeconomic factors like low income and increasing mortgage stress is causing CQHHS residents to delay health checks, appointments, and treatment.

Limited partnerships

CQHHS has limited formal partnerships with CQWBSC PHN, universities and other organisations, which provide opportunities to improve social determinants of health across the community.

In consultation, many individual programs or partnerships were mentioned (E.g., Gladstone Region Together) but opportunities exist to broaden and strengthen these partnerships.

Proposed potential solution (high level)

- Make targeted changes to models of care to accommodate for the socioeconomic factors that influence access to health care across CQHHS. (For example, providing outpatient clinics for at risk cohorts in more accessible settings to reduce the reliance on transport for access to care.)
- Advocate for primary health services in CQHHS in partnership with CQWBSC PHN. Leverage off the first 2,000 days program that is operating currently.

- Ensure our highly skilled workforce, including A&TSIHW and A&TSIHLOs, are working to the top of their scope - and appropriate alternative resources or tactics are engaged to support with logistics/admin support for vulnerable patients.
- Continue to develop and strengthen existing partnerships with CQU and universities, CQWBSC PHN, other primary care providers and the NGO sector to address social determinants of health.
- Cooperate across government to ensure CQHHS has the right local relationships to help patients that require access to social housing.

Alignment to system priorities

- Queensland Health's Virtual Healthcare Strategy (2020)
- Queensland Health Telehealth Strategy (2021-26)
- Digital Strategy for Rural and Remote Healthcare (2022-2032)
- Unleashing the potential: an open and equitable health system
- My health, Queensland's future: Advancing health 2026 (Advancing health 2026)
- Digital Health 2031 - A digital vision for Queensland's health system.

5.7 Priority #7: High prevalence of health risk factors including obesity, smoking, and use of alcohol and other drugs

Description of health needs

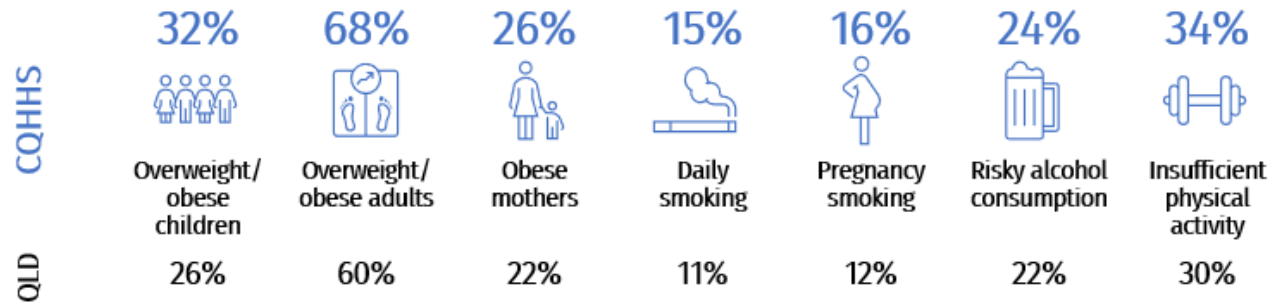
Engagement identified high prevalence of health risk factors throughout the Central Queensland population, including high rates of obesity, smoking and use of alcohol and other drugs. These health risk factors were identified across all communities, but particularly emphasised for young adults and Aboriginal and Torres Strait Islander people. Engagement identified a limited focus on prevention and health promotion activities in the community, which has resulted in generational cycles of poor lifestyle choices and low health literacy resulting in key health risk factors across the community.

Evidence of health needs

When compared to Queensland, the Central Queensland population has a higher prevalence of health risk factors including obesity, smoking, and use of alcohol and other drugs, see Figure 22.

Central Highlands- East and Mount Morgan SA2 areas had the highest prevalence of adult daily smoking (22%).

Figure 22: CQHHS health risk factors prevalence, 2017-20



Data source: Public Health Information Development Unit (PHIDU) material from: Social Health Atlas of Australia: Population Health Areas (Disability tab). Prepared by System Planning Branch, Planning Portal.

Description and evidence of service needs and gaps

Potential for early intervention strategies

CQHHS services could better embed screening for modifiable health risk factors and implement early intervention strategies to reduce the prevalence of smoking, improve diet, and reduce use of alcohol and other drugs. In consultation, local service providers (both HHS and non-HHS) identified health literacy and community education and prevention initiatives as being a key service gap across CQHHS.

Capacity for these services is limited, as evidenced by:

- The waitlist for clinics related to the treatment and prevention of health risk factor behaviours: Dietitian clinics and, Alcohol and Other Drugs, and Screening Programs currently have 210 waits across CQHHS, with 36.7% of these classed as long-waits.
- Rates of cancer screening: In the age range of 50-74, 2018-19 data shows the CQHHS rate of bowel cancer screening participation is 41%, 1% below the state rate (42%).
- Waitlists for outpatient drug and alcohol services: Of the 145 total waits for drug & alcohol outpatient services, 89 (61.4%) are classed as long-waits.

Underutilised health promotion and prevention activities

The uptake of health promotion and prevention activities is underutilised by populations with a higher prevalence of health risk factors.

The utilisation of outpatient clinics for health risk factor related services is 7.7 non-Aboriginal and Torres Strait Islander individuals to each 1 Aboriginal and Torres Strait Islander individual. Compared to the CQHHS population ratio of 7. This indicates lower representation of Aboriginal and Torres Strait Islander individuals in the cohort accessing these services

Proposed potential solution (high level)

- Promote cancer screening services to enable early detection.
- Review outpatient processes and identify opportunities to increase timely access to care for drug and alcohol outpatient services.
- Embed health literacy and patient education (secondary promotion and prevention) into acute models of care.

- Explore strategic partnerships with local universities, public health unit, and organisations such as CQShines, to embed hospital avoidance, prevention and health promotion initiatives across the community, targeting high risk or vulnerable people.
- For First Nations people, this should include partnerships with local ACCHOs and First Nations service providers to engage the community in health promotion and prevention activities.

Alignment to system priorities

- Prevention Strategic Framework 2017 to 2026
- My health, Queensland's future: Advancing health 2026 (Advancing health 2026)
- Cancer Screening Strategic Framework 2019 to 2026
- Digital Health 2031 - A digital vision for Queensland's health system

5.8 Priority #8: High rates of respiratory disease linked to high rates of smoking and occupational exposure through mining and industry.

Description of health needs

Respiratory conditions of both chronic nature (COPD, chronic bronchitis, occupational asthma, lung cancer) and acute nature (shortness of breath, chest pain) are a key health need of the Central Queensland community. Both industry and occupational factors, as well as other risk factors including lifestyle behaviours and environmental influence in some areas (silicosis and fine particulate air pollution ($PM_{2.5}$)) were identified as key causative factors throughout engagement.

Occupational exposures affecting the respiratory health of workers was raised regularly throughout engagement. This included acute, sub-acute and chronic respiratory diseases which may be malignant, non-malignant, or infectious.

Stakeholders described due to the strong presence of industry in the Central Queensland region, workers within the community are exposed to occupational hazards such as dust, fibres, fumes, and other substances in their work roles. Specific health needs arising from this exposure included:

- Chronic conditions: COPD, chronic bronchitis, occupational asthma, and other respiratory disorders such as lung cancer.
- Acute symptoms and injuries: shortness of breath, chest pain and trauma potentially requiring emergency medical care.

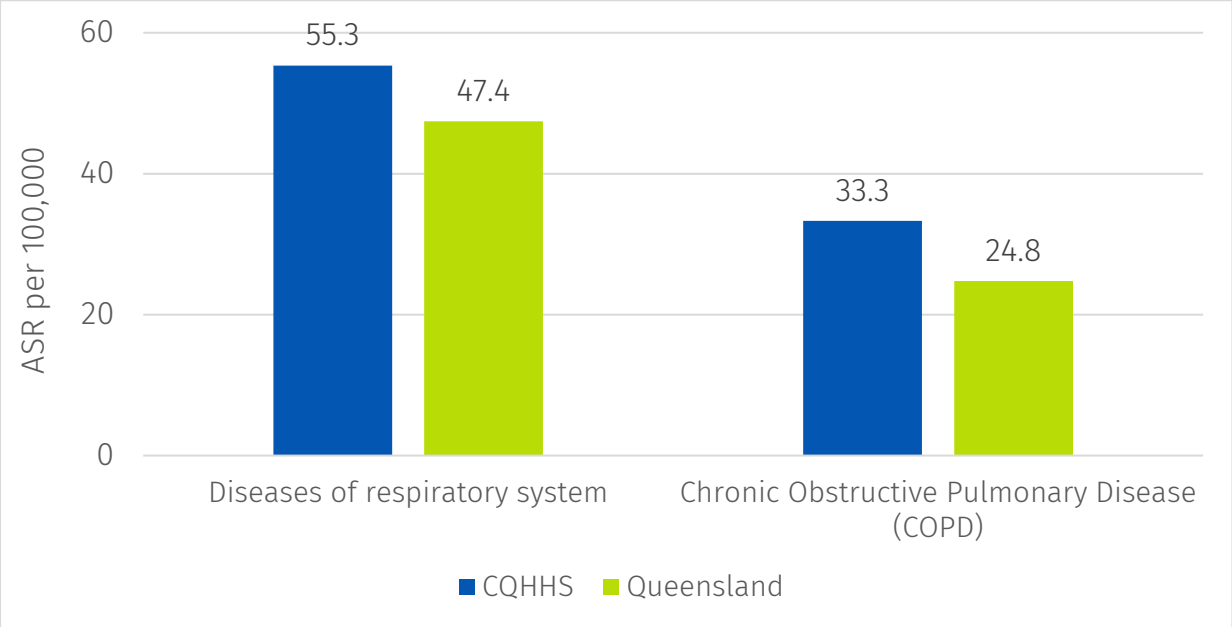
However, given the frequency of smoking and other risk factors for respiratory disease throughout this population cohort, it was acknowledged that some of these conditions are also

likely caused by non-occupational factors and not always clearly linked to work-related exposure.

Evidence of health needs

In 2016-17, CQHHS age standardised mortality rates (ASR per 100,000) from diseases of respiratory system and chronic obstructive pulmonary disease were statistically higher than Queensland rates (see Figure 23).

Figure 23: CQHHS age-standardised mortality rates by condition, 2016-17



Data source: Cause of Death Unit Record File, Australian Coordinating Registry, Population Source: Australian Bureau of Statistics (ABS) Catalogue No. 3235.0 - Population by Age and Sex, Regions of Australia; ABS Consultancy for Queensland Government Statistician's Office. Prepared by Statistical Services Branch, Queensland, Department of Health. Data extracted 18/6/2020.

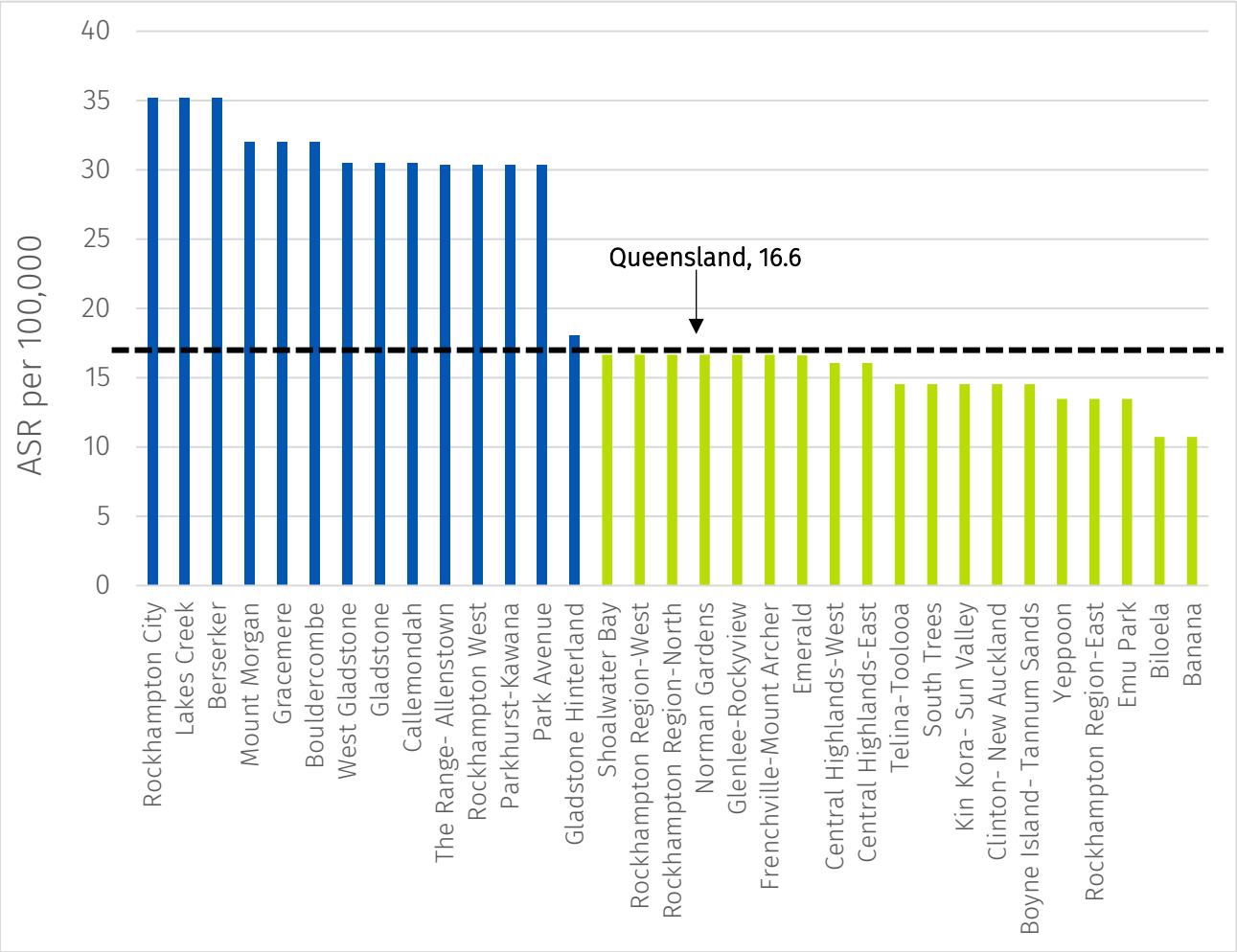
During 2014-18, 21 SA2s within CQHHS were estimated to have higher ASRs of premature deaths from respiratory system diseases (RSD) than the estimated Queensland ASR (16.6 per 100,000), see Figure 24.

According to 2021 census data, Aboriginal and Torres Strait Islander populations in the Banana, Central Capricorn, Gladstone and Rockhampton/Yeppoon Indigenous areas (IARE 2021) reported

greater incidence (ASR per 100) of both lung conditions and asthma (specifically), when compared to these areas' non-Indigenous population.

Further, Aboriginal and Torres Strait Islander people residing in Gladstone experienced three times the Queensland ASR of premature death from respiratory system diseases, with estimated ASRs being 78.7 and 24.9 per 100,000 respectively.

Figure 24: CQHHS premature deaths from respiratory system diseases, SA2, persons aged <75 years, 2014-18



Data source: Public Health Information Development Unit material: School Health Atlas of Australian: Population Health Areas

Description and evidence of service needs and gaps

Access to specialist care

Local access to contemporary, case-managed respiratory care is limited, especially outside of Rockhampton, with CQHHS staff highlighting in consultation that there are no respiratory physicians working in the HHS.

For outpatient clinics relating to respiratory disease, there are currently 112 patients waiting across CQHHS, with 57.1% of these being classed as long-waits. This is concentrated for residents of the Central Highlands SA3, with most of these residents waiting for services at Woorabinda. 73.9% of waits for Woorabinda clinics are classed as long-waits.

For outpatient service events related to treatment of respiratory disease, 98% of all service events were provided to residents of the Rockhampton SA3. In FY22, the delivery of outpatient

services for the treatment of respiratory disease in the Rockhampton SA3 is 97.2% in-person. This falls to 16.7% for residents of the Biloela SA3, and 28.1% for the Gladstone SA3.

First Nations access to care

First Nations people in the CQHHS region are more likely to be waiting for respiratory disease care, and are less likely to receive care within clinically recommended timeframes.

Of 112 CQHHS residents currently waiting for specialist outpatient services related to the treatment of respiratory disease, 52 (46.4%) identify as First Nations people. This is 39.2% greater than the region's First Nations population share (7.3%).

Of First Nations people currently waiting, 71.2% are classed as long-waits. This compares to 45.0% for non-Indigenous persons currently waiting.

Proposed potential solution (high level)

- Build a multidisciplinary respiratory service for CQHHS including medical workforce and respiratory physician, nursing and allied health.
- Improve access to care. Specific initiatives include:
    - Considering a rapid access pathway for access to respiratory care for known patients presenting to ED with exacerbations of chronic disease.
    - Review outpatient processes and identify opportunities to increase timely access to care for respiratory outpatient services, especially for Woorabinda long wait patients.
- Work with local industries to ensure education and screening processes are in place for their workers.
- As part of developing an appropriate workforce model, consider inclusion of Aboriginal and Torres Strait Islander-identified workforce positions.
- Explore opportunities for partnership with the primary care sector and local ACCHOs to ensure seamless support for First Nations patients requiring ongoing support for chronic respiratory conditions.

Alignment to system priorities

- Unleashing the potential: an open and equitable health system
- My health, Queensland's future: Advancing health 2026 (Advancing health 2026)
- Prevention Strategic Framework 2017 to 2026
- Digital Health 2031 - A digital vision for Queensland's health system.
- Queensland Health, Health Equity Framework 2021

5.9 Priority #9: Vulnerable families and adverse impacts of child abuse/neglect, domestic violence and trauma on health and wellbeing

Description of health needs

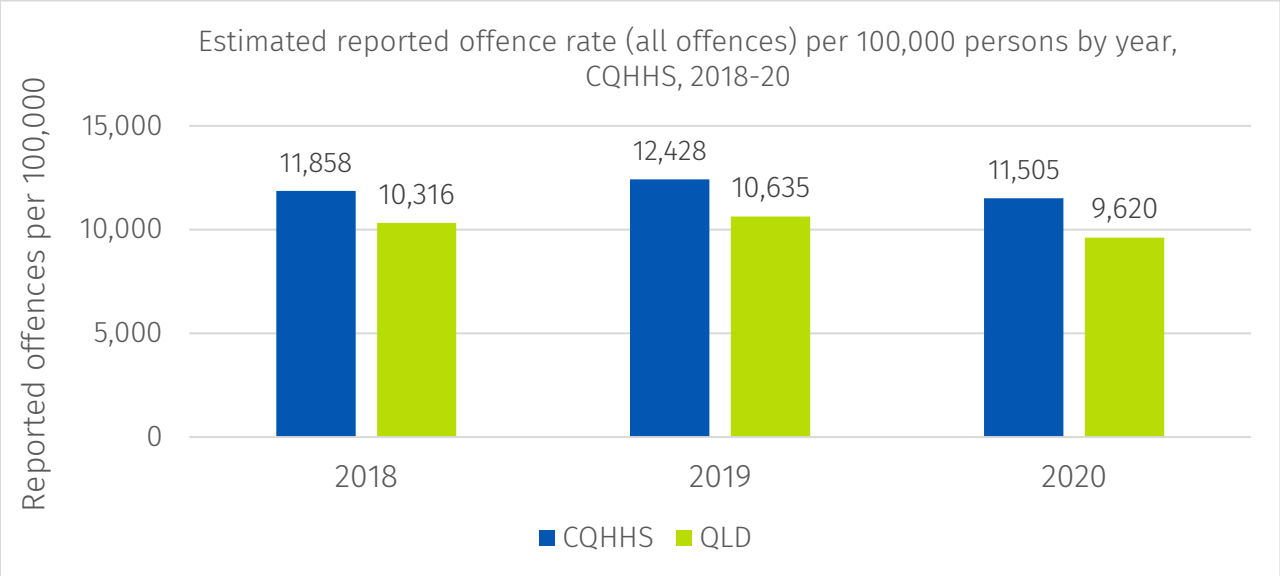
Stakeholders across Central Queensland frequently cited health needs related to the adverse impacts of child abuse and neglect, domestic violence, trauma throughout the region. Stakeholders referenced low employment, housing affordability, homelessness, alcohol and other drugs, youth crime, limited community facilities and intergenerational trauma as key contributing factors to this health need.

Evidence of health needs

In 2018-20:

- CQHHS reported offence rate (all offences) per 100,000 persons was higher than Queensland rate
- Breach of domestic violence protection order was the third highest offence reported in CQHHS.

Figure 25: Annual offence rate per 100,000 people, CQHHS, 2018-20



Data source: Queensland Police Service, Maps and statistics. HHS to LGA concordance derived by population weighted allocation from applying 2016 mesh block census counts to LGA and HHS geographic intersections, following methods used by Australian Bureau of Statistics to produce population weighted ABS to non-ABS ASGS 2016 concordance files. Estimated Resident Population (ERP) as per Queensland Government Statistician's Office (QGSO) – ABS consultancy for QGSO, September 2020. These estimates correspond with 30 June 2001-2019. ERP by SA2 as released in Regional Population Growth, Australia, 2018-19 (cat.no. 3218.0) and Regional Population by Age and Sex, Australia, 2019 (cat no. 3235.0). Prepared by QGSO, Statistical Reporting and Coordination Unit (SRC) and Statistical Analysis Linkage Unit (SALU).

Description and evidence of service needs and gaps

Workforce challenges

Additional social worker workforce is required to provide support for vulnerable families and at risk children, and address current waitlist and capacity requirements. This is an ongoing recruitment and retention challenge.

The health system often fails to understand Aboriginal and Torres Strait Islander family structures and relationships and therefore, fails to provide culturally appropriate support.

Outpatient service volumes and waitlist reflect these workforce challenges, with outpatient services delivered by social workers for Central Highlands residents have decreased by 43% in FY22 compared to FY21.There were 89 patients waiting for outpatient social work and child protection-related services across CQHHS, with 48 of these being long-waits (53.9%).

Aboriginal and Torres Strait Islander communities

Vulnerable families in the Aboriginal and Torres Strait Islander community require culturally appropriate support. Consultation with Aboriginal and Torres Strait Islander representatives highlighted the need for support for alcohol and other drugs education, sexual health, birthing on country, domestic violence intervention, culturally appropriate antenatal care and education and counselling support as key needs for many Aboriginal and Torres Strait families and children across the region.

Gumbi Gumbi identified that multigenerational trauma impacts on the health of the Aboriginal and Torres Strait Islander community. Services need to be responsive to the needs of individual families, community, and culture, and respect the cultural significance of family relationships that may differ from traditional Western ideas of family. The previously documented gaps in the A&TSIHW and A&TSIHLO workforce (Priority 2) compound difficulties accessing culturally appropriate support for these families.

Limited services

There are limited services and support available in the community sector for the at-risk youth cohort (including homeless, in-out-of-homecare, and LGBTQI youth).

External service providers highlighted the lack of counselling and support offered to people experiencing domestic and family violence, and other traumas. Stakeholders described service gaps relating to the need for 24/7 locally available support services for those fleeing domestic violence, and counselling support for families and children to reduce ongoing cycles of trauma and violence impacting the health and wellbeing of the community.

Proposed potential solution (high level)

- Include social worker workforce in a workforce strategy for allied health across CQHHS to address vacancies, particularly in regional SA3s.
- Consider telehealth models and partnerships with other government agencies and NGOs to support vulnerable families, particularly in Central Highlands and regional areas.
- As for Priority 2, recruitment, and retention workforce strategies for Aboriginal and Torres Strait Islander identified positions and Aboriginal and Torres Strait Islander health workers should be considered.

- Support and participate in an interjurisdictional approach with key government departments and stakeholders to better support at-risk youth (e.g., Develop partnerships with education providers and NGOs -See Priority 5.)

Alignment to system priorities

- Queensland Health, Health Equity Framework 2021
- Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2026 (the Framework)
- Unleashing the potential: an open and equitable health system
- My health, Queensland's future: Advancing health 2026 (Advancing health 2026).

5.10 Priority #10: Complex health needs of people with profound or severe disability

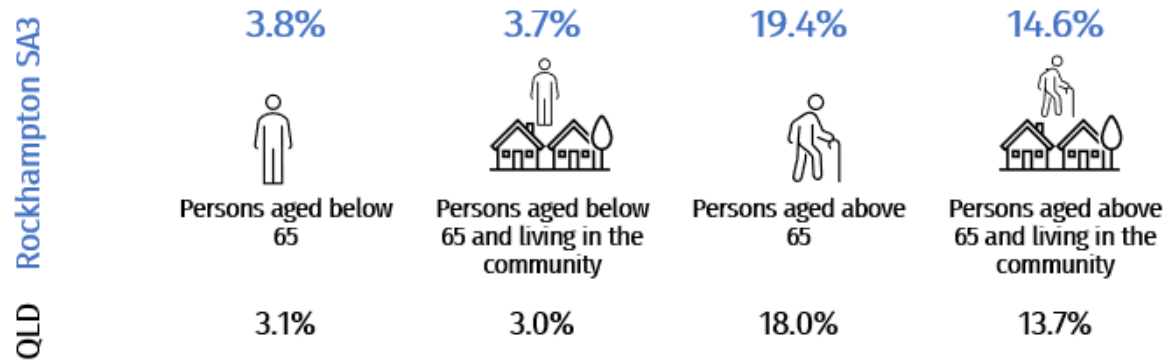
Description of health needs

Incidence of profound or severe disability across the Central Queensland community was highlighted throughout consultation. Stakeholders described poorer health outcomes and higher levels of psychological distress in people living with disability in the region, as well as frequency of modifiable health risk factors and behaviours including poor diet, insufficient physical activity, smoking and overweight and obesity in this cohort.

Evidence of health needs

In 2016, CQHHS rate of profound or severe disability was 5.1%, lower than Queensland average of 5.3%. However, there was a higher estimated rate of persons with profound or severe disability over the age of 65 years (18.2%) than the estimated state average (16.8%), particularly in Rockhampton SA3 (19.4%).

Figure 26: Rate of individuals with profound or severe disability, 2016



Data source: Public Health Information Development Unit (PHIDU) material from: Social Health Atlas of Australia: Population Health Areas (Disability tab). Prepared by System Planning Branch, Planning Portal.

In December 2019, there were 4,410 NDIS participants in the NDIS service district (Rockhampton) that encompasses CQHHS. This is projected to increase to 6,000 NDIS participants by 2023.

Description and evidence of service needs and gaps

Access barriers

Access to in-home NDIS supports is limited outside of Rockhampton, particularly in Woorabinda.

Consultation in Woorabinda identified the gap in NDIS service provision. Stakeholders identified the need to enable patients with a disability to have equitable access and participation in their healthcare journey across the full spectrum of health services in the region. Specifically, access barriers relating to transportation and receiving assistive technologies and support in the community (including allied health services) were raised as frequent barriers impacting the health status of people living with disability. It is important to note that many disabilities may not be recognised due to a lack of availability of specialists that are able to undertake assessments.

The requirement of persons in the CQHHS region to access NDIS services is projected to increase from 4,410 participants in December 2019, to 6,000 in 2023.

Proposed potential solution (high level)

- Develop formal relationships, joint and shared service models, and patient pathways with NDIS providers to ensure timely access to care when needed from partners. Consider capacity for HHS to provide education to increase the maturity and skills of the local disability service providers for relevant patient cohorts.

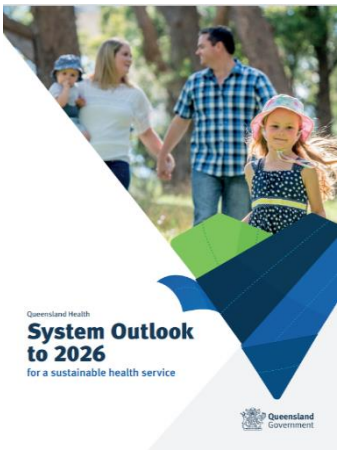
Alignment to system priorities

- National Disability Insurance Agency operational plan to improve hospital discharge for NDIS patients.
- Queensland Health, Health Equity Framework 2021.

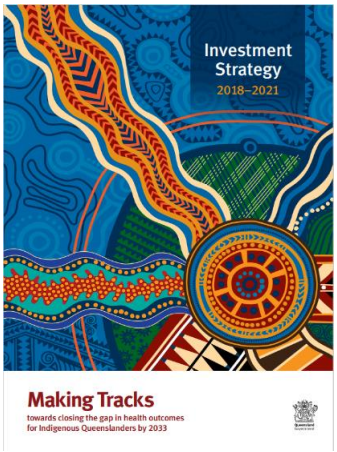
6. Alignment to system priorities

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

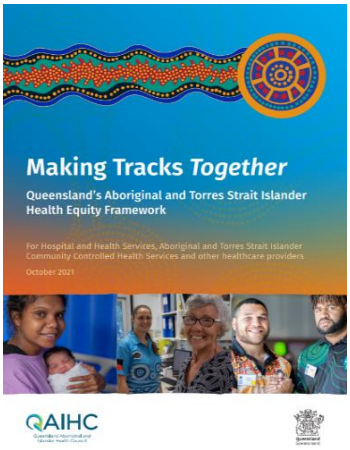
Queensland Health System Priorities outlined seven priorities, two of which are particularly relevant to the HHSs, and the development of this Plan. These are (1) the implementation of Rapid Access clinics to provide direct access to specialised care, reducing ED attendances and enabling discharge from 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.



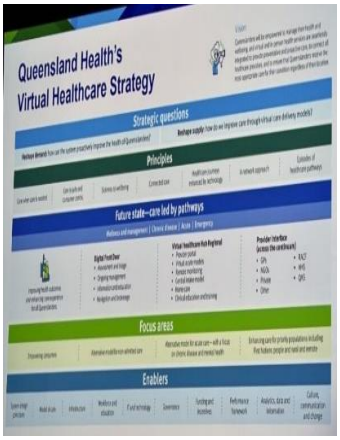
Queensland Health System Outlook to 2026 contains strategies to transform, optimise and grow Queensland health services. Transform strategies include better support for non-hospital care especially for the frail and elderly, expanded investment in nurse navigators to improve care co-ordination, an increase 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.



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

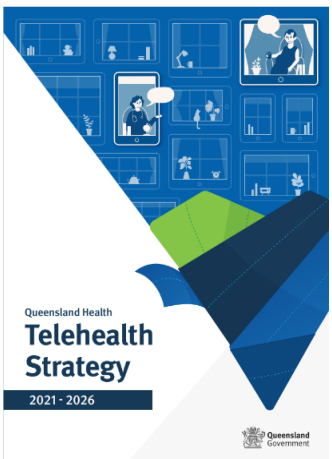


Health Equity Strategy has recently become a requirement of the HHSs. The strategy will outline mechanisms for the HHS to address how inequities in Aboriginal and Torres Strait Islander health outcomes in their region. This strategy will be completed in April 2022.

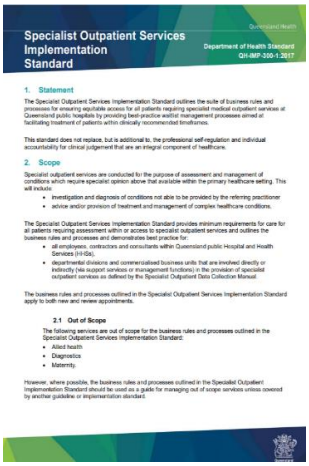


Queensland Health's Virtual Healthcare Strategy (2020) presents a vision for the way that consumers and providers will access and interact through virtual health care initiatives. These focus on the two key priority areas of non-admitted referrals and chronic disease which both present a significant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

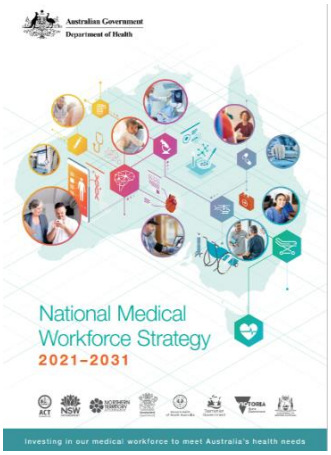
Digital Strategy for Rural and Remote Healthcare (2022-2032) 10 year plan articulates a vision for putting in place the right digital infrastructure, systems and solutions to deliver better patient care for Queensland rural and remote patients and integrating that care across the health system.



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.

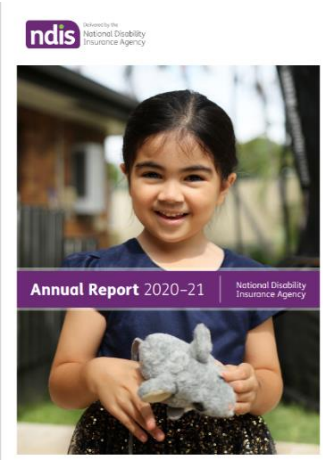


Queensland Health's Specialist Outpatient Strategy (2016) which outlines a series of actions to improve the patient journey through public specialist outpatient services, resulting in state-wide investment in an electronic referral system (Smart Referrals), introduction of clinical decision support tools (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.

Unleashing the potential: an open and equitable health system provides recommendations on how best to harness the opportunities arising from the COVID-19 pandemic response to support the best possible health and healthcare for Queenslanders and make prevention and public health a system priority. The Australian and Queensland health systems have made some rapid changes to healthcare delivery in response to the COVID-19 pandemic, and some of these innovations have ongoing potential. A 'window of opportunity' exists for Queensland's health system to build on the pandemic response reforms and innovations that deliver better value for our patients, our workforce and partners, and the wider community.



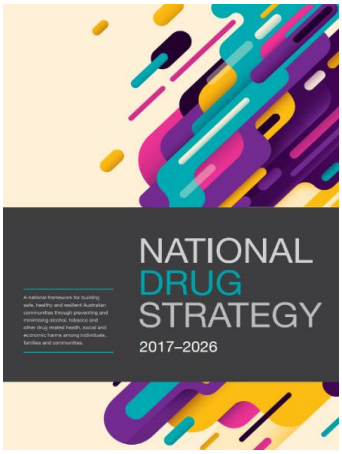
Queensland Government implementation of the National Disability Insurance Scheme (NDIS) from 2018 added another layer of complexity to a health and disability support system already fragmented by Commonwealth and State funding

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 BHHS 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 CQHHS), 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. Conclusion

CQHHS' Local Area Needs Assessment will underpin Central Queensland future strategic direction and assist in the development of CQHHS Service Plan and future strategic plans. The integration of these important strategic documents will ensure alignment and clarity of focus as CQHHS targets priority areas to set to deliver contemporary, quality, and sustainable services for the community.