



Health Service Strategy

2015–2020 | 2017 refresh

© 2017 State of Queensland, Metro North Hospital and Health Service

Health Service Strategy 2015–2020: 2017 Refresh by Metro North Hospital and Health Service is licensed under a Creative Commons Attribution 3.0 Australia licence. In essence, you are free to copy, communicate and adapt this report as long as you attribute the work to the Metro North Hospital and Health Service.



To view the terms of this licence, visit:
<http://creativecommons.org/licenses/by/3.0/au>.
For permissions beyond the scope of this licence,
contact qgcio@qld.gov.au

To attribute this material, cite the Metro North Hospital and Health Service
Health Service Strategy 2015–2020: 2017 Refresh.

Public availability

Where possible, readers are encouraged to download the report online at:
www.health.qld.gov.au/metronorth/publications

Where this is not possible, printed copies are available using one of the
contact options below:

Physical address: RBWH, Butterfield Street, Herston Qld 4029
Postal address: Post Office, Herston Qld 4029
General phone: (07) 3646 8111
Office hours: 8am to 5pm, Monday to Friday
General e-mail: md16-metronorthhsd@health.qld.gov.au

Interpreter Services Statement



Metro North Hospital and Health Service is committed to providing accessible services to the community from culturally and linguistically diverse backgrounds.

If you have difficulty in understanding this Report, please contact us on 07 3646 6102 and we will arrange an interpreter to communicate the report to you effectively.

Version 5 Effective: 05/2017 Review: 05/2018

Contents

Foreword from the Board Chair and Chief Executive	4
Introduction	6
How to read this Strategy	7
Listening to our staff, partners and patients, families and carers	8
What we have achieved	9
Organisational overview	10
Our challenges	15
Outcomes	18
Focus areas	19
Living healthy and well in our local communities	20
Delivering person-centred, connected and integrated care	22
Effective delivery of healthcare to address growing population health needs	24
Responsive healthcare that meets the high health needs of identified groups	26
– Older people including frail old people	27
– Children and/or young people	28
– People with mental illness and/or alcohol and drug dependence	29
– People with a disability	30
– Aboriginal and Torres Strait Islander	
– Culturally and linguistically diverse communities	32
What's next	33

Foreword from the Board Chair and Chief Executive



Dr Robert Stable AM

Chair, Metro North
Hospital and Health Board

As Australia's largest public health service, Metro North has a responsibility and an opportunity to lead the development of responsive, accessible, innovative health services.

Shaun Drummond

Chief Executive,
Metro North
Hospital and Health Service

In 2014, we developed the *Health Service Strategy 2015–20* to address a range of challenges including increasing demand for services, changing care needs, pressure on existing infrastructure, and the need to maintain a skilled and committed workforce. The Strategy outlined priority actions to be delivered over a five year period.

(This Strategy) refocuses our efforts to provide connected, accessible, high quality services that help improve the health of the communities we serve, while using our resources efficiently and effectively.

Over the past two years, thanks to the dedication and commitment of Metro North staff, significant progress has been made in the implementation of the Strategy with many priority actions achieved or well underway. In 2016, we reviewed the Strategy to ensure it continues to align with the changing needs of our population to 2020, including the following objectives:

1. Always put people first.
2. Improve health equity, access, quality, safety and health outcomes.
3. Deliver value based health services through a culture of research, education, learning and innovation.

The Strategy has been refreshed through broad consultation with staff, consumers, community and healthcare partners, and in line with *Metro North's Strategic Plan 2017-2021*. It refocuses our efforts to provide connected, accessible, high quality services that help improve the health of the communities we serve, while using our resources efficiently and effectively.

Metro North is committed to continuing to be a world leader in innovative clinical care, research and education. Through the refreshed Strategy, we have developed four new focus areas which reinforce our commitment to supporting our population to remain healthy and well in their local communities and accessing high quality healthcare that is effective, equitable, sustainable, and centred around individual needs and preferences.

The new focus areas, which have been informed by health needs and service activity data, include:

- Living healthy and well in our local communities
- Delivering person-centred, connected and integrated care
- Effective delivery of healthcare to address growing population health needs
- Responsive holistic healthcare that meets the specific needs of vulnerable groups including but not limited to:

- older people including frail older people
- children
- young people
- people with mental illness
- people with alcohol and other drug dependence
- people with disabilities
- Aboriginal and Torres Strait Islander peoples
- Culturally and Linguistically Diverse Communities (CALD).

We are committed to implementing the refreshed Strategy over the next three years to 2020. It will continue to guide the health service priorities of our Clinical Directorates and Clinical Streams, underpinned by the supporting elements of our workforce, infrastructure, funding arrangements, and our information and communication technology.

We look forward to working with our staff, partners and patients to achieve the goals of this refreshed Health Service Strategy and improve health outcomes for our communities.

Introduction

In 2014 Metro North Hospital and Health Service (MNHHS) developed *The Health Service Strategy 2015 – 2020* (the Strategy) outlining organisational directions and priorities for a five-year period. Informed by consultation with staff, consumers, community and healthcare partners, the Strategy outlined service priorities to be progressed by the newly established MNHHS matrix governance structure including Clinical Directorates and Clinical Streams.

Through the dedication and commitment of staff over the past two years significant progress has been made in the implementation of the Strategy with many priority actions achieved or well underway.

In 2016, MNHHS undertook a review of the Strategy. This review has been undertaken to ensure our Strategy continues to align with the changing needs of our population to 2020. Guided by the MNHHS Strategic Plan 2017–2021 and through broad consultation

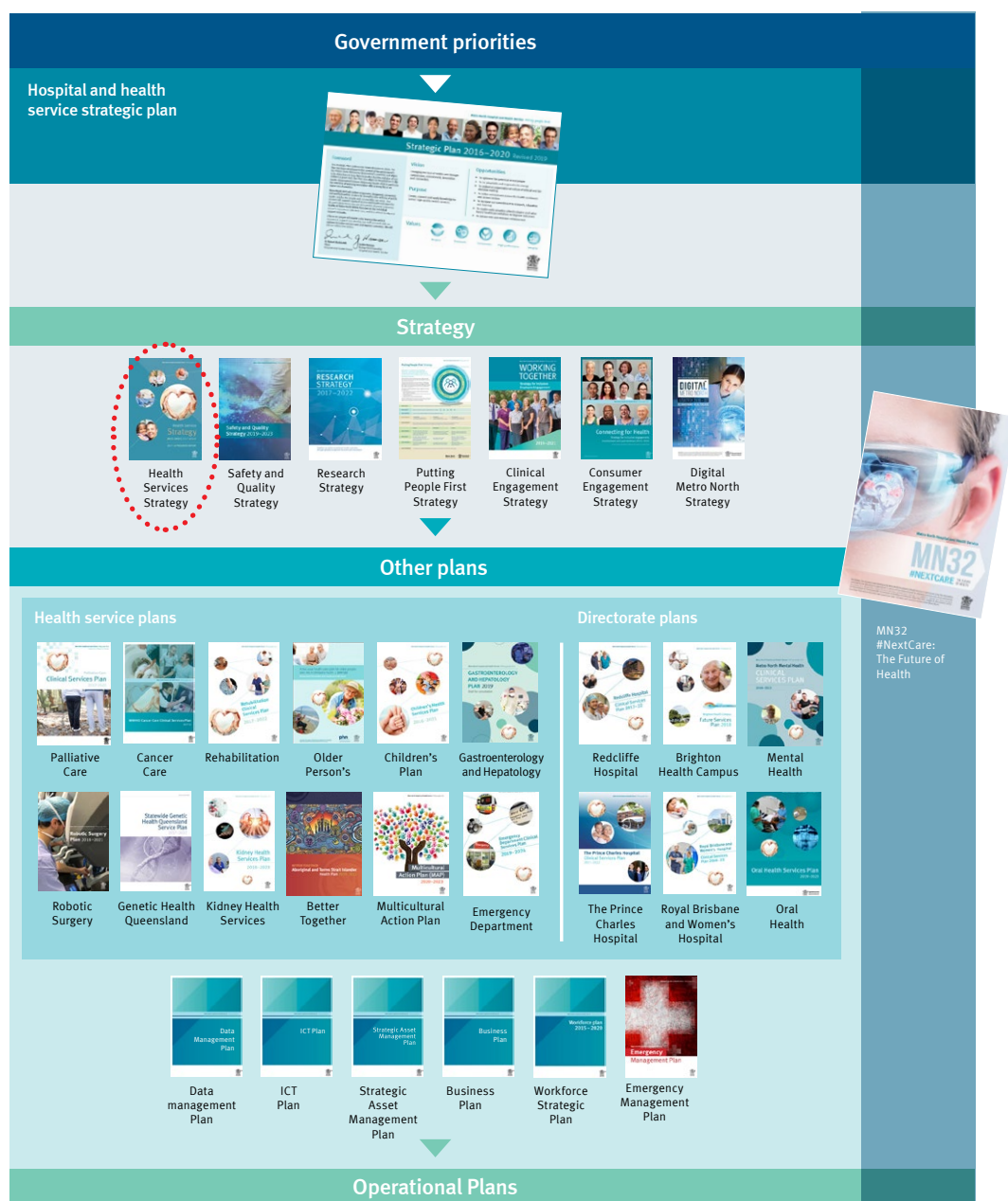
with staff, consumers, community and healthcare partners, the Strategy has been refreshed. The refreshed Strategy refocuses our efforts to provide connected, accessible, high quality services that help improve the health of the communities we serve making efficient use of available and future resources.



How to read this strategy

The MNHHS Strategic Plan describes MNHHS vision, purpose and service objectives. This Strategy is one of six strategies that will assist in the delivery of MNHHS Strategic Plan.

The relationship and cascade of strategic documents is described below. The health service strategy focus areas will be translated into actions in the Plans of our business areas and activities of individual staff.



Effective: October 2019 / Review: October 2020

Working together MNHHS will provide connected, accessible, high quality services that help improve the health of the communities we serve making efficient use of available and future resources.

Listening to our staff, partners, patients, families and carers

Building on the extensive consultation undertaken to develop the original Strategy, this refreshed Strategy has been developed based on engagement with MNHHS staff, the Community Board Advisory Group, the Brisbane North PHN, consumers and our community. Hearing the feedback from our staff, consumers, community and healthcare partners has resulted in the refresh of the Strategy having a much stronger focus on:

- the role and value of people who look after patients including carers and families
 - supporting people to maintain or regain health through optimising their physical, mental and emotional wellbeing and independence
 - improving connection, access and care for people who experience greater risk of poor health
 - services that are connected, integrated and responsive to local social and health needs.
- the promotion of a patient-centred care approach across all MNHHS services where the holistic care needs of the patient are recognised



What we have achieved

Through the dedication and commitment of MNHHS staff most actions identified in the original strategy have been achieved. Below is a summary of some of MNHHS achievements as at December 2016.

Priority 1: Increasing capacity for our services to support population growth

- Additional bed capacity was created at Caboolture Hospital, Redcliffe Hospital and The Prince Charles Hospital (TPCH).
- Approval to proceed with the Specialist Rehabilitation and Ambulatory Care Centre (SRACC) providing 100 rehabilitation beds, seven operating theatres for elective surgery, three endoscopy rooms and supporting ambulatory therapy services and outpatient services to open in 2020.
- Approval to progress Caboolture Hospital stage 1 redevelopment to business case.

Priority 2: Supporting the mental health needs of our communities

- Implementation of an emergency department frequent attendee management project for people with multiple and complex health and social support needs many of whom have a mental illness delivered in with Micah Projects, Footprints, and Brisbane North PHN.
- Approval and construction commenced for a ten bed 'step up step down' model-of-care facility at Nundah.

Priority 3: Supporting the rehabilitation needs of our communities

- Stakeholder engagement progressing to inform models of care at SRACC.
- Additional rehabilitation bed capacity at TPCH.

Priority 4: Other service priorities

- MNHHS Children's Health Service Plan developed and released.
- Review of stroke services completed.
- Telehealth portal operational enabling outpatient services to be delivered to patients in regional Queensland via telehealth.
- Co-joint renal and genetic specialist consultation clinics established supporting patients and families affected by inherited or genetic forms of kidney disease.
- A statewide epilepsy service started at the RBWH.

Priority 5: Work in partnership to better connect care across the service system

- Opportunities for consumer involvement in MNHHS have grown. Eighty one consumer advisors were appointed to more than 200 consultation opportunities in 2016; double the opportunities that were available to consumers in 2015.
- Significant number of joint projects were completed in partnership with Brisbane North PHN including the preparation of a joint health needs assessment for the Brisbane North catchment.
- The number of patients waiting for specialist outpatient appointments were reduced by more than 5,500 patients in 2015–16.
- Partnerships established with regional Hospital and Health Services (HHS) to deliver connected care for the most acutely unwell Queenslanders requiring specialist care were enhanced.

Supporting elements

- Development of a Research Strategy to lead the direction and priorities for research across MNHHS.
- Investment of \$21.3M over the past two years in modern ICT foundations including WiFi data capability, enterprise grade computers and storage capability, and personal computing modernisation.
- A comprehensive total asset management plan to inform priority infrastructure replacement and renewal.

Organisational overview

MNHHS has a proud history of delivering public hospital and health services for:

- a local catchment of the north side of Brisbane
- a regional catchment including neighbouring HHSs
- a statewide catchment for complex and specialised services.

MNHHS is one of the largest HHSs in Queensland and is responsible for the direct management of the facilities within the HHS's geographical boundaries including the RBWH, TPCH, Redcliffe Hospital, Caboolture and Kilcoy Hospitals and the Brighton Health Campus. MNHHS clinical services incorporate all major health specialties including medicine, surgery, psychiatry, oncology, women's, children and neonates, trauma, subacute and more than 30 sub-specialties.

The RBWH and TPCH are quaternary/tertiary referral facilities, providing complex levels of acute healthcare which are highly specialised. Statewide services such as heart and lung transplantation, genetic health,

cancer services and burns treatment are provided at these sites for all Queenslanders.

Redcliffe and Caboolture Hospitals are regional hospitals providing emergency, medical, surgical and birthing services to the northern region of MNHHS. Kilcoy Hospital is a rural community hospital providing emergency stabilisation and medical services to its local population.

Mental health, oral health, community health, subacute and Aboriginal and Torres Strait Islander health services are provided from many sites across MNHHS including hospitals, 11 community health centres, residential and extended care facilities and mobile service teams. Dedicated units provide

services to Woodford Correctional Facility. MNHHS also has a dedicated Public Health Unit.

The statewide Clinical Skills Development Service located on the Herston Health Precinct at the RBWH is one of the world's largest providers of healthcare simulation both on site and via outreach to satellite hospitals. The Herston campus is also home to a wide range of research and collaboration entities including the University of Queensland, Queensland University of Technology, and the Queensland Institute of Medical Research. MNHHS also hosts co-located private hospital facilities at TPCH and Caboolture Hospital.





Metro North has a population of 957,590 – approx 20% of Queensland



Redcliffe and Caboolture are experiencing significant population growth

3.7%

The number of people aged 65 and over will increase by 3.7% per annum

Our population

In 2015 the estimated resident population of MNHHS was 957,590 people which accounted for approximately 20 per cent of the Queensland population. By the year 2021, MNHHS population is expected to increase by 1.5 per cent per annum to reach a total population of 1,049,826 people.

Population growth within MNHHS will not be evenly distributed between our hospital catchment areas or age groups. Over the same period, the northern region of MNHHS (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, (RBWH and TPCH catchments) at 1.2 per cent per annum.

Similar to other jurisdictions, MNHHS will experience the impacts of an ageing population. Across MNHHS, the number 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 MNHHS. By the year 2021, the MNHHS 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 MNHHS.

Similar trends can be seen in the population growth of MNHHS children aged 0–14. Across MNHHS the children's population will increase by 1.5 per cent per annum with the highest percentage of growth expected in the northern region of MNHHS.

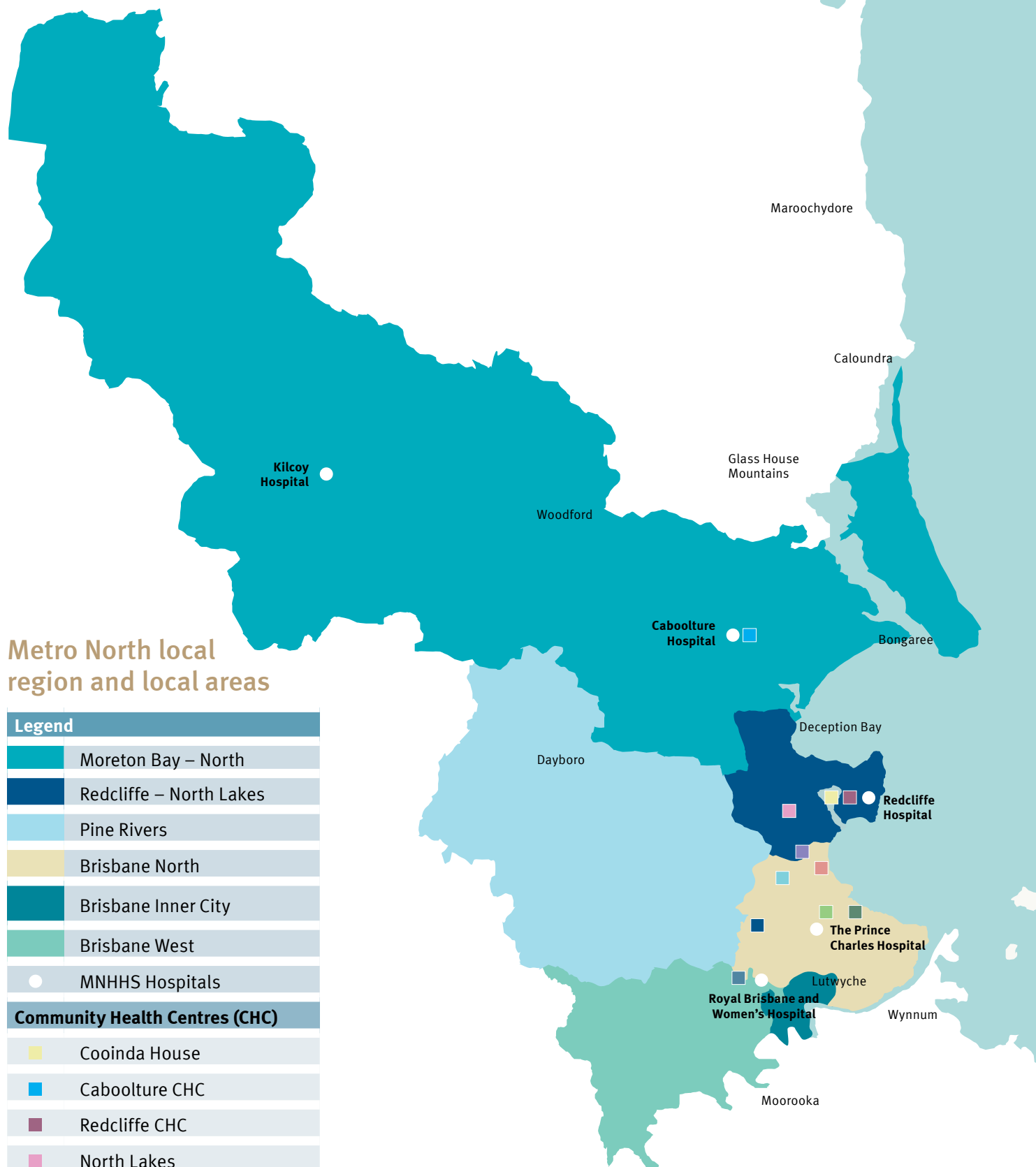
MNHHS is also home to a multi-culturally diverse community. People who were born overseas accounted for 22.1 per cent (189,128 people) of the total MNHHS population with the largest proportions residing in the RBWH and Redcliffe Hospital catchments.

It is estimated that 4.1 per cent of the MNHHS population are living with a profound or severe disability with highest rates recorded in the northern region of MNHHS. 10.2 per cent of the MNHHS adult population are providing unpaid assistance to people with a disability.

It is estimated that 14.3 per cent of the MNHHS population have mental and behavioural disorders and 10 per cent of adults are living with high or very high levels of psychological distress. Levels of distress are highest in the northern region of MNHHS.

MNHHS provides selected speciality services to a statewide population catchment. It is expected that by the year 2021 the Queensland population will have increased by 9.9 per cent to reach a total population of 5,250,292 people. Over the same time period the child population will increase by 8.8 per cent, while the older people population will experience significantly larger growth with a 24.1 per cent population increase.

MNHHS is home to many culturally diverse community.





**One in four adults
are classified
as obese**



**16.7% of adults
are current
smokers**



**5% of adults
consume alcohol at
levels of high risk**

Social determinants and health risk factors

Two in five MNHHS residents live in areas considered to be least disadvantaged and almost one in eight people reside in areas considered most disadvantaged. There are defined pockets of socioeconomic disadvantage within MNHHS, many of these are located in the northern region of MNHHS.

In MNHHS:

- one in four adults are classified as obese,
- 16.7 per cent of adults are current smokers,
- 5 per cent of adults consume alcohol at levels of high risk,
- almost half the adult population in MNHHS suffer from a long term health conditions.

Mental disorders, diabetes and nervous system and sense organ disorders are the largest causes of illness with cardiovascular disease, cancer and unintentional injuries the largest causes of death.

Service activity and trends

As the population grows and increasing chronic disease and ageing of our population continues, so will the demand on health services.

Emergency presentations

In 2015–16 there were over 280,000 emergency department (ED) presentations in MNHHS hospitals, a 4.9 per cent per annum increase from 2013–14.

Emergency department presentations are expected to increase 3.2 per cent per annum

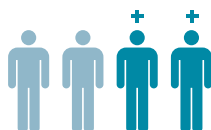
to almost 340,000 presentations by 2021–22. The highest growth in emergency department presentations is expected in the older population.

Growing demand for services

In 2015–16 there were over 230,000 admitted separations in MNHHS public hospitals, a 7.9 per cent per annum increase from 2013–14.

Admitted public hospital separations are expected to increase 2.9 per cent per annum to over 274,000 admitted separations by 2021–22.

The highest growth in public hospital admitted separations is expected in the older population. In 2015–16 people aged 65 years and over represented approximately 13.5 per cent of the MNHHS population but accounted for 34.4 per cent of total admitted public hospital separations for MNHHS residents.



**Almost half the adult
population in MNHHS
suffer from a long
term condition**



**ED presentations are
expected to increase
3.2% per annum by
2021–22**



**In 2015–16 there
were over 230,000
admitted separations
in MNHHS public
hospitals**



2,360 MNHHS residents access Hospital in the Home

8,800 MNHHS residents were referred to post acute care following a hospital admission

In 2015–16 MNHHS residents that identified as Aboriginal and Torres Strait Islander represented 2.2 per cent of the population and 3.5 per cent of total admitted public hospital separations.

Growth in hospital admissions for Aboriginal and Torres Strait Islander people was 11.8 per cent per annum since 2013–14 compared to 7.7 per cent growth per annum for non-indigenous people.

Access

MNHHS residents use of public hospital services is increasing. In 2013–14 admitted public hospital separations accounted for 48.4 per cent of total separations (public and private hospitals) and is expected to increase to 50.9 per cent of total separations by the year 2021–22.

Residents of the northern region of MNHHS were more likely to utilise public hospital services than residents of the southern region. In 2015–16, 66.1 per cent of separations for residents of the Redcliffe Hospital catchment

and 65.1 per cent of separations for residents of the Caboolture Hospital catchment were in a public hospital. In contrast, 48.3 per cent of separations for residents of TPCCH catchment and 33.9 per cent of separations for residents of the RBWH catchment were in public hospitals.

52.4 per cent of all admitted hospital separations were elective admissions with 47.6 per cent emergency admissions in 2015–16. RBWH had the highest percentage of elective admissions (70.9 per cent) while Caboolture Hospital had the highest percentage of emergency admissions (73 per cent).

Over 11,000 patients visited more than one MNHHS hospital in 2015–16.

MNHHS residents are also utilising community services. In 2015–16, 2,360 residents accessed Hospital in the Home to complete their admission in their own home and approximately 8,800 residents were referred to post-acute care after their hospital admissions.

Almost 6,400 residents undertook an Aged Care Assessment and of those 580 older people were supported through community transition care and 1,780 were supported through residential transition care. In 2016, 493 MNHHS residents that identified as Aboriginal and Torres Strait Islander were referred to community services, creating 9,600 occasions of service.

Patient flows

MNHHS hospitals largely provide care to residents of MNHHS. Approximately 87 per cent of hospitalisations were for MNHHS residents in 2015–16.

15.7 per cent of MNHHS public separations were for residents of other HHSs in 2015–16. The number of separations for residents of other HHSs has decreased from 18.7 per cent in 2011–12 to 15.7 per cent in 2015–16.

25 per cent of outpatient occasions of service were residents of other HHSs in 2015–16 – an increase from 22.4 per cent in 2013–14.



MNHHS resident's use of public hospital services is increasing



Our challenges

The refreshed Strategy has been prepared within the context of a range of challenges. These include:

Changing community expectations

Increasingly consumers expect to receive more timely and individualised care. Patients more than ever before have access to information about their illness and treatment options. They have views on their healthcare including what is reasonable in terms of access, safety and outcomes.

Determinants of health contribute to poor health status

There are great variances in the health and well-being of our diverse culture, population influenced by where people live, work and go to school, age, gender, social connectivity, environment factors and finances. This combined with limited access to local health services contribute to poorer health status.



The northern region of MNHHS has higher levels of socioeconomic disadvantage, limited access to general practitioners, and many patients have more than one illness requiring more complex care, all of which are placing a higher demand on services.



Lifestyle factors contributing to disease burden

Lifestyle factors are significantly increasing the risk of disease burden. While some risk factors such as smoking rates have decreased in recent years, lifestyle-related factors including inadequate physical activity, continued promotion and sale of products harmful to health, inadequate nutrition, obesity, alcohol and drug consumption and sun exposure will continue to have an impact on increasing disease prevalence in MNHHS.

Growth and ageing population

Meeting the demand of a growing and ageing local, regional and statewide population will continue to put pressure on MNHHS health services.

Population diversity

MNHHS is home to a diverse population including people with disabilities, Aboriginal and Torres Strait Islander communities, and people from culturally and linguistically diverse communities. Ensuring all populations receive equitable, accessible and culturally appropriate services is challenging, with many people from diverse communities less likely to access services, often resulting in poorer health outcomes.

Rising rates of chronic disease

Chronic disease rates including mental health, diabetes and respiratory disease are increasing. This combined with an ageing population in MNHHS will continue to impact on service demand.

Access and health need

The geographic distribution of health services is no longer in line with population health needs. The health status of MNHHS residents varies significantly across our hospital catchment areas. The northern region of MNHHS has higher levels of socioeconomic disadvantage, limited access to general practitioners, and many patients have more than one illness requiring more complex care, all of which are placing a higher demand on services.

Service connectivity

The connectivity between our MNHHS services together with our connectivity with primary care and other community providers is inconsistent. Poor service system connectivity impacts on the ability for the right care to be provided in the right setting at the right time, creating gaps for patients, inefficiencies and barriers to access, influencing health outcomes.

Changing service delivery models

The service system is slow to respond to changing service delivery models, for example moving from hospital to ambulatory, community and home based service settings, changing workforce capability and introducing new technology to manage demand pressures on acute services.

Increasing service capacity and capability in regional HHSs

Wide Bay, Central Queensland and Sunshine Coast HHSs will continue to increase capacity and capability of health services available locally. As a result, patients who once may have accessed services in MNHHS will receive more of their care closer to home. Referral to RBWH and TPCCH for highly specialised and complex care will continue. This changing service profile will result in MNHHS seeing fewer patients requiring lower-level care and growth in the number of patients requiring higher acuity treatment, impacting the MNHHS case-mix profile.

Funding environment is complex

All levels of government together with private health insurers contribute to the delivery of healthcare across Brisbane North. This complex funding environment results in different funding priorities resulting in barriers to delivering coordinated and integrated care.



Outcomes

Through listening to our staff, consumers, community and healthcare partners, together with a review of determinants of health and wellbeing, current and projected service activity data and literature, we aim to achieve the following outcomes through implementation of the refreshed Strategy:

- equity of access and improved health outcomes for all patients, particularly those with complex health and social support needs;
- patients, families and carers are empowered to take an active role in managing and improving their health;
- the highest standard of care centred around individual needs and preferences that offer the best possible patient experiences as close to home as clinically appropriate whilst supporting efficient service delivery;
- care that is connected, coordinated, integrated and promotes continuity, making it easy for patients to navigate the system;
- an empowered, compassionate and engaged workforce
- a culture of connectivity, cooperation and working collaboratively with the wider care provider system
- evidenced-based practice in all aspects of healthcare;
- staff who are engaged in research, innovating and using technology to improve patient and carer experience and outcomes;
- one health service, with multiple facilities and community based services working towards the one goal of high quality, integrated and compassionate care for people.



Focus areas

To ensure MNHHS is well placed to respond to the needs of our population to 2020 MNHHS has refreshed the five prioritised strategies documented in our current Strategy to four focus areas.

Shaped by feedback received from our staff, consumers, community and healthcare partners, the refreshed focus areas reinforce MNHHS's commitment to supporting our population to remain healthy and well in their local communities whilst enabling them to connect with efficient, effective, equitable, sustainable high quality healthcare centred around individual needs and preferences. Our commitment to being an innovative world leader in clinical care, research and education is also reinforced.

Our refreshed focus areas include:



Living healthy and well in our local communities



Delivering person-centred, connected and integrated care



Effective delivery of healthcare to address growing population health needs



Responsive holistic healthcare that meets the specific needs of vulnerable groups including but not limited to:

- older people including frail older people
- children
- young people
- people with mental illness
- people with alcohol and other drug dependence
- people with disabilities
- Aboriginal and Torres Strait Islander people
- culturally & linguistically diverse communities.



These focus areas are interconnected. Over the next three years we will need to balance our efforts to ensure our current and future skills and resources align with our focus areas.

Each focus area describes the key strategies and priority actions MNHHS will focus on for the next three years. Performance measures will enable monitoring progress towards achieving key strategies over the life of the refreshed Strategy.



Living healthy and well in our local communities

We will work collaboratively to support health and wellbeing within our local communities, empowering people to live healthy and active lives.

Health and wellbeing is a complex combination of a person's physical, mental, emotional, social and environmental health factors. There are many ways that we can encourage people in their community to live healthy lives, and move beyond simply treating disease after it occurs. Enhancing our efforts in prevention, earlier diagnosis and innovative treatments mean we have a realistic opportunity to improve quality of life and survival.

Given that a significant proportion of burden of disease is avoidable, it is important MNHHS works in partnership with other organisations delivering health and community services to address the broader health needs of people who live in Brisbane North. Working together to improve the health of our communities may affect demand pressures facing the primary, community and secondary health service system and work towards addressing the wider determinants of health.

MNHHS has a particular part to play in managing and reducing the impact of existing disease or injury, as well as in advocating with other agencies in all aspects of prevention. MNHHS's role in

improving health and wellbeing is through promoting health messages, empowering people to engage in healthy behaviours, supporting healthy environmental design, providing immunisations, supporting screening programs for disease and environmental testing.

The ability to understand the health system is influenced by educational and social circumstances. MNHHS, in conjunction with primary care, has a direct role in improving the health literacy of people who live in Brisbane North to support people to better manage their own health, navigate the health system, communicate with health providers, manage their illness and to be empowered to make informed choices and decisions.





Key strategies

1. Embed inclusiveness and health literacy in service delivery and support staff to encourage health promoting behaviours at every opportunity.
2. Collaboratively work with partner organisations (e.g. general practice, local governments, schools and community groups) to improve health literacy and encourage healthy behaviours.
3. Model healthy behaviours within our hospitals and facilities (e.g. no smoking, healthy food options, encourage public and active transport use) and make healthy choices easy.
4. Address priority health areas including cancers, cardiovascular disease, mental illness and musculoskeletal conditions, with a prevention and early detection focus.
5. Provide faster access to tests and results to enable timely diagnosis and treatment.

What we will do:

- Increase health literacy and inclusiveness training for staff to improve the way knowledge is shared and acted upon.
- Work with partners to develop initiatives to improve health literacy including the development of patient and carer portal to access information regarding healthy behaviours, health conditions and services.
- Support carers to stay healthy and well through promotion of health checks, flu vaccination providing the timely access to information, support and advice.
- Advance local promotion of State health promotion campaigns including (not limited to) *My health for life* campaign.
- Develop volunteering opportunities within MNHHS, in partnership with community organisations to support active citizenship and social inclusion and make our health campuses vibrant, inclusive and culturally diverse.
- Work with partners to improve access for all people to screening programs for common diseases and conditions including diabetes, kidney failure, heart disease, cancer, stroke and mental illness.
- Engage with patients who are obese and/or smoke and/or have high alcohol consumption— assess the patient's readiness for change, provide advice and refer to support programs.
- Ensure MNHHS premises enable healthy food and drink options for staff, visitors and patients as the easiest option.
- Expand evidence based diagnostic and investigation services within MNHHS services and with partners including (not limited to) clinical measurements, pathology and medical imaging services to support timely diagnosis and treatment.

We will measure:

- The number of staff completing training that includes health literacy principles and practices
- Participation of eligible residents in screening programs for identified priority health areas
- The number of potentially preventable hospitalisations.



Delivering person-centred, connected and integrated care

Person-centred care

Partnering with patients (and carers and families) to deliver responsive, respectful, tailored holistic care

Connected care

Primary, acute and community care services work together throughout the patient journey

Integrated care

Seamless care that reflects all aspects of a person's health, both physical and mental

We will provide a comprehensive person-centred health system that is connected and integrated. The system will be easy to navigate and enable delivery of care that is integrated throughout the patient journey.

“People want services to work together to provide them with person-centred coordinated care”.

Over the next three years of the refreshed Strategy, MNHHS will move away from providing episodic care and will move towards a more holistic approach to healthcare that puts the needs and experience of people (patients, families and carers) at the centre of how services are organised and delivered. Understanding and receiving feedback on what is important to patients, their family and carers will continue to be pursued. Building on the patient and carer experience approach to understand what is important to patients and carers, MNHHS will be able to continue to improve service provision.

MNHHS is made up of geographic catchment areas with a natural population connection to HHSs. These geographic areas will be used to develop a population approach to planning and delivering care that focuses on health needs and enables

relationships to be established with patients, community and healthcare partners. To partner with others on joint services or formalising patient pathways takes time, capacity, strong relationships and commitment from all parties. Sharing ideas, outcomes, resources and recognition are essential to working together to achieve collective impact and deliver healthcare that is integrated for consumers and provides people with the services they need, in the right place, at the right time.

As MNHHS is a significant provider of specialist quaternary and tertiary services to Queensland, we will also continue to connect care and build stronger relationships within the patient's home HHS to support seamless transitions of care as well as safe and appropriate care for patients close to home.



Key strategies

1. Empower people to participate in their own care supported by their networks of family, friends and community.
2. Listen to people, value their contribution and use the information to make improvements to our care.
3. Plan, commission and deliver health services based on local health needs collaboratively with staff, patients, consumers, and health and social care partners.
4. Develop connected systems and support functions that are responsive.

What we will do:

- Build on work undertaken to date, to educate, inform, support and communicate clearly with patients, carers and family to enable an active role in managing their health condition and/or improving their general health and wellbeing.
- Promote care coordination/navigation roles throughout MNHHS, building on those already in place, to assist patients and carers in understanding and traversing the healthcare system.
- Continue to increase patient, consumer and community engagement through:
 - » asking what is important to patients, families and carers
 - » adopting a “nothing about us, without us” approach
 - » including patients, families and carers in care, service redesign and continuous improvement
 - » communication of engagement feedback and how MNHHS will use the feedback to improve care.

- Increase education and training resources to enable person-centred connected care to be embedded into normal operational business.
- Establish the Brisbane North and Moreton Bay Health Alliance including collaborative space, where the local health sector can come together and develop a shared understanding of the problems, and generate workable solutions that improve patients’ experiences and outcomes.
- Forge stronger links with partners building a culture of trust and respect to deliver integrated person-centred care. This will be supported through incentive approaches e.g. enhanced leading innovation through networking and knowledge sharing (LINK) program
- Develop and document an increased range of evidence based integrated care pathways across the care continuum for common patient journeys inclusive of those that cross HHSs.
- Pursue digital technologies that assist with seamless care.

We will measure:

- The number of consumers and community members participating in significant service planning, service redesign/design and evaluation processes
- The number of joint initiatives of the Brisbane North and Moreton Bay Health Alliance
- The uptake of integrated care pathways
- The utilisation of telehealth services
- The number of patient experience surveys completed and achieve 90% rating or above for the eight CaRE survey core domains across Metro North.



Effective delivery of healthcare to address growing population health needs

The delivery of healthcare will be innovative, evidence-based and add value to MNHHS operations with the aim of reducing inefficiencies and ensuring that services are provided at the right place at the right time to support growing population health needs.

The population cared for by MNHHS is continuing to grow and age, while the prevalence of chronic disease also continues to increase. This causes demand for health services to continue to increase and exceed supply. As one of the largest HHSs in Queensland providing tertiary and quaternary

hospital services, world leading education and research, and regional hospital services together with a comprehensive range of community services, MNHHS is well placed to respond to these demand pressures.

Responding to such demand pressures will require service redesign, expansion of clinical services and continued planning for new facilities to meet current and projected needs. We need to ensure additional services are the right services and are provided in the right place, in the right service settings at the right time. Maximising the utilisation of current infrastructure will also enable some services currently provided on hospital campuses to be reorientated to be delivered in community.

We recognise demand for health services is not uniform across MNHHS. Our commitment to improving healthcare access for the northern region of MNHHS remains. We will continue to pursue innovative models of care and service solutions to support patients to have improved access to high quality care locally. We are also actively advocating and planning for new infrastructure to support current and projected service demand.

Continuing to seek innovative and evidence-based solutions is vital to providing a health service that is efficient and effective and represents good value for money. New innovations allow us to reduce inefficiencies in our operations and do things better.





Key strategies

1. Improve timely access to the right care at the right time in the right place through advancing care out of the traditional hospital setting and into community and home-based alternatives.
2. Improve access to services as close to home where safe, efficient and effective to do so.
3. Deliver evidence-based care that is high value, improves patient outcomes and is resource effective.
4. Continue to deliver exceptional specialist tertiary and quaternary services.
5. Advocate and plan for new facilities to support growing population health needs.
6. Actively pursue early adoption of new innovations and technologies.

What we will do:

- Reorientate community service provision to focus on rapid response, rehabilitation and restorative care.
- Work with primary care and community organisations to enable timely follow up care post discharge particularly for at risk population groups.
- Work with Queensland Ambulance Service, general practice and other primary care providers to provide more flexibility for ambulance services to decide how patient care should be developed, including alternatives to transferring to hospital.
- Strengthen support to residential aged care facilities to ensure they have direct and timely access to clinical advice, including appropriate on-site assessment and treatment in place where appropriate.
- Separate emergency from elective surgery/procedures in dedicated facilities to improve timely access to services and theatre productivity.
- Reduce unnecessary variation in clinical practice to improve consistency of care while focussing on individual patient needs.
- Transition services that can be provided in the community or home-based setting rather than major hospital facilities.
- Optimise patient flow through the adoption of evidence based strategies including:
 - » early consultant assessment at all transition points
 - » more timely patient movement between hospital services
 - » adopting a 'discharge to assess' approach.
- Reorganise community health services to enhance care in the community, avoid emergency presentations where appropriate and support earlier transition from emergency departments and hospital inpatient beds.
- Increase capacity to deliver palliative care across settings.
- Increase high value and reduce low value healthcare through programs such as Choosing Wisely, e.g. reviewing appropriateness of certain procedures of questionable clinical value.
- Roll out new services/procedures, e.g. mechanical thrombectomy, live kidney donor renal transplant service, proton therapy to improve patients quality of life.
- Increase capacity to provide statewide and regional services for complex care patients from across MNHHS, Queensland and northern New South Wales.
- Advance innovations, e.g. biofabrication, biobanking, artificial intelligence, application of genomics to medicine to continue to improve healthcare.

We will measure:

- Wait times for specialist outpatient services
- The number of discharge summaries completed within 48 hours
- Access to local services for Caboolture and Redcliffe residents
- The number of patients discharged directly to Metro North community health services from the Emergency Department.



Responsive healthcare that meets the high health needs of identified groups

The health of high needs groups will be improved through the provision of care that is timely, targeted, accessible and coordinated.

This focus area aims to improve care and inclusiveness to our diverse community. Addressing the needs of those who have complex needs or experience poorer health outcomes in our communities is essential. Different expectations and experiences of health services exist and this is often culturally or socially determined. Engagement with high needs groups require identification of appropriate conduits or intermediaries to engage with consumers and communities. This requires tailored activities and targeted services.

We recognise there are many high needs groups across Brisbane North. Whilst MNHHS will focus on certain groups over the next three years, many strategies and actions will also be beneficial to other high needs groups.

High needs groups, for the purpose of this refreshed Strategy, are those that have complex care needs that require additional and/or specific care and include:

- older people including frail older people
- children
- young people
- people with mental illness
- people with alcohol and other drug addiction
- people with disabilities
- Indigenous and culturally diverse communities.

No one group has greater priority than any other.

MNHHS recognises the interdependency between health of the high needs groups and the social determinants of health including social connectivity, access to housing, employment, education and finance. Many high needs groups are also marginalised in one or more of the determinants of health. For this reason many of the actions within this focus area will only be successful if delivered in partnership with patients, families, carers and the broader health and social services sector.



Older people including frail older people

Older people including those who are frail are significant users of our health services. We know that older people are often admitted to hospital because of challenges in providing care in the community, that if provided early, may mean the older person would not need hospital care. Over the next three years we will work in

partnership with primary health and community organisations to support optimal older people care in the community. When older people do require care in the hospital setting we will provide best practice care tailored to the individual. We will undertake comprehensive and evidence-based screening, assessment,

early intervention and discharge planning commencing from time of admission aiming to prevent functional decline and loss of independence following an illness and hospitalisation. We will actively work with older people, carers and family to enable people to return home as soon as clinically appropriate with community service support if required.



Key strategies

1. Enable older people to be active, engaged and independent at home.
2. Implement evidence-based models of older people care that focus on improving healthcare and quality of life, and preventing functional decline through consideration of physical, psychological, emotional, and social needs.
3. Provide timely, responsive and high quality end of life care that is respectful and responsive to the social, emotional and spiritual needs of patients, families and carers.

What we will do:

- Work with partners to deliver coordinated integrated healthcare to enable older people to live well at home.
- Enable rapid response to the deteriorating patient in own home if possible.
- Introduce consistent comprehensive risk screening, frailty identification and care planning across MNHHS.
- Improve care coordination both within and between the hospitals and the community to enable older people to return home with the ongoing support they require.
- Identify those older people most at risk of deconditioning and frailty in hospital through frailty screening, consistent assessment and care planning.
- Implement evidence-based care pathways to improve the patient journey for people with delirium, dementia and frailty.
- Increase the use of shared care plans to improve communication and information exchange between providers, patients and families.
- Engage older people and their family/carers in care planning including discussion regarding Advance Care Plans.
- Increase timely referral to palliative to care to implement best practice care for people who are dying that is respectful and responsive to the social, emotional and spiritual care needs of patients, families and carers.

We will measure:

- Timely identification of people over the age of 75 who are frail
- Number of people over the age of 75 who are discharged to same address.

Children and/or young people

Supporting early childhood health and wellbeing, including a child's physical, cognitive, social and emotional development, is critical to achieve lasting benefits into adulthood. The benefits of early childhood intervention in health and social care are well documented. Timely early interventions for children and young people that are family

centred based in the community or in the home and focus on social, developmental, behavioural and health issues are recognised to have the potential to create long term health benefits and prevent diseases. Keeping children and young people well will be a priority for MNHHS particularly for those with complex and chronic care needs.

We recognise young people as a priority population and understand their specific needs as they transition to adulthood. We will support young people and their families providing holistic care across physical, cognitive, social and emotional development.



Key strategies

1. Enhance capacity of services to enable children and young people to have optimal health.
2. Children and young peoples health services in Metro North will be delivered through a networked, integrated and coordinated service system where care is provided as close to home as clinically appropriate in partnership with other children's health service providers including Children's Health Queensland.

What we will do:

- Increase child, young person and family awareness of disease and illness prevention, maintenance of wellbeing and healthy behaviours
- Enhance early assessment, identification and support of young people with a mental illness
- Enhance local capacity and capability of children and young people services across community, inpatient and outpatient settings of care to better meet demand.

We will measure:

- Access to children's services for MNHHS residents.

People with mental illness and/or alcohol and drug dependence

A recovery approach to care for people with mental illness will be a focus for MNHHS providing timely and coordinated care when needed. Our commitment to delivering care in the least restrictive environment remains—recognising some patients are admitted to hospital or remain in our hospital when they could be better supported in the community.

We understand many people with alcohol and other drug dependence also have a mental illness. Effective coordination of services will be enabled for people with comorbid mental health and alcohol and drug issues as well as for those who experience comorbid physical health issues.

Further, guided by advice from consumers and partner organisations, we acknowledge people with alcohol and other drug dependence are vulnerable and complex and recognise the need for specific strategies complementary to those identified for people with a mental illness.



Key strategies

1. Be leaders in delivering evidence based quality care to people with mental illness and/or alcohol and other drug dependence.
2. Increase access to recovery focused mental health and alcohol and drug services available in MNHHS.
3. Elevate the focus on physical health, psychological and social wellbeing to support consumers and carers in their recovery journey.
4. Work with partners to increase and facilitate access to a broader range of whole of life services, including community based alternatives to hospital admission and provision of meaningful vocational opportunities.

What we will do:

- Provide alternatives to hospital admission and support recovery of consumers through additional step up/step down facilities across MNHHS.
- Build on existing relationships with emergency services in joint responses to people who may be at risk/in crisis, including co-responder models, implemented in priority areas of need.
- Collaborate with partners to develop and implement service models and

associated care pathways for inpatient services that meet the needs of older people with a mental illness who have sub-acute care needs.

- Strengthen community resources particularly in the northern part of MNHHS to improve service responsiveness to people with mental illness and people with alcohol and other drug dependence.
- Expand perinatal mental health services across specialist community and inpatient services.
- Collaborate with partners to grow capacity and capability of alcohol addiction services

including alcohol withdrawal management for adults and young people.

- Improve governance, accountability, responsibility, fund holding, and service delivery arrangements for child and youth community health and mental health services across MNHHS in collaboration with CHQ.

We will measure:

- Access to services delivered in the community setting.

People with a disability

Some people with a disability often have diverse, complex and unique health, social and emotional needs. For people with a disability that are accessing health services MNHHS will work to develop care pathways that improve the patient journey to enable care to be provided in the most appropriate setting. Effective care coordination across providers is essential to keep people with a disability healthy and well. We will work to increase the use of shared care plans to improve communication and information exchange between providers, patients and families.



Key strategies

1. Empower people with disabilities that are accessing health services to be active participants in their healthcare.
2. Deliver holistic, individual, tailored, coordinated and integrated care for people with a disability that are accessing health services and their carers.
3. Deliver equitable, accessible, safe and respectful care for all people with a disability that are accessing health services across MNHHS service settings

What we will do:

- Increase health literacy resources targeted to people with a disability that are accessing health services that to enable people to be empowered to participate in their care and to feel comfortable sharing information about their care needs, condition management and health goals.
- Implement evidence-based care pathways to improve the patient journey for people with disabilities.
- Increase the use of shared care plans to improve communication and information exchange between providers, patients and families.
- Enhance workforce capabilities to provide evidence-based patient-centred care for people with a disability, intellectual disability and complex care needs.
- Partner with people with disabilities, families and carers, and other support agencies to jointly plan, design and deliver health services sensitive to the needs of people with a disability.
- Develop systems, processes and pathways to enable people timely access to National Disability Insurance Scheme funding to support care.

We will measure:

- Participation of people with a disability and their carers in planning, delivering and evaluating health services.

Aboriginal and Torres Strait Islander peoples

MNHHS is committed to working in partnership with our Aboriginal and Torres Strait Islander peoples to improve health outcomes. Due to a range of determinants, Aboriginal and Torres Strait Islander people and communities often experience poorer health outcomes. Building a culturally capable service system is critical to improving the health and wellbeing of Aboriginal and Torres Strait Islander people.



Key strategies

1. Work with Aboriginal and Torres Strait Islander to plan, design and deliver health services.
2. Deliver holistic, comprehensive and culturally responsive health services.

What we will do:

- Build relationships with our Aboriginal and Torres Strait Islander communities and peak organisations to jointly plan, design and deliver services that reflect local health needs
- Provide culturally aware inclusive service environments that are spiritually, socially and emotionally safe, as well as physically safe for people, where there is no challenge or denial of their identity, of who they are and what they need emotionally safe, as well as physically safe for people, where there is no challenge or denial of their identity, of who they are and what they need
- Continuously improve culturally and capable staff including communication, training, education and awareness through an increased focus on Aboriginal and Torres Strait Islander communities
- Develop a Reconciliation Action Plan which will provide a framework to create and realise a shared vision for reconciliation. The plan will be built on relationships, respect and opportunities and designed to create health and social well-being and opportunities for new ways of working to close the gap in healthcare for Aboriginal and Torres Strait Islander people.

We will measure:

- Increase the number of Aboriginal and Torres Strait Islander communities participating in significant service planning, service redesign/design and evaluation processes

Culturally and Linguistically Diverse Communities

Metro North HHS is home to many diverse communities, including many Culturally and Linguistically Diverse communities (CALD). Enhancing our cultural capability to be leaders in delivering respectful, holistic and appropriate health services across home, community and hospitals settings will continue. Working together with people from diverse communities we will develop local innovative evidence-based solutions to deliver responsive health services



Key strategies

1. Work with CALD to plan, design and deliver health services.
2. Deliver holistic, comprehensive and culturally responsive health services.

What we will do:

- Build relationships with our CALD communities and peak organisations to jointly plan, design and deliver services that reflect local health needs.
- Provide culturally aware inclusive service environments that are spiritually, socially and emotionally safe, as well as physically safe for people, where there is no challenge or denial of their identity, of who they are and what they need.
- Continuously improve culturally and capable staff including communication, training, education and awareness through an increased focus on CALD communities.

We will measure:

- Increase the number of CALD communities participating in significant service planning, service redesign/design and evaluation processes

What's next

MNHHS is committed to implementing the refreshed Strategy over the next three years. The refreshed Strategy will guide the health service priorities of the MNHHS Clinical Directorates and Clinical Streams, and will be integrated into local clinical service plans and operational plans.

Key strategies were prioritised based on available information regarding the prioritised health needs, ability to redesign services and the ability to resource or negotiate for resources. Some key strategies will require resourcing over time through normal organisational budgetary processes.

Monitoring, reporting and review

The Strategy will be monitored and reported on an annual basis (end of financial year). These processes will allow changes in health needs or service developments during the implementation of the Strategy to be identified and ensure the Strategy can be reviewed and updated if required.



