Cairns and Hinterland
Hospital and Health Service

CLINICAL SERVICES PLAN

2022 – 2027

(With outlook to 2032)

Queensland Government

Accessability

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Aboriginal and Torres Strait Islander people are advised that this publication may contain words, names and descriptions of people who have passed away.
Cairns and Hinterland Hospital and Health Service (HHS) formally recognises the Australian South Sea Islanders as a distinct cultural group within our geographical boundaries. Cairns and Hinterland HHS is committed to fulfilling the Queensland Government Recognition Statement for Australian South Sea Islander Community to ensure that present and future generations of Australian South Sea Islanders have equality of opportunity to participate in and contribute to the economic, social, political and cultural life of the state.

Document history and approval

Contact enquiries about this report: chhhs_planning@health.qld.gov.au

Version No.	Date	Description of change
1.01	January 2023	Final report

ACKNOWLEDGMENT OF OUR TRADITIONAL OWNERS

We acknowledge Aboriginal people and Torres Strait Islanders as this country's First Nations people.
We recognise First Nation people and communities as traditional and cultural custodians of the lands on which we work to provide safe and quality health services. We pay our respect to Elders past, present and emerging.

Introductory Messages

Board Chair message

As the Chair of the Cairns and Hinterland Hospital and Health Service Board, I am immensely proud of the level and quality of health services we deliver to Far North Queenslanders every day, however there is always room for improvement.

The Cairns and Hinterland Hospital and Health Clinical Service Plan 2022-2027 details how to improve and grow our services over the next five years, with an outlook to 2032 to meet the needs of our community.

The Plan sets out a collective vision for the growth and future direction of the Health Service, articulated following extensive consultation and engagement with clinicians, stakeholders and community representatives who provided valuable insight.

Our latest Clinical Services Plan builds on our previous plan, is informed by our recent Local Area Needs Assessment and outlines a clear pathway to continue to address the health challenges faced by our community now and into the future.

This plan also helps set the direction to deliver on our full potential as the Far North's largest employer and provider of health services and includes a strong focus on building our relationships with existing health and service providers.

We would like to thank and acknowledge the many staff, community members and stakeholders who have informed our Clinical Services Plan and helped set us on the right path towards the future.

Clive Skarott
Chair

Clinical Council message

It is very easy to take some things for granted. One example is health: when you are fit and well, it is easy to forget what it is like to need care.

And when care is needed, most of us do not really think about the complex system that seeks to restore us back to our potential.

However, the only reason our healthcare system is there when we need it most is because someone planned it so.

The Clinical Services Plan before you is both for us and by us.

It contains a wealth of information about the needs of our community, our potential patients, and the challenges that we will face providing care for all who need it.

There are a lot of statistics and numbers which, we can forget, are people. People counting on us to properly plan for a health service which can deliver care to those who desperately need it, when they need it most.

Dr Alex Kochi
Chair
Clinical Council

Table of Contents

1.0 Our clinical services plan

1.1 Executive Summary

The Cairns and Hinterland Hospital and Health Service (CHHHS) Clinical Services Plan (CSP) (2022-2027 with outlook to 2032) provides the directions for how we will improve and grow our services over the next five years (with a ten-year outlook) to meet the needs of our people and communities in Far North Queensland.

The population in our region has higher health risk factors, lower life expectancy, a higher prevalence of disease, and a higher number of potentially preventable hospitalisations compared to the rest of Queensland. There are challenges to sustainable and timely health service delivery, including geographical distance, workforce gaps and the growing cost of service delivery.

The CSP provides a roadmap of clinical service directions, designed to address health service challenges, support improved health outcomes and access to healthcare for our communities. It aligns with the Health Q32 priorities of maximising wellbeing, strengthening access to care in the community and closer to home and optimising safe, appropriate and timely hospital care. The plan positions the health service to meet the community's health needs now and into the future.

The Clinical Service Plan outlines five key areas for clinical service direction. It should be noted that the directions do not act in isolation, but rather require integration to ensure cohesive and coordinated clinical service provision. The five key areas are listed below with a high-level summary of the initiatives for implementation:

First Peoples services	Primary and preventative care, health promotion, advocacy, and partnerships	Mental health and addiction services	Cairns and surrounds services	Rural and remote services
• Implementation of the CHHHS First Peoples Health Equity Strategy • Clinical models and services provided at Yarrabah • Opportunities to work across the care continuum in partnership with other providers to meet First Nations peoples' health needs	• Opportunities for the TPHS service and infectious disease management • Partnerships and a regional health plan • Improving navigation of health care • In reach and home-based services, community-based primary and preventative care, health promotion and early intervention services	• Implementation of 'Better Care Together' • Partnering to meet mental health and addiction needs for children, youth and adults • Expanding mental health capacity (acute and community based)	• Increased CSCF capability for select services at Cairns Hospital • Expansion of services to meet need • Leverage virtual, technology enabled and/or telehealth models of care • Progress towards Cairns University Hospital status	• More streamlined access to high value care that is closer to home for rural and remote regions • Expansion of key clinical services in regional ad remote areas across the CHHHS • Facilitation of prisoner health services

One of the key underpinning enablers of the CSP is our workforce. Our ability to attract and retain a highly skilled and capable health workforce to the region will be essential. Our commitment to enhance education, research, and professional development opportunities must be incorporated into all our clinical service planning considerations, and will also pave the way to transition to Cairns University Hospital status.

There is strong recognition that the strategies we are working to implement and outcomes we are aiming to influence are highly reliant on working in partnership with other health and service providers. The CSP builds on our existing and commits to developing new relationships with other providers and organisations across Northern Queensland. Our partnerships will be key to reduce duplication, address service delivery gaps, provide more seamless access to services, ensure sustainable service provision, and enhance health equity.

The clinical service delivery strategies set out in the CSP are supported by a series of other enabling strategies and plans that either already exist or are in the process of being developed. The CSP will also be supported by more detailed operational planning including consideration of various factors such as models of care, workforce, infrastructure, environmentally sustainable health care and funding.

1.2 Introduction

To develop the Clinical Services Plan (CSP), we undertook extensive community and staff consultation (in conjunction with the Local Area Needs Assessment consultation), examined historical activity and waitlists and projected activity data and referred to significant previous planning work. Consultation was critical in better understanding local needs and to identify specific clinical service delivery strategies, key enablers, and implementation considerations for the local context.

Governance was provided by a steering committee, comprising of executive leads, clinical leaders, key stakeholders and subject matter experts. The service directions were considered in the context of government direction, strategic objectives of the CHHHS and considerations of the local health and service needs.

The following sections of the plan outline the strategic alignment and longer term vision for our clinical services, followed by contextual information, service delivery strategies and steps for implementation. Please refer to the '*Clinical Services Plan 2022-2027 (with outlook to 2032) supporting information*' paper for further details on our community, our regions and our organisation.

1.3 Strategic alignment

The CHHHS CSP aligns with the *CHHHS Strategic Plan 2023-2027* and a variety of broader system strategies and policies, including but not limited to:

- Queensland Health System Outlook to 2026
- My health, Queensland's future: Advancing health 2026
- Unleashing the potential: an open and equitable health system (HealthQ32 strategy)
- Making Tracks Investment Strategy (Queensland's Aboriginal and Torres Strait Islander Health Equity Framework)
- Digital Strategy for Rural and Remote Healthcare
- Queensland Health's Virtual Healthcare Strategy
- Queensland Health Telehealth Strategy
- Rural and Remote Health and Wellbeing Strategy (2022-2027)
- The National Medical Workforce Strategy

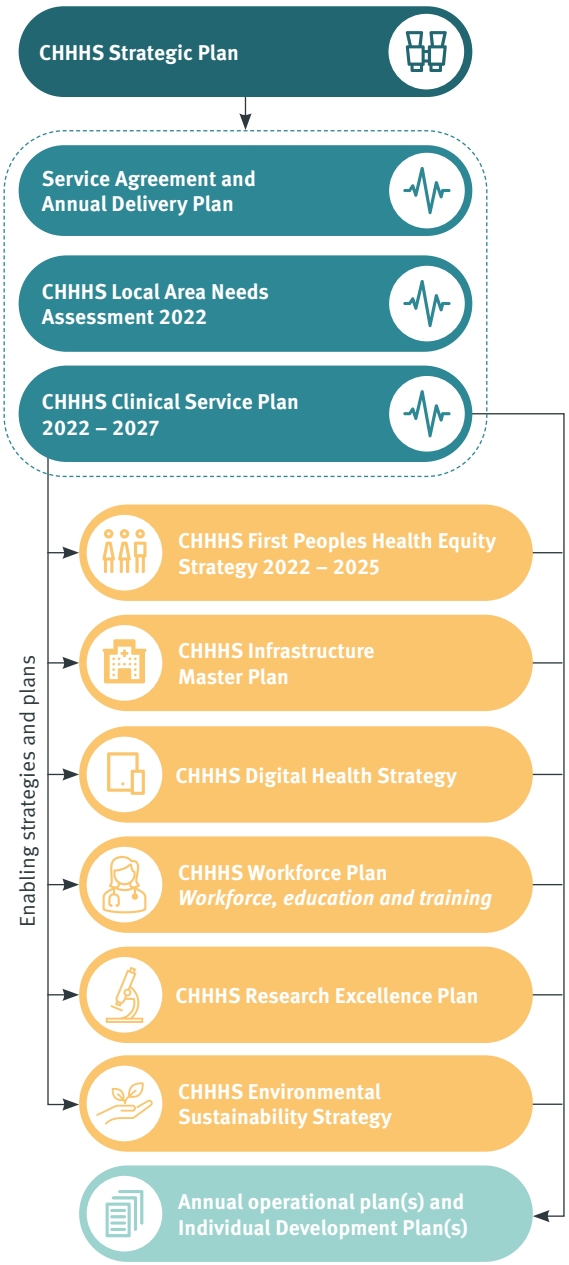
The *CHHHS Strategic Plan 2023-2027* sets a strong vision for the future – 'excellent and sustainable healthcare for all in Far North Queensland'. To deliver on this vision, the CHHHS has identified four strategic objectives. These are:

- Our care
- Our people
- First Peoples health
- Our sustainability

The four strategic objectives include a strong focus on partnering and community engagement and are intended to have a meaningful impact on health outcomes and access for the CHHHS and the North Queensland population more broadly. The service directions of the CSP align with the strategic direction and objectives of the CHHHS.

A series of enabling strategies and plans will be or are in the process of being developed to support the service delivery directions and strategies that have been identified in the CSP. These plans are described in section 3.3.

Figure 1: CHHHS Strategies and Plans



1.4 The future of our clinical services

Our strategic vision and purpose set the ongoing direction for our services.

Vision:

Excellent and sustainable healthcare for all in Far North Queensland

Purpose:

Working together for best-practice care that improves health outcomes and equity for our communities

In line with this vision and purpose, we envisage that by 2032, the CHHHS clinical services will have the following key attributes.:

Our role as leaders in service provision

The CHHHS will be known as a leader in the delivery of high value care for tropical health and infectious diseases as well as the most pressing and important health needs for our communities including complex chronic disease, mental health, and early years health (the first 3,000 days of life). This will include a focus on improving health outcomes and access for our First Peoples and the prioritisation of health equity and our cultural capability.

Locally relevant models of care

Our models of care and referral pathways will be aligned to the needs of our communities and underpinned by a coordinated network of partners across the health system and adjacent sectors. This will include, but will not be limited to, primary care, education, housing and local councils. Care that is coordinated and supported by seamless flows of data and information between providers will be business as usual.

Innovative use of technology

We will be experts in harnessing technology to enable care that is as close to home, family and country as possible. Our rural staff and facilities will be empowered with real time access to specialist oversight and support as required, enhancing professional development, and learning opportunities, and ensuring that we are delivering the best possible outcomes for patients and families.

Health services across the continuum

We will be known as a Hospital and Health Service that embraces and invests in health service provision across the continuum – from health promotion and early intervention, primary and preventative care, to acute and tertiary services. The activity profile for the health service will have shifted towards more home based and locally based community health services (in partnership with others).

A sustainable, local, and highly skilled workforce

The CHHHS services and facilities will be a place where staff and health professionals want to come to work. Cairns Hospital will be established as a University Hospital and research and education will be embedded as part of our day-to-day practice. This will support our staff with increased opportunities for professional development, research and education and training.

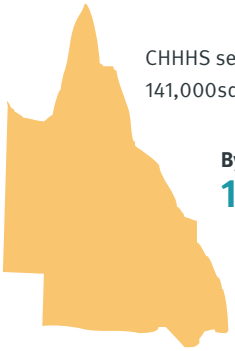
Our leadership in environmental sustainability

We will be known and looked to as leaders in environmentally conscious health service delivery. We will be smarter in how we are utilising our already limited resources, including innovative and sustainable use of infrastructure, technology, and models of care that actively lower our carbon footprint, reduce environmental waste and consider the increasing impact of climate change on health needs.

2.0 Context

The following sections provide a very high-level snapshot of the current state of our community, organisation, services, and partnerships. Further detail can be found in the supporting information document that accompanies this plan. All data in the plan is taken from the CHHHS Local Area Needs Assessment (LANA), unless otherwise stated.[2]

2.1 Our community



CHHHS services a **diverse population** of approximately **261,000** people[3] spread over an area of approximately 141,000sq km of outer regional, remote, and very remote Qld.

By 2031 the **population** is expected to reach **306,000** people representing an average annual growth rate **of 1.5%**. (below Queensland-wide growth of 1.7% annually, with 6.2 million people living in the state by 2031).

The region is made up of **six statistical area 3s (SA3s)**: Cairns North, Cairns South, Innisfail – Cassowary Coast, Port Douglas – Daintree, Tablelands (East) Kuranda and Far North.

16.2% of the CHHHS population is **aged over 65 years** (QLD 15.7%)

First Nations people comprise **11.6%** of the population (QLD 4.6%)

>50% of people fall in the lowest quintiles of **socioeconomic disadvantage**.

Areas with the **greatest volume and proportions of First Nations people are Cairns South** SA3 and **Yarrabah and Innisfail** SA2s (in the Innisfail – Cassowary Coast SA3).

Proportion of the population who engaged in...

Figure 2: Daily smoking

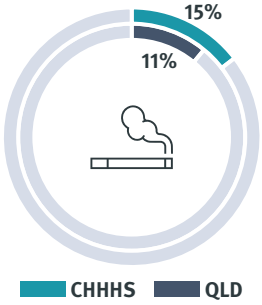


Figure 3: Risky lifetime drinking

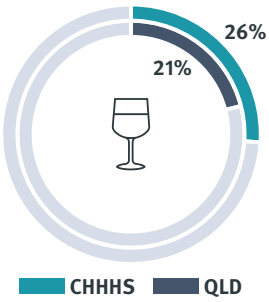
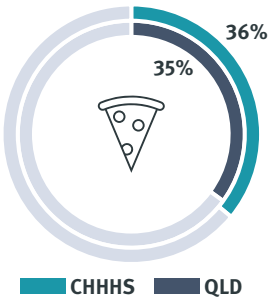
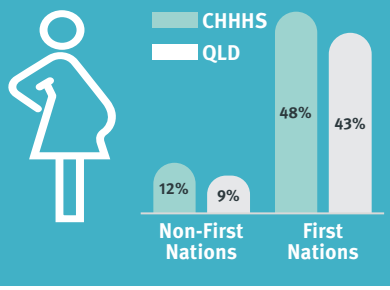


Figure 4: Overweight



There are nearly **3,000 births annually in the region and mothers and babies experience poorer health outcomes than Queensland.**

Figure 5: Rates of smoking in pregnancy



- The CHHHS First Nations peoples birth rate is higher (20.7 per 1,000) compared to the Queensland First Nations rate (13.4 per 1,000).
- Higher low birth weight rate compared to Queensland for First Nations people (13% vs 11%) and the total population, (8.4% vs 7.5%).
- Higher premature birth rate compared to Queensland for First Nations people (14.6% vs 12.3%) and the total population, (10.1% vs 9.3%).
- Higher infant mortality rate compared to Queensland (5.8 vs QLD 4.9 per 1,000).

2 It is acknowledged that some data sets are not recent, as per the available data.

3 Data source: Australian Bureau of Statistics, catalogue no. 3235.0. Data modified and rebased by Queensland Government Statistician Office (QGSO) via ABS consultancy -Aug 2021, as per the Queensland Health Planning Portal. Data extracted September 2022.

Utilisation of primary care is generally lower for the CHHHS region compared to Queensland with the exception of First Nations Peoples Health Checks (noting that proportionally this is lower, given the CHHHS First Nations people population is 2.5 greater than the Queensland population):

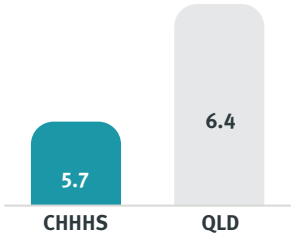


Figure 6:
Average **number of GP visits** per person

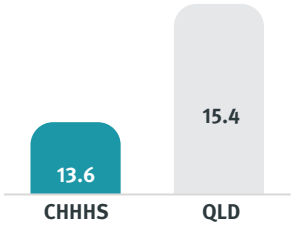


Figure 7:
Utilisation of (MBS billable) **mental health care plans**

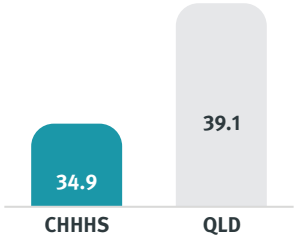


Figure 8:
Utilisation of (MBS billable) **Chronic Disease Management Plan**

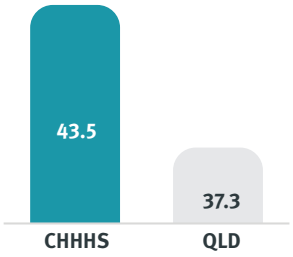


Figure 9:
Utilisation of (MBS billable) **First Nations peoples Health Check**

Median life expectancy for females in the CHHHS between 2017 and 2019 was **84.3 years compared** to 84.8 years for Queensland females, and **78.2 years for males** compared to 80.3 years for Queensland males.

First Nations peoples' median life expectancy in the region is 61.3 years. Median life expectancy for First Nations females in the CHHHS region between 2017 and 2019 was 66 years and for males was 59 years.[4]

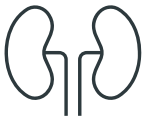
The **Far North region has the lowest life expectancy rates** for the overall population in the CHHHS region, at 76.5 years for males and 81.2 years for females

The conditions that impact the highest number of people in the CHHHS region:

Mental health
55,443 people impacted between 2017 and 2018

Arthritis
33,745 people impacted between 2017 and 2018

Asthma
28,447 people impacted between 2017 and 2018



Diabetes
15,175 people impacted between 2017 and 2018

First Nations people residing within the CHHHS region **experience poorer health outcomes** than the rest of CHHHS.

Compared to the rest of CHHHS, First Nations people residing within CHHHS are:

6 
times more likely to have
End Stage Kidney Disease

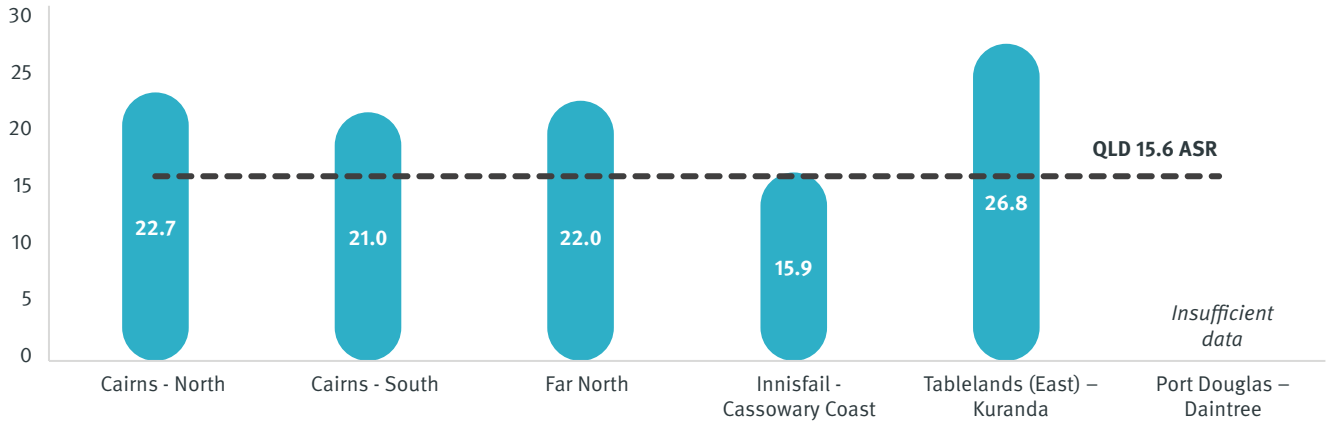
46 
times more likely to have
Rheumatic Heart Disease

3 
times more likely to have a
Sexually Transmitted Infection

4 Data source: Cairns and Hinterland Analytical Intelligence (CHAI) median life expectancy First Nations people, from the Cairns and Hinterland region (2017-2019) calculated by median formula according to male and female breakdown. It is noted that not all First Nations people in the region may be included in this count.

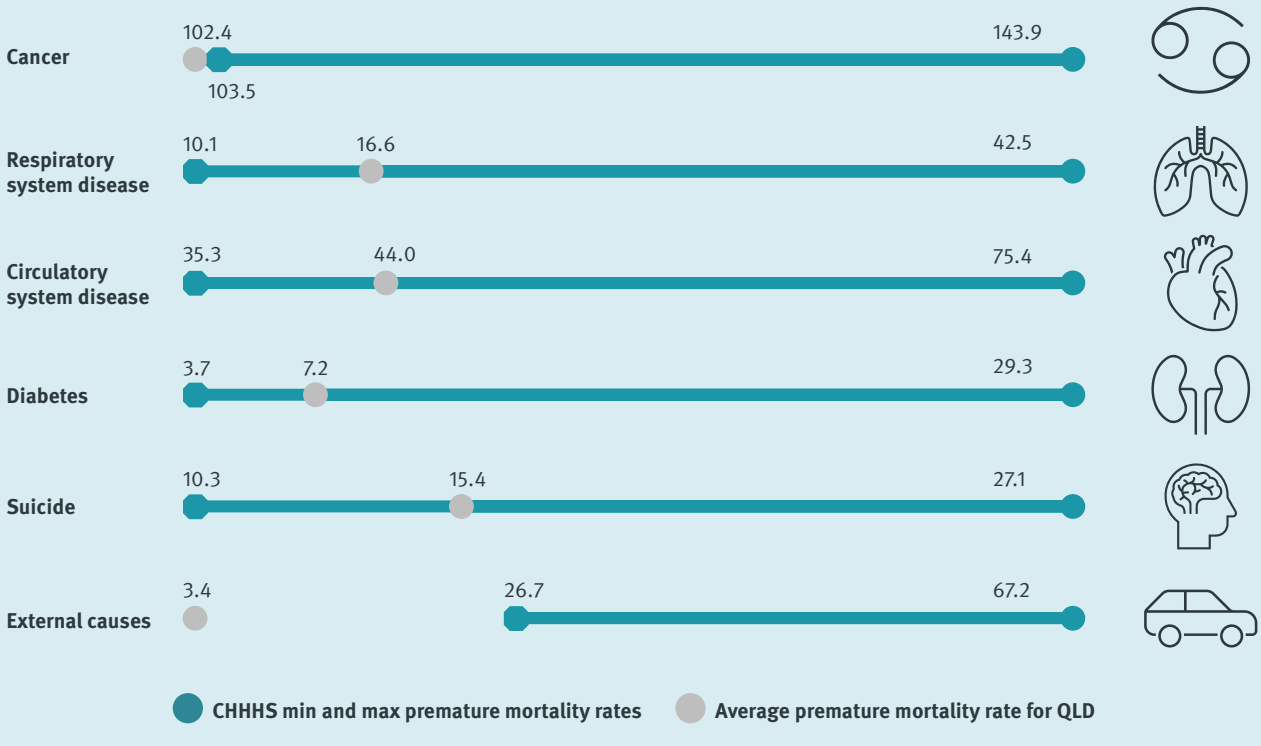
Rates of suicide for all reported CHHHS areas **are higher when compared to Queensland** (ASR per 100k)[5].

Figure 10: Age standardised rate of suicide per 100,000 population by SA3s within the CHHHS



The population within the **CHHHS region experiences higher rates of premature mortality** in most areas when compared to the rest of Queensland.

Figure 11: Minimum and maximum age standardised premature mortality rates per 100,000 population by condition



5 The Age Standardised Rate (ASR) per 100K for suicide is different (15.6 vs 15.4) due to the time period for the two different data points. The 15.4 rate is for 2014-2018, the 15.6 rate is for 2015-2019. The 2015-2019 data breakdown does not have SA2 level detail, hence the two different data points have been used.

2.2 Our organisation

The CHHHS is the primary provider of health services to residents of the Cairns and Hinterland region, and specialist services to the Torres Strait and Cape York region. Services are provided over a large geographical area covering approximately 141,000sq km from Tully in the south, Cow Bay in the north and Croydon in the west, the equivalent of approximately 8% of the Queensland area.

The facilities in the CHHHS are listed below, by region and Clinical Service Capability Framework (CSCF) level. The CSCF is a framework that describes the level of clinical services, ranging from Level 1 (lowest) to Level 6 (highest) for clinical services. The CSCF lists a number of different clinical services and the full CSCF details for each CHHHS facility can be found here: CSCF public hospitals | Queensland Health. The table below provides an overall CSCF level (where applicable) for each facility (as at Nov 2022).

Table 1: CHHHS facilities by CSCF level

SA3 region	Hospitals	Primary Health Centres (PHCs)[6]	Community Health Centres (CHCs)	Other
Cairns North			• Cairns North CHC • Smithfield CHC	

Cairns South	• Cairns Hospital (CSCF 5)
	• Gordonvale Hospital (CSCF 2)
			• Edmonton CHC
			• Cairns South Health Facility
				• Community residential mental health:-
				  • Community care unit
				  • Adult step-up-step-down
				  • Youth-step-up step-down)
				• Subacute Care Unit (Oregon St – opening late 2022)

Far North[7]		• Croydon PHC • Forsayth PHC • Georgetown PHC • Chillagoe PHC		
Innisfail – Cassowary Coast	• Babinda Multi-Purpose Health Centre (CSCF 2) • Innisfail Hospital (CSCF 3) • Tully Hospital (CSCF 2)		• Innisfail CHC • Mission Beach CHC • Jumbun CHC	• Yarrabah Emergency Service (CSCF 2) and other CHHHS services
Port Douglas – Daintree	• Mossman Multi-Purpose Health Centre (CSCF 3)	• Cow Bay PHC	• Mossman CHC	
Tablelands (East) – Kuranda	• Atherton Hospital (CSCF 3) • Mareeba Hospital (CSCF 3) • Herberton Hospital (CSCF 2 – select services only)	• Dimbulah PHC • Malanda PHC • Millaa Millaa PHC • Ravenshoe PHC • Mount Garnet PHC	• Atherton CHC • Mareeba CHC	• Lotus Glen Health Service (CSCF 2 – select services only)

6 Generally CSCF level 1 services -select services only.

7 This region also includes outreach primary health nursing to The Lynd, Einasleigh and Mt Surprise areas.

2.3 Our clinical services

Historical growth in our services from 2020 to 2022

Our activity and demand for services

Over FY20 to FY22, our services have experienced growth that exceeds the growth of our population and this is despite the disruptions due to COVID-19. Growth is particularly significant for non-admitted services with ED services growing at 6.2% and outpatient services growing at 5.5% year on year.

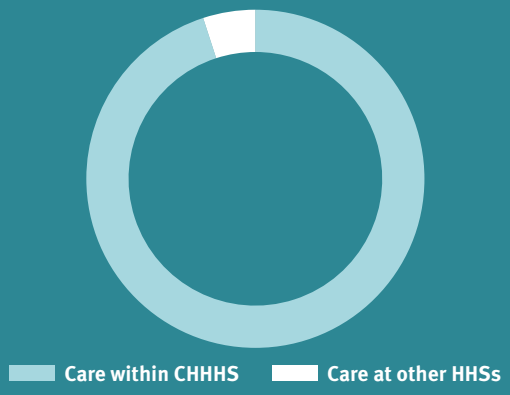
Table 2: CHHHS historical activity summary FY20 to FY22

Service	Unit	FY20	FY21	FY22	Change (FY20 – FY22)
Inpatients					
Separations	Separations	71,736	74,721	76,205	+4,469
Proportion of day admissions	%	58%	59%	60%	+2%
Overnight avg length of stay	Days / Separation	4.9	4.7	4.8	-0.1
Procedures[8]					
Episodes	Episodes	40,347	45,270	45,133	+4,782
Outpatients					
Outpatients	Occasions of service	339,352	373,031	377,706	+38,354
Emergency Department					
Presentations	Presentations	153,882	168,441	173,457	+19,575

Our waitlists for specialist outpatient appointments and elective surgery[9] continue to exceed the growth of the population. We continue to deliver increasing numbers of outpatient appointments and hospital episodes of care to help meet the growing community demand and need.

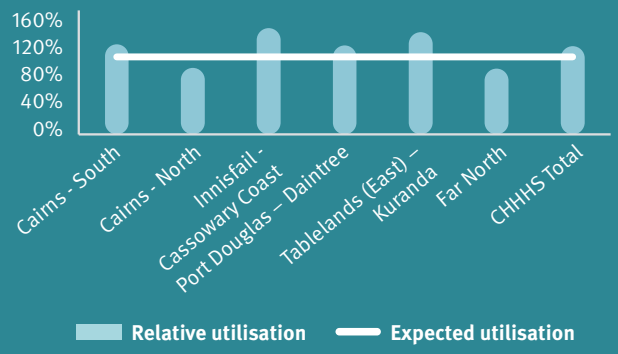
Access to care in our region

Figure 12: CHHHS public self-sufficiency



Our services are relatively self-sufficient[10], with 95% of residents accessing care locally within CHHHS. We work within an integrated network of HHSs across Queensland to deliver care where we don't have the capability to deliver locally. Plans to grow the CHHHS capability locally will help to increase self-sufficiency.

Figure 13: CHHHS relative utilisation of public hospital services



Relative utilisation[11] of public hospital services is high for our local residents, except for Cairns North and Far North residents. Relative utilisation is typically linked to private health insurance rates and socioeconomic factors, as well as burden of disease. Access to inpatient care in Far North is likely further impacted by the remoteness of the region.

8 Episodes include admitted and non-admitted procedures for renal dialysis, chemotherapy, interventional cardiology, and endoscopy. Procedural activity excludes public renal dialysis undertaken at Cairns Hospital.

9 Impacted also by COVID-19 pandemic response and periods of non-urgent surgery cessation.

10 Self-sufficiency refers to the proportion of people from a region who can receive hospital care within their region.

11 Relative utilisation is the ratio of the number admissions for residents of a geographical region, regardless of where they were admitted, to the expected number of admissions based on the state admission rate adjusted for age and sex.

Demand for inpatient services

Figure 14: CHHHS services that experienced the greatest volume of growth in overnight separations with annualised growth rates (FY20 to FY22)

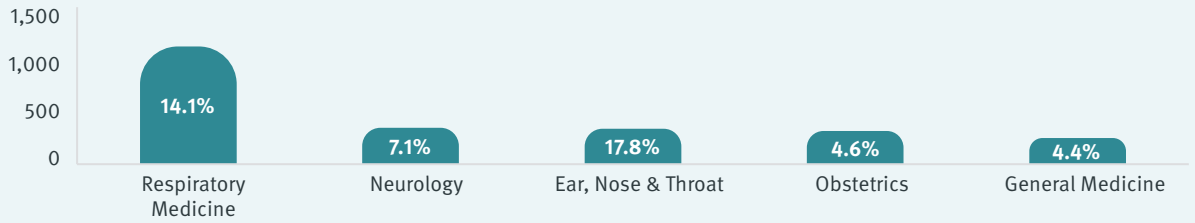
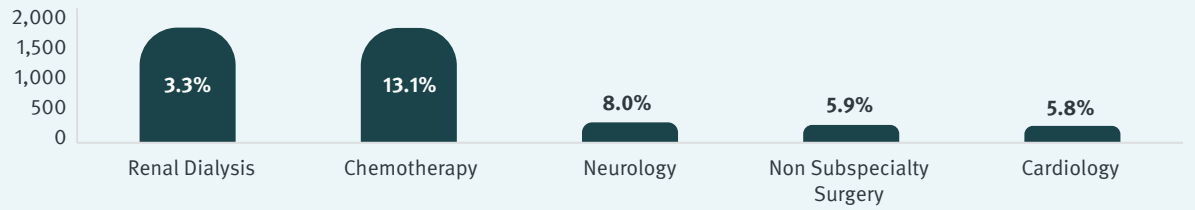


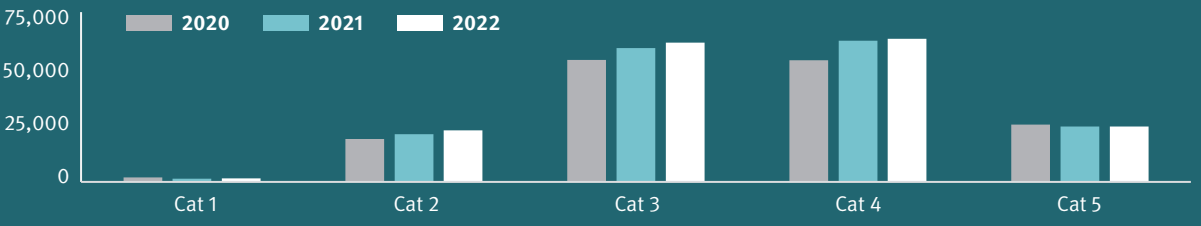
Figure 15: CHHHS services that experienced the greatest volume of growth in same day separations with annualised growth rates (FY20 to FY22)



Emergency Department presentations

We continue to have strong growth in the volume and rate of Category 3 and 4 presentations. Growth in these categories emphasises the importance of hospital avoidance strategies and models that redirect to alternate settings, particularly given the majority of these presentations (Cat 3 and 4) and CHHHS ED presentations *overall* are not admitted.

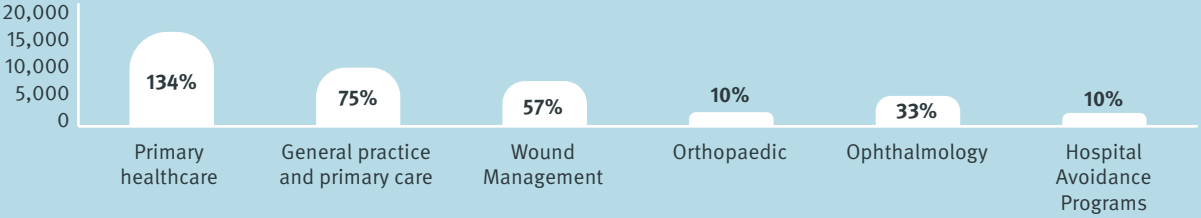
Figure 16: Growth in ED presentations by triage category (FY20 to FY22)



Outpatient occasions of service

CHHHS Primary Health Care and General Practices and Primary Health Care Tier 2 outpatient clinic codes experienced the greatest volume of growth in occasions of service between FY20 and FY22. Primary Health Care outpatient clinics also experienced the greatest annualised growth in activity. This points to challenges with regional primary care access.

Figure 17: Growth in outpatient occasions of service by Tier 2 clinics that experienced the greatest volume of growth (FY20 to FY22)



Projected activity growth across CHHHS from 2022 to 2032

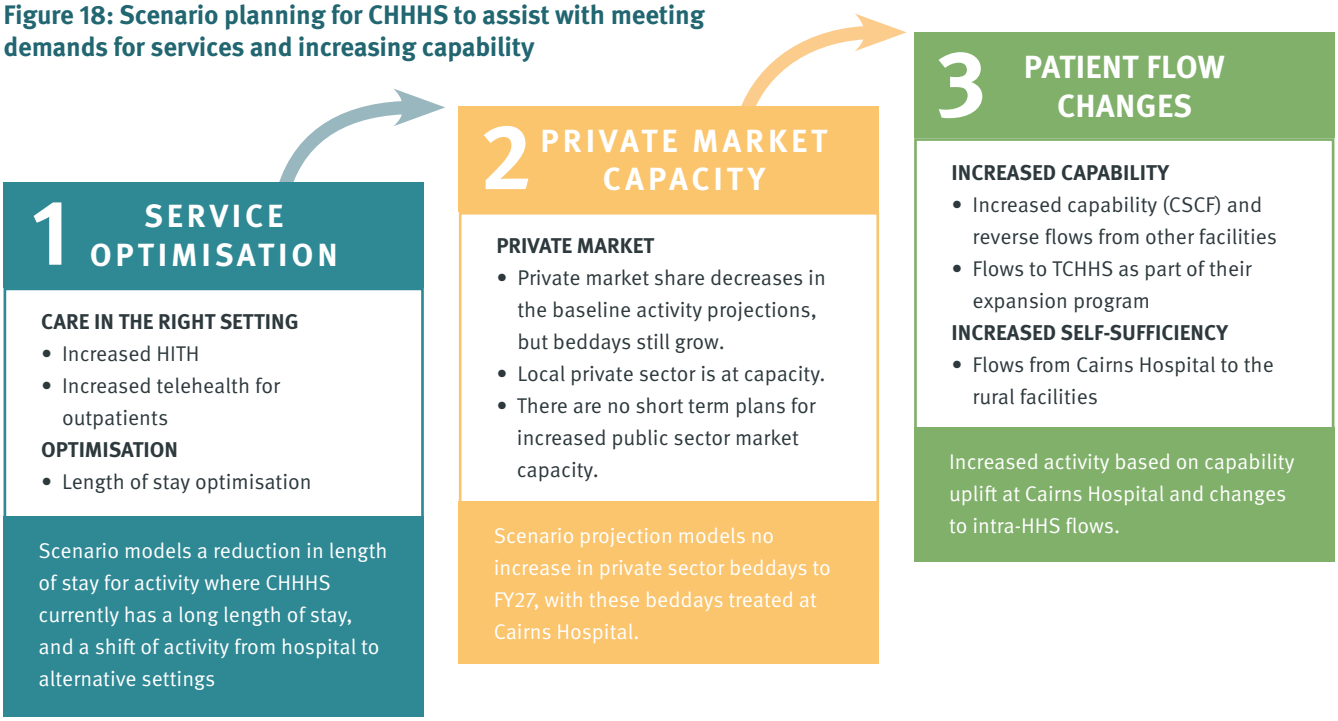
Over the next 10 years, the CHHHS is expected to experience significant growth in demand for acute services across the board. Admitted, non-procedural services[12] are projected to grow by 4.8% each year to FY32 for inpatient services, with commensurate increases in emergency department and outpatient services activity. Procedural activity is also projected to grow significantly, with endoscopy growing at 6.1% annually, renal dialysis growing at 6.5% annually, chemotherapy growing at 6.4% annually and interventional cardiology services growing at 4.3% annually. This growth is well above projected population growth of 1.5% per annum to 2031 and brings significant challenges in terms of timely access and health sustainability if not managed proactively.[13]

Table 3: Projected activity growth across CHHHS from 2022 to 2032

Activity Type	Baseline projected growth per annum (2022-2032)
Admitted separations (excluding procedures)	4.8%
Procedures – Endoscopy	6.1%
Procedures – Renal Dialysis	6.5%
Procedures – Chemotherapy	6.4%
Procedures – Interventional Cardiology	4.3%
ED Presentations	3.9%
Outpatient Occasions of Service	6.0%

The CHHHS has examined several different opportunities to meet the continued expected increase in demand on its health services, including considerations of service capability uplift (providing more care to patients in the CHHHS region, rather than having to travel outside of the CHHHS region for care) over the next 10 years as well as service optimisation and consideration of private market capacity (refer to Figure 18).

Figure 18: Scenario planning for CHHHS to assist with meeting demands for services and increasing capability



12 Growth rate excludes renal dialysis, chemotherapy, interventional cardiology, and endoscopy.

13 Projection volumes that have been used in calculating these growth rates have come from the Department of Health Estimates of Future Activity where the base year is FY21. The modelling completed by the Department of Health is based on analysis of multiple years of historical trends. Growth rates have been calculated relative to CHHHS actual FY22 historical volumes.

Two sets of projected activity volumes are included in Table 4:

1. The baseline projections are a 'status quo' projection based on 5-7 years of historical trends. This projection represents the estimated activity volumes for each facility if current service delivery continues into the future.

2. The scenario projection is an adjustment of the baseline projection to incorporate the impacts of the service delivery strategies outlined in Figure 18.

Table 4: Projected growth in activity for the CHHHS clinical services from FY22 – FY32

	Actual	Baseline Projection			Scenario Projection		
	FY22	FY27	FY32	CAGR 2022 - 2032	FY27	FY32	CAGR 2022 - 2032
Inpatient Separations[14]	**76,205**	**102,596**	**122,138**	**4.8%**	**104,036**	**123,112**	**4.9%**
Acute	64,509	85,311	101,900	4.7%	86,607	102,815	4.8%
Adult Overnight	33,501	39,773	46,557	3.3%	40,223	46,792	3.4%
Adult Same Day	24,565	37,314	45,960	6.5%	38,089	46,589	6.6%
Paediatric Overnight	4,332	5,029	5,730	2.8%	5,051	5,748	2.9%
Paediatric Same Day	2,111	3,195	3,653	5.6%	3,244	3,685	5.7%
Maternity	7,264	11,047	12,830	5.9%	11,131	12,913	5.9%
Subacute	2,303	3,029	3,747	5.0%	3,068	3,724	4.9%
Mental health	2,129	3,210	3,661	5.6%	3,231	3,661	5.6%
Medical Imaging Examinations							
X-Ray	86,019	110,189	126,656	3.9%	110,189	126,656	3.9%
CT	38,907	61,063	83,429	7.9%	61,063	83,429	7.9%
Ultrasound	22,171	28,279	35,659	4.9%	28,279	35,659	4.9%
MRI	7,259	9,356	11,179	4.4%	9,356	11,179	4.4%
PET/CT	2,988	4,933	6,470	8.0%	4,933	6,470	8.0%
Interventional and theatres	6,481	9,509	11,190	5.6%	9,509	11,190	5.6%
Procedures[14]							
Chemotherapy	7,799	12,933	14,457	6.4%	12,933	14,457	6.4%
Renal Dialysis	40,352	62,749	75,979	6.5%	62,749	75,979	6.5%
Facility dialysis	38,546	48,096	58,238	4.2%	48,096	58,238	4.2%
Home dialysis	1,806	14,653	17,741	25.7%	14,653	17,741	25.7%
Endoscopy	7,867	13,134	14,261	6.1%	13,134	14,261	6.1%
Interventional Cardiology	1,620	2,122	2,473	4.3%	2,122	2,473	4.3%
Emergency Department Presentations[15]	**173,457**	**216,940**	**254,480**	**3.9%**	**216,940**	**254,480**	**3.9%**
Triage Category 1 (Most urgent)	1,571	2,120	2,368	4.2%	2,120	2,368	4.2%
Triage Category 2	22,761	26,007	29,430	2.6%	26,007	29,430	2.6%
Triage Category 3	61,453	79,655	95,894	4.6%	79,655	95,894	4.6%
Triage Category 4	63,154	80,372	95,925	4.3%	80,372	95,925	4.3%
Triage Category 5 (Least urgent)	24,518	28,786	30,863	2.3%	28,786	30,863	2.3%
Outpatient Occasions of Service	**377,706**	**558,953**	**674,683**	**6.0%**	**558,953**	**674,683**	**6.0%**
In person	298,791	462,596	558,375	6.5%	412,234	497,585	5.2%
Telehealth and other	78,915	96,357	116,308	4.0%	146,720	177,097	8.4%

14 Inpatient activity volumes presented in Table 4 exclude separations for procedural activity. Procedural activity includes both admitted and non-admitted episodes.
15 Excludes Yarrabah ED presentations

2.4 Our partnerships

We have a number of partnerships and joint models of care in place that are important to ensuring timely, equitable and targeted access to services across the health care continuum.

Over the last five years and as part of delivering on the priorities of our previous CSP, we have worked to establish Collaborative Service Agreements with all ACCHOs within our health service region. These agreements provide the foundations for improved collaboration and coordination between our organisations and a shared commitment to progressing health equity for our First Nations peoples at all levels of health service.

Increasingly, we are working in collaboration with neighbouring Northern Queensland HHSs within a networked health care system to streamline and better coordinate access to services locally including through the Care Coordination Service initiative with TCHHS and QAIHC. Working as part of a broader regional health network through initiatives such as these is at the core of our commitment to reducing duplication and providing access to the highest quality of care as close to home and country as possible.

We continue to work closely with private providers and NGOs within the region to support timely and equitable access to care within the context of increasing demand for services. This includes outreach services to our rural and remote communities and leveraging additional private sector acute capacity.

Moving forward, the CHHHS CSP considers our services in terms of activities that need to occur within our organisation, but also focusses on where we need to partner to ensure seamless holistic care and sustainable health services across the care continuum. This includes partnerships across the health care continuum but also with adjacent sectors and services, and with local councils, peak bodies, and government to be able to influence health experiences and outcomes.

Figure 19: CHHHS partnership mapping

2.5 Considerations for our health service planning

2.5.1 Key insights from consultation

When developing the future clinical service directions for the CSP, a number of key themes were raised during consultation that relate to the realisation of the directions and provide important considerations that inform how the CHHHS will work to implement the service delivery strategies set out in the plan

Table 5: Key insights from consultation

Key theme identified	Considerations for clinical service planning
Workforce	• Strong desire for models that enable clinicians to work to top of scope of practice. • Recognition of the essential role of education, training, and research to attract and retain staff and ensure sustainable and safe services. This included strong support for rural generalist training and embedded cultural capability training. • Exploration of models that utilise different workforce configurations. • Enhanced recruitment processes that are streamlined and investigate opportunities for workforce accommodation in rural and remote areas to assist with retention of staff.
Processes for new models of care	• Strong desire to embed the CHHHS First Peoples Health Equity Strategy into clinical services and new models of care. • Need for streamlined processes (business cases, model of care design etc.) to ensure consistency with considerations for changes across services, the system, teams and regions. • Considerations for infrastructure to enable existing and growing services.
System resilience	• Shifting the focus to preventative models, particularly for chronic disease. • Progressing opportunities to reduce low value care and where we can support our partners to reduce impacts on the acute care system. • Investment in rural areas (including electronic medical records, equipment and medication management systems etc. to facilitate efficient and effective care).
Partnerships	• Recognition of the impact on acute care services (particularly emergency departments) with the challenges of accessing GPs and primary care services in the community setting. • Desire to work with NQPHN and others to examine opportunities for joint initiatives to address access challenges. • Recognition of National Disability Insurance Scheme (NDIS) access (with limited availability of services, particularly for paediatrics and in rural areas) as a challenge for acute care services, particularly for ongoing care post an acute care episode.
Technology and data	• Support for innovative ideas (including things such as virtual pharmacy services, medication, and pathology logistic models etc.). • Opportunities for telehealth expansion, with consideration of resourcing requirements. • Technology opportunities as an enabler for clinical care (including things such as a pharmacy robot at Cairns Hospital, ieMR release 4 for Cairns Hospital, electronic medical record for rural facilities, virtual care models- as a component of Hospital in the Home (HITH)). • Need to ensure accuracy and efficiency with data collection and reporting to understand current services, gaps and opportunities for clinical redesign and new models of care.

2.5.2 Key challenges and opportunities

The CHHHS faces a range of service delivery challenges and opportunities for the region. These are grouped into seven key themes outlined below and align directly to the health and service needs for our region and communities.

Population health need and rising cost of living

Higher than average burden of disease and mortality rates when compared to the rest of the state, particularly for First Nations people, creates an increased demand for health services in the region. This is exacerbated by the prevalence of risk factors such as the number of daily smokers, risky alcohol intake and the proportion of the population with a low socio-economic profile. In addition, the cost of living is rising, placing additional pressure on our communities including challenges accessing affordable housing, nutritious food, and transportation. This increases risks factors for poor health outcomes, particularly for members of the community with a higher burden of disease and low socio-economic profile. These barriers demand a whole of community approach to support equitable health outcomes and access, including a greater focus on influencing the social and economic determinates of health.

Geographical barriers to equitable service access

A high burden of disease and rising cost of living are further amplified by the large geographical area for which CHHHS provides services. The distance that separates our communities presents a number of unique challenges in terms of providing equitable access to health care including proximity to supporting services, travel time and distance, limited to no options for public transport and temperamental internet access and telephone connectivity. Again, solving these challenges requires partnerships and a whole of community approach, supported by innovative adoption of technology and local community infrastructure to provide care locally and reduce the need to travel away from home and country.

Gaps in primary care, aged care, disability care and community care

Gaps in primary, aged, disability and community care access are increasing across the region particularly for our rural and remote communities. This is significantly impacting health access and outcomes, increasing demand pressures for CHHHS services and facilities, and impacting the overall resilience of the Far North Queensland health system. This is not sustainable, and we have an opportunity to strengthen our partnerships and work together to increase the focus, capacity, and investment necessary to align access with need. This is important to ensuring a more resilient and integrated system, that is equipped to adapt and respond to health and service needs now and into the future.

Mental Health and addiction outcomes and access

Consultation identified mental health as a high priority for our communities and this is reinforced by the burden of disease profile across the region with increased utilisation of acute services for mental health and addiction. Challenges exist with access to services across the health continuum and for all age groups (children, adolescents, adults, and older people) and is exacerbated in rural and remote areas. Combined with a renewed system focus on mental health, alcohol, and other drug services through the *Better Care Together* program, we have the foundations to work with our partners to prioritise the mental health and addiction needs of our community.

Workforce sustainability, capacity, and capability

The geographical factors impacting access to equitable services also present persistent challenges attracting and retaining a skilled workforce, which compounds broader workforce sustainability challenges experienced across the system, and in turn impacts our ability to grow and expand services, particularly to provide equitable access to care for our rural communities. We have opportunities with our clinical services to look at different ways to provide care, including considerations for alternative models, working to top of scope of practice and use of technology and partnerships to meet community need. We also need to consider our workforce planning, education, and training to enable provision of clinical services.

The momentum and enablers for change

Through the COVID-19 pandemic, as a health system and community, we were more connected on the health and wellbeing of our people and region than we have ever been. Combined with a system wide focus and commitment to enablers for reform of health services, this presents significant opportunity and appetite to drive the change and innovation necessary to impact our most pressing and long serving challenges to health equity and sustainability. Our unique region and demographics put us in good stead to invest further in education and research. We are in a strong position to progress our ambitions towards university hospital status, to enable our capacity and capability.

Leaders in environmental sustainability

The impacts of climate change are increasingly challenging the delivery of sustainable, quality health services and impacting on the health of our communities. The increasing frequency of natural disasters demands a resilient system that can adapt and respond efficiently and effectively. There is an opportunity for CHHHS to set the standard and lead the way in terms of environmentally conscious, sustainable, and resilient service delivery, and infrastructure planning as well as preparing for the increasing health impacts of climate change. This will ensure that we are not only fit for purpose and actively reducing our carbon footprint but helping others to do the same.

2.5.3 Progress against 2018-2022 CSP

In 2018, we released and progressed the implementation of the *Cairns and Hinterland Hospital and Health Clinical Service Plan 2018 – 2022* (previous CSP). Like this CSP, our previous CSP was informed by an extensive consultation process and provided service delivery directions with corresponding strategies targeted to improve and grow our services to meet community needs and address key challenges in service delivery. The service directions within the previous CSP included a stronger focus on partnerships, addressing demand pressures, the delivery of patient centred and integrated services, care closer to home and a focus on improving the health outcomes of Aboriginal and Torres Strait Islander Peoples.

The release of this CSP provides an opportunity to reflect on the progress we have made and celebrate the collective success of our people, partners, services, and communities. Below are some examples of initiatives that have been successfully implemented and progressed against the service directions of our previous CSP.[16] The new CSP builds on the momentum of the previous CSP and harnesses the opportunities that arose during the COVID-19 pandemic, in terms of innovative and flexible health service delivery.

Partnering to deliver joint models of care, focused on improved health outcomes particularly for our First Peoples

Some of the strategies delivered as part of service directions 1, 3 and 5 of the previous CSP.

- Partnering with the BHNQ collaborative to expand our HITH program and palliative care services.
- Partnering with BHNQ collaborative, TCHHS and QAIHC to establish the Care Coordination Service project.
- Collaborative Service Agreements with all ACCHOs for specialist outreach services such as paediatric clinics.
- Expanding on the *Stronger Mob, Living Longer Plan*, working with neighbouring HHSs, NQPHN, ACCHOs and First Peoples to co-design and co-implement the *CHHHS First Peoples Health Equity Strategy 2022 – 2025*.
- Co-designing the *Queensland Aboriginal and Torres Strait Islander Rheumatic Heart Disease Action Plan 2018-2021, North Queensland STI Action Plan 2016-2021* and the *Queensland HIV Action Plan 2019-2022*.

Delivering evidence based, patient-centred services and growing and expanding our capacity to meet demand closer to home and country

Some of the strategies delivered as part of service directions 2 and 4 of the previous CSP.

- Expanding renal dialysis capacity at Cairns South Health Facility and Yarrabah Emergency Service.
- Establishing additional cardiac, surgical and endoscopy capacity at Cairns Hospital.
- Implementing the Access 2 Care project at Cairns Hospital to improve patient flow through the hospital.
- Implementing changes to the mental health MoC, including improved access across rural areas.
- Delivering Stage 1 of the Atherton Hospital redevelopment project and commencing Stage 2.
- Increasing capacity at our rural facilities for endoscopy, chemotherapy, dialysis, obstetrics, and gynaecology.
- Maintaining access to critical service provision while managing the COVID-19 pandemic response.
- Implemented the Specialist Palliative Care Rural Telehealth (SPaRTa) model of care.
- Cardiac outreach model implemented and nursing home in reach model implemented.

16 Please refer to the CHHHS Clinical Services Plan 2018-2022 Evaluation Report for further details on progress against the plan.

3.0 Service delivery strategies

3.1 Commitments already in the pipeline

There are a number of CHHHS clinical service uplifts that are already committed and important to delivering the CHHHS vision and aspirations for clinical service delivery by 2032, within the context of our service delivery challenges and opportunities. These are summarised in the table below.

Table 6: CHHHS already committed clinical services

#	Already committed clinical services
1	Care Coordination Hub and Northern area outpatient referral hub (Phase 1) (commenced 2022)
2	Connected Community Pathways- Diabetes service expansion (commenced 2022)
3	Nurse Practitioner model at Mareeba Hospital Emergency Department (commenced 2022)
4	Patient Flow Intensive Program (Cairns Access to Care Phase 2, commenced 2022)
5	Virtual Care service (commenced as virtual COVID ward and transitioning to new model, October 2022)
6	Oregon Street subacute care facility- 45 subacute inpatient beds (end of 2022)
7	Step down general medical service at Gordonvale Hospital (end of 2022)
8	Atherton Hospital redevelopment (2023)
9	Cow Bay Primary Health Centre (PHC) replacement (2023)
10	Cairns Hospital Emergency Department expansion project (2024)
11	Mental Health Unit at Cairns Hospital (by 2024)
12	Renal transplant service at Townsville Hospital, networked service across the Northern HHSs (by 2024)
13	Youth Alcohol and Other Drug (AOD) residential unit Cairns South (by 2024)
14	Cairns Hospital Expansion Project- 96 inpatient beds, 4 theatres and associated services (est. 2026)

3.2 Future service delivery strategies

Our CSP is structured around delivering on a number of priorities that will support our achievement of the CHHHS vision and will support improved health outcomes, access and service quality and sustainability for our communities. These service areas reflect local needs and are targeted to deliver impact in relation to our most pressing areas of community need, service delivery challenges and opportunities.

Five service areas for focus have been identified in total, including:

A. First Peoples services

B. Primary and preventative care, health promotion, advocacy, and partnerships

C. Mental health and addiction services

D. Cairns and surrounds services

E. Rural and remote area services

To deliver and realise impact, each service area is underpinned by a series of corresponding service delivery strategies for implementation over the immediate to longer term. Service delivery strategies have been categorised to the service areas based on their primary area of intended impact but will often contribute to and have impact against multiple service areas.

This is particularly true for the service areas focused on First Nations people's health and our rural and remote services. While there are a number of service delivery strategies more heavily targeted to improving health outcomes and access for First Nations people and services for rural and remote communities, every delivery strategy regardless of the primary service area of impact has a focus on health equity and the delivery of care that is culturally appropriate and closer to home and country.

Another important consideration for the service directions is business continuity and ability to respond and manage in a disaster. Every clinical area within the CHHHS must have a business continuity plan in place and the health service must retain its agility to move in and out of a disaster response as required. There were many lessons learned during the COVID-19 pandemic response and the health service is well placed to activate its disaster response as required. We must remain vigilant in our disaster preparedness and factor this into our clinical service planning.

The following section describes the five service areas and underpinning service delivery strategies for implementation over the next five years.

3.2.1 A. First Peoples services

We will continue to work in partnership across the health continuum and with adjacent services to deliver improved outcomes and health equity for First Peoples. This service area is strongly linked to and informed by our inaugural *CHHHS First Peoples Health Equity Strategy (2022-2025)*.

We will:

A1

Implement the clinical service strategies of CHHHS First Peoples Health Equity Strategy inclusive of improving the provision of culturally appropriate care, and prioritising the implementation of the *Ending Rheumatic Heart Disease: Queensland's First Nations Strategy 2021-2024 and the Sexually Transmitted Infections (STI) strategy*. Key areas of focus will include:

- Acute Rheumatic Fever and Rheumatic Heart Disease (RHD)
- Collaboration between service providers
- Delivering sustainable, culturally safe and responsive healthcare services
- Sexual health
- Maternity and early childhood
- Suicide and self-harm

A2

Develop the clinical models and services provided by the CHHHS at **Yarrabah** including but not limited to:

- Implementing the Yarrabah Emergency Department model of care
- Advocating for the Yarrabah Infrastructure Plan
- Maximising opportunities for the CHHHS visiting services including child health, chronic disease services, mental health, palliative care, school-based nursing etc. with our partners

A3

Explore and enable **opportunities to work across the care continuum, in partnership** with other providers to meet First Nations peoples' health needs such as joint initiatives with NQPHN and ACCHOs.

3.2.2 B. Primary and preventative care, health promotion, advocacy, and partnerships

We are committed to delivering improved health outcomes and access for our regions. This requires a whole of community approach and a resilient and sustainable health care system for Far North Queensland now and into the future. As part of this commitment, we will enhance our focus on strengthening partnerships across our region (spanning the health and human sector service) to provide more seamless access to care and looking for opportunities for increased health promotion and advocacy to influence the social determinates of health. To achieve this, we will:

B1 **Explore opportunities to build on the existing Tropical Public Health Service (TPHS)** for the region, considering opportunities for greater alignment to the HealthQ32 Strategy to ensure a service that is fit for purpose now and into the future. We will give specific consideration to infectious disease management, pathology and requirements associated with increased surveillance and testing.

B2 Partnering across the care continuum to **progress opportunities to enhance community-based primary and preventative care, health promotion, and early intervention services** with a focus on maternal and antenatal health, social and emotional wellbeing, chronic disease and enablers and innovations in line with the BHNQ collaborative priorities.

B3 Continue **in-reach into RACFs** (including considerations for nursing home HITH) and **examine feasibility of expanding the Geriatric Emergency Department Intervention (GEDI) model.**

B4 Work with partners to **improve access to care and services for older people at home especially in rural and remote areas.**

B5 Explore opportunities for **joint models of care or partnerships to improve access to care and services for people living with a disability, particularly those living in rural and remote areas.**

B6 **Improve the coordination and navigation of care.** This includes co-delivery of the Care Coordination Hub to address access issues (including the Patient Transport Subsidy System) and the networked Northern Queensland Referral Hub model to manage outpatient referrals.

B7 **Maximise opportunities for care provision to meet health needs** including continuing to invest in key partnerships to enable opportunities for joint funding, resource sharing and delivery of health care services. Key partnerships of focus are identified in the CSP in section 2.4.

B8 **Partner with others across organisations and sectors to develop a Cairns and Hinterland Regional Health Plan**[17] designed to facilitate collaboration to meet the health and service needs of the region.

17 This may be under the auspice of Better Health North Queensland collaborative.

3.2.3 C. Mental health and addiction services

To support the mental health and wellbeing of the children, youth and adults of our region, we will expand community-based mental health and addiction services (especially for our rural and remote communities), build on our partnerships to integrate our mental health and addiction services with the care provided by the primary care sector, and implement models of care for acute services that enable more access to care closer to home and country (where safe and sustainable to do so).

To achieve this, we will:

C1 Work with the DoH to **implement the Better Care Together: A plan for Queensland's state funded mental health, alcohol and other drugs services to 2027 for the CHHHS region** (capitalising on partnership approaches, dedicated funding stream opportunities, recognition of improvement of health equity for rural and remote areas, and care across the lifespan).

C2 Partnering across the care continuum and region to explore and **enable opportunities to work in partnership with other providers, to better meet mental health and addiction needs for children, youth and adults** (such as the Better Health North Queensland Joint Regional Wellbeing Plan for Northern Queensland and co-responder models with QAS and GP/specialist arrangements).

C3 **Expand mental health bed capacity at Cairns Hospital** (including adolescent mental health beds and older people beds).

C4 Expand the **Community Care Unit (CCU) mental health beds** (including older persons extended treatment beds).

C5 Implement a **partnership model with the NQPHN for extended mental health care** outside of the acute setting (Head to Health), supported by the CHHHS clinical in-reach, with a specific focus on support services for rural areas.

3.2.4 D. Cairns and surrounds services

As part of responding to growing demand for health services we will progress targeted uplifts in capability and capacity at Cairns Hospital and supporting services in the Cairns surrounds. This will include progressing opportunities to optimise the use of current and planned infrastructure, alternative care models and partnerships with community and primary care services. There will be a focus on expanding opportunities for care in the community, home and outpatient settings instead of the acute setting. This will be key to maintaining timely access to high value and quality care and shifting services to a CHHHS-wide perspective to enable improved access to care and services for people in rural and remote areas to improve health equity.

D1

Increase the capability of selected services at Cairns Hospital, as per the Clinical Services Capability Framework:

- Children's medical services from CSCF Level 4 to CSCF Level 5 (by 2024)
- Adult trauma services from CSCF Level 2 to CSCF Level 5 (by 2024)
- Adult medical services from CSCF Level 5 to CSCF Level 6 (by 2026)
- Adult surgical services from CSCF Level 5 to CSCF Level 6 (by 2026)
- Select geriatrics services – ambulatory care CSCF Level 4 to CSCF Level 5, rehabilitation CSCF Level 5 to CSCF Level 6 and orthogeriatrics CSCF Level 4 to CSCF Level 5 (by 2026)

D2

Expand the Emergency Department at Cairns Hospital and continue to develop and embed models of care to ensure the right care is provided at the right time by the right person. This includes a focus on rapid access services (e.g., older persons rapid response models) and patient flow intensive / priority programs (particularly for people with chronic condition exacerbation), trauma and paediatric emergency department services, maximising use of the CHHHS Patient Access and Coordination Hub (CPACH) and partnership models.

D3

Expand access to key services[18] including through private / public partnerships, use of HITH models (or other home/community-based models) and optimisation of preadmission clinics, day procedures and outpatient models of care.[19] Key services of focus include:

- Surgical, endoscopy, and obstetrics and gynaecology services
- Medical services
- Cancer care services
- Maternity and child and youth services (including consideration of a maternity assessment service and embedding the 'Child Safe Organisational Commitment' into child services)
- Chronic kidney disease strategies and renal dialysis (per the recommendations in the CHHHS Renal Dialysis Plan)

D4

Leverage virtual, technology enabled and / or telehealth models of service provision and clinical governance / supervision to expand access to key services where safe and clinically appropriate.

18 The CHHHS Surgical Demand Profile (2021) outlines projected demand for surgical services across the CHHHS to assist with future planning.

19 Refer to the CHHHS Ambulatory Care Plan for more specific recommendations.

D5 **Continue to implement the CHHHS Subacute Care Plan**, inclusive of a day therapy service and expansion of services, including HITH type models and optimisation of outpatient models of care (including use of virtual and/or telehealth models where clinically appropriate). Expand palliative care services, including models that enable people to palliate at home where possible. Explore subacute care for people with a disability, including maximising appropriate care in the appropriate setting.

D6 **Ensure that supporting clinical services (including allied health, pathology, pharmacy etc.) are considered within service growth** and maximised for efficient clinical service delivery, including development, and embedding of alternate models of care as a first consideration for service growth, particularly for outpatient and/or diversionary models of care.

D7 **Implement the CHHHS Medical Imaging Plan**, including expansion of medical imaging services, maximising public/private partnerships and ensuring high value care is embedded into medical imaging ordering and processes.

D8 **Complete a current state analysis of community health services and interfaces with the primary care sector**. Develop a plan for the expansion of community and home-based services as alternatives to hospital-based care (or to facilitate faster flow from acute care) in partnership with the primary care sector where possible. This should include consideration of services for the southern Cairns area (in line with projected significant growth rates).

D9 **Develop a plan for oral health services for the region** (inclusive of private / public partnerships, James Cook University, and school partnership opportunities).

D10 **Examine sexual health services for the region**, including opportunities to expand services, care planning and referral pathways.

D11 Investigate opportunities to **expand the use of genomics to increase targeted surveillance, screening and promote high value care** (in line with the Queensland Health Digital Genomics Strategy).

D12 **Progress towards Cairns University Hospital status:** in addition to increasing the capability and capacity of clinical services, research and education / training models will need to be incorporated into models of care. This will enable sustainability of services and ensure the workforce is skilled and supported to provide evidence based and best practice care. Continuous quality improvement and translational research opportunities will be considered in clinical service redesign and new models of care.

3.2.5 E. Rural and remote services

We will maximise the efficiency and self-sufficiency of our rural and remote facilities[20] and services to provide care as close to home and country as possible and enable future growth. As part of this, we will promote models that provide care closer to home and country (whilst being safe and sustainable) inclusive of considerations of 'hub' and 'spoke' type models, virtual care and telehealth and alternative models (such as allied health or nurse led models, and community pharmacy models).

E1

All areas: progress opportunities for **more streamlined access to high value care that is closer to home (where safe and sustainable) for all rural and remote regions** with specific focus on the following areas:

- Optimisation of day procedures, outpatient models of care and visiting specialist services (including use of virtual and/or telehealth models where clinically appropriate).
- Feasibility assessment of HITH and other home and / or community-based care models in rural areas: Examine opportunities for expansion of community and home-based services as alternatives to hospital-based care (or to facilitate faster flow from acute care) in partnership with the primary care sector where possible. Focus areas include maternal, child and youth models, complex chronic disease (especially diabetes, RHD and chronic kidney disease), subacute care and palliative care.
- Improvement of inter-HHS collaboration for care of residents in border towns in the west (with NWHHS), south (with THHS) and north (with TCHHS).
- Ensure that supporting clinical services (including allied health, pathology, pharmacy etc.) are considered within service growth and maximised for efficient clinical service delivery, including development, and embedding of alternate (and/or virtual) models of care as a first consideration for service growth, particularly for multidisciplinary and outpatient/diversionary models of care.
- Implement the CHHHS Medical Imaging Plan including development of sustainable medical imaging models for CHHHS rural and regional areas, with considerations for feasibility, workforce models and accessibility to services.
- Review of CHHHS provided primary care services (as per Council of Australian Governments (COAG) funding) to ensure maximised primary care functions and models of care across COAG funded and CHHHS funded services.
- Work with QAS on models of care that enable improved coordination of care and options for care outside of the acute hospital setting (where safe and sustainable to do so).
- Embed research and education / training models, continuous quality improvement and translational research opportunities into clinical service redesign and new models of care. This will enable sustainability of services and ensure the workforce is skilled and supported to provide evidence based and best practice care.

E2

Tablelands

(Tablelands (East) – Kuranda SA3 region)

- Expansion of access to subacute care services (inclusive of palliative care).
- Increased surgical, medical, chemotherapy, renal dialysis, and endoscopy services.
- Undertake assessment of Ravenshoe PHC and Herberton Hospital utilisation, funding opportunities, and role to maximise service delivery at these facilities.
- Investigate opportunity for expanded subacute care unit in the Tablelands.
- Progress improvements for ED patient flow for Atherton and Mareeba Hospitals.

20 Refer to the CHHHS Rural Health Plan 2021 for further detail for rural facilities and services: PowerPoint Presentation (health.qld.gov.au)

E3 Cassowary Coast

(Innisfail – Cassowary Coast SA3 region)

- Expansion of access to subacute care services (inclusive of palliative care).
- Increased surgical, medical, chemotherapy, renal dialysis, and endoscopy services.
- Improvements for ED patient flow at Innisfail Hospital (including increased opportunities for Tully and Babinda Hospital flows to Innisfail Hospital instead of Cairns Hospital).
- Explore opportunity for National GP accreditation for Tully Hospital, Mission Beach Community Health Centre and Jumbun Community Health Centre to maximise service provision.

E4 Mossman and Surrounds

(Port Douglas – Daintree SA3 region)

- Increase general medicine service access at Mossman Multi-Purpose Health Centre and access to specialist outpatient services.
- Review of community needs and services provided by Mossman Hospital as a Multi-Purpose Health Service (MPHS) and develop future clinical service delivery plan for this area.
- Explore opportunity for National GP accreditation for Cow Bay Primary Health Centre to maximise service provision.

E5 Western Tablelands

(Far North SA3 region)

- Assess existing service models for sustainability.[21]
- Investigate opportunities for partnerships and joint models of care across health and care service providers.

E6

Explore opportunities to facilitate and expand prisoner health services in line with the Reducing barriers to health and wellbeing - The Queensland Prisoner Health and Wellbeing Strategy 2020-2025 at the Lotus Glen Correctional Centre.

21 Inclusive of Chillagoe Primary Health Centre.

3.3 Critical enablers for success

Consultation with our people and community also identified a series of critical enablers necessary for successful planning and implementation of each of the committed service delivery strategies (refer to section 2.5.1), many of which align with commitments and actions identified within existing (or in development) CHHHS enabling plans and strategies.

As part of this CSP, we will continue to work with our local partners and communities to develop and implement against the commitments and actions identified within these plans and strategies acknowledging their critical role in achieving the CSP Service Directions and CHHHS vision.

Health Equity A commitment to health equity is critical to improving health outcomes and access for First Nations people, especially those living in our rural and remote communities. We will be guided by our *CHHHS First Peoples Health Equity Strategy* to ensure investment and prioritisation of targeted services, models of care, infrastructure and workforce support to achieve the key priority outcome area targets.	**CHHHS First Peoples Health Equity Strategy**
Workforce We will enhance education and research opportunities and address attraction and recruitment challenges. This will include a focus on building a local pipeline of workforce, fostering strong leadership and working in virtual and team models of supervision and clinical governance that support our people to work to top of scope, particularly in rural areas. The Plan will build on the CHHHS Workforce Framework and clinical subplans.	**CHHHS Workforce Plan**
Infrastructure We will work with the DoH to deliver new and upgraded infrastructure. We will refresh the CHHHS Infrastructure Master Plan in light of the updated CSP, with considerations of ageing infrastructure and growth priorities, and requirements to support changing models of care. The refresh will build on the 2019 CHHHS Infrastructure Master Plan.	**CHHHS Infrastructure Master Plan**
Technology We will continue to progress investment in digital technology to enable clinical care models and improve patient safety. We will develop the updated CHHHS Digital Health Strategy, with a focus on enablers such as ieMR release 4, an electronic medical record solution for our rural facilities, enablers for virtual care and platforms for information sharing. The Strategy will build on the CHHHS Digital Health Service Plan 2018-2022.	**CHHHS Digital Health Strategy**
Research and education We will continue to progress the opportunity for Cairns University Hospital status including increasing opportunities for clinical trials, research and education focused on Far North Queensland communities. As part of this we will strengthen partnerships with universities, research organisations and other key stakeholders to enable local research. The new Research Excellence Plan builds on the previous 2018-2022 plan.	**CHHHS Research Excellence Plan**
Environmental sustainability We will look to develop models of care that reduce our carbon footprint and reduce waste. We will ensure our facilities are resilient and our services incorporate business continuity planning in the event of natural disasters. Our future planning will consider the impacts of climate change on health services and needs for our area. The inaugural Strategy is anticipated to be released in early 2023.	**CHHHS Environmental Sustainability Strategy**

4.0 Our steps for implementation

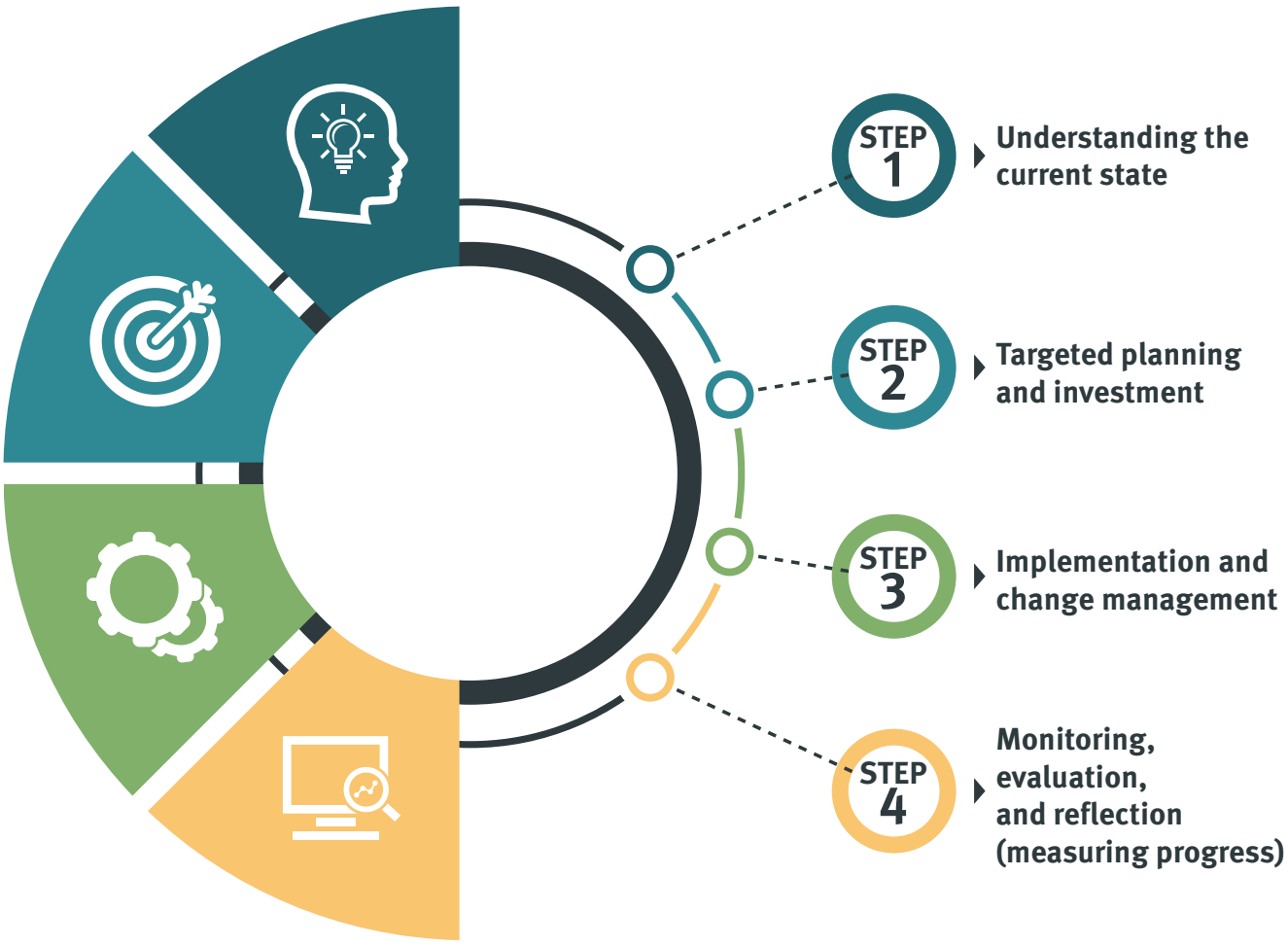
We are committed to delivering on the strategies and actions identified within the CSP. They are necessary to realising our strategic vision and to transitioning to our ambitious future state for clinical services over the next 10 years.

The CSP forms part of a broader integrated planning framework to support the delivery of strategic priorities at the various levels of the organisation. Integration of the CSP service directions and strategies within this framework will help to inform the prioritisation and strategic phasing of initiatives balancing available resources with the ability to achieve the greatest possible impact.

Delivering on these strategies within the agreed phasing will require dedication and a significant program of work. Detailed project planning, change management processes and business case development will be critical to enabling the realisation of the clinical service directions. In addition, a culture of continuous improvement, reflection, and the ability to change models of care is required to meet the current and emerging health and service needs of the region.

The following section details key steps for implementation as part of a planning and implementation cycle to support the successful operationalisation of identified strategies. It is important to acknowledge that strategies identified within this CSP are at various stages of the planning and implementation cycle.

Figure 20: Our steps for implementation to deliver on Clinical Service Plan Service Directions and Strategies



Step 1. Understanding the current state

Understanding the current state is focused on a more detailed assessment or review of the current state of need, and service delivery challenges and opportunities specific to each service direction and strategy. This is important to ensure clear understanding of the need, challenge or opportunity that is being targeted through the proposed strategy, and what needs to occur to deliver on the desired change and future state. Key activities for consideration as part of this step include undertaking a more detailed analysis of historical and projected activity, a review of past or current related planning documentation and consultation with key stakeholders and organisations.

Step 2. Targeted planning and investment

This step is focused on undertaking targeted planning to understand and communicate the level of work, resources, and investment necessary to ensure the successful implementation of strategies. This step will draw on key findings of the 'Understanding the current state' step to justify why the proposed level of work, resources and investment is important to delivering on the CHHHS vision and a more safe and sustainable future state. Key activities for consideration as part of this step include but are not limited to consideration of implementation partnerships and alternate sources of investment, developing the business case for change (including the identification of expected benefits and required investment), undertaking logic and process mapping as part of the process of clinical and model of care re-design and detailed implementation and operational planning.

Step 3. Implementation and change management

This step is focused on operationalising the strategy commencing with establishing the project of work and foundations necessary to deliver on the agreed scope of the strategy within committed timeframes and budget. This includes clearly defined project scope and activities, roles and responsibilities (including those internal and external to the CHHHS), governance, and mechanisms for engagement and reporting. Consideration should be given to the capability and experience necessary to deliver on the agreed scope within the committed timeframes and the degree to which this can be sourced internally from within the CHHHS. Status update reporting against key project activities and milestones will provide transparency of implementation progress.

Step 4. Monitoring, evaluation, and reflection (measuring progress)

Ongoing monitoring and reporting against progress and impact will be important to ensure we remain on track for our plan. Progress against the CSP strategies will be reported annually. As part of this, it is important that a framework is established to help determine not only implementation progress but also impact. The framework should be informed by the strategic vision and objectives of the CHHHS and then align strategies and key measures of impact accordingly.

The evaluation of impact should be supported by evidence and be informed by our people and partnerships with key stakeholders. KPIs will be developed and monitored in line with CHHHS performance and accountability processes. This will increase visibility of implementation progress (including acting as a supportive early warning mechanism for deviations from project milestones or timeframes), to support informed decision making and corrective actions. A continuous improvement approach will be adopted to account for changes in health needs or service developments throughout implementation (e.g. census data release), and inform adjustments that will ensure lasting implementation success.

Figures

Tables

Acronyms

Abbreviation	Definition
ACAT	Aged Care Assessment Team
ACCHOs	Aboriginal Community Controlled Health Organisations
AOD/ATOD	Alcohol and Other Drugs, Alcohol, Tobacco, and Other Drugs[1]
BHNQ	Better Health Northern Queensland
CHC	Community Health Centre
CHHHS	Cairns and Hinterland Hospital and Health Service
CAGR	Compounded Annual Growth Rate
COAG	Council of Australian Government
CCU	Community Care Unit
CHSP	Commonwealth Home Support Program
CPACH	CHHHS Patient Access and Coordination Hub
CSCF	Clinical Service Capability Framework
CSP	Clinical Service Plan
DoH	Department of Health
ED	Emergency Department
FROGS	Far North Queensland Regional Obstetrics Gynaecology Service
GEDI	Geriatric Emergency Department Intervention
GP	General Practitioner
HDU	High Dependency Unit
HHS	Hospital and Health Service
HITH	Hospital in the Home
ICU	Intensive Care Unit
LANA	Local Area Needs Assessment
MHATODS	Mental Health and Alcohol, Tobacco and Other Drugs Service
MNHHS	Metro North Hospital and Health Service
MoC	Model of Care
MPHS	Multi-Purpose Health Service
NACCHO	National Aboriginal Community Controlled Health Organisation
NDIS	National Disability Insurance Scheme
NGOs	Non-Government Organisations
NQPHN	North Queensland Primary Health Network
NWHHS	North West Hospital and Health Service
OPERA	Older Persons Evaluation Rehabilitation and Assessment
PHC	Primary Health Centre
QAIHC	Queensland Aboriginal and Islander Health Council
QAS	Queensland Ambulance Service
RACFs	Residential Aged Care Facilities
RFDS	Royal Flying Doctor Service
RHD	Rheumatic Heart Disease
RSQ	Retrieval Services Queensland
SA	Statistical Area
SRG	Service Related Group
STI	Sexually Transmitted Infection
TCHHS	Torres and Cape Hospital and Health Service
TCP	Transition Care Program
THHS	Townsville Hospital and Health Service
TPHS	Tropical Public Health Service

1 Different terminology is used depending on different service names.