Metro North Hospital and Health Service *Putting people first*

Brighton Health Campus

Future Services Plan 2018

Queensland Government

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For more information contact:

Health Service Strategy and Planning, Metro North Hospital and Health Service, Level 14, Block 7, RBWH QLD 4029, email: MNHHS_PlanningStrategy@health.qld.gov.au, phone: 3647 9557.

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1.0 Introduction

The Brighton Health Campus (BHC) provides healthcare services for adults of all ages in the subacute phase to recover from an illness or injury; or who require specialised residential or aged care services. The range of services provided from BHC since it was established in 1946 as a benevolent home, have changed, adapting to changes in healthcare and aged care policy.

Over the years the services provided at BHC have evolved in response to changing health needs, government policies, growth in non-government community sector services and improvements in healthcare interventions and therapies. The physical site and infrastructure has also undergone significant change including the re-purposing of Royal Australian Airforce training dormitories to re-house people transferred from Dunwich Asylum (North Stradbroke Island).

Feedback from community, staff, patients, residents and families consistently acknowledges the location and environmental attributes of BHC that foster healing and recuperation. Consultation with community, referring health specialists and staff confirms the continued importance of growing and expanding both the type and scale of services available from the BHC. The development of a future services plan for the BHC and its role in servicing Metro North Hospital and Health Service (Metro North) in general and the local community in particular is critical to realising the full potential of the campus.

Future opportunities for BHC have been developed in the context of broader planning relevant to services delivered in community centres and the home environment, as well as long term disability, residential and respite services.

BHC has a critical mass of workforce, concentrated clinical skills and its future role in supporting services provided at other Metro North facilities based at Zillmere, Bracken Ridge, Red Hill and Redcliffe need to be further understood in light of changes associated with National Disability Support Scheme (NDIS).

Additional planning will be required for options that relate to new infrastructure. All service actions requiring additional investment will be progressed through the usual Metro North budgetary processes and submission to Department of Health for Estimates consideration. Infrastructure and financial considerations are not detailed in this paper. Furthermore it is important to note that issues relating to patient flow and resourcing have been considered and consultation regarding the most appropriate service options to pursue has occurred. Historical issues are not further examined in this paper.

The focus of this paper is on people with health and disability care needs and their pathways across subacute, transition care (residential and community) and other residential/ community settings. The paper aligns to the Vision for Brighton and all service options specifically examine opportunities to leverage further core capacity through partnerships including community partners, service partners and strategic partners.

2.0 Context

The *Vision for Brighton* project engaged extensively with community organisations, campus staff, and other clinicians to understand the community needs to inform enhancement of services at the BHC. The Brighton community prioritised actions which fall under the four themes of health service delivery, social health and wellbeing, building a community and research, education and training.

The Brighton community is keen to see the BHC site enhanced and developed to continue to provide care to vulnerable people and people with complex care needs and limited choices. The specific commitments from these consultations are:

- Brighton will continue to play a critical role in supporting the wider health system, particularly in the care of older people. Brighton can enhance its role and capacity to train the future health workforce and create expertise to be drawn upon in the management of complex and challenging conditions, in addition to its continuing provision of residential aged care.
- Brighton can evolve its role in the development of health innovation and research translation to improve care founded on consumer and person centred models of care.
- Brighton can develop better ways of involving the community in health and well-being outcomes.
- *Vision for Brighton* document available here: https://metronorth.health.qld.gov.au/ciss/wp-content/uploads/sites/7/2018/04/vision-for-brighton.pdf

The BHC provides an opportunity to manage service demand from the expected growth in the Metro North population. The Metro North population of 957,590 people is expected to increase by 1.5 per cent per annum to reach a total population of 1,049,826 people by 2021.

Over the same period, the northern region of Metro North (Caboolture Hospital and Redcliffe Hospital catchments) is expected to experience significant growth increasing by 2.3 per cent per annum, almost double the rate of growth of the southern region (Royal Brisbane and Women's Hospital (RBWH) and The Prince Charles Hospital (TPCH) catchments) at 1.2 per cent per annum.

Similar to other jurisdictions, Metro North will experience the impacts of an ageing population. Across Metro North, the numbers of older people aged 65 years and over are expected to increase 3.7 per cent per annum over the next five years with the largest proportionate growth in the northern region of Metro North. By the year 2021, the Metro North population aged 85 years and over will increase by 2.5 per cent per annum with the largest increases expected in the northern region of Metro North. Given the current projected demographic profile and recognising that some vulnerable patients are not receiving care in optimal settings, BHC has been considered as a highly desirable solution to address service needs.

The *Metro North Strategic Plan 2016-2020 (2017)* describes the vision for our Hospital and Health Service (HHS) and provides objectives, strategies and performance indicators that guide the delivery of health services over a five year timeframe. The BHC Future Services Plan aligns with these objectives focusing on subacute and community service options that reduce avoidable demand for acute hospital services.

The *Metro North Health Service Strategy 2015-2020 (2017)* provides an overview of the health needs of our population to 2020 and examines the factors that are likely to influence the design and delivery of healthcare services to identify challenges and opportunities. It also presents four focus areas, developed after extensive consultation with clinicians and community partners and outlines the strategies to address them. The BHC Future Services Plan will present actions that contribute to achieving the strategies of Metro North.

The jointly developed (Brisbane North PHN and Metro North) A five year health care plan for older people who live in Brisbane North 2017-22 provides the future directions and supporting actions to guide service delivery and enhancement for older people over the next five years. Services at the BHC will support delivery of a number of actions including the development and implementation of an integrated, evidence-based model for screening, assessing, managing and supporting older people with behavioural and psychological symptoms of dementia and other mental illness. The *Metro North Rehabilitation Clinical Services Plan 2017-2022* includes actions to increase inpatient rehabilitation capacity, establish a centre-based ambulatory rehabilitation service and enhance/introduce clinical support services such as medical imaging, pathology and pharmacy at BHC.

3.0 Brighton Health Campus current service profile

Over the past decade BHC has been subject to comprehensive service and master planning activities to respond to the needs of both the Brighton community and the broader Metro North population. This planning resulted in provision of an appropriate level of access to a continuum of subacute services in line with policy directions and the catchments changing demographic profile. The Vision for Brighton work and the consultation process to explore future opportunities acknowledges and builds upon current services based at BHC.

The BHC has undergone redevelopment, expansion and reorienting of health services to create additional capacity in subacute care including rehabilitation, transition and aged care services. The services serve multiple aims including facilitating patient flow from acute facilities to improving and maintaining a person's functional capacity and independence. Services provided at BHC are summarised below with detailed service profiles available.

Residential aged care services

Residential aged care is for older people who can no longer live at home. Services provide continuous supported care ranging from help with daily tasks and personal care to 24-hour nursing care of more complex needs.

Gannet House is an accredited and Commonwealth funded Residential Aged Care Facility, administered by the State Government and under the governance and strategic direction of the Metro North. Gannet House has the capacity to accommodate 40 residents who may require a range of specialised care within the purpose built residential aged care facility. Care is provided by a multidisciplinary team comprised of skilled nursing staff and allied health staff with the support of administrative and ancillary staff.

Rehabilitation services

Brighton Rehabilitation is a Clinical Services Capability Framework (CSCF) Level 4 subacute rehabilitation service providing restorative care to improve a person's functional capacity and independence.

Rehabilitation services aim to improve the functions relating to impairment, activity limitation or participation restriction due to a health condition or event in line with patient-led goals for recovery and where possible, transition home or to supported living as appropriate.

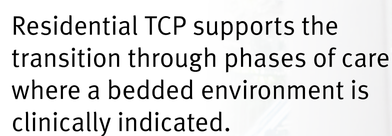
Clients work in partnership with a team of healthcare professionals to develop an individualised and goal oriented rehabilitation program. Patients receive 24 hour nursing support as well as regular medical reviews. Medical care is provided on site during business hours and as an on call basis after hours. Patients are accommodated in Level 1 and Level 2 of Dolphin House with a total of 50 beds, 38 and 12 beds respectively with access to indoor multidisciplinary therapy spaces.

Transition Care (community and residential)

Transition care is goal-oriented, time-limited and therapy-focused. It provides older people with a package of services that includes low intensity therapy such as physiotherapy and occupational therapy, as well as social work, nursing support or personal care to maintain and improve physical and/or cognitive functioning.

It seeks to enable older people to return home after a hospital stay rather than enter residential care prematurely.

Transition care facilitates a continuum of care for older people who have completed their hospital episode, including acute and subacute care (e.g. rehabilitation, geriatric evaluation and management (GEM)), and who need more time and support to decide on their long term aged care options. The BHC operates both community and residential transition care services on the campus. There are currently 70 funded Transition Care Program (TCP) packages provided in the community that aim to support short term care and case management to assist older people complete their restorative care and optimise their capacity in their own home following a hospital admission. Clinicians travel to clients homes across the HHS, from a base at BHC, to provide clinical care and services. There are currently 70 beds that provide the balance of the TCP packages in a residential setting.



Residential TCP supports the transition through phases of care where a bedded environment is clinically indicated.

Children’s health services

Children’s Health Queensland provides child health checks (including home visits) under the umbrella of community child health services in Metro North at the BHC.

Clinical support services

Pathology is accessed by in-reach public and private service arrangements with all simple blood tests able to be performed at the point of care.

Pharmacy services/arrangements differ across the residential aged care, transition care and rehabilitation units.

While the rehabilitation service has access to clinical pharmacy support, off campus private providers are used in the other services at BHC.

There is limited access to medical imaging services with nursing escorts usually required for off-site appointments.

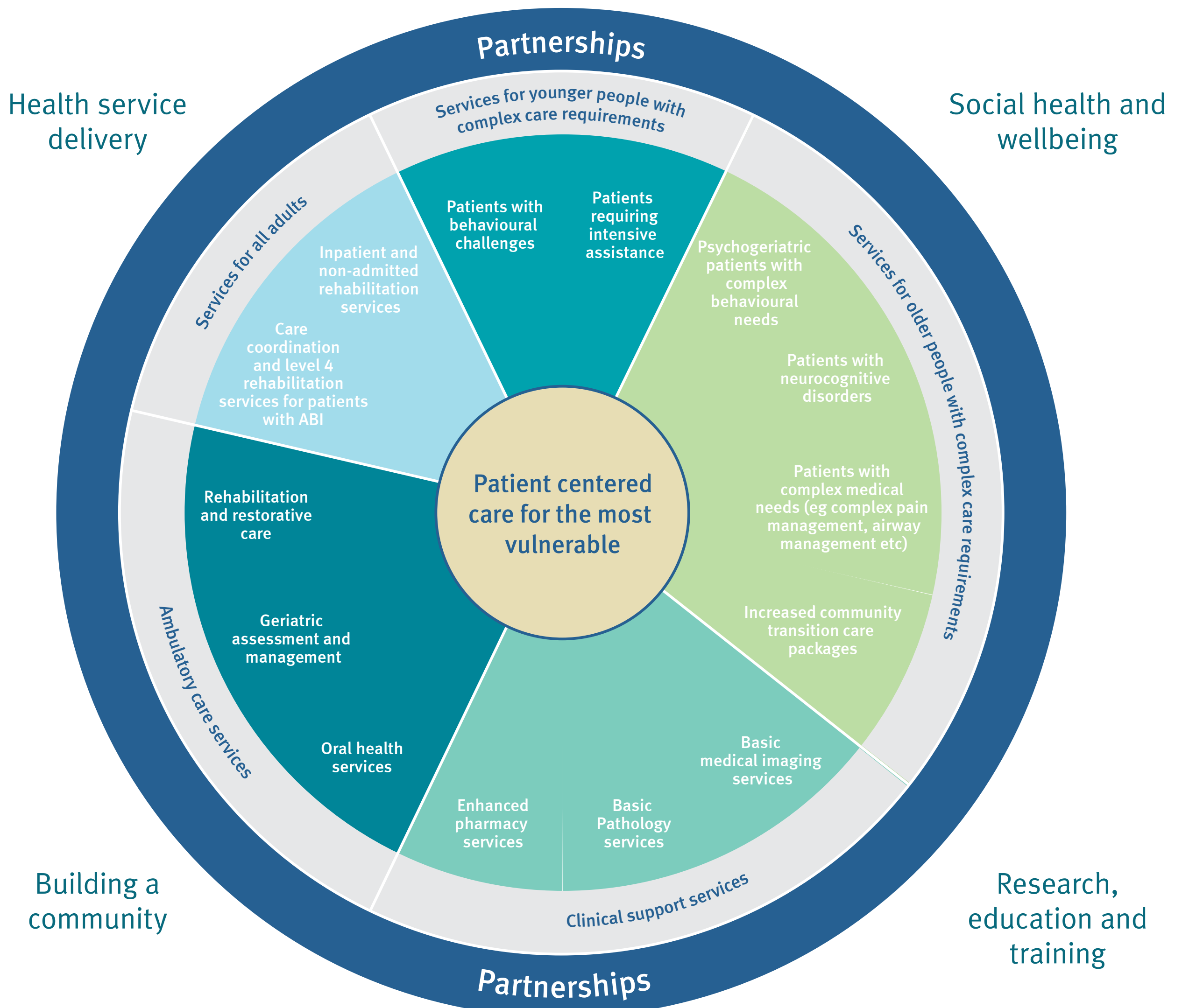
4.0 Future clinical services directions

Metro North recognises a growing number of people admitted to hospitals are older and have increasingly complex conditions. Many of these people benefit from comprehensive and ongoing rehabilitation over an extended period of time to attain functional improvement after an acute injury or illness. Optimising outcomes in this way through timely rehabilitation also increases patient choice and options to return, where possible and practical, to pre-hospital living arrangements, allowing the continuance of age-in-place and staying connected to family, friends and the community.

The BHC provides Metro North with a unique opportunity to create an integrated service system that will enable the most vulnerable patients with complex care needs to be transitioned (as clinically appropriate) from the hospital environment to a community setting.

The BHC is located in the northern region of Metro North. Services at this site offer access to patients in the local Brighton community and more broadly patients who reside in the northern end of the health service who would otherwise be required to travel to the RBWH or TPCH for services. This section groups the future services within the Plan by phase of care and target cohort with Figure 1 providing an illustration of the services explored.

Figure 1: Plan for Brighton Health Campus future services



4.1 Clinical support services

Overview

The residents, clients and patients receiving care at BHC will benefit from access to an increased range of on-site clinical support services including:

- medical imaging and point of care diagnostics
- iStat pathology and point of care testing
- pharmacy service expansion.

Enhanced access to clinical support services presents a range of opportunities, including less time to organise, transfer and attend off-site appointments and timely response to diagnostics to confirm or eliminate injury or changes to clinical status.

Actions

As the service capacity at BHC increases, the residents, subacute and ambulatory patients receiving care will benefit from access to an increased range of on-site clinical support services.

1. Develop a basic high quality diagnostic imaging service at BHC commencing with one session a week. The services in scope are general x-ray for all regions of the body and ultrasound. The x-ray unit will be fixed and require structural shielding considerations. The diagnostic ultrasound equipment will be mobile.
2. Improve pathology testing by providing training, education and support to staff at BHC to increase awareness and utilisation of point of care (e.g. iStat) pathology testing.
3. Enhance the current pharmacy services to increase capacity and capability:
   a. increase service capacity to meet anticipated growth in other services at BHC
   b. improve dispensing capacity, including the use of recent advancements in dispensing technology
   c. explore an outpatient and home visiting service with a particular focus on reducing harm from polypharmacy.

4.2 Specialist ambulatory services

Overview

The BHC provides an opportunity to establish specialist medical, nursing and allied health outpatient services to residents and patients at an accessible community hub. There is opportunity to strengthen links with GEM across Metro North to plan transfer of care to home with access to day therapy programs (e.g. memory clinics, falls clinics) at BHC. Technology can assist in service delivery, including telehealth and electronic access to health records.

Actions

Rehabilitation

1. Day therapy unit – provide a centre-based (including indoor and outdoor environments ambulatory multidisciplinary rehabilitation service for all Metro North residents and in particular people living in the northern catchment of Metro North (Redcliffe, Brighton and Caboolture area)
2. Rehabilitation consultant – establish a medical consultation clinic to guide ongoing care planning in the community
3. Upper limb clinic – provide assessment and management of upper limb deficits through the delivery of specific therapies including hypertonicity management, dynamic splinting/ orthotic therapy, and robotic therapy
4. Balance and lower limb clinic – create an ambulatory clinic with particular focus on gait retraining, falls assessment, hypertonicity management and lower limb strengthening
5. Dysphagia clinic – create and offer assessment (including Modified Barium Swallow), treatment and care planning service to manage swallow disorders
6. Dysphasia clinic – establish an ambulatory service focussing on intensive short term communication therapy.

Geriatric assessment and evaluation

1. Provide Geriatrician assessment and review
2. Provide a pharmacy review and medication reconciliation
3. Develop a vestibular assessment clinic and service to comprehensively assess functions of the inner ear to reduce symptoms of dizziness, improve balance and reduce falls risk
4. Establish cognition clinic to provide a service to assess, diagnose and treat cognitive impairments with a focus on care planning to operate in conjunction with existing memory clinics
5. Provide a mood check clinic and create a diagnostic service for people with cognitive impairment manifesting as changes in mood.

Other ambulatory services

1. Establish a driving assessment service to:
   a. assess client's medical fitness to drive utilising simulation technology to enhance off and on road assessment
   b. engage a qualified driving instructor to work with a skilled multidisciplinary team, comprising occupational therapy, neuropsychology and access to a geriatrician
   c. link with a driving school and the University of Queensland Driver Cessation Program.
2. Develop an oral health service that includes dental therapy/hygiene services with a focus on both preventative and emergency dental. Undertake education and awareness campaign in line with national approach regarding good oral hygiene for those in long term care.
   a. Explore a denture and prosthetic program in line with Commonwealth initiatives supporting better dental care.
   b. Modernise public oral health services provided to the local catchment at a community hub.
   c. Develop partnerships with University for research, training and student placement as well as opportunities with non-government sector to collaborate and leverage public health resources.

4.3 Rehabilitation services

Overview

Together with other planned service developments in Metro North, there is opportunity to enhance existing BHC rehabilitation service capacity and expertise for specialist and generalist post rehabilitation through step-down models of care, ambulatory transition and enhancing home based pathways. BHC provides an opportunity to bridge this infrastructure gap in the immediate future through a combination of inpatient and same day rehabilitation, requiring less investment to create these care environments. In expanding rehabilitation services, alignment with Metro North and statewide planning for specialised brain injury rehabilitation will be considered. Providing specialist rehabilitation services at BHC will create a suite of connected services across the multiple acute, sub-acute and community settings for patients requiring rehabilitation post acquired brain injury (ABI). Statewide ABI planning to date has identified groups within the ABI cohort including:

- acute pathways to assist patients and their families to access early rehabilitation immediately following the acute phase to optimise functional recovery to transition home
- slow to awaken pathways for patients and their families where slower to recover rehabilitation expertise is required to assist with transition home
- those who have completed rehabilitation and require medium term supported care in an intensity ‘step down’ model while community support packages are finalised
- long term residential care clients undertaking NDIS planning that is unlikely to secure the concentration of resources required to maintain the person in the community setting, or the specific complex care requirements are not readily provided by another service.

Actions

1. Expand the current inpatient rehabilitation service at the BHC from the current 50 to 80 beds. To achieve this, investigate the following two options:
    a. reorientate existing beds to rehabilitation, requiring alternative service delivery options for affected services; or
    b. build a new inpatient unit at BHC.
2. Increase gym/therapy space with exploration of extended hours of operation to improve access for the full range of future service opportunities.
3. Explore delineation across the MNHHS rehabilitation units to reflect subspecialty collocation and clinical workforce expertise with BHC to expand the stroke rehabilitation pathway and access nationally recognised skills, expertise and technologies to support optimal recovery.
4. Commence a navigation service operating within the Community, Indigenous and Subacute Service (CISS) Referral Assessment and Navigation Service to assess and match patients to the right service.
5. Improve service matching for post-acute non-weight bearing patients across rehabilitation units and whether close to home or collocated will be the primary indicator for care location until rehabilitation can commence.
6. Review the mix of residential and community transition care places (currently140 places which are 70:70 mix)
    a. Explore impacts from the commencement of Zillmere Interim Care on Residential TCP and the recent rollout of the 4 week GP referred community restorative care packages.
    b. Plan for future flexibility where a proportion of care packages can be deployed in either a residential or community setting based on referral volume, service capacity and patient needs.
    c. Explore options for partnership arrangements to enhance package flexibility with the non-government sector.
    d. Improve geographic distribution across the MNHHS catchment to enable close-to-home residential TCP options.
    e. Increase the access of community TCP to Aboriginal and Torres Strait Islander people and older people with dementia by extending Indigenous Liaison Officers into TCP to support Aboriginal and Torres Strait Islander clients.
    f. Introduce medical and specialist support to the TCP multidisciplinary team.
    g. Develop flexible workforce deployment models for nursing, allied health and support staff to provide the flexibility for different TCP settings.
7. Develop a Clinical Service Capability Framework Level 4 ABI rehabilitation inpatient service (12 rehabilitation beds) on the BHC for younger adults (18-64 years) and specific pathways taking into account other service expansion across Metro North.
8. Grow the multidisciplinary resource base to Metro North Community Based Rehabilitation (CBRT) to increase the capability and capacity of this ambulatory home visiting team for rehabilitation patients and those transitioning to the home environment.

4.4 Residential care choices for older people with complex care requirements

Overview

BHC has the physical capacity to increase residential care focussing on those where choices are often limited due to their complex care requirements. There are a range of options to explore including reorientation of existing non-residential services and/or building new capacity either by Metro North or in partnership with the non-government sector.

Specific patient/client/resident cohorts include:

- older persons with specialised health care needs (e.g. complex pain management, complex wound management, tracheostomy care)
- persons with dementia, including the neurodegenerative subset of clients who display challenging behaviours
- older persons with mental health needs already in aged care as well as those displaying treatment resistant psychosis who remain in an acute care setting for longer than necessary. This second group may otherwise be transferred to a residential facility that is not appropriately resourced or equipped to meet their needs
- bariatric patients experience limited choice in terms of residential aged care placement and are limited to facilities with bariatric equipment including hoists, beds, wheelchairs, door width for bathrooms, toilets and exits and appropriate staffing levels.

An opportunity exists to enhance existing residential aged care services and increase local capability to manage a greater range of complexity. System issues including limited care choices for vulnerable groups arose and were noted during consultation. A key focus will be the provision of a residential aged care service for patients with specialised health care needs (e.g. complex pain management, complex wound management, tracheostomy care). Other services to be developed will cater for older persons with specific mental health needs, both transitioning to permanent accommodation as well as those who require longer term care at BHC.

Actions

By working together with older people and their families, a safe and sustainable transition back to the community or alternative care facility for people requiring behavioural support can be facilitated.

1. Create Brighton Extended Care Service (BECS) for clients requiring behavioural support and staff the service with a specialised multidisciplinary team to provide evidence based interventions in managing secondary behavioural issues. The formation of a multidisciplinary team in BECS would require:
    a. recruitment of medical staff including geriatrician, psycho-geriatrician and neurology consultation liaison
    b. development of a core nursing workforce including consideration of nurse navigators to liaise within Metro North and across other sectors
    c. identification and recruitment of key allied health clinicians (clinical psychologist, neuropsychologist, occupational therapist and speech pathologist with expertise in communication)
    d. enlisting support staff (recreational, administrative and research officers).
2. Establish an in reach and inpatient speciality service to support both long stay residential care and those transitioning into a residential setting.
3. Realign existing services to create functional linkages with the Older Person's Mental Health Services across Metro North, including inpatient units at each of the acute facilities.
4. Review admission criteria, shared care planning for tenured residents and also for new referrals to existing aged care services, including psychogeriatric model of care at services such as Cooinda House.
5. Create care models for a range of dementia presentation types, including older people with neurocognitive disorders such as Alzheimers, Parkinson's disease, and Huntington's disease.
6. Refurbish and upgrade an existing 16 bed facility at BHC to create a suitable care environment for the client group displaying complex or challenging behaviours. The existing infrastructure could be recommissioned as 12 bed inpatient unit to provide subacute extended inpatient care with nursing services provided 24 hours 7 days a week.

Service elements and functional relationships of BECS would include:

- an outreach model that links to each Metro North Hospital to assist with developing behaviour management plans that assist in discharge, or actively flow patients stranded because of their behaviours to BECS for more intensive and appropriate behaviour assessment, planning and evidence based interventions.
- multidisciplinary specialised outpatient services at BHC to assist in maintaining recently discharged clients in their new environment as well as those who are in the community and experiencing escalating behaviours.
- a clinical workforce trained to meet the mental health needs and behaviour management service requirements, particularly regarding communication and the deployment of contemporary evidence based restrictive practices (physical, mechanical, chemical or isolation).

4.5 Residential care choices for younger people (65 and under) with complex care requirements

Overview

There is a requirement for more suitable long term residential options for younger people (aged 65 and under) with complex care requirements. Client needs may range from complex manual handling requirements and assistive devices to management of behavioural challenges and the creation of support plans. Resolving access and service provision issues for this broad range of people in the short to medium term may require partnerships with the non-government sector.

Whilst there is a natural focus relating to ageing, these opportunities also acknowledge that due to lifestyle, risk factors and trauma transition to longer term care may occur earlier in life. Step-up and step-down services enable greater potential for people to return home with support and therefore remain connected to their community, while maintaining access to day therapy and local specialist services.

In conjunction with the rollout of NDIS, work must continue with people under the age of 65 in residential aged care to determine whether more age-appropriate supported accommodation is possible. Consideration must be given to building compliance and service objectives under NDIS funding variables.

Realising the service opportunities outlined in this paper, BHC provides Metro North the ability to create an integrated system that will help vulnerable people with complex care needs to be transitioned (as clinically appropriate) between the hospital environment to a community setting via transitional, rehabilitative and restorative care.

It is acknowledged that the concept of certainty of care is important, particularly with many family members now being admitted to residential aged care causing a second generation of guardians and decision makers. Work should proceed to identify residents in long stay residential care interested in transitioning to community supported living under NDIS and determine what capacity this may create to accommodate growth.

Actions

1. Complete the NDIS pre planning to identify the current level of care delivered and the agreed level of care that will be provided in the funded individualised NDIS plans.
2. Commence planning for a younger person transition care/ subacute service with step down to community supported living with particular focus on external partnerships at each phase of care.

5.0 Enablers

The following key enablers have been identified to prepare BHC for future service opportunities detailed in this paper:

- **Research** will be embedded as core business and findings translated into innovative care that assists care delivery, care coordination and self-care during transition, rehabilitation and restorative care at BHC. Research opportunities exist in areas such as:
  a. ageing in place and holistic care of the older person
  b. the impact of the environment and physical design on care; an engaged and integrated community setting with social supports encouraging health promotion, information and belonging
  c. benefits of creating connection between clinical and social care interventions.
-
- The BHC will create a **learning** environment, including an education centre, to meet the contemporary training needs of current and future staff offering:
  a. the use of simulation and remote technologies to assist in preparing staff to deliver care in non-traditional environments of care and for families to practice transition home with patients
  b. training and education to build capability with consumers, carers and non-government organisations, including:
  - increased focus on the management of fatigue (physical, emotional, mental and spiritual)
  - develop further capability in consumer engagement, such as motivational interviewing techniques and goal setting skills
  - inclusion of the resident/patient and their carer/family in care planning, goal setting and quality improvement.
- Strategic **partnerships** will be further developed with tertiary educational institutions for research, education and training to support the needs of staff. The BHC services will be led by accountable management teams who will provide dynamic inter-professional leadership and commitment to the MNHHS values. Co-design will feature prominently as resident, patient and staff engagement will be actively sought, valued and incorporated.
- Existing physical **infrastructure** will be utilised to its full potential with contemporary models, technologies and potentially new builds to yield pipeline dividends and future proof for multi-generational benefit.

6.0 Where to from here

An implementation plan will be developed to progress the initiatives outlined in this paper. The implementation plan will be developed by CISS in consultation with Clinical directorates, Streams and other business units to gain engagement and commitment in progressing actions. The paper will inform infrastructure planning to assess options that relate to new infrastructure. All service actions requiring additional investment will be progressed through the usual Metro North budgetary processes and submission to Department of Health for Estimates consideration. CISS will be responsible for managing the program of work detailed in the paper and escalating issues and risks.

There may be opportunities that arise through other planning which may have relevance to the BHC and will therefore be included in review and update processes.

Monitoring, reporting and review

The paper will be monitored, reported and refreshed on an annual basis by CISS through a collaborative process with Health Service Strategy and Planning Unit. Clinician, consumer and community input will also inform this ongoing planning review.