A five year health care plan for older people who live in Brisbane North | 2017-22

Brisbane North PHN and Metro North Hospital and Health Service

The five year health care plan for older people who live in Brisbane North is a partnership between Metro North Hospital and Health Service and Brisbane North PHN. This activity is supported by funding from the Australian Government under the PHN Program.

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A note to our future health care providers

Below is a letter from Cecil and Gilbert who are older residents of Brisbane North.

Our life as we know it could change tomorrow, it could change in the next hour and some of us already know that the end of life is looming. Going to the bathroom, taking out the rubbish and getting to appointments are all getting harder, and we may not always understand technology or your technical jargon. We've talked to friends and we all agree, we may be older but we want the same things as everyone else. We come to hospital to get better. We expect to leave hospital feeling better. When it is all over, we hope to be able to say, 'well that wasn't so bad after all' and we trust you to help us achieve this.

Because we are older you try to be kind, but when you ask us, 'how are you today?' there is a tone in your voice. We have experience of life, have wisdom in many areas and do not like to be treated like children. We want to be able to ask questions, get proper answers and not be fobbed off, so that we can be clear to make a choice and come to a decision for ourselves. Treat us with respect and please don't talk down to us. When we are trying to tell you that we have a pain, but you can't see anything wrong, listen to us, take things seriously and properly check it out - it's not always, 'just a touch of arthritis'.

In hospital we want to feel safe. We worry, are we going to get the right treatment? We hear about people who contract a disease from the hospital and die? It's always at the back of our minds. We want reassurance. We want to be safe from people running around who might cause trouble, safe from attacks. And it might sound silly, but if you have to get something serious done and you don't know if you are going to come out, we need to know that our possessions are there and that they are safe.

Going home from hospital there is the fear of the unknown. Understand that we are looking for the situation to be the way it was before and can feel a sense of impatience that we have to depend on others. Most of all we need to know some-body cares and if we need more help when we leave hospital we don't want to be forgotten. Give us hope but not false hope

It's good to have the family support; the family can make it okay, you can tell them things, they can remind you but they can also forget and some of us don't have family to talk to. We find it difficult to ask for help, sometimes we aren't always truthful about how we feel or we tell you what you want to hear. Living alone isn't for everyone, we can hide how we feel, we can hide how much we are grieving so, look out for the signs.

When we leave hospital we want to know about our follow up treatment, know our options and make a choice. When we are followed up at home by somebody who's been involved it makes us feel like somebody actually cares. It reassures us that it is going to be okay and that we are coping and treating ourselves properly. When somebody cares enough to look after you it makes you feel like it is worthwhile living.

To Cecil and Gilbert,

We sincerely thank you for taking the time to share your life experiences in a way that has given us insights about what is important for older people.

Forward

Shaun Drummond

Abbe Anderson

Joint message from Metro North Hospital and Health Service Chief Executive and Brisbane North PHN Chief Executive

With a growing, ageing population it is our duty to ensure that we tailor our approaches when it comes to understanding the health needs and requirements of older people in our community.

Brisbane North is one of the most populous and fast-growing areas in Queensland. It is home to a diverse and growing community aged 65 and over, many of whom are living longer and enjoying a healthier and more independent old age than ever before. Equally, a growing number of older people are presenting more often to health care providers with complex co-morbidities.

This document is at once a plan and a vision, fully endorsed by the Metro North Hospital and Health Service and Brisbane North PHN, which will guide the way we deliver health care services to this group of people in our community. It is not the last word, but a document that will allow the vision to expand and grow.

Ageing is a natural part of life, which is influenced by a range of environmental, social and behavioural factors. Our research is showing that the health care requirements of older people are often complex. There is the likelihood of multiple chronic illnesses, frailties and disabilities that impact not only on the patient and their families, but on service providers as well.

Over the next five years, a coordinated, networked service system will evolve to help as many older people as possible to remain in their home environment, connected with their communities and supported by general practice and other community services.

One of the aims of providing this focused community care is to reduce the number of patients requiring prolonged acute care or hospitalisation.

The plan will ensure these people get access to a range of timely and appropriate health care services in their local communities. When they require acute care, appropriate back up services will be available so they can return home from hospital as soon as it is clinically safe to continue their healing and rehabilitation.

This is an inclusive plan involving not only health care providers but also patients and their families, community organisations and other stakeholders who will help keep our older population engaged, healthy and connected to their community.

It is our pledge that we will work together to implement this plan over the next five years to improve the coordination, integration and provision of care services to support the health and wellbeing of older people to help them stay healthy and at home.

Shaun Drummond
Chief Executive
Metro North Hospital and Health Service

Abbe Anderson
Chief Executive
Brisbane North PHN

How to read this plan

Working in partnership, Brisbane North PHN (the PHN) and Metro North Hospital and Health Service (MNHHS) have developed a five year plan for the health care of older people who live in Brisbane North (this Plan). Informed by the **PHN Annual Plan** and **MNHHS Strategic Plan 2017-22** and associated **Health Service Strategy 2015-2020** this Plan describes ambitious directions and actions to enhance the health care system to better support the needs of older people who access health care services in Brisbane North. This Plan has been prepared in three parts:

- **Part A: The health care plan** – presents the future directions, success measures and supporting actions that will guide service delivery and enhancement for older people over the next five years.

The directions reflect the PHN and MNHHS commitment to:

1. Delivering tailored person-centred care to older people who live in Brisbane North.
2. Growing a connected and integrated health care service system that delivers local care wherever possible.
3. Supporting older people to stay healthy, well and independent.
4. Providing older people with access to high quality care in our hospitals.
5. Caring for older people with specific needs.
6. Advancing continuous improvement in the care of older people.

- **Part B: Context and background** – describes the background information that was analysed and informed the development of the future directions contained in Part A. Information described in Part B includes the policy context, current service arrangements, a review of the population and health status of older people who live in Brisbane North together with a summary of the issues and challenges facing the current service environment.
- **Part C: Implementation, monitoring and review** – details the implementation, monitoring and review process that will be implemented on approval of this Plan.

For the purpose of this plan, older people are defined as 65 years of age and over and people who are Aboriginal and Torres Strait Islander persons aged 50 years and over.

Ten key facts regarding health in Brisbane North

Population and health status

1

AVERAGE LIFE EXPECTANCY

80.7 years

84.5 years

2

In 2014-15 approximately **one in three Australians aged 65 years and over** reported having three or more chronic diseases, compared with just 2.4 per cent of those under the age of 45 years

1 IN 3 AUSTRALIANS AGED 65 YEARS AND OVER HAVE 3 OR MORE CHRONIC DISEASES

65 years and over

3

By 2026, the older person population will **increase by 44 per cent**, a rate significantly higher than the general adult population which is expected to increase by 12.9 per cent

Primary care

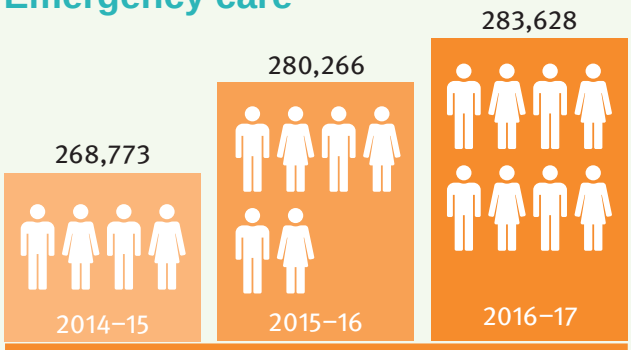
4

GP HEALTH ASSESSMENTS

16% increase in GP health assessments since 2012-13

The highest proportions were provided in Redcliffe, Chermside and Caboolture statistical areas.

Emergency care



FAST FACTS AS AT 30 JUNE 2017

5

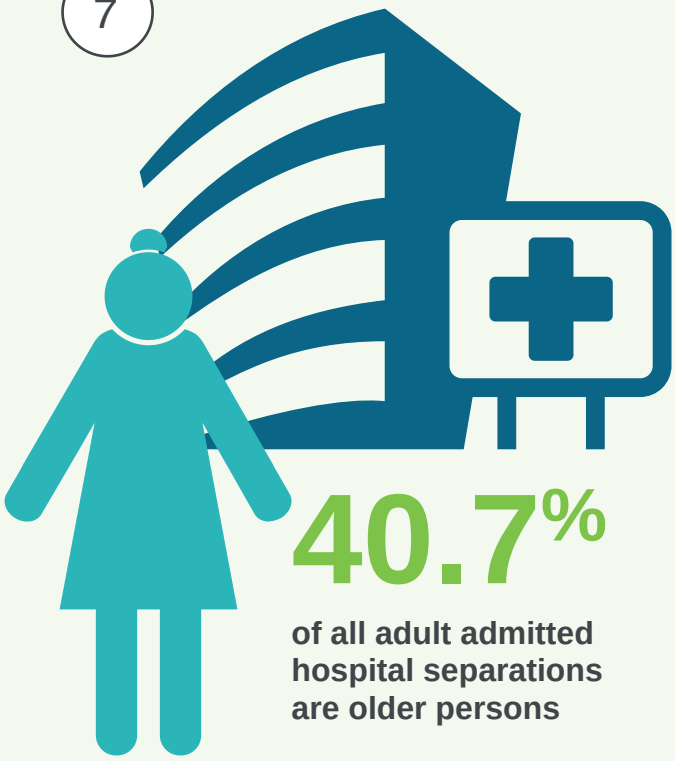
Increase of **3,362** ED Presentations

6

Increase of **3,659** ambulance arrivals

Hospital care

7



40.7%

of all adult admitted hospital separations are older persons

Aged care

9

NUMBER OF AGED CARE PLACES

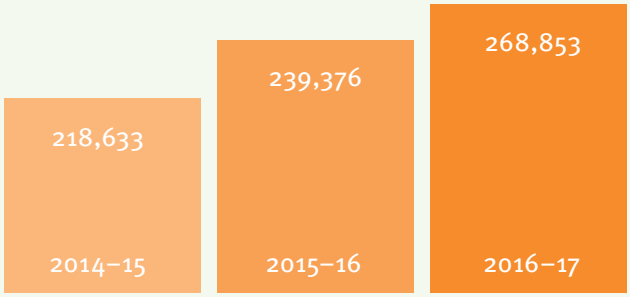
Higher

than national rates

8

12.3% more

hospital admissions



10

Between 2012 and 2015 there were over **280,000 GP services** delivered in residential aged care in the region

RESIDENTIAL AGED CARE

280,000

GP services delivered

Part A: The health care plan

Introduction

Why does Brisbane North need a plan to support the health care of older people?

Brisbane North is one of the most populous health catchments in Queensland with a population of over 957,000 people. It covers an area of around 4000km^2. The catchment includes urban and regional communities crossing the local government areas of Brisbane City northern suburbs, the whole of Moreton Bay Regional Council and parts of Somerset Regional Council. Brisbane North is home to a diverse community that is growing and ageing rapidly. Population projections indicate that people aged over 65 years will increase by almost four per cent per annum over the next five years, with people aged 75 years and over increasing at the fastest rate.

Most older people who live in Brisbane North are living longer, healthier and more independently than the previous generation, however, with a growing and ageing population, Brisbane North health care providers are seeing an increasing number of older people presenting for health care. Many older people receiving care have complex conditions and in many cases, more than one complex condition—referred to as co-morbidities. Likewise many older people accessing health care are frail and are vulnerable to rapid deterioration of health.

Whilst Brisbane North has a comprehensive range of public, private and non-government health and aged care services available, the services are not distributed equally and the mix and breadth do not always align with local health need.

The Brisbane North service system is challenged by increasing demand for services, competing policy reform agendas, different funding models, poor service relationships, service duplication, service fragmentation and increasing costs.

Figure 1: Brisbane North

Figure 2: Brisbane North Service System Summary Diagram

What is the scope of this Plan

Recognising the benefits of working together across primary care, community and hospital service settings the Health Care Services Plan for Older People (this Plan) has been prepared as a partnership between the PHN and MNHHS. The scope includes health and aged care services delivered in Brisbane North across the health continuum. For the purpose of this Plan older people are defined as people aged 65 years and over and people who are Aboriginal and Torres Strait Islander persons aged 50 years and over.

What do we hope to achieve?

This Plan aims to communicate getting older is not a disease—it is part of our natural life course. It recognises ageing occurs at different rates and that our health is strongly influenced by our behaviours and environments. This Plan is an ambitious five-year plan to integrate and coordinate the health services system in Brisbane North that will enable older people to receive:

- **person-centred care**—older people, their carers and family will actively inform their care to improve quality of life
- **effective care**—evidence-based practices and systems will be delivered across service settings through strong relationships between providers
- **safe care**—there will be reduced care complications such as delirium, functional decline, falls, pressure injuries, and adverse drug events
- **integrated care**—high quality communication and referral processes will be established between services to support navigation for older people, particularly those who are frail and those with complex care needs
- **equitable and accessible care**—older people have equitable and timely access to evidence-based health care services
- **supportive care environments**—the physical environment of health care facilities will be older people friendly
- **efficient care**—wasteful practices and duplication of services will be minimised, leading to reduced inappropriate hospital presentations, optimised length of stay, and timely and durable care transitions
- **better care experiences** – older people and their carers and family are satisfied with the quality of care they receive.

How will we work together to deliver this Plan?

Recognising that the health care system for older people across Brisbane North is delivered by a diverse range of services, the following six principles have been developed as a framework to foster collaboration. It is proposed that the principles be used to inform the provision of health care for older people across Brisbane North, enabling the development of a service system that is integrated and delivers excellent care to older people, their family and carers. These principles have been informed by age friendly principles and practices for managing older people in the health care service environment developed by the Australian Health Ministers Advisory Council (2005) and stakeholder consultation. The six principles are:

1. **Value, respect and engagement**
   Older people are valued, respected and engaged in all aspects of their care. They are recognised as individuals inclusive of a diverse population who live in Brisbane North including Aboriginal and Torres Strait Islander people, and Culturally and Linguistically Diverse populations. All are empowered to make choices about their care and are engaged in the design, delivery, and evaluation of services.
2. **Partnerships with families and carers**
   Families and carers are recognised as critical partners in the care of older people and will be supported in their role.
3. **Optimising health and wellbeing through evidence-based holistic care**
   Care for older people is evidence-based, focused on improving health and wellness, improving quality of life, and preventing functional decline through consideration of physical, mental and social needs.
4. **Service cooperation**
   Services that deliver care for older people will promote relationships based on mutual cooperation to support older people's care coordination and service integration.
5. **Skilled and compassionate workforce**
   Services for older people are delivered by care providers with the clinical knowledge, skills (including skills required for effective teamwork) and values to care for older people.
6. **Leadership to maximise access and inclusion**
   Leadership will drive quality provision of services for older people across the care continuum, enhancing access and inclusion particularly for the most vulnerable and disadvantaged.

The future health care service system for older people in Brisbane North in 2022

Brisbane North health care services will lead the way in caring for older people

Older people who live in Brisbane North will be amongst the most healthy, well and independent in Australia. General practice, health care providers, community organisations and all levels of government will work together to support older people to maintain healthy lifestyles, stay socially connected, as well as be informed about and have access to timely and appropriate health care.

Older people will be respected and valued, empowered to be active participants in their health and health care. Across the service system older people, their carers and family will be provided with education, information and support to empower them to be partners in decisions that contribute to their health, wellness, their care needs and treatment options.

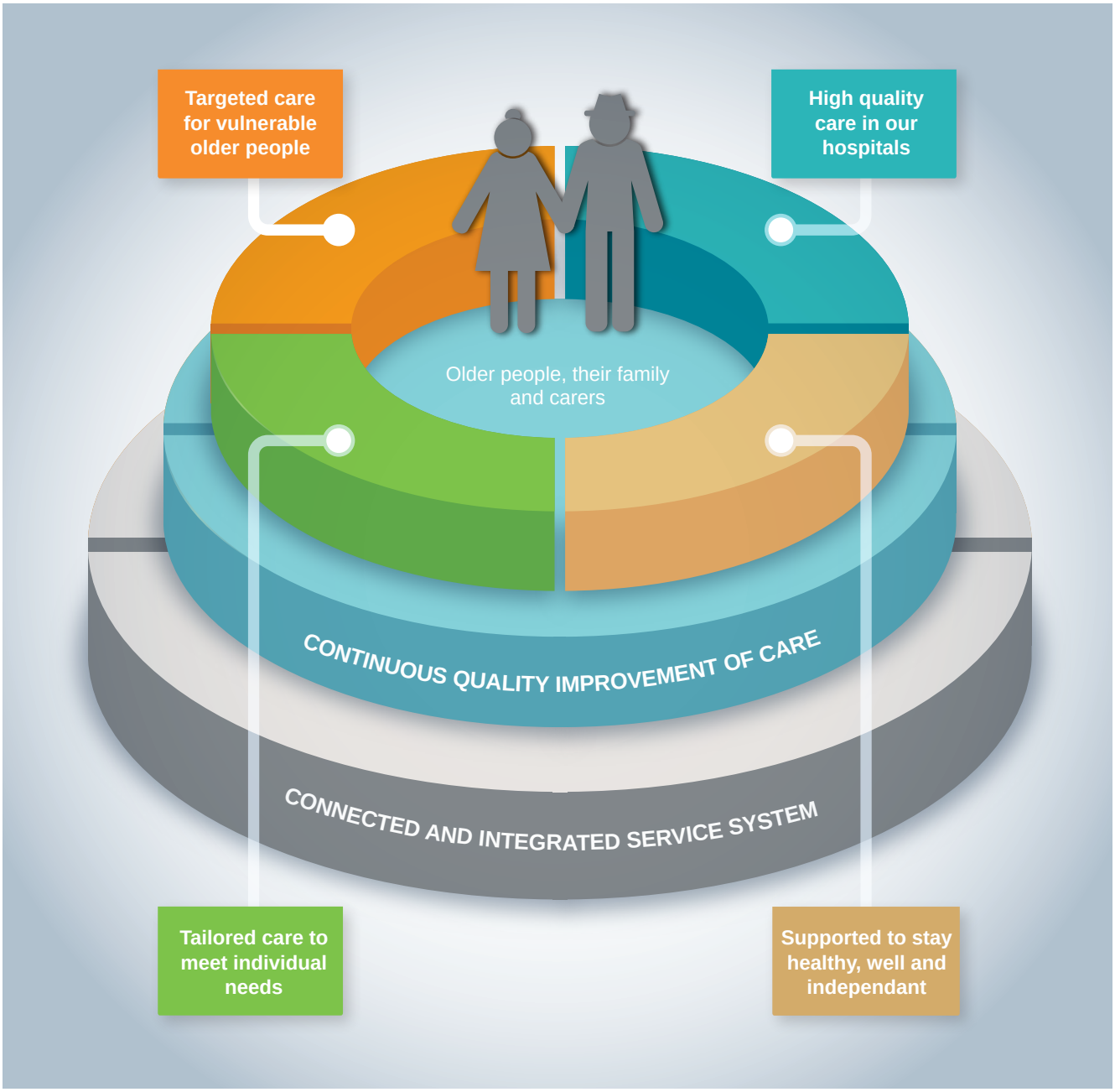
Ageing is a natural part of life with our health and wellbeing affected by a range of environmental, social and behavioural influences—rather than biological age. It is recognised however as older people age, their care requirements often become more complex. They have an increased likelihood of having multiple chronic illnesses, frailty and disabilities. The Brisbane North service system will evolve over the next five years to enable coordinated care for older people across providers, settings and time.

Brisbane North is made up of geographic catchment areas where there is a natural population connection to hospital and health care services. Aligning with the direction of MNHHS and the PHN these geographic areas will be used to plan and deliver coordinated health care services that are tailored to meet the local health needs of older people and enable local relationships to be established with patients, carers, general practice, community care providers and hospitals.

Across Brisbane North a coordinated networked service system will evolve to enable older people to:

- remain in their home environment, maintain their independence, and stay connected to their communities with the support of general practice and other community services
- access a range of timely and appropriate health care services in their local communities
- receive care that is coordinated across providers, across settings and across professional disciplines
- navigate health care services across Brisbane North easily with information shared across service providers
- receive timely access to best practice care in hospital including a focus on rapid, comprehensive and evidence-based screening, assessment, early intervention as well as rehabilitation and discharge planning. All care will be documented in a care plan that will be developed by an interdisciplinary care team in collaboration with the patient and their family and carers
- return home from hospital (including to residential aged care facilities) as quickly as clinically safe to do so whilst continuing to receive treatment and/or rehabilitative care and support as required from community services
- receive support to enable transition between services in a safe and timely manner
- be supported to transition to residential aged care services with dignity and respect
- receive targeted, respectful and appropriate care for older people with cognitive impairment, mental illness and those who are approaching the end of their life
- access timely and appropriate palliative care services tailored to the individual that are respectful and responsive to the physical, social, emotional and spiritual care needs of older people, families and carers.

Figure 3: Brisbane North Service System Summary Diagram



Directions

The following six directions will guide development of services for older people in Brisbane North over the next five years. Many actions will be delivered by doing things differently without requiring additional resources. Some actions will require new resources to advance. These actions are planned to progress over a five-year period and will be subject to normal budgetary processes.

The directions and actions are ambitious and will require a commitment from all health care providers across Brisbane North to deliver.

Direction 1: Older people who live in Brisbane North will receive tailored care to meet individual needs

All older people who access health care in Brisbane North will receive tailored care that is respectful and responsive to their individual health, social and emotional needs. Older people, their family and carers will be equal partners in planning, developing and monitoring their care to make sure care choices and decisions align with their quality of life goals. Their decisions and choices about how they manage their health and wellbeing will be valued. Care providers across disciplines, professions and settings will work together throughout the person's journey, delivering person-centred care to all older people in Brisbane North.

Older people will be encouraged and supported to provide feedback on their care to ensure that the PHN and MNHHS continue to improve care across the service system. We commit to being transparent in communicating what will be done differently as a result of the feedback.

Why this is important – What older people who live in Brisbane North told us

- I want to have choices in decision-making and have my views respected.
- I want to feel safe and be treated with kindness and respect.
- I want information about my care options to understand how they will meet my health goals.
- I want my carers and family to be involved in my care and I want them to feel supported to provide care.

What we will do

No.	Actions
1.1	Design and deliver a coordinated program of education, training, information and communication for health care providers across Brisbane North on: a) person-centred care principles and implementation in practice b) building respectful relationships with older people, carers and families to understand what is important to the person c) treating older people, carers and families as partners in care when identifying treatment options, setting goals, care planning and making decisions d) providing timely, comprehensive and accurate information that is easy to understand, to enable older people to make decisions about care, support or treatment e) identifying sensitive non-clinical issues, such as homelessness f) recognising and respecting diversity and tailoring care to the individual.

What we will do

No.	Actions
1.2	Improve access to information, education and support for older people and their family and carers (including people from diverse communities) to empower them to be active participants in their health and wellness including care planning, decision making and treatment.
1.3	Employ staff using processes that include value-based competencies that continue to develop a workforce where respectful, responsive person-centred care is imbedded into operational practice .
1.4	Promote and enable continual upskilling of care providers in principles and practices that are friendly to older people through: a) workplace programs, including inclusion in orientation programs b) working with educational institutions to improve the focus on these principles and practices in undergraduate, graduate and post graduate programs.
1.5	Identify and support leaders across services and settings to champion and promote the principles of person-centred care for older people.
1.6	Develop one patient experience tool to be used by all service providers across Brisbane North to better capture patient, family and carer experiences, opinions and preferences that will be utilised to inform service improvements for older people. Develop and communicate processes on how the information will be used for service improvement. This action will be led with engagement and consultation with older people, their family and carers.
1.7	Building on existing interdisciplinary care models, expand the approach to better care for older people across settings and care providers.
1.8	Involve older people, their family and carers in the design of services.
1.9	Explore opportunities for health services to have access to an ethicist to provide advice on the broad range of ethical issues regarding providing care to older people.

Success will look like

- increased proportion of care providers participating and completing identified training programs that provide staff with skills to deliver person-centred care
- increased proportion of older people, their families and carers that have been consulted and supported to participate in their own care
- increased proportion of older people, their families and carers that have been consulted and supported to participate in the design and enhancement of services for older people
- improved experience for older people, their families and carers with the care they receive
- increase in the number of frail older people and those with complex conditions receiving interdisciplinary assessment and subsequent care plans developed
- increased involvement of older people, their family and carers in the planning of services.

Direction 2: Older people are supported to stay healthy, well and independent

Ageing is not a disease; rather it is a part of the normal life course. The physical, mental and emotional changes associated with the ageing process are different for each of us and are strongly influenced by our culture, behaviours and environments. As we get older is important to keep physically fit, eat a healthy diet, stay hydrated and maintain social relationships with family and friends to ensure quality of life is maintained. All older people who live in Brisbane North will be encouraged to be active in managing their own health.

Consistent with the **World Health Organization report on ageing and health (2015)** the PHN and MNHHS will support older people in Brisbane North to have local access services that optimise physical and mental health, address disadvantage and improve social connectively. Older people together with many agencies across all levels of government, together with the private, community and non government sectors, will be required to work together to support this direction.

Why this is important – What older people who live in Brisbane North told us

- I want to participate in health and wellness activities and programs that are age-appropriate, affordable, close to home and connected to community.
- I want better nutrition through access to adequate and healthy food.
- I want sufficient staffing levels and infrastructure to ensure prompt and affordable health and community services.
- I want a central point where I can access information on health and social services and activities.
- I want better coordination of my care.
- I want home care services that are affordable, consistent and of high quality.
- I want better information and communication for carers about the services available to them.

What we will do

No.	Actions
2.1	Work together with older people, local councils, community service providers and other relevant organisations to build healthy communities for older people, incorporating exercise, nutrition and social inclusion activities that are culturally diverse, evidence-based, age-appropriate and affordable.
2.2	Work in partnership with agencies to identify and implement strategies for older people who: a) are homeless - to access affordable and appropriate housing b) have a mental illness and require services c) require support to navigate advocacy, legal, financial and social care service systems d) require support to maintain social connectivity.
2.3	Promote assistive technology that supports older people to remain living independently in their own home to community service providers.
2.4	Enhance information and support for carers and families to assist them in caring for older people at home.

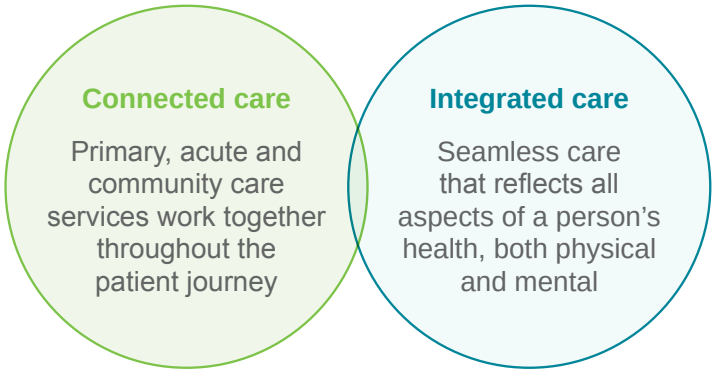
What we will do

No.	Actions
2.5	Align with whole of government public awareness campaigns to create greater awareness of the mistreatment and neglect of older people by: a) educating and training the health workforce in the prevention, early identification and response to issues specific to older people including elder abuse b) promoting community support and health care services that respond to elder abuse, fraud or exploitation.
2.6	Increase immunisation rates amongst older people through active promotion across service settings.
2.7	Work with GPs to increase the use of comprehensive risk screening, assessment and care planning for older people.
2.8	Grow the capacity of hospital in the home services to enable older people to access medical, nursing, allied health and rehabilitation services in their home.
2.9	Promote the early development of advance care planning by health care providers across all settings in partnership with the person, their family and carers.
2.10	Identify and implement evidence-based hospitalisation prevention strategies to reduce unplanned presentations, admissions or readmissions of older people to acute care facilities, particularly those from residential aged care facilities.
2.11	Promote awareness of importance of nutrition and hydration for health and wellbeing of older people across service settings.
2.12	Promote awareness of importance of good oral hygiene to prevent dental disease for older people
2.13	Promote awareness of existing care coordination programs such as Team Care Coordination, Staying Healthy; Staying Home, and encourage MNHHS staff to refer suitable patients to these programs
2.14	Pilot new models for improved primary health care such as Health Care Homes and nurse-based coordination.
2.15	Implement an integrated community model for older people.
2.16	Increase the capacity of primary and community care providers to implement a wellness and reablement approach to service delivery.
2.17	Work with the Queensland Ambulance Service and care providers to support flexibility and care alternatives to transporting to hospital.
2.18	In line with the **MNHHS Health Service Strategy 2015-2020**, work with partners to develop initiatives to improve health literacy including the development of a patient and carer portal to access information regarding healthy behaviours, health conditions and services.

Success will look like

- increased number of health assessments conducted in primary care
- frailty score implemented in general practice
- the number of joint initiatives between the PHN, MNHHS and other partners
- the number of patient experience surveys and corresponding actions completed
- decreased number of preventable hospitalisations.

Direction 3: Older people will have access to a health care system that is connected and integrated, delivering care locally wherever possible



As people age they use health care services more often and their care becomes more complex. Many older people develop multiple chronic illnesses, frailty and disabilities and have a number of health professionals involved in their care. Over the next five years, an integrated and coordinated care system will be developed to support older people, their family and carers to receive the right care, in the right place, at the right time, by the right person. Working together across services and settings the PHN and MNHHS will work to remove barriers, and streamline policies, processes and procedures including sharing of information between care providers.

Supporting older people to receive care as close to home as possible will be a priority. Brisbane North is made up of natural community catchment areas where there is a natural connection between local populations, primary, community and hospital services. Aligning with the **MNHHS Health Service Strategy 2015-2020** and the PHN's strategic plan these natural catchment areas will be used to plan and deliver connected local health care services over the next five years and reorient the health system to care in our community.

Why this is important – What older people who live in Brisbane North told us

- I want better connectivity between my health care providers.
- I don't want to have to repeat information to every health care service I see.
- I want services close to home.
- I don't want to come to hospital on three different days for different outpatient appointments.

What we will do

No.	Actions
3.1	Design, develop and implement a local catchment approach to delivering connected health care across the continuum through a partnership with older people, local communities, GPs, community and hospital services.
3.2	Look for opportunities to base new services in local communities rather than hospital settings.
3.3	Continue to implement evidence-based health pathways for specific conditions across settings.

What we will do

No.	Actions
3.4	Enhance care coordination strategies so that information can be shared in real-time between providers in a standardised way.
3.5	Enable staff to work across sectors to strengthen relationships across the service system and understand the capacity and capabilities within different service settings.
3.6	Work with the newly established Brisbane North and Moreton Bay Health Alliance to advance collaboration across the health care sector and generate workable solutions that improve health experiences and outcomes for older people.

Success will look like

- increased number of older people treated in hospital in their local catchment
- increased proportion of older patients receiving care in primary and community settings
- increased uptake of health pathways by all primary care providers
- improved standardisation of information sharing between all care providers in Brisbane North
- improved communication between hospitals and primary, community and residential aged care.

Direction 4: Older people in Brisbane North will receive access to high quality care in our hospital services

Brisbane North's growing and ageing population together with the increasing prevalence of chronic disease is resulting in increasing demand for hospital services. Responding to such demand pressures, MNHHS will continue to enhance clinical services, redesign and introduce new evidence-based models of care and plan for new facilities to better meet the care needs of older people now and into the future. MNHHS will actively plan to grow service capacity at Redcliffe and Caboolture Hospitals to better support demand pressures.

Recognising there is not a 'typical' older person, MNHHS will tailor care to the individual, their family and carers. Hospital care for older people will move away from predominately focusing on treating disease and trauma to focusing on the holistic care needs of older people (physical, mental and social). Improving the care experience of older people, their family and carers will be a priority. Our commitment to quality care of the highest standards will be supported through active implementation of the new soon to be released **2017 National Safety and Quality Health Service Standards** version 2.

Why this is important – What older people who live in Brisbane North told us

- I want care to meet all of my needs not just my health needs.
- I want better communication between clinicians when staff change to avoid problems and not have me retell my story.
- I want to be able to receive care locally and within a reasonable timeframe.

What we will do – Screening, assessing and care planning

No.	Actions
4.1	Develop and implement a consistent screening and assessment tool for older people including frail older people at all MNHHS hospitals. This will include: a) agreed frailty screening utilised at all entry points in MNHHS b) comprehensive assessment undertaken where clinically recommended c) timely development of a care plan with involvement from older people, their family and carers d) interdisciplinary care based on the goal directed care plan e) care plan shared to all care providers within and across service settings and with older people and their carers.
4.2	Promote and implement timely discharge planning with active involvement of older people, their family and carers. This will include assessment of health, social and emotional care needs and early engagement of MNHHS community teams regarding planned date of discharge, and likely support required.
4.3	Improve the quality of the referral and discharge information to facilitate rapid MNHHS community service support including the medication reconciliation and discharge summary distributed within 24 hours to all primary care providers.
4.4	Provide older people, their family and carers with a plain language patient-held discharge summary with follow-up appointments that enable discussions with specialist regarding complex care needs.

4.5	Enhance capacity of Aged Care and Assessment Teams to undertake assessments within recommended timeframes to support older people who require transition to residential aged care services from hospitals.
4.6	Over time, enhance the physical environment of MNHHS hospitals to comply with the design principles of caring for older people.

What we will do – Care in the emergency department

No.	Actions
4.7	Enhance emergency medicine workforce capabilities in care of older people, including frail older people, through training pathways and support to ensure that older people receive the high quality person-centred care they require in the emergency department.
4.8	Develop and implement patient pathways to enable prompt triage and senior medical officer assessment of older people who are frail and/or have complex conditions in emergency department to improve timely transition to appropriate care in the right setting.
4.9	Establish processes to enable comprehensive referrals and discharge summaries to be provided to MNHHS community central intake teams for triage and rapid response.
4.10	Identify and implement evidence-based models of care that will improve care quality and expedite care, ensuring that a care decision is made and actioned in a timely manner.

What we will do – Inpatient care

No.	Actions
4.11	Optimise patient flow through the adoption of evidence-based strategies including: a) early senior medical officer assessment at all transition points b) more timely patient movement between hospital services c) adopting a 'discharge to assess' approach.
4.12	Promote and implement evidence-based models of care, including early comprehensive assessment and discharge planning, preventive and rehabilitation strategies, to minimise hospital stay complications and improve the patient journey for older people particularly those with delirium, dementia and frailty.
4.13	Develop and implement interdisciplinary models of care for medication reconciliation and rationalisation, particularly for older people on more than five medications.
4.14	Improve early identification of older people requiring specialist aged care assessment and services (e.g. geriatric evaluation and management, rehabilitation) and develop a care plan that takes their clinical, social and cultural needs into consideration.
4.15	Improve early identification of older people at risk of nutritional decline and malnutrition through screening older people at regular intervals during inpatient care and provide tailored approaches to address.

4.16	Improve early identification of older people with (or at risk of) dental and oral health disease to provide tailored approaches to address.
4.17	Increase the uptake of multicomponent delirium/functional decline programs across MNHHS that focus on timely patient recovery.
4.18	Improve timely discharge to enable older people to return home with the ongoing treatment, rehabilitation and support they require by: a) enhancing the care coordination and integration both within and between the hospitals and the community to best meet the needs of older people b) improving the capacity and capability of medical staff to enable discharge on weekends.
4.19	Enhance processes to ensure critically ill, frail patients are identified in a timely way and that end of life discussions are commenced early, by: a) introducing evidence-based frailty scoring tools to be administered by trained nurses with patients that are critically ill and may be frail b) developing a process for patients with a high frailty score to enable discussions with all care providers (multidisciplinary team) to refer to palliative care c) developing a process to discuss multidisciplinary team recommendation to refer to palliative care with the patient, family and carers for quality of life outcomes.

What we will do – Outpatient care

No.	Actions
4.20	Empower older people, their carers and family to communicate their preferences with clinical staff coordinating outpatient care.
4.21	Identify frail older people and/or older people with complex care requirements at point of entry to MNHHS services and assign care navigators to provide care coordination.
4.22	Enhance the mix and volume of outpatient appointments provided via telehealth reducing the need for patients to attend hospital.
4.23	Expand mix and breadth of outpatient services aligning with local catchment needs for older people including (not limited to): • falls • nutrition • rehabilitation • incontinence • memory • falls • wound treatment and management.
4.24	Explore the option for outpatient services provided on hospital campuses to be reorientated to be delivered in the MNHHS community service environment.

Success will look like

- increased proportion of frail older people with complex conditions in emergency departments will be assessed, triaged with a decision made regarding their care within two hours
- number of people over the age of 75 who are discharged home
- reduction in hospital acquired geriatric syndromes
- increased proportion of older people discharged to have a discharge plan distributed to primary care provider within 24 hours of discharge
- the number of patient experience surveys completed and achieve 90 per cent rating or above for the eight CaRE survey core domains across MNHHS.

Direction 5: Enhance care for older people who are vulnerable

Whilst improving the health of all older people who live in Brisbane North is the focus of this Plan, there are some older people within our catchment that are particularly vulnerable. This direction complements all other directions in this Plan whilst focusing on vulnerable (physically, mentally, socially, emotionally and financially) older people who require care for:

- cognitive impairment including dementia and delirium
- mental illness
- frailty *(note actions regarding improving care of older people who are frail are described in other directions of this Plan)*
- end of life.

Many older people will experience cognitive impairment including dementia and delirium. Whilst delirium is preventable and dementia can be managed through timely identification and treatment, these are often not identified or treated early. This results in serious quality of life consequences for older people including falls, accelerated cognitive decline, and reduced independence. Some older people also exhibit a range of behaviours that are challenging and can result in considerable distress for older people, their family and carers. These behaviours also present challenges to delivering high quality person-centred health care across service settings.

Building on existing models of care, older people with cognitive impairment will increasingly be cared for by interdisciplinary teams, including geriatric and psychiatric medical, nursing and allied health care. Carers and family members will receive information, education and support to understand the care needs of older people with cognitive impairment. Delivering evidence-based care to older people with cognitive impairment will be enhanced through advancing the MNHHS evidence-based principles on the care of the confused older people across Brisbane North (Appendix 1).

Mental illness including depression and anxiety is also often poorly recognised in older people. Brisbane North will increasingly include older people as a key population focus group when designing care for people with mental illness. A recovery approach to care will be a focus, which will include working together across sectors such as health, social, housing, income support to deliver care when needed. Delivering care in the most appropriate and least restrictive care setting will be a priority.

Frailty is commonly associated with older people. Supporting older people to remain engaged in daily living activities and reduce the risk of frailty through self-management strategies or where necessary referral to restorative care programs will be actively advanced across Brisbane North. On presentation to any MNHHS service, older people will be assessed for frailty using a common assessment tool and a tailored care plan will be developed.

Death and dying is an area of the life continuum that many of us do not want to talk or think about. Health care providers recognise that end of life decisions and discussions are difficult and they understand that individual beliefs, values and experiences will influence care. Many people die without discussing or documenting their end of life care decisions. The PHN and MNHHS will actively work with older people to encourage conversations with family and carers and support the documentation of care decisions. The **MNHHS Palliative Care Clinical Service Plan 2017-22** outlines specific objectives and actions to achieve this direction.

Why this is important – What older people who live in Brisbane North told us

- I want improved mental health care services in the community including services that promote self-esteem and independence.
- I want the signs of dementia recognised earlier by clinicians and individuals/ community members.
- I want services that treat people with respect irrespective of the level of cognitive decline.
- I want care to be provided in my usual living environment.

What we will do

No.	Actions
5.1	Develop local solutions to better manage confused older people at each facility in line with MNHHS management of the confused older person principles (Appendix 1).
5.2	Develop and implement an integrated, evidence-based model for screening, assessing, managing and supporting older people with behavioural and psychological symptoms of dementia and other mental illness by: a) implementing an agreed cognitive screening tool to enable early diagnosis, timely and appropriate management b) developing a purpose built subacute psychogeriatric/neuro cognitive disorder unit at the Brighton campus in partnership with MNHHS mental health c) reorienting the cognitive assessment model at TPCH to focus on screening, assessment and early targeted intervention and develop referral criteria for referral to the behaviour unit at the Brighton Health Campus d) developing a risk management approach for the detection of older people at suicide risk e) use evidence-based design principles for people with cognitive impairment in design and refurbishment of hospital and MNHHS community facilities.
5.3	Investigate the development of ambulatory mental health services for older people that are co-located in the community setting and integrate medical, diagnostics and allied health together with providing support to navigate housing, social and finance matters.
5.4	Develop and implement a training program that educates clinicians and service providers on best practice approaches to care for older people who have behavioural symptoms.
5.5	Promote Dementia Behaviour Management Advisory Service (DBMAS), Severe Behaviour Response Teams (SBRTs), Dementia Training Australia to GPs, residential aged care facilities and community service providers.
5.6	Investigate establishing a forum where organisations with an interest and commitment to improving care for older people with mental illness and/or cognitive impairment could meet to share information and ideas to improve service delivery and community support.
5.7	Continue to enhance and promote health pathways for dementia to support primary care providers to manage symptoms and conditions and when needed integrate with other community and hospital services.
5.8	Continue to promote the uptake of advanced care planning. Promote the importance of advanced care planning for older people with dementia including discussion regarding substitute decision makers across service settings.
5.9	Provide access to integrated specialist geriatric and psychiatric input for older people with mental illness.
5.10	Support the provision of low intensity mental health care services to older people with mental illness (including depression) living in residential aged care facilities.
5.11	Across settings, increase timely referral to palliative care that is respectful and responsive to the social, emotional and spiritual care needs of older people, family and carers.

What we will do

No.	Actions
5.12	Establish a whole of Brisbane North multimodal communication strategy that builds on the Department of Health care at the end of life public awareness campaign. The campaign will support staff, patients, families and carers to discuss death and dying and reinforce the importance of early conversations and documentation regarding end of life care. Communications will include: a) tailored resources for culturally diverse populations including Aboriginal and Torres Strait Islander people and culturally and linguistically diverse communities. These will be developed in partnership with each diverse population group b) resources for people who live in other HHSs but receive care in MNHHS. These will be developed in partnership with other HHSs c) palliative care for people who live in an aged care facility d) importance of conversations and documentation regarding Advanced Care Planning e) fact sheets to debunk common myths regarding palliative care.
5.13	Design and establish a specialist multidisciplinary palliative care service that provides specialist advice and support to ensure primary care and MNHHS community-based service providers do not work in isolation and patients cared for in their homes receive high quality multidisciplinary care. This service could be via a range of modalities including telehealth and include: a) 24/7 access to specialist symptom management and support b) access to specialist medical, nursing, allied staff c) bereavement care d) rapid response service.

Success will look like

- all MNHHS facilities will have an action plan addressing the MNHHS management of the confused older person principles
- a model of care is developed to support older people with behavioural and psychological symptoms of dementia and other mental illness
- increased proportion of staff completed training for managing older people with behavioural and psychological symptoms of dementia and other mental illness
- increased uptake of health pathways for dementia by primary care providers
- increased number of older people have opportunity to discuss and develop Advance Care Plans
- families and carers feel that the care provided to older people at end of life was respectful and responsive to their needs.

Direction 6: Advancing continuous improvement in older people's care is our (the PHN and MNHHS') priority

The PHN and MNHHS commit to continuous quality improvement of care provided to older people. We will monitor key processes and outcomes of care with older people and focus on identifying and implementing current best practice and understanding where knowledge gaps exist.

Older people, particularly those with comorbidities and physical or cognitive impairments, remain under-represented in clinical research and therefore in evidence-based guidelines. Over the next five years, we will enhance our efforts in research and innovation in care of older people across the entire care continuum and support translation of evidence into practice. We will foster a culture of innovation and research involving older people, invest in evidence-based research translation strategies, and enhance workforce skills in evidence-based practice and continuous quality improvement to leverage successful innovations. Interdisciplinary and interagency research will be encouraged and we will identify and support mentors to nurture new research talent.

We will actively increase our research collaborations including collaborations between departments, professions and facilities in MNHHS; partnerships with other health care services, the PHN, non-government organisations; and partnerships with academic organisations. We will support the respectful involvement of older people and their carers in design, conduct and dissemination of research and quality improvement.

Why this is important – What older people who live in Brisbane North told us

- I want more research into the conditions of ageing and the diseases associated with it.
- I want best practice care.

What we will do

No.	Actions
6.1	Inform and influence State and Commonwealth policy, strategy and processes to continually improve older persons care.
6.2	Enhance existing and build new partnerships with universities, research institutes, service providers and older people their carers and family to build a strong research culture and identity in care of older people by: a) partnering with universities and other training organisations to provide staff training in skills related to research and quality improvement b) supporting engagement between research groups and older consumers and their carers to inform research priorities, design and conduct and assist in public dissemination of findings c) supporting involvement of older people, their carers and family in the co-design of service improvements.
6.3	Support the development of a workforce skilled in advancing health literacy, evidence-based practice and continuous quality improvement.
6.4	MNHHS will recruit and retain staff with interest and qualifications in research involving older people.
6.5	Identify mentors to support new researchers across disciplines and service settings wishing to undertake research involving older people.
6.6	Provide access to up-to-date evidence and guidelines for care of older people.
6.7	Promote and invest in use of implementation science methods to enhance uptake of evidence into practice.
6.8	Develop processes for ongoing monitoring, evaluation and improvement of routine care delivered with older people.
6.9	Establish mechanisms for collaboration and coordination of service development activities between facilities.

Success will look like

- increase in number of successful funded research and innovation projects specifically including participants aged 65 and older
- increase in interdisciplinary and interagency collaborative projects specifically including participants aged 65 and older
- increase the uptake of key evidence including guidelines in the care of older people, particularly for delirium and dementia care and preventive care.

Part B: Context and background

Part B of the Plan summarises the background information that was analysed to inform the development of the future directions contained in Part A. Information described in Part B includes the policy context, current service arrangements, a review of the population and health status of older people who live in Brisbane North together with a summary of the issues and challenges facing the current service environment.

Issues and challenges

A range of issues and challenges have been identified through a review of the literature, data analysis and stakeholder consultation. A summary of these are described below.

Growing and ageing population increasing service demand

The rate of population growth for people aged 65 years and over is significantly higher than the general population. This growth will drive increases in service demand across all service settings.

Older people often have complex care needs

As people age there is an increased risk of comorbidities, physiological and cognitive decline and reduced social function. Together these factors result in older people having complex care needs and a greater reliance on the health care system across all care settings.

Disadvantaged regions of Brisbane North

The health status of older people varies significantly across Brisbane North. Older people residing in the northern corridor of Brisbane North have higher levels of socio-economic disadvantage and a poorer health status.

Population diversity

Across Brisbane North, older people cannot be viewed as one homogenous group. The population group is diverse across different age groupings, and within the genders and life experience. Brisbane North is also home to a diverse older population including people with disabilities; Aboriginal and Torres Strait Islander people; people from lesbian, gay, bisexual, transgender and intersex communities; and people from culturally and linguistically diverse communities.

Lifestyle choices and behaviours that contribute to disease burden

Smoking, obesity and sedentary lifestyle contribute to high rates of chronic disease in older people across Brisbane North.

Policy reform agenda

The aged care system is complex and difficult to navigate. The Commonwealth aged care policy environment is driving major reforms, implemented over a ten-year period to 2022.

Ageism

Older people and their carers can experience discrimination in our health care system because of their age. Influenced by individual attitudes, beliefs and preconceptions the care of older people in Brisbane North can vary significantly across settings and between health professionals.

Poorly integrated services with communication gaps

Poorly integrated services and inadequate communication between service providers and across service settings can cause delays in delivering appropriate health care services to older people.

Local access to geriatric and other specialist services is inequitable

Older people who live in the northern corridor of Brisbane North have less local access to specialist geriatric and other specialised services than those who live closer to the city.

Support for carers and family is inadequate

Brisbane North does not have a consistent approach to supporting the psychosocial, emotional and bereavement needs of family and carers. Access to information, support and education for carers and families varies depending on where the care is provided and who is providing the care.

Research is limited

At present there is limited research and clinical trials being performed within Brisbane North that specifically relates to the care of older people.

Hospitalisation carries risks for older people

Older people are at an increased risk of deconditioning and irreversible functional decline as a result of immobilisation during a hospital admission. Environment and design in many MNHHS facilities is not optimal for the care of older people.

Training and education in care of older people is limited

Few health care undergraduate curricula offer core training in geriatrics and options for postgraduate qualifications in geriatrics are limited.

Stigma attached to working in care of older people

Health professionals who work with older people are often stigmatised and perceived as less competent than those that work in other specialty areas.

Policy context

Improving the health and wellbeing of older people is an area of priority internationally and within Australia. This Plan has been developed within the context of a range of international, national and state policy frameworks, as outlined below.

International policy environment

The United Nations Principles for Older Persons (1991) reinforce the human rights of older people in confirming independence, participation in care and respect and dignity of the individual.

The World Health Organization's (WHO) **World Report on Ageing and Health (2015)** identifies the public health framework for Healthy Ageing as the process of optimising the functional ability and intrinsic capacity of older people to enhance quality of life across the life course. The framework also acknowledges the need to enable older people regardless of their level of capacity.

Commonwealth policy

Primary health care

The National Primary Health Care Strategic Framework is a nationally agreed approach for the Commonwealth, States and Territories to work in partnership to better integrate health care across care settings and to improve health outcomes for all Australians. Re-orienting the health system towards primary health care will need solutions that help to overcome some of the inherent challenges in the Australian health care system.

The introduction of the Health Care Homes initiative in 2017 will coordinate comprehensive care for patients with chronic and complex conditions and develop a shared care plan with the patient, which will be implemented by a team of health care providers. This plan will:

- identify the local providers best able to meet each patient's needs
- coordinate care with these providers
- include strategies to help each patient better manage their conditions and improve their quality of life.

Aged care

In response to The Productivity Commission's 2011 Inquiry Report **Caring for Older Australians**, the Australian aged care system is in transition. National reforms are progressively being implemented over a ten-year period from 2012 to 2022. These reforms move away from universal care arrangements to a safety net system where consumers contribute financially to subsidised services (unless the consumer is experiencing financial disadvantage). The intent of the reform is to create a market based aged care system that is affordable and offers greater choice, flexibility and control to consumers and supports people to remain independent and in their own homes for as long as possible.

The establishment of My Aged Care has created a single point of entry for all subsidised aged care services and comprises of a website, national call centre and single client record. The reform makes a shift to a wellness and re-ablement approach linked to goal-oriented support plans. Outcomes reporting will also be introduced.

The Aged Care Sector Committee was tasked by the Commonwealth Government with developing a roadmap that sets out future reform directions for aged care. The roadmap sets out short, medium and long-term strategies for the reform and includes dementia as a priority.

Increasing consumer choice and control is a major reform policy position including the expectation that older people will contribute to their care costs. This position is likely to result in increased expectations from consumers about what care and support they receive, and where, when and how they receive it. This will create a more competitive and innovative market in regional and metropolitan areas that requires providers to build their capacity and flexibility to respond to the diversity and individual care needs of consumers.

State policy

Queensland state policy agenda focuses on improving the health of the whole population whilst targeting vulnerable populations including older people. **My Health, Queensland's future: Advancing health 2026** describes a 10-year vision and strategy to support Queenslanders to maintain and improve their health and wellbeing into the future. A Statewide Older Persons Health Clinical Network was established in recognition

of the unique care required for many older people and to initiate improvements in service delivery. Established to guide service improvements and standardisation of best practice in the care of older people, the statewide steering committee has multidisciplinary membership and includes a consumer representative, a GP and a pharmacist.

The Department of Communities, Child Safety and Disability Services **Queensland: an age-friendly Community Action Plan** describes eight age-friendly domains for supporting seniors to remain independent and engaged in their community.

Local policy

The Brisbane City Council **Seniors' Strategy 2012-2017** outlines Council's strategic priorities in delivering a seniors-friendly city and supporting seniors' participation in the Brisbane community. To do this, it considers each of the Brisbane Vision 2031 themes of friendly and safe city, active, health city, accessible, connected city, well-designed, subtropical city, clean and green city, smart, prosperous city, vibrant, creative city and regional, world city. Moreton Bay and Somerset Regional Councils have the needs of older people considered in a number of their broader strategic plans.

Population and health status

Brisbane North is home to almost 957,000 people and is projected to increase to over 1,200,000 residents by 2036 with high growth expected in Moreton Bay North, Brisbane Inner City and Redcliffe–North Lakes. Brisbane North is one of the most diverse areas in Queensland with:

- one in five (22.1 per cent, 189,128 people) residents being born overseas, which is a slightly higher rate than the Queensland figure (20.5 per cent)
- more than 87,000 (10.2 per cent) people residing in Brisbane North speaking a first language other than English compared to the Queensland rate of 9.5 per cent
- the median age of 35.6 years, which is lower than the Queensland median age of 36.8 years
- over 14,000 people of Aboriginal and Torres Strait Islander descent living in Brisbane North, representing 1.7 per cent of Brisbane North's total population as at 2011
- a younger Aboriginal and Torres Strait Islander population in Brisbane North compared to the general population, with more than half (55.6 per cent) aged less than 25 years.

Brisbane North residents are living longer with average life expectancy of 80.7 years for males and 84.5 years for females. In 2015, older people aged 65 years and over, represented approximately 13.5 per cent of the total Brisbane North population. By the year 2026 this is expected to increase by 44 per cent, a rate significantly higher than the general adult population which is expected to increase by 12.9 per cent. The older people population growth will not be evenly distributed within the Brisbane North with substantial pockets projected to occur in the planning regions of Brisbane Inner City (58.5 per cent), Redcliffe-North Lakes (57.3 per cent) and Moreton Bay North (44.9 per cent).

Almost half of the adult Brisbane North population suffer from a chronic condition, with a five per cent increase in the number of adults who had a chronic condition between 2011-12 and 2012-13. Moreton Bay North reported the highest prevalence of seven of the eight reported chronic conditions in Brisbane North. The proportion of people living with a disability is highest in Moreton Bay North at 5.6 per cent, followed by Redcliffe-North Lakes at 5.5 per cent compared to the Brisbane North rate of 4.1 per cent. As people age there is an increased risk of co-morbid chronic conditions. In 2014-15 approximately one in three Australians aged 65 years and over reported having three or more chronic diseases, compared with just 2.4 per cent of those under the age of 45 years.

Brisbane North's rate of Aboriginal and Torres Strait Islander people with one long-term health conditions was 25 per cent with 51.2 per cent living with two long-term health conditions. This is higher than the national rate of 20.9 per cent and 46.9 per cent respectively and is 1.7 times greater than the non-Indigenous population of Brisbane North.

Approximately 14.3 per cent of the total adult population in Brisbane North are estimated to have mental and behavioural disorders. The planning regions with the largest proportions of mental and behavioural disorder incidence are Redcliffe-North Lakes and Moreton Bay North planning regions (14.7 per cent) followed by

Table 1: Older people population projections 2015-2026 by planning region

			2015-2026 change	
Planning regions	**2015**	**2026**	**n**	**%**
Brisbane Inner City	**17,034**	**26,995**	**9,961**	**58.5**
Brisbane West	**17,836**	**22,995**	**5,159**	**28.9**
Brisbane North	**31,314**	**42,003**	**10,689**	**34.1**
Pine Rivers	**14,431**	**20,784**	**6,353**	**44.0**
Moreton Bay – North	**25,532**	**37,006**	**11,474**	**44.9**
Redcliffe – North Lakes	**22,888**	**36,013**	**13,125**	**57.3**
Brisbane North region	**129,035**	**185,795**	**56,760**	**44.0**

Source: Queensland Government Statistician's Office. Population Projections, 2015 edition (medium series). Prepared by Statistical Reporting and Coordination, Health Statistics Branch, Department of Health. July 2016.

Brisbane Inner City (14.2 per cent).

In line with the comparable jurisdiction of Australia it can be expected that dementia prevalence in the Brisbane North will increase with age. It is projected that by the year 2020 the Australian population aged 65 years and over will experience a 35.9 per cent increase in dementia cases, of which a greater proportion will be amongst people aged 85 years or older.

In addition, family structure, social structure, single households and increasing age of carers are contributing to social disadvantage within the Brisbane North and are challenging the ability of families to provide care in the home.

There is a proportion of the Brisbane North population living without a permanent dwelling and as such further impact their health and ability to access appropriate health care.

The social determinants of health

The social determinants of health recognise that factors including a person's income, occupation, education, social support networks and housing status can affect their health and contribute to the health status of communities (Australian Institute of Health and Welfare, 2014a). The World Health Organization (WHO) describes these social determinants as being responsible for health inequality.

Brisbane North generally experiences low rates of socioeconomic disadvantage, with almost two in five people (37.6 per cent) residing in areas considered least disadvantaged. However, one in eight people in Brisbane North (12.2 per cent) reside in areas considered as most disadvantaged and these areas are not evenly distributed across Brisbane North. There are high rates of socioeconomic disadvantage present in the northern areas of Brisbane North, particularly in Redcliffe-North Lakes and Moreton Bay North planning areas.

Brisbane North service system context

Health care services in Brisbane North include, but are not limited to general practice, public and private hospitals, allied health, private specialists, pharmacies, community health care services and Aboriginal and Torres Strait Islander health care services. There is also a range of community health providers and non-government organisations in Brisbane North who deliver health care to the population.

Health care has been divided into three main types, primary health care, hospital and emergency care, and aged care.

Primary care

There are 304 general practices that provide the majority of primary health care services in Brisbane North and they are distributed similarly to Brisbane North's population; however, there are service gaps particularly in Moreton Bay North. The full time equivalent (FTE) rate for general practitioners in Brisbane North is 116.8 FTE per 100,000 people, which is higher than the Australian rate of 110.6 FTE per 100,000 people.

Across Brisbane North:

- on average, residents visited a GP just under six times in 2014-15, an increase from 5.3 visits in 2011-12
- the number of visits to a GP ranges from 4.3 attendances at the Sherwood – Indooroopilly and Brisbane Inner – West statistical areas to 7.2 attendances in the Bribie – Beachmere statistical area
- an estimated 11 per cent of the population are frequent or very high GP attenders, accounting for approximately 41 per cent of non-hospital Medicare expenditure in 2012-13
- between 2012-13 and 2014-15, approximately six per cent of the population commenced a GP chronic disease management plan and four per cent were on a GP mental health treatment plan
- in 2014-15 there were 6202 Aboriginal and Torres Strait Islander health assessments delivered in Brisbane North. This was an increase of 12.1 per cent from 2011-12, with the greatest percentage increase of 85.8 per cent in the Strathpine statistical area.
- in 2014-15 a total of 34,378 patients over the age of 75 received a GP health assessment, an increase of 16 per cent since 2012-13. The highest proportions were provided in Redcliffe, Chermside and Caboolture statistical areas.

In 2014-15, 78.4 per cent of GP attendances were bulk billed in Brisbane North, less than the national average of 84.3 per cent, however:

- bulk billing rates increased in line with the national increase of 4.3 per cent since 2011-12
- bulk billing rates varied 35 per cent across Brisbane North with Brisbane Inner – West at 58.2 per cent compared to Bribie – Beachmere and Caboolture at 93.2 per cent.

Hospital and emergency care

MNHHS is one of the largest hospital and health care services in Queensland and is responsible for the direct management of the facilities within the HHS' geographical boundaries including the Royal Brisbane and Women's Hospital (RBWH), The Prince Charles Hospital (TPCH), Redcliffe Hospital, Caboolture and Kilcoy Hospitals and Brighton Health Campus.

Mental health, oral health, community health, subacute and Aboriginal and Torres Strait Islander 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.

Emergency care

All MNHHS hospitals provide general emergency care. Emergency services specific for older people may be provided as a dedicated geriatric-specific service, or may apply aged-friendly principles and processes to existing services. Redcliffe and Caboolture Hospitals manage older people in the general emergency service. Similarly at RBWH older people are treated in the general emergency unit, however all patients have a patient risk assessment which includes cognitive screening. In addition, RBWH has a Community Assessment and Referral Service (CARS) when community support is required on discharging home by assisting with safe and effective discharge of elderly. At TPCH geriatric specific services include:

- appropriate environments for the assessment and management of older people
- multidisciplinary assessment with appropriately trained allied health staff and on call geriatricians
- GP Rapid Access to Consultative Expertise (GRACE) service which provides GPs with access to an internal medicine specialist to guide decisions about the assessment, management and treatment of older people when considering referring older people to the emergency department
- Rapid Assessment Medical and Surgical (RAMS) unit, which provides a shared surgical and medical model of care for patients needing specialist assessment and treatment.

In 2015-16, there were approximately 225,000 emergency department presentations at Brisbane

North public hospitals for older people. As people get older, they are more likely to arrive at an emergency department via an ambulance, with 62.6 per cent for persons aged 65 years and over and 75 per cent of persons aged 80 years and over arriving in an ambulance. When compare to the general adult population, older people presented to emergency department with a higher urgency triage category, with majority of presentations for older people being triage category three (53.4 per cent). Similarly emergency presentation for older people resulted in an admission to hospital more often than the general adult population, 63.8 per cent and 39.3 per cent respectively. This rate elevates to 70.3 per cent for people aged 80 years and over. The most common reasons older people presented to the emergency department were diseases of the circulatory system and diseases of the respiratory system. Diseases of the respiratory system was also the fastest growing International Classification of Diseases group increasing by 30.2 per cent from 2013-14.

Hospital care

Brisbane North has a number of quaternary, tertiary and secondary public and private hospitals. MNHHS provides hospital care older people from five public hospitals. While there are limited dedicated acute care services for older people within these facilities, care of older people is considered core business.

At TPCH, general physicians with dual-training in geriatric medicine and multi-disciplinary teams with expertise in the care of older people operate within the wards. Additional services including the geriatric and rehabilitation service (GRLS) and the external services facilitator (ESF) provide services to the general medical unit to coordinate referral and post-discharge support for older people.

RBWH utilises a geriatric model of care through internal medicine that is supported by both the Eat Walk Engage (EWE) initiative, which aims to reduce hospital-acquired geriatrics syndromes, and the multidisciplinary GRLS.

Redcliffe Hospital delivers a comprehensive geriatric model for the care older people in all medical wards, which are supported by access to multidisciplinary teams including geriatricians.

Additional hospital care services include:

- geriatric evaluation and management (GEM) beds in all facilities
- inpatient rehabilitation services in all MNHHS facilities (CSCF Level 4 inpatient rehabilitation services at TPCH, Redcliffe Hospital, RBWH (Rosemount Campus), and Brighton Health Campus)
- ortho-geriatric services provided at TPCH, RBWH and Redcliffe Hospital
- palliative care services provided at TPCH, Redcliffe Hospital and Community, Indigenous and Subacute Services (CISS)
- psycho-geriatric services inpatient services at RBWH, TPCH and Redcliffe Hospital.

In 2015-16, of the almost 170,000 hospital separations (discharges) for older people, 86.7 per cent of these separations were for residents who live in Brisbane North. In the same time period older people represented 16.5 per cent of the adult population but represented 40.7 per cent of all adult admitted hospital separations in public and private MNHHS hospitals. While older people in Brisbane North attended private hospitals (54.9 per cent) marginally more than public hospitals (45.1 per cent), public hospital separations increased by 19.3 per cent over the past three years. More specifically the proportion of public hospital overnight separation for residents aged 65-79 years has increased from 56.6 per cent to 57.4 per cent between 2013-14 and 2015-16. Residents aged 65-79 years also had the highest growth rate for same day admitted hospital bed days (25.5 per cent) over the same period.

The service related group with the highest same day admitted separations in 2015-16 was for renal dialysis while the highest overnight service related group separations was for respiratory medicine. The enhanced service related group with the highest number of overnight separations in public and private hospitals for residents aged 80 years and over was rehabilitation services and the highest for residents aged 65 to 79 years of age was hip and knee replacement.

Potentially preventable hospitalisations for chronic conditions and acute/vaccine preventable conditions accounted for six per cent of all hospital admissions within Brisbane North in 2013-14.

In 2015-16, 953 individuals were identified as frequent presenters (more than five overnight hospitalisations within a financial year). These individuals generated 6209 separations and occupied 34,900 bed days. Approximately 70 per cent of

frequent presenters were aged 50 years and over, with one in three over aged 70 years and over.

Non-admitted hospital care

MNHHS provides a range of non-admitted hospital service for older people. These services include a range of outpatient services and a number of geriatric specific services including Complex Chronic Disease Team (CCDT) and psycho-geriatric services delivered in community health centres, community based rehabilitation teams, Geriatric Assessment and Rehabilitations Unit (GARU) at the RBWH and memory clinics at TPCH and Redcliffe Hospital.

Aged care

There were 21 home care places per 1000 people aged 65 years and over in Brisbane North, consistent with national rate of 20 home care places per 1000 people aged 65 years and over. Within Brisbane North, the number of home care places varied from zero places in the Hills District to 360 places in the Caboolture statistical area.

Residential aged care places are more common than home care packages with 2.7 residential aged care places to every home care place in Brisbane North. The average number of residential aged care places per 1000 for Brisbane North is 58, slightly higher than the national average of 54. The distribution of residential care places is varied across Brisbane North with 145 places per 1000 people in the Brisbane Inner area compared to Bribie-Beachmere of 18 places per 1000 people. Across Brisbane North residential aged care also access GP services. Between 2012 and 2015 there were over 280,000 GP services delivered in residential aged care.

Similar to many of the determinants of health, the proportions of the population aged 65 years and older who have unmet needs for aged care assistance are not evenly distributed across Brisbane North. The highest proportions are in the northern areas, particularly Sandgate and Caboolture statistical areas.

Part C: Implementation, monitoring and review

Part C of this Plan details the implementation, monitoring and review process that will be implemented over the life of this Plan.

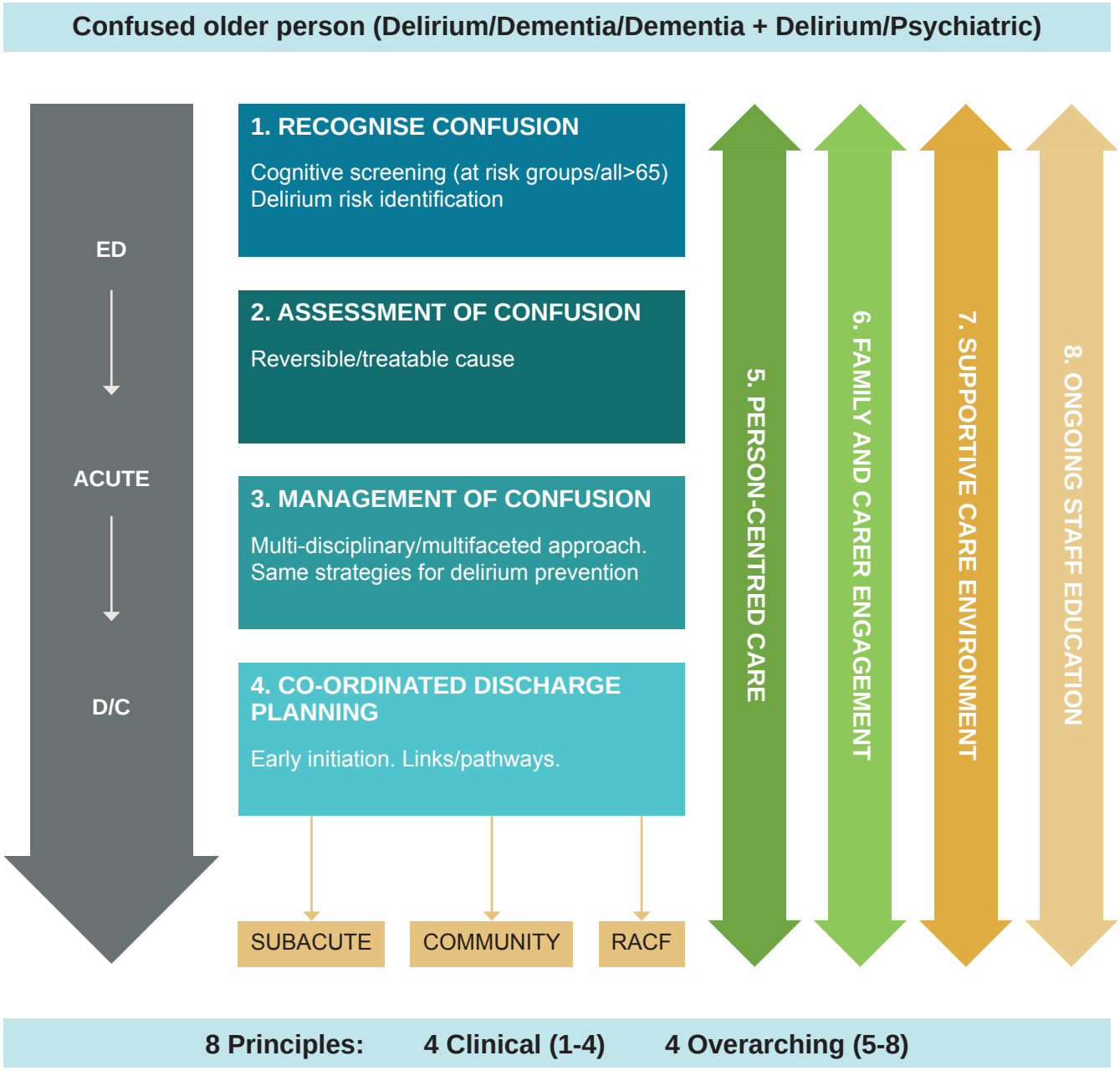
The PHN and MNHHS is committed to implementing this Plan over the next five years and will actively work in partnership with private, community and non-government providers to progress the service directions across settings across Brisbane North. An implementation plan will be developed to progress actions over time and will guide the priorities of the PHN and MNHHS. Some actions will require resourcing over time through normal budgetary processes.

Monitoring, reporting and review

This Plan will be monitored and reported on annual basis. These processes will allow changes in health needs or service developments during implementation of this Plan to be identifies and ensure this Plan can be reviewed and updated if required.

Appendix 1

Principles of Management of the confused older person in Metro North



4 Clinical Principles

1. RECOGNISE CONFUSION

Screen for confusion

Identify delirium risk

- Over 65 years of age
- Severe illness or risk of dying
- Known cognitive impairment
- History of previous delirium
- Hip fracture

Use validated screening tools.

Screening within 8 hours of admission.

2. ASSESSMENT OF CONFUSION AND PREVENTION OF DELIRIUM

Assess for treatable and reversible causes such as

- Acute medical/surgical illness
- Drugs and alcohol
- Drug withdrawal
- Pain
- Constipation/urinary retention
- Malnutrition
- Sleep deprivation
- Environmental disruption

Comprehensive assessment.

Document all diagnoses including dementia.

3. MANAGEMENT OF CONFUSION

Multi-disciplinary and multifaceted team approach

- Establish goals for treatment
- Implement and monitor treatment plans
- Ongoing medication review
- Alleviate distress – patient and family/carer

Treatment underlying cause of confusion and develop behaviour management plans.

4. CO-ORDINATED DISCHARGE PLANNING

Early initiation of timely, multidisciplinary discharge planning.

- Family/carer involvement
- Estimated date of discharge
- Coordinated links to community resources and services
- Clear discharge pathways

Seamless care across the acute, subacute, community continuum.

4 Overarching Principles

5. PERSON CENTRED CARE

Develop individualised behaviour and management plans

- 'Get to know you' tools
- Wall flowers
- 'top five'
- Memory/photo books
- Communication books
- Personal items

Adapt care to meet the needs of the individual patient throughout admission

6. FAMILY AND CARER ENGAGEMENT

Involve family/carer in all aspects of care

- Vital source of information on initial assessment
- Important resource for developing behaviour management plans
- Involve in future planning/ decision making
- Provide support and education

Building relationships

7. SUPPORTIVE CARE ENVIRONMENT

Key factors

- Promote continence
- Promote mobility
- Lighting and noise
- Activity appropriate areas
- Signage/orientation
- Personal items/areas
- Safe outdoor areas/access
- Single sex bays/rooms

Think small, think simple, think adaptable

8. ONGOING STAFF EDUCATION

Must be hospital wide, multidisciplinary and patient focused

- Raise general awareness
- Increase knowledge, skills and confidence of staff
- Use wide range of educational tools and strategies
- Occupational violence prevention training

Ongoing, adaptable and relevant

Notes

The five year health care plan for older people who live in Brisbane North is a partnership between Metro North Hospital and Health Service and Brisbane North PHN. This activity is supported by funding from the Australian Government under the PHN Program.

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