Townsville Hospital and Health Service

Health Service Plan

Stakeholder inputs into the planning process

Queensland Government

Health Service Plan, Stakeholder inputs into the planning process

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APPENDIX A: List of stakeholders consulted

1. Introduction and document purpose

Carramar Consulting has been engaged to provide health service planning services for the Townsville Hospital and Health Service (Townsville HHS).

The purpose of the engagement is to support the Chief Executive and Board to make decisions regarding the development of services across the Townsville HHS, by exploring the implications of a number of alternative service options for The Townsville Hospital (TTH) and rural hospitals, in terms of health service activity and capacity requirements.

The planning process has four stages:

1. Development of a Health Service Plan Background Paper comprising a detailed analysis of population and hospital activity data
2. Stakeholder consultations based on an agreed Stakeholder Engagement Plan
3. Development of Health Service Activity and Capacity Requirement Projections quantifying a "base case" and four scenarios for future infrastructure requirements
4. Development of the Health Service Plan.

The purpose of this document is to highlight relevant comments derived from stakeholder consultation that have been used as inputs into the development of the four scenarios for the Health Service Activity and Capacity Requirement Projections, and will inform the development of the Health Service Plan.

According to the endorsed Stakeholder Engagement Plan, stakeholders have been categorised as follows:

- Strategic partners in acute clinical service delivery (including nominated representatives of Mater Health Services North Queensland, James Cook University and other North Queensland Hospital and Health Services)
- Key internal stakeholders (including representatives from clinical specialty groups)
- Strategic partners in community service delivery, and consumers and community members.

A complete list of stakeholders consulted is at Appendix A.

Four planning scenarios have been identified from the background data analysis and the key themes emerging from the stakeholder input. These scenarios can be viewed as 'what-if's' based around key strategic questions for Townsville HHS. That is, what would the impact be, in terms of health service activity and capacity (physical infrastructure) requirements, if the Townsvile HHS:

- Systematically implemented a series of targeted model of care changes aimed at reducing demand on acute inpatient beds? (Scenario 1)
- Pursued an altered future role for rural / remote facilities? (Scenario 2)
- Took steps to consolidate the role of TTH as a regional tertiary referral facility across a range of prioritised specialty services? (Scenario 3)
- Pursued public/private arrangements for future acute service delivery? (Scenario 4).

Input from the stakeholder groups has been ordered within this document against the four key planning scenarios, and areas where strategic level planning decisions would potentially have an impact across multiple "scenarios" have been provided separately within Section 6.

2. SCENARIO 1: Changing models of care

2.1 Key points

For the purposes of the planning exercise, both key internal stakeholders and other North Queensland Hospital and Health Services were consulted to inform modelling around consolidating the role of TTH as a regional tertiary referral hospital.

The purpose of the consultation was to (from the Stakeholder Engagement Plan):

- Identify any peculiarities and/or opportunities that may be addressed through the implementation of altered (or expanded) service models
- Test the viability of alterations to current service models (for example, increasing service provision to rural / regional areas).

Key points from stakeholders included:

- There are a range of different models of care that are known to reduce overall demand for hospital services or reduce the length of time spent in hospital that are both relevant and feasible to implement (or expand) in Townsville HHS
- Changes focussed both on models of care "within the hospital walls" and service models "outside the walls" particularly those targeting services for the frail aged and people with chronic disease
- Initiatives specifically aimed at reducing length of stay and hospital admissions included:
    - Expansion of community based care including nursing and allied health
    - Implement hospital avoidance / hospital diversion programs from the ED
    - Increased Hospital in the Home (HITH) / Hospital in the Nursing Home (HINH) for Adults
    - Introduction of HITH for Paediatric patients (12 - 14 years only)
    - Further integration with primary care services for Aboriginal and Torres Strait Islander People
    - Expanded palliative care services and increase support for home based care.
- Within TTH, a range of changes to the way services are organised were identified:
    - Expansion of the Acute Medical Unit (AMU) model of care at TTH
    - Expansion of the Same Day Geriatric Management Unit at TTH
    - Creation of an Orthogeriatric Unit
    - Establishment of a dedicated acute older person's mental health unit within the additional bed allocation for adult acute mental health
    - Allocation of dedicated drug and alcohol detoxification beds
    - Creation of a Family Unit for mental health treatment of mothers and babies and for children aged 0-11 years
    - Expanding interventional radiology services linked to neurosciences and cardiothoracic services
    - Clarifying the need for a High Dependency Unit
    - Establishment of a Paediatric Short Stay Unit
    - Increased Day of Surgery admission rates by addressing access to diagnostic services.

2.1.1. Input from Key Internal Stakeholders

Hospital Avoidance and Diversion

Expansion of community based care - "Many front doors"

Improving access to community-based services via "many front doors" was a hospital avoidance/diversion strategy frequently discussed by stakeholders. Key enablers identified by Allied Health included a greater presence in the community setting, heightening awareness of services available, and streamlined referral pathways for easier access. Stakeholders discussed opportunities for community health services to be the central entry point for patients requiring treatment of a wide range of health conditions, particularly chronic illnesses, leaving hospital services to focus on high acuity work only done in a hospital.

Stakeholders also considered there to be several key opportunities that should be pursued for hospital avoidance / hospital diversion out of the Emergency Department (ED). These include implementing a 'GEDI' Nurse in the ED for geriatric patients (model out of Nambour Hospital). Other opportunities include implementing primary contact allied health models in the Emergency Department. For example, primary contact physiotherapists for agreed musculoskeletal presentations and social work for patients presenting with primary psychosocial needs. Several other well documented allied health initiatives that improve patient flow, support NEAT and NEST, and improve health services are also available.

These models require a multidisciplinary approach within the ED, a close working relationship with hospital discharge planners and strong support from community health services and General Practitioners.

Expanding Hospital in the Home / Hospital in the Nursing Home

With regard to HITH services, stakeholders considered a target of 3% of all adult separations to be achievable in future, with the development of clinician 'buy-in' and the implementation of an 'absolute hospital avoidance' model supported by streamlined and facilitative access mechanisms. In addition to the range of services already provided, orthopaedics was identified as a priority area to target for growth in HITH services. Medical governance of a HITH service was noted as having been shown to improve the rate of referral and broaden the conditions able to be treated as it allows deviation from guideline based therapy.

The streamlined approach to Ambulatory Care proposed consisted of a single point of, and coordination for referral, with triage of each referral to the appropriate service occurring the following day. There would be a focus on home based care (any home including nursing homes, caravans, hotels, motels and private residences) with the fall back being presentation to the community campus (for example, if the patient's place of residence is unsafe or out of range). Service provision could be in-house or contracted depending on what is most cost efficient.

Closing the Gap for Aboriginal and Torres Strait Islander Health - Integration with Primary Care

The vision for Aboriginal and Torres Strait Islander Health services is to support holistic / wrap-around primary care services in order to address chronic disease within the population as early as possible. The overarching goal is to take a proactive approach to avoid hospitalisation, and for chronic disease conditions to be managed as much as possible in the community primary care space. Priorities to achieve this vision include:

- Ongoing partnership with the Townsville

Aboriginal and Islanders Health Services (TAIHS) community controlled primary healthcare services (GP and multidisciplinary services) to increase the level of service integration with TTH. Better integration includes TAIHS health workers at TTH to support patient transition back into the community, better use of technology and overcoming barriers to information sharing

- Strengthening the role of the local indigenous health worker in the smaller rural and remote facilities and working closely with Northern Australia Primary Heath Limited to coordinate services

- Developing comprehensive primary health care for Palm Island residents. The priority is for Townsville HHS in partnership with Palm Island Aboriginal Shire Council is to support the development of a new Palm Island Health Action Plan.

Palliative Care in the Community

With a higher than desirable rate of palliative patients dying in hospital across Townsville HHS, coupled with a large number of admissions for patients in the last year of life, palliative care was discussed as an area providing significant opportunity to better utilise services to divert patients and reduce admissions. The vision is for TTH to take the lead for Palliative Care, and strategies discussed included providing support to the ED in order to reduce admissions and identify / plan the care of palliative patients, and to provide support to other non Townsville HHS services to increase home based care (for example, providing assistance to nursing homes to plan and deliver patient care).

Inpatient Models of Care - Improving Patient Flow "Within the Walls"

The "Acute Medical Unit" Model of Care

- A key model of care proposal from stakeholders aimed at shortening overnight length of stay for adult medical patients is to expand the concept of acute medical units (AMU's) similar to those implemented in the United Kingdom. AMU's adult medical admissions come both from the ED and directly from General Practitioners. Referrals to the AMU include acute presentations for Respiratory, Cardiology, Gastroenterology, Infectious Diseases, Endocrinology and suspected stroke patients as well as non-life -threatening problems where referral to hospital is the result of a simple fall (or series of falls), or physical decline associated with the ageing process.

- AMU's are staffed by multidisciplinary medical, nursing and allied heath teams. The model of care is that once initial assessment is completed, a plan is developed which may include a short period of time under observation/receiving treatment in the AMU, admission into the wider hospital under the care of another speciality team if necessary, or home to continue care in the community.

Same Day Geriatric Management Unit

A proposal to expand the same day geriatric management unit was discussed by stakeholders, involving the establishment of a "day hospital" service for Geriatric Evaluation and Maintenance (GEM) patients. The new subacute care unit would be suitable for GEM day rehabilitation, and the unit interface would be to outside of the hospital (GP's and community based services) to reduce some bed stays and admissions (the model would also include a daily "sweep" from the ED). Other similar models were noted as having been implemented elsewhere (for example, the Geriatric Rapid Acute Care Evaluation (GRACE) model of care), but these models are dependent on effective links with GP's for referring and sufficient access to community based nursing and allied health. At present,

community rehabilitation is currently brokered to a community organisation or provided through Transition Care, and there is limited capacity in community allied health teams (to treat and assess).

Creation of an Orthogeriatric Unit

An orthogeriatric model of care was described by stakeholders for the care of frail older orthopaedic patients. With reference to fall associated or fractures non-surgical, this model involved a comprehensive medical admission assessment with surgeons consulting in as required.

Dedicated Mental Health/ATODS units for special needs groups.

A number of model of care changes for mental health services were highlighted by stakeholders. These include:

- Creation of a dedicated acute older persons unit within the additional bed allocation for adult acute mental health
- Allocation of dedicated drug and alcohol detoxification beds within one of the medical units to address the current issue of these patients being distributed throughout the hospital
- Expansion of the Eating Disorders services to increase community alternatives to care and to support more children to transition to adult services once they are aged 18
- Creation of a Family Unit for treatment of mothers and babies and for children aged 0 - 11 years.

Refer to Section 6.2 for additional information provided by stakeholders in relation to future requirements for Mental Health services.

Neurosciences and Cardiothoracic Services - Linkages with Interventional Radiology

Rapid advances in technology for minimally invasive techniques were identified by surgical stakeholders as increasingly blurring the traditional workforce lines between medicine, surgery and radiology. Neurosciences (combining neurology and neurosurgery) and Cardiothoracics (combining cardiac surgery, thoracic surgery and interventional cardiology) were highlighted as two key areas needing a close organisational alignment between medical, surgical and interventional radiology colleagues in order to support contemporary service models. This is critical for a recruitment strategy which is aimed at seeking specialists with overlap in skills / scope of practice who can perform both within their area of subspecialty expertise and across disciplines. There is also a critical dependence on anaesthetic services.

High Dependency Patients

The need for a High Dependency Unit (HDU) for close observation and step-down care of complex, potentially unstable patients was raised by several stakeholders as a limiting factor to providing increased services in terms of volumes and capability. The most appropriate location for these patients was a source of differing opinion, as some units have the capability within their specialty unit to provide these services, while others remain reliant on the intensive care unit. It was noted that the Queensland Department of Health Clinical Service Capability Framework no longer provides a definition for 'high dependency'.

Paediatric Short Stay Unit

The paediatric ED service is staffed by paediatric specialty staff (medical and nursing), but has no short stay unit. Stakeholders indicated that the model that was previously agreed was still appropriate and should be pursued.

Coordination of access to Diagnostic (and other support) Services

Access issues for some diagnostic services were identified as being the cause of increased length of stay. Admitting "well" patients for

workup prior to surgery or other interventions was identified as a strategy to ensure timely access to the necessary tests. The reason provided by stakeholders is that inpatients receive priority that then expedites the workup process. Otherwise patients sit on several different outpatient waiting lists and the appointments are not able to be coordinated with the need to commence treatment. However, if a patient is admitted and needs to do "a, b, c and d" (e.g. a CT, respiratory function test, bronchoscopy, infectious disease consultation or bone marrow aspirate) the process can be completed fully in less than 5 days. It was noted that while this is "standard practice" it is not affordable, but it means that patients get the treatment they need in a timely manner. Representatives from both Cancer Services and Cardiothoracic Services indicated that this was an issue particularly related to patients from outside Townsville who frequently stayed a few extra days for workup. Access to bronchoscopies (a frequently performed diagnostic procedure) was specifically highlighted as they are currently performed in an endoscopy suite, with only one afternoon per week allocated for this purpose. Another constraint can be the capacity of the anaesthetic department and the need for coordination with these services.

It was suggested that a nurse navigator role may be useful for coordinating access to diagnostic services for specific groups of patients. However this would not address issue of capacity of the diagnostic services which is a contributing factor.

2.1.2. Input from Strategic Partners

The North Queensland PHN was identified as the key strategic partner is terms of supporting initiatives for changing models of care. A short telephone interview was conducted with the Chair NQPHN Clinical Council who is based in Mackay.

The focus of the PHN for the first 12 months was on managing the business transition from a Medicare Local as well as minimising any resulting disruption to service delivery. North Queensland was also a site for the My Health Record Participation "opt out" trials which was a major focus of attention for the PHN.

An initial Needs Assessment was undertaken in early 2016 and broad work plans developed. These are on the NQPHN website.

The focus is now moving to further developing the Needs Assessment and commissioning processes. The PHN have recently employed an Epidemiologist to work on the next Needs Assessment.

Palliative Care is a priority for the Commonwealth and there will be an opportunity for the PHN to submit a work plan in November 2017 seeking funding to be a pilot site for GP upskilling in palliative care. Aged Care is also an increasing focus.

There is an opportunity for Townsville HHS to contribute the priorities of the clinical health service plan in to the PHN consultation processes. It was suggested that the Director Planning Townsville HHS make further contact with the PHN to confirm timeframes and specific opportunities in Townsville to participate in the PHN planning.

2.1.3. Input from Community Partners

Community Partner forum members from Townsville were consulted, with the following issues identified as key concerns:

- The need to seek efficiencies in service delivery:

  Comments provided relating to the perceived inefficient use of healthcare resources were many and varied. Comments included:

  - A need for improved care coordination

between primary and acute providers, and also between acute and subacute service providers was discussed (with an example provided relating to difficulties connecting providers of palliative care services)

- Between treating specialists in an acute setting. One stakeholder recounted having been given several outpatient appointments and attending all to be provided with information that they already had, and that didn't change their treatment at all. Another stakeholder discussed several consultants treating a family member at the same time all independently, resulting in lots of separate appointments and several instances of conflicting advice

- A desire for patient-centred models of care:
  - Queuing for outpatient appointments and the need for "some honesty from the hospital regarding appointment times", and "more patient-centred scheduling would be great" was raised. Stakeholders discussed an example whereby all patients were told to arrive at clinic at 12:00, and it depended on who is in the line first as to when they were seen
  - Options for reducing the requirement to travel to Brisbane were discussed, with a stakeholder recently having to travel to Brisbane for a pacemaker change, and taking a carer at "tremendous cost"
  - Hospital in the Home was discussed as both a way to relieve the hospital of inpatient stays, and to meet the preference of patients of all ages. One stakeholder spoke of a recent experience where an adult son had IV antibiotics at home for 5 days as "brilliant".

- The need to harness ICT and improved health technologies to improve local service provision:
  - Support for service models involving telehealth and videoconferencing was provided, with the need for improvements to local ICT capability to support these models stressed by stakeholders.

3. SCENARIO 2: The future role of rural and remote services

3.1 Key points

For the purposes of the planning exercise, key internal stakeholders, consumer representatives and Community Advisory Networks were consulted to inform modelling around consolidating the future role of rural and remote services across the Townsville HHS.

The purpose of the consultation was to (from the Stakeholder Engagement Plan):

- Identify any peculiarities and/or opportunities that may be addressed through the implementation of altered (or expanded) service models involving the future role of rural and remote services
- Test the viability of alterations to current service models (for example, increasing service provision to rural / regional areas)
- Understand concerns and aspirations with regard to service level planning (rather than operational planning) from local community members and service providers.

Key points from stakeholders included:

- The aim is to increase service capability and local self-sufficiency through further development of a hub and spoke model based on rural primary hubs (i.e. CSCF Level 3 facilities) at Ayr, Ingham and Charters Towers. Hughenden and Richmond would be supported from Charters Towers
- The Rural Generalist model (medical, nursing and allied health) is already having impact on the scope of services that can be provided
- The generalist model for medical, nursing and allied health is critical, supported by outreach, videoconferencing and telehealth (inpatient and outpatient), and requires all staff working to full scope
- From a clinical safety perspective, there is further opportunity to increase the volumes of some clinical services provided in rural locations including restoring core secondary health services (day surgery, endoscopy, emergency, inpatient, low-risk maternity, rehabilitation and palliative care)

There remains a need to:

- Improve collaboration with local primary and community-based healthcare providers
- Make use of enhanced radiology and point of care technologies
- Resolve issues regarding workforce and support requirements (such as infrastructure and equipment).

Rural-based community stakeholders consistently expressed a desire for the following:

- Services to be provided for the community, in the community
- Efficient service delivery models
- Patient-centred models of care
- Increased use of ICT and other health technologies to support and improve local service provision
- To consider new models for supporting workforce attraction and retention.

3.1.1. Input from Key Internal Stakeholders

The following specialties identified potential opportunity to (from a clinical safety

perspective) increase the levels of service provision in Townsville HHS rural and remote facilities. Importantly, no conclusions in relation to models of service provision (for example with services to be performed by Rural Generalists or via outreach from TTH) were drawn, however comments in relation to potential barriers have been noted:

- **Urology:** Additional minor procedures (mostly day procedures done on an outpatient basis, that don't necessarily impact bed requirements but do impact theatres) could be performed in the rural facilities (Level 3 facilities). Rural Generalists could be utilised with training to provide these services, but without accessing these staff to perform the procedures, 'incentives' to have Specialists travel from Townsville would need to be provided.
- **Ophthalmology:** There is opportunity to perform procedures locally from a clinical safety perspective
- **Ophthalmology:** There is opportunity to perform procedures locally from a clinical safety perspective. However, barriers that need to be considered include workforce constraints (workforce numbers are small, meaning there would be an impact in Townsville and the person visiting the rural facilities would need to be a Registrar), and the requirement for specialised nursing staff and equipment make increasing activity in these locations "impractical". Existing Rural Generalists refer their patients to Townsville as they don't currently have the ability (knowledge, skills and requisite support) to perform procedures locally.
- **Endoscopy:** There is opportunity to utilise theatres in rural/regional locations for uncomplicated scopes done by Rural Generalists.
- **Renal Dialysis:** There is opportunity to reconsider existing models of care for dialysis provision in the rural centres. An exploration of models of care that enable clients to return as close to home as possible is required. There is a community demand for a service option which allows clients to receive maintenance dialysis services as close to home as possible. These models include expanded satellite and / or self-care models.
- **General Surgery:** There is opportunity to perform basic general surgery procedures locally (from a clinical safety perspective). These include routine hernias, gall bladders, appendix, etc. Stakeholders noted that TTH has attempted to have some of the more basic general surgery procedures performed in the rural facilities, however it is hard to get TTH staff to travel there. Procedures requiring intraoperative radiology or anything with the potential for significant intra-operative bleeding would be out of scope (due to no timely access to blood bank services).
- **Mental Health:** A Rural Generalist with advanced skills in Mental Health in Charters Towers is planned (currently Charters Towers relies on limited psychiatry outreach). This model would free up the visiting psychiatrist to see more complex cases by being able to deal with the 'bread and butter'.
- **General Medicine:** There are plans to start doing medical clinics via telemedicine in peripheral hospitals and a complex / chronic patients clinic (for COPD and other general medical issues) making use of Nurse Practitioners.
- **Chemotherapy:** End of life or maintenance chemotherapy occurs at some rural facilities, and could be further expanded.
- **Paediatrics:** There is opportunity to build the skills of Rural Generalists for paediatrics, along with allied health and nursing staff, complemented by support from Townsville.
- **Orthopaedics:** Stakeholders considered that performing additional procedures in smaller facilities depends on the availability of equipment, which makes the proposition possibly 'not worth it'.

- **Birthing Services:** The only site identified by stakeholders as having the potential to commence birthing (that is not currently birthing) was Charters Towers, who have an established midwifery group with a safe track record and accessible and suitable existing infrastructure. The model would be overseen by a Rural Generalist with a midwifery group practice.
- **Gynaecology:** Stakeholders considered there to be possibility to expand the provision of gynaecology services in rural facilities (such as hysteroscopy, dilation and curettage procedures, tubal ligation etc.).
- **Stroke Services:** Stakeholders considered that smaller hospitals such as Ingham and Ayr could 'stand-alone' in the initial management of stroke patients, with the option to call for advice. The major constraint in Ayr, Ingham and Charters Towers is access to 24 hour CT scanning which is essential to manage stroke patients, along with staff upskilling. The model would be: the patient is assessed at the rural facility e.g. at Ingham, the patient receives a CT scan and a phone call is made to TTH, IV lysis is administered and a determination regarding transfer is made. The patient is transferred to interventional radiology, stabilised and returned to Ingham for rehab / recovery. Stakeholders discussed that the miniaturisation of CT scanners will enable provision of stroke lysis locally. Examples for this exist, such as Victorian statewide stroke response and models from Ontario in Canada.

Allied Health stakeholders outlined a vision for all Allied Health professionals to be working to full scope in rural facilities, with Allied Health Assistants in place and well supported. This vision included all professions being available (while not necessarily physically present), supporting a 'step down' network of services that focus on an outpatient service delivery and inpatient recovery.

An overall vision for rural health services was provided by stakeholders of the Rural Hospital Service Group:

- There is opportunity to increase service capability and self-sufficiency for admitted and non-admitted services at Level 3 rural facilities (these being Ayr, Ingham and Charters Towers Health Services). Service areas to target include day surgery, endoscopy, emergency, inpatient, low-risk maternity, rehabilitation and palliative care
- The implementation of the Rural Generalist model, and investment in the rural generalist pathway is key to harnessing this opportunity. Rural Generalists would ideally be supported by a local workforce that is maintained and grown with support in terms of training and potentially supervision from TTH
- Level 2 rural facilities would function as part of a rural primary hub, within which services could be accessed and also staff on a rotational basis
- Improved collaboration with local primary and community-based healthcare providers is required to enhance coordination of care for patients with chronic conditions and long-term needs
- Enhanced ICT capability with the aim of digital-hospital readiness is required, along with enhanced diagnostic tools, including pathology, radiology and point of care technologies
- Rural facilities wold provide patient-centred pathways that improve accessibility to services, enable more efficient staff and patient flows, and are supported by clinically appropriate and respectful treatment environments.

3.1.2. Input from Community Partners and Community Advisory Networks

Community Partner forum members from

Townsville, along with Community Advisory Network members from Ayr, Charters Towers, Ingham, Hughenden and Richmond were consulted.

While local contexts such as population demographics and socio-economic profiles, levels of access to health services and infrastructure, and health and social needs differed between sites, the following themes were common among stakeholders:

- The need to seek efficiencies in service delivery:

  Comments provided relating to the perceived inefficient use of healthcare resources were many and varied. Comments included:

  - The inefficiency of tendered / brokered services that travel to rural communities was noted by stakeholders. These services spend half their time driving and therefore away from service provision (driving takes away from contact hours) and they also don't have a sense of community. The consensus view was that they don't represent value for money.

- A desire for patient-centred models of care:

  - Hospital in the Home was discussed as both a way to relieve the hospital of inpatient stays, and to meet the preference of patients for patients of all ages.

- The importance of providing services to the community, in the community:

  - Stakeholders discussed that it is both costly and dislocating for individuals to have to go out of the community to receive services. Access to imaging services particularly out of hours was identified as one of the contributing factors causing transfer to Townsville. This is a major issue for smaller hospital facilities when they have to provide an escort for the patient
  - Compounding this are issues associated with patient flow, with ambulances only taking patients back to communities on backload. Patient transfer was discussed as also being disruptive to staffing levels in rural facilities, due to the need for an escort. The overall goal would be to minimise transfers where possible
  - Visiting specialists were discussed as being well received as well as there being a high degree of satisfaction with telehealth service provision.

- The need to harness ICT and improved health technologies to improve local service provision:

  - Support for service models involving telehealth and videoconferencing was provided, with the need for improvements to local ICT capability to support these models stressed by stakeholders
  - iEMR was discussed as "great, as it gives local staff the ability to track their patients to enable continuity of care"
  - The need to develop local pathology and imaging services to decrease the need for transfer and improve the quality of care were discussed.

- The need to consider new models for workforce attraction and retention:

- Issues around attracting and retaining a skilled workforce were consistently discussed, and desire to empower local workers through increased opportunities for upskilling and support from Townsville HHS

- General support for the Rural Generalist model was apparent.

4. SCENARIO 3: Consolidating the role of The Townsville Hospital as a regional tertiary referral hospital

4.1 Key points

For the purposes of the planning exercise, both key internal stakeholders and other North Queensland Hospital and Health Services were consulted to inform modelling around consolidating the role of TTH as a regional tertiary referral hospital.

The purpose of the consultation was to:

- Identify any clinical service areas where either service consolidation or an increase in capability would be both feasible and advantageous from equity of access and workforce recruitment and retention perspectives
- Understand service networking arrangements, and any proposed changes to these arrangements including endorsed and sustainable service development within other North Queensland Hospital and Health Services.

Key points from stakeholders included:

- TTH is a major referral centre for North Queensland. Referrals from other HHS's and from other facilities within Townsville HHS are for both tertiary level services as well as for secondary level services
- For tertiary services, TTH is the major centre for trauma, cardiothoracic, cancer and neurosciences services as well as supporting the retrieval services for adult, paediatric and neonatal intensive care patients. These services are key priorities for consolidation of TTH's role as the North Queensland tertiary provider. The sustainability of these tertiary level services is dependent of effective networking and referral relationships with the other North Queensland HHS's. TTH is dependent on flows from these other HHS's in order to retain critical mass for a number of these specialties
- Enhancement of tertiary services at TTH would enable reduction of outflows of both adults and children from North Queensland to public hospitals in metropolitan Brisbane. There are key outflows of both adults and children from across North Queensland to public hospitals in metropolitan Brisbane that would be feasible to reverse. This would provide equity of access as well as improve workforce recruitment and retention for some sub-specialties
- General surgery, ENT, maxilla-facial surgery, plastic surgery, radiology, ophthalmology and orthopaedics all have critical regional roles supporting service delivery across North Queensland. TTH's regional role has a major impact on capacity not only for inpatient services but also for outpatients / telehealth / outreach clinic services
- For paediatric services, the vision for the service model is to maintain a strong general paediatric base with increasing development of selected sub-specialty services in collaboration with LCCH. The service is trying to build the skills of Rural Generalists for paediatrics, as well as support staff of Cairns and Mackay in order to reduce the volume of transfers to TTH. The trend for paediatrics is to move increasingly to ambulatory and outpatient services
- The following clinical support services were also identified as key constraints for the

further development of tertiary level services:

- Medical Imaging services and in particular access to MRI/CT (noting that both medical imaging and nuclear medicine are Level 5 CSCF services at TTH)
- Access to a hybrid theatre
- Capacity of anaesthetics, allied health services, ICU and PICU to manage the flow on impact of provision of increased volumes of higher complexity services.

- A generalist workforce model supported by targeted sub-specialty development is crucial to the sustainability of the TTH workforce. There are currently some specialties that are particularly vulnerable from a workforce point of view due to the small numbers working in the public sector. Plastic surgery, maxilla-facial surgery, vascular surgery, urology and hyperbaric medicine are the services currently most 'at risk' in terms of recruitment and retention
- The vision to develop an academic health research and teaching campus in collaboration with JCU is a key opportunity and would significantly contribute to consolidating the role of TTH as the regional referral centre
- All stakeholders agreed that there is a need to adequately represent the secondary level services, not just focus on the "high end" work.

4.1.1. Input from Key Internal Stakeholders

TTH is a major referral centre for North Queensland. Referrals from other HHS's and from other facilities within Townsville HHS are for both tertiary level services as well as for secondary services. In particular, TTH is the major referral centre for trauma, cardiothoracic, cancer and neurosurgical services as well as supporting the retrieval services for adult, paediatric and neonatal intensive care patients.

Demand for tertiary services was considered to be increasing as a result of population growth as well as advances in clinical practice that enable the treatment of increasingly complex conditions and patients with multiple co-morbidities. Further enhancement of tertiary services at TTH would enable reduction of outflows of both adults and children from North Queensland to public hospitals in metropolitan Brisbane as well as strengthen recognition of the role of TTH within North Queensland.

A generalist workforce model supported by targeted sub-specialty development is crucial to the sustainability of the TTH workforce. There are currently some specialties that are particularly vulnerable from a workforce point of view due to the small numbers working in the public sector. Plastic surgery, maxilla-facial surgery, vascular surgery, urology and hyperbaric medicine were the services identified as currently most 'at risk' in terms of recruitment and retention.

The longer term sustainability of tertiary level services is also highly interlinked with the effectiveness of the networking and referral relationships with other North Queensland HHS's. TTH is dependent on flows from these other HHS's in order to retain critical mass for a range of specialties including in particular, neurosurgery, cancer services (including radiation oncology) and interventional cardiology. The preferred model would be to increase outreach to Cairns and Mackay for these services and progress more formal arrangements such as an MOU in relation to planning and delivery of specific services. It was also noted that inflows to TTH from other North Queensland HHS can fluctuate significantly as a result of local workforce recruitment and retention issues particularly in Cairns, Mackay and Mt Isa for particular specialties.

4.1.1.1. Adult Services

A number of specialties provided information in relation to trends for specific services for adults. These were:

Neurosciences (Neurosurgery and Neurology)

Demand for neurosciences is increasing significantly with continual expansion of the use of minimally invasive techniques expected. Treatment of cerebral aneurysms, stroke, epilepsy, solid brain tumours and a range of spinal surgery are all examples of conditions which will increasingly be managed using interventional radiology rather than traditional surgical procedures.

Advances in cancer treatments through delivery of localised radioactive particles, gene targeting and immunotherapy are also key areas of change.

Maintaining a sustainable workforce is a key challenge and is necessary to ensuring an equitable standard of care to services in Brisbane. Partnering with both public and private services is a key strategy from a workforce and a professional standards point of view. Townsville requires enough personnel to provide an on-call roster that is acceptable for current standards. The future workforce model will be to recruit a mix of specialists (neurologists, neurosurgeons and interventional radiologists) who share skill sets in relation to minimally invasive techniques.

Ophthalmology

Demand for ophthalmology at TTH is significantly related to referrals for patients who have come to Townsville for other services (for example, renal services, trauma services) but also require access to ophthalmology specialists. The workload from the NICU for monitoring and early intervention for eye problems is increasing as a result of advancing technology and the improved interface with LCCH. This demand is not reflected in inpatient datasets.

In the future, Townsville Hospital should focus on tertiary procedures in particular. A large volume of elective work can be done more efficiently in a private surgery.

Cardiothoracic

Cardiothoracic surgery is only provided in Townsville. Cairns and Mackay both have cardiac catheterisation laboratories so the demand for these services from inflows has reduced over time. However there are more patients referred for further treatment as a result of improved access to diagnostic angiography. There is potential to do outreach to Cairns and Mackay to do lower complexity cases.

Demand for cardiac services is expected to increase significantly but increased demand for thoracic services is linked to the cancer service. In future, interventional cases will increase (TAVI procedure etc.). As a result, demand for ICU beds will reduce but the requirement for close observation beds will increase as more procedures are done under local anaesthetic/sedation.

A hybrid theatre for cardiovascular, vascular surgery, neurosurgery and cardiology is a high priority.

Average length of stay for cardiothoracic surgery is currently high due to low rates of day of surgery admission with patients from outside Townsville admitted a few extra days early for work up, as well as bed block on return transfer of these patients.

General Surgery

TTH is the referral centre for oesophageal, gastric and pancreatic diseases for North Queensland with increasing demand as a result of TTH's role in cancer services. Demand for general surgery is impacted on by the workforce skills in other locations, for example, Mackay is not able to treat patients with rectal cancer.

The overarching trend for general surgical patients is a decreasing average length of stay.

Respiratory / Sleep

This service provides outpatient and inpatient services including several outreach clinics across North Queensland. There is a "huge demand" for outpatients, with the goal of trying to keep patients out of hospital. Patients are currently waiting 2 - 3 years for a sleep study (the sleep lab only has two beds, and there are no public services between Townsville and the Sunshine Coast).

Endobronchial Ultrasound is not available at TTH, meaning patients outflow to Brisbane. This should be a service that is developed as part of a tertiary-type facility.

A key issue is transitional care for cystic fibrosis patients which requires a multidisciplinary team approach to avoid hospitalising these patients. The service is currently provided by The Prince Charles Hospital (TPCH) as an outreach clinic. TPCH currently provides a 6 monthly clinic but this may be reduced in future.

There is a need for increased access to bronchoscopy which is currently constrained due to the capacity of the endoscopy suite.

Intensive Care Unit

In the last 10 years the caseload of the ICU has been consistently comprised of around 40% medical patients and 60% surgical patients. Patients most often come to the ICU not because of their surgical intervention but because of comorbidities (that increase complexity). Many ICU patients are admitted due to the requirement for complex monitoring and close observation due to complexity / comorbidities rather than a need for intubation. There is also increasing demand for ICU beds related to the trauma retrieval service role of TTH and the increased complexity of cases being managed.

The issue of High Dependency Unit beds, where these should be located within the hospital and the impact on the number of ICU beds required as defined by Queensland Health was highlighted. Some services such as neurosurgery have the capacity to manage HDU type patients within their units and therefore elective neurosurgery is less dependent on ICU capacity.

Anaesthetics / Perioperative Services

The increase in minimally invasive procedures will not equate to minimally invasive (or less complex) anaesthetics. Technological advancements will most likely be more resource intensive for anaesthetics as more procedures are done on patients with significant comorbidities. Creation of extended recovery areas should be considered as a way of avoiding ICU admission for close monitoring as some patients are only unstable post operatively for a short period.

The number of anaesthetists is a major constraint to expanding services.

Medical Imaging

The three key areas of burgeoning use are CT, MRI and ultrasound.
Access to medical imaging services outside of Townsville is an issue particularly in relation to after-hours services and is a cause for referral of patients to Townsville.
In line with trends elsewhere there is significant demand for MRI services much of which comes from outpatients. There is currently an eight week waiting list for booked MRI at TTH. This is reported to be one of the reasons for the low rate of day of surgery/day of procedure admissions for cardiothoracic and cancer patients (along with the difficulty of coordinating multiple outpatient appointments) as inpatients are given priority over booked patients.

Trauma Services

While the current service meets the service requirements as a level 1 trauma service, it is currently not an accredited service as it does not meet all the governance arrangements and workforce / leadership requirements.

Maxilla-Facial Surgery

There is no surgeon specialising in free-flap surgery in North Queensland. Ideally maxilla-facial surgery should be a regional service with outreach to Cairns and Mackay.

4.1.1.2. Paediatric Services

The general paediatric service from TTH plays a key role in supporting services for children across a wide area. TTH receives a large number of transfers from small facilities as well as providing a significant volume of outreach (e.g. to Palm Island, Charters Towers and Ayr). Some telehealth is provided (but stakeholders noted that initial assessments for paediatric patients are difficult via telehealth) and TTH also takes a leadership role in the development of policies to ensure the safe delivery of paediatric services.

The vision for the service model is to maintain a strong general paediatric base with increasing development of selected subspecialty services. The service is trying to build the skills of rural generalists for paediatrics, as well as support staff of Cairns and Mackay in order to reduce the volume of transfers to TTH.

The trend for paediatrics is to move increasingly to ambulatory and outpatient services rather than treat children as overnight inpatients and this will have a further impact on the need for outpatient clinic space. Paediatric services also need to have a strong multidisciplinary focus. The need to build a rural generalist allied health service for paediatrics complemented by specialist support from TTH was highlighted. Allied health services need to have the capacity to provide an increasing role in the management of chronic conditions in children not just acute management. The important role that child health nursing plays in linking primary healthcare and secondary / tertiary-level care was also highlighted.

Detailed discussions have commenced between Townsville HHS and LCCH to identify the levels of support required to increase the specialist paediatric role of TTH. Townsville HHS are looking to maintain a networked service with LCCH with continued referrals to Brisbane for cardiac surgery, initial diagnosis and commencement of cancer care and a small number of highly specialised services such as complex craniofacial services. The extent to which specific flow reversals are achievable requires further detailed planning and expert clinical advice at an individual service level.

Key specialty areas identified for reversal of paediatric outflows to Lady Cilento Children's Hospital include:

- Neurosurgery and neurology
- Cardiology
- Respiratory Medicine (including Cystic Fibrosis)
- Rehabilitation
- Specialty integrated services such as Spina Bifida, Cystic Fibrosis and Endocrine Diabetes.

It will be critical to consider the impact of flow reversal on outpatient services as services such as respiratory medicine and endocrinology are increasingly provided on an ambulatory basis. The discussions with LCCH provide an opportunity to put in place the preferred model of care in terms of the balance between inpatient and ambulatory services. A key example is for rehabilitation services for children post head injury or major burns who may require ongoing rehabilitation in Townsville on return from LCCH but could stay at Ronald

MacDonald house and attend as outpatients.

It should be noted that Townsville HHS already provides the paediatric surgical service for North Queensland at a Level 5 capability and also is able to treat children with burns up to 50-60% of their bodies without needing to transfer the child to LCCH. Anecdotally, 30% of total paediatric service at Townsville HHS is for patients from outside the Townsville area. This is heavily influenced by children requiring surgery. Townsville HHS has 2 Staff Specialists and a VMO for surgery. It is considered unlikely that any other hospitals in North Queensland would be able to recruit and retain an adequate number of paediatricians to sustain a viable Level 5 service. Cairns Hospital does not employ a paediatric surgeon and would need at least 3 FTE to provide a comparable service (including PICU). It is therefore expected that Cairns will continue to provide a part-time service and be reliant on TTH for cover of their paediatric services.

Paediatric anaesthetic capacity is a major constraint to the further development of services. Demand is related to the requirement for a child to often be given a general anaesthetic for diagnostic and other minor procedures such as MRI and insertion of PICC lines. This can be the cause of a bottleneck that keeps children in hospital for longer. Access to theatres is also an issue with the current theatre template fully allocated.

The Paediatric Intensive Care Unit is currently physically located within the adult ICU and shares some staff (with separate medical staff and one dedicated Paediatric CNC). A supportive role is provided to Mackay and Cairns who have adult ICUs that can provide short term care for an intubated child. The ability for the Cairns and Mackay ICU's to care for a child is strongly linked to the skills of the individual clinicians in those locations and hence the volumes of transfers fluctuate. In future, there is potential for the PICU to be relocated to a separate space with its own dedicated nursing roster.

The limited capability and capacity to provide timely and efficient retrieval services has been previously identified. A recent review by the Queensland Department of Health has recommended that significant additional funding be allocated to enhance and ensure a coordinated and sustainable paediatric retrieval system in North Queensland hosted by TTH.

4.1.2. Input from Strategic Partners in Acute Clinical Service Delivery

4.1.2.1. North Queensland Hospital and Health Services (HHS)

There will be an ongoing reliance on Townsville HHS to support a range of specialist services in other North Queensland HHS's for the foreseeable future. This support will vary from service to service and will include increasing outreach and telehealth support as well as maintaining sufficient capacity at TTH to accept inflows. The specific areas identified by each HHS were:

Cairns and Hinterland HHS

Clinical service planning is Cairns and Hinterland HHS is also currently underway. Their five year vision is for consolidation of CSCF Level 5 services rather than increasing to Level 6. Cairns and Hinterland HHS are looking to Townsville HHS to take a leadership role in the health system but not to be the sole provider of all high-level services.

There are no plans to significantly change the volume or mix of patients that are being referred to TTH, with the possible exception of interventional cardiology, as there is planning occurring for an additional catheter laboratory and an EPS service. The existing catheter lab in Cairns is at capacity but there is not likely to be any change in the short term.

There are also early discussions occurring with Ramsay to develop robotic urology services. The private operator would own the service and Cairns and Hinterland HHS would purchase approximately 50 cases per annum from them. Mental health services are being increased in Cairns with $70M allocated for a new medium secure mental health unit as well as 48 – 50 community beds.

There were four areas that Cairns and Hinterland HHS identified as needing a more whole of North Queensland networked approach from a workforce perspective:

- Radiology - the radiology service in Cairns is not comprehensive or sustainable as an outsourced and fly-in fly out model
- Ophthalmology
- Plastic surgery – each location should have general services but it would be more economic to have a shared service model for specialist services
- Paediatrics and neonates - Cairns will not be increasing the capability of their special care nursery, but will continue to ventilate babies for 24-hours and then transfer to TTH as per current practice.

Torres and Cape HHS

Torres and Cape HHS are seeking additional telehealth outpatient services plus onsite orthopaedics, general medicine, ENT and echocardiography clinics. The potential for Cairns Base Hospital to provide these depends on any future plans for its capability levels. Torres and Cape HHS would like Townsville HHS participation in terms of the provision of these services, and the preferred arrangement would be that Service Level Agreements would be forged.

North West HHS

Discussions are already underway to increase the number of outreach cardiology clinics from TTH as well as gastroenterology and endoscopy services.

Mt Isa would like to increase orthopaedic outpatient capacity. Telehealth is currently provided from Brisbane but NWHHS are looking to partner with TTH to ramp this service up. Other services that should be considered for increased outpatient clinic services (telehealth and outreach) are neurology, ENT and Endocrinology (Diabetes).

The intent is also to take responsibility for renal dialysis locally as part of a hub and spoke model with TTH. The major barrier at this stage is funding.

Over the next 10 years, the biggest challenge for Mt Isa will be to maintain CSCF Level 4 services particularly if the mining industry continues to decline. This could have a major impact on Townsville HHS.

Mackay HHS

Mackay HHS is currently undertaking internal operational planning activity, which will serve as a precursor to the development of a clinical service plan (scheduled to begin in August and complete by the end of the 2017/18 financial year). This effectively means that clinical service planning is occurring across the 3 main NQ HHSs at roughly the same time, which is promising from a regional coordination perspective.

The timing for the MHHS planning process (which is a number of months behind Townsville HHS and CHHHS) is to some extent impeding their ability to contribute to the Townsville HHS planning process with any great level of confidence, as they are yet to articulate and agree on their planning priorities. However, initial feedback was as follows:

- Mackay HHS is unlikely to pursue any change to its CSCF and will instead be focussed on the

sustainability of core services

- Mackay HHS expects to have a continued reliance on VMO services from TTH
- Demand for ENT services is not well understood from a MHHS perspective. Townsville HHS is currently providing adult outreach services, however the potential and readiness for paediatric outreach requires further investigation and consideration
- Radiation oncology remains a risk for Townsville HHS, with MHHS yet to understand the impact that the introduction of a private supplier setting up in Mackay will have on local services
- Mackay HHS expect an increasing need for haematology services from Townsville HHS
- Mackay HHS is keen to see a continued formalisation of arrangements between MHHS and Townsville HHS, including such examples as improved networking / support amongst paediatric clinicians.

Over the coming months Mackay will continue to progress their local planning processes (as will CHHHS). This will ultimately provide improved capacity for North Queensland HHSs to articulate their planning priorities for the next 10+ years. On this basis, Townsville HHS engagement with MHHS and CHHHS should continue as an iterative activity over the coming months, to ensure that emerging service plan priorities are captured and factored into local planning as required.

4.1.2.2. James Cook University

Representatives of the James Cook University (JCU) articulated a vision to create an Academic and Health Research Campus. This is a key opportunity and would contribute significantly to consolidating the role of TTH as a regional referral centre. JCU are also pursuing a vision to operate a private hospital on the site, with significant teaching and research capability, located on land adjacent to the Townsville Hospital. Future master planning would see the two campuses joined.

JCU consider that their proposal supports the future role of TTH as a premier tertiary institution. This role would involve leadership with regard to 'front line' public health provision, disease control and health security for North Queensland, harnessing innovation through researched technologies and different models of care / planning across the region, and leading regional health workforce development. There would need to be agreement on how work is distributed between Cairns and Townsville as part of the regional approach.

5. SCENARIO 4: Private sector risk assessment

5.1 Key points

For the purposes of the planning exercise, both key internal stakeholders and strategic partners in acute service delivery (from the private sector) were consulted to inform the private sector risk assessment.

The purpose of the consultation was to (from the Stakeholder Engagement Plan):

- Test the realities of assumptions relating to private service utilisation within Queensland Health projection modelling
- Confirm any proposed infrastructure developments as an indicator of future service developments.

Key points from stakeholders include:

- General consensus regarding the impact of drivers (local, State and National) that may result in a decreasing or relatively stagnant level of use of private hospital services in Townsville
- Of note though is the recent growth in selected services in the private sector including mental health, day cancer services and rehabilitation as well as the development of an ED at the Mater Townsville
- Mixed views regarding the potential viability of proposed infrastructure developments, including private hospitals operated by James Cook University (JCU) and another located on the West State site
- The future policy directions of Government in relation to admitting chargeable private patients to public hospital beds is unknown
- There are several opportunities for partnering ranging from the outsourced delivery of clinical services, to workforce attraction and retention, to activities supporting the proposition for an Academic Health Centre on TTH campus.

5.1.1. Input from Key Internal Stakeholders

Most internal stakeholders felt that there will be a decreasing private hospital sector in Townsville as a consequence of a range of factors including a contracting economy, increases in the cost of private health insurance, reducing cover and increased excess payments.

However, it was also noted that a proposed new private hospital on the site of the old West State School is currently advertising for staff to commence in 2018. In addition, ICON Cancer Care Townsville have also recently established a specialised day hospital to provide a full range of treatments for people diagnosed with cancer or blood conditions.

The future of the private sector in Townsville was seen as posing both a risk and an opportunity for Townsville HHS.

At an operational level, clinical staff noted there is a close working relationship between the Mater Townsville and TTH with many medical staff working across both campuses. This provides a platform on which to build. With regard to partnering for service delivery, the following comments were made by stakeholders:

- Outsourcing some clinical services to the private sector would be acceptable and beneficial in creating capacity for trauma and emergent work, and to support The Townsville Hospital to focus on tertiary / quaternary procedures in future

- Some work, for example elective Ophthalmology, is more efficiently undertaken in a private surgery
- A collaborative arrangement between public and private ICUs may improve bed block for elective work. An issue with this would be the low levels of access to allied health in the private hospital, and ICU is a heavy user of these services (e.g. social work)
- There are opportunities for partnering with the private sector (although the partnership model was not defined by stakeholders), for example, for the provision of radiology services.

5.1.2. Input from Strategic Partners in Acute Clinical Service Delivery

Representatives from Mater Health Services North Queensland and JCU provided their opinions on demand for private services within Townsville. Mater representatives considered that the state of the Townsville economy would not drive an increase in the privately insured population in the foreseeable future. While JCU representatives acknowledged the impact of private insurance decline, they considered that strategically, this would not impact future partnership service delivery models within Australia.

Of great concern to the Mater Hospital Townsville was the opinion that growth in the treatment of private patients across the full spectrum of services (including elective surgical services) is occurring in the public sector rather than the private sector. Consequently, growth in the private sector is dependent upon whether this trend continues, and unless there is change in government policy, besides some growth in day surgery, local private operators believe that there will be very little growth in the private sector in Townsville, as it will all be absorbed by The Townsville Hospital.

In recent times the Mater Hospital Townsville has opened up a dialysis unit (2 years ago), opened up inpatient and outpatient rehabilitation services (12 months ago), and is opening an ED in the near future. The Mater advised that the latter move is intended to facilitate the conversion of inpatients (including from Defence Forces staff who "often seek treatment via an ED"), who are not transferring to the Mater for an inpatient stay once attending The Townsville Hospital ED.

The Mater Hospital Townsville discussed an interest in collaboration in order to attract doctors, for staff training, and regarding technology and communications to improve accessibility and networking.

The vision of the James Cook University (JCU) is for broader collaboration in the creation of an Academic and Health Research Campus on the collocated JCU/The Townsville Hospital campus. JCU consider that their proposal supports the future role of The Townsville Hospital as a premier tertiary institution, and see this role as involving leadership with regard to 'front line' public health provision, disease control and health security for North Queensland, harnessing innovation through researched technologies and different models of care / planning across the region, and leading regional health workforce development.

As part of their vision, JCU are aiming to operate a private hospital on the site, with significant teaching and research, located on land directly adjacent to The Townsville Hospital site (future master planning would see these two campuses joined as part of the Academic Health Centre). JCU are proposing a partnership model with the private sector that involves joint funding but on JCU land. JCU has gone to market for their proposal, but advised that the 'timing wasn't right' and players pulled out due to private health insurance uncertainty.

6. Other issues identified through consultation pertinent to Townsville HHS strategic or service level planning

The stakeholder engagement process and the associated data analysis revealed areas where strategic level planning decisions would potentially have an impact across multiple "scenarios", that is they are linked to changes of models of care as well as affecting the future role and capacity of smaller rural facilities and TTH. The inputs from stakeholder engagement in relation to these areas in discussed within this Section.

6.1. Closing the Gap for Aboriginal and Torres Strait Islander Health

6.1.1. Input from Key Internal Stakeholders

The high rates of admission to hospital for Aboriginal and Torres Strait Islander people were discussed. One of the reasons for this is the tertiary referral centre role for TTH which results in significant inflows and contributes to the high proportion of admissions that are for Aboriginal and Torres Strait Islanders. The large inflows for renal, endocrine, maternity and cardiovascular were highlighted.

As a general comment, the Aboriginal and Torres Strait Islander community is less likely to use GPs / Primary Healthcare regularly. For this reason, they are often sicker when they make first contact with the acute sector, thereby having increased admissions. Additionally, many have a preference to using hospital emergency and outpatient services over Primary Healthcare. This relates to the ease of access and there not being a need to pay for services but contributes to the increased use of hospital ambulatory services for primary care.

The Townsville Aboriginal and Islanders Health Services (TAIHS) provide a community controlled option for primary healthcare services (GP and multidisciplinary services). They are proactive in trying to provide a full range of services, and have sought to integrate with the hospital as best they can. For example, the Aboriginal and Torres Strait Islander Health team provides information on clinic lists to TAIHS so that they can provide assistance to / reminders to patients to attend appoints as required. As a consequence Failure to Attend rates for specialist appointments have dropped. While TAIHS focus is on primary care they have made rooms available for specialist appointments to address barriers to getting to the hospital. They also attend case conferencing meetings regarding frequent presentations to ED / complex patients. Responsibility for case management is an issue still to be resolved in terms of who takes the lead in managing the ongoing care of these patients.

The vision for Aboriginal and Torres Strait Islander Health is to provide holistic / wrap-around primary care services in order to address chronic disease within the population early. The overarching goal is to take a proactive approach to avoid hospitalisation, and for chronic disease conditions the best place for this is within the community primary care space. Therefore, supporting and promoting the TAIHS model additional to the ongoing role of providing acute care as required is the priority. Better integration is possible, for example, having TAIHS health workers at TTH to support patient transition back into the community, better use of technology and overcoming barriers to information sharing.

Providing services in a community setting should be pursued as much as possible. The underlying principle should be that patients only attend the hospital for secondary and tertiary level inpatient services. A common issue is the difficulty of navigating through the outpatient process, for example to get onto a surgical list, with patients often having to leave their community for up to week to attend TTH for a 15 minute appointment.

In rural locations the role of Health Workers is to support clients who have specialist appointments in TTH, undertake a health promotion role (ensuring that all messages are culturally appropriate), and run their own locally relevant programs (for example hearing screening). They coordinate with other services, such as the Northern Australia Primary Heath Limited. Their focus is on programs that Queensland Health deliver with the major focus being on linking people with services and ensure that they are culturally appropriate rather than hands-on interventions. The cultural capability training program for staff is vital.

The next iteration of the Palm Island Health Action Plan will soon be available. It was noted that the consultation for the Townsville HHS Clinical Service Planning process won't cut across that Action Plan engagement activities but will be informed by the Action Plan outcomes. The priority for the Action Plan is to develop comprehensive primary health care for Palm Island residents with Townsville HHS working in partnership with Palm Island Aboriginal Shire Council to support the development of a new Palm Island Health Action Plan. The Queensland Government will contribute $16.5 million for the building of a new primary healthcare service for Palm Island. It was noted that the Joyce Palmer Health Service won't be moving beyond a CSCF Level 2 service.

The issue of identification of Aboriginal and Torres Strait Islander people in the inpatient datasets is unreliable. The 2014/15 base year figures in AIM appear to under-represent services provided to ATSI people. Staff are trained to always ask if the patient is ATSI but in practice this doesn't occur 100% of the time. One of the key issues is that if a person who comes to Townsville regularly for treatment (e.g. a renal patient) relocates and changes their address to Townsville, it is difficult to identify local demand from their original community. An issue with relocation is that they lose their access to the Patient Travel Subsidy Scheme (PTSS) if they have a Townsville address but may not have any suitable accommodation in Townsville. This is particularly an issue for renal patients.

6.1.2. Input from Strategic Partners

Palm Island Key Stakeholders

An extensive engagement process was undertaken by the consultants engaged to develop the *Palm Island Health Action Plan 2017-2027*. It was agreed that the output of these consultations would be used to inform the development of the Townsville HHS Health Service Plan so as not to duplicate any activity.

Consultations meetings for the Action Plan have been held with:

- Joyce Palmer Health Service staff and visiting service providers as possible
- Government agencies including the State and Commonwealth Health Departments, the Department of Local Government, Infrastructure and Planning (DILGP) and Department of Aboriginal and Torres Strait Islander Policy (DATSIP) in Townsville and Brisbane, the Palm Island Aboriginal Shire Council (PIASC), the North Queensland Primary Health Care Network and Education Queensland (EQ)
- Non-government services that are resident on Palm Island or visit Palm Island to provide health and social services.

A structured questionnaire has also been used to systematically collect information about key policy directions, services delivered, actions implemented from the *Palm Island Health Action plan 2010 – 2015* and initiatives planned for the future.

The process had also involved a community workshop and a two-day Health Planning meeting held on November 30 and December 1, 2016 on Palm Island to share the outcomes from the stakeholder engagement and data analysis.

The key priority identified from the Palm Island Health Action Plan process is to develop, over the next 5 years, an integrated model of care based on the establishment of a community controlled health service and governed by a Health Board elected by the Palm Island community. The model will be based on a Partnership approach to health service delivery with all health and community services coming together under a deed of commitment arrangement.

A major commitment is the construction of a purpose built primary health facility in the community precinct which will offer general practice and non-acute multidisciplinary primary health care services. Outreach services will be scheduled regularly to be delivered in the community using the mobile health van, conducting clinics from other facilities in the community or by home visiting. Transport will be provided to assist clients to attend the primary health care service. Emergency care, inpatient care, renal dialysis, high needs aged care and pharmacy services will continue to be delivered and managed from the Joyce Palmer Health Service.

The patient journey will be based on a population health approach or "wellness model". That is routine health checks will be scheduled and delivered by a multidisciplinary team lead by Aboriginal and Torres Strait Islander Health Workers. Care plans will be developed by the general practitioner to respond to risk factors identified from health checks and to manage diagnosed chronic disease or mental health conditions. Education about risk factors and chronic conditions will routinely be provided by Aboriginal and Torres Strait Islander Health Workers. Effective referral systems to secondary services will be implemented through the use of information technology. Patient information will be shared across service providers with the consent of patients.

Enhancements to the scope of primary health care services as described in the Palm Island Health Action Plan will be funded by increasing Medicare revenue.

A range of specific services issues relating to the broader clinical service planning process for Townsville HHS were also identified within the Technical Background Report for the *Palm Island Action Plan 2017-2027*. A summary of these is below:

Birthing in community

Birthing in community was the issue raised consistently at every community consultation. To reintroduce birthing on Palm Island, it was recognised that action is required by individuals, families and the health services to address risk factors in pregnancy including smoking, substance misuse and gestational diabetes to reduce the large number of high risk pregnancies. Workforce and infrastructure issues would also need to be addressed to enable low risk birthing on Palm Island to be re-established.

Child and youth health

Young people are exposed to high levels of health risks which are leading to poor education, unemployment, substance abuse, injury, disability, trauma, incarceration and premature death. Regular health checks

for children to identify problems early and to remove barriers to poor education were highlighted. Parenting programs to assist with strengthening families was also the solution suggested by many community members. The Children and Family Centre already provides an integrated program of activities targeting early development through play groups and parenting support programs for new parents, but more families need to access the service. Families with older children and challenging children also need help.

Chronic illness prevention and management

The issue of excess hospitalisation and premature death for Palm Island residents from chronic disease was highlighted. It was recognised that chronic illness can be prevented by the uptake of a healthy lifestyle but requires addressing the underlying intergenerational trauma and social determinants of health. Enhancing opportunities for local employment and addressing the disempowerment caused by a large component of the workforce being fly in fly out workers will contribute to a reduction in chronic disease. Action is also required to implement a wider range of health promotion and recreational activities, and strategies to improve the affordability of food and to assist people to stop smoking. Fundamental changes are required to the approach to care to ensure that risk factors are identified early; chronic illness is managed by a multidisciplinary team and funding for service delivery is claimed through Medicare.

Sexual Health

North Queensland is currently experiencing an outbreak of syphilis and a growth in STIs including HIV. This is a public health emergency for Aboriginal and Torres Strait Islander communities and Palm Island is not immune. Actions are required to implement community based actions contained in the N*orth Queensland Sexual Health Strategy 2016– 2021*.

Care of older people and people with disabilities

Older people and people with disabilities who have high care needs must be moved to Townsville separated from family on Palm Island. This is repeating the cycle of forced removal and trauma which brought their families to Palm Island in the first place. Reorienting the Joyce Palmer Health Service to a multipurpose facility will enable people with high care need to remain on Palm Island.

Townsville Aboriginal and Islanders Health Services (TAIHS)

The key priority for TAIHS is the development of a collocated service model with Townsville HHS. The vision is for a “service hub” where the two organisations work together seamlessly from the same physical location. There is a major opportunity for this to be a reality as TAIHS are working on an infrastructure strategy and have sufficient land to enable expansion.

In TAIHS experience, a collocated service model works best when the HHS is able to come to the community controlled location. This enables clinical services to be delivered in a seamless model with social, emotional and well-being services supported by robust case coordination. It also ensures that the model has a platform of cultural capability.

Two major components of the service hub that need to be supported by Townsville HHS would the medical specialist clinics and a hub for allied health services which included comprehensive rehabilitation. The service hub model should be strongly supported by telehealth with the principle being to retain people within their communities as much as possible.

The vision for the service hub also includes working closely with JCU and the PHN.

Maintaining an ongoing presence within TTH

is also a priority. This includes continuing "in-reach" services from TAIHS and the close working relationship with the liaison officers and nurse navigators.

The role of the health worker is the key. Significant expansion in the numbers of indigenous health workers is required. TAIHS would be keen to work with Townsville HHS on developing a collaborative workforce plan in this area. Development of a skilled local workforce is noted as one of the main ongoing issues for TAIHS on Palm Island where they deliver maternal and child health and alcohol and drug services in conjunction with the Joyce Palmer Health Service.

A number of specific service issues were also discussed including the need for:

- improved case coordination – effective case coordination and case management is critical to ensuring ongoing engagement of indigenous patients with treatment regimens and with prevention and promotion programs. This is a key role for the health worker. The need for better case coordination is particularly evident for patients referred to Townsville from remote areas. These patients frequently arrive without documentation and without a specific plan for organising ongoing family support and/or accommodation. Ideally a formal case plan would be developed prior to transfer which identified both the clinical and social support arrangements required.
- increased capacity for chronic disease management - demand particularly for diabetes and mental health significantly exceeds available resources.
- access to the full range of allied health services – key areas include rehabilitation as well as greater access to social work and other support services.
- effective primary prevention – access to young people is critical particularly for services such as sexual health.
- a closer relationship with HITH and Transition Care programs to ensure that patients referred to these programs by the hospital are supported to participate.

6.2. Meeting Demand for Mental Health Services

6.2.1. Input from Key Internal Stakeholders

The Queensland Department of Health projections were discussed with stakeholders. It must be noted that the Queensland Health planning benchmarks are outdated and the projected bed requirements for Townsville HHS will need to be revised in line with work underway within Mental Health Branch and National Mental Health Framework.

The naming convention used by the Department does not align with the service model for Townsville and the geographic location of the projected beds is not appropriate. The total number of projected beds does not need to be changed but re-categorisation of bed types is required.

The flows modelled by the Department should not be changed at this stage. The catchment for acute beds is North West and Townsville. Mackay and Cairns run their own acute units. Flows from Cape York and Torres Strait go to Cairns.

It was agreed that the information provided in the following table should be used instead of the format provided by the Department.

Table 1: Designated Mental Health Bed Projections (@ 90% occupancy for adults, 70% for children)

Location	Primary Classification	2015 - 2016	2021 - 2027	2026 - 2027	2031 - 2032	2036 - 2037
The Townsville Hospital	Adult Acute Inpatient		29.9	31.6	33.4	35.3
	Older Acute Inpatient (65+)		19.1	23.2	27.1	30.9
	Acute Total	**36**	**49.0**	**54.7**	**60.5**	**66.2**
The Townsville Hospital	Medium Secure Mental Health Rehabilitation	25	27.2	29.5	31.8	34.1
Kirwan (satellite of TTH)	Child and Adolescent Acute Inpatient and Day Service	8	17.6	18.7	19.7	20.7
Kirwan	Acquired Brain Injury	10	12.0	12.9	13.8	14.8
Kirwan	Community Care	24	29.1	31.4	33.7	36.1
Charters Towers	Extended Treatment and Rehabilitation	27	24.0	25.8	27.7	29.6
TOTAL		**130**	**158.9**	**173.0**	**187.2**	**201.5**

It was noted that the number of operational medium secure mental health rehabilitation beds at TTH will gradually increase to 20 from 1 July 2017, and then to 25 in January 2018. This is important because until 2012 Townsville HHS used to have a hybrid model (would admit acute patients into the secure unit which is for long stay rehabilitation, stable patients).

The unit at Kirwan is a community care unit not a rehabilitation unit as Department activity projections infer. The unit at Charters Towers is an adult extended treatment and rehabilitation service.

It must be noted that according to the Queensland Health planning framework, requirements for high secure beds for North Queensland are allocated to The Park facility in West Moreton HHS. Demand for forensic mental health services and access to high secure beds is an ongoing issue and is related to the presence of two large correctional centres in North Queensland (Townsville and Mareeba) which require ongoing support.

It was highlighted by stakeholders that the priority for investment would be best directed to alternatives to admission programs and community based care. This will require additional community based staff and may require a physical space for delivering these services. The current physical capacity of the Adult Acute Unit at TTH is 43 beds and is considered adequate for the medium term. The capital bed stock in Charters Towers for residential long stay rehabilitation for North Queensland meets the needs of the future.

There will be also be need for capital investment/rebuild/refurbishment of the Townsville Community Care Unit within the planning period.

A number of desired changes to models of care were identified. These include:

- Creation of a dedicated acute older persons unit within the additional bed allocation for adult acute mental health. Townsville HHS currently has 36 adult and older persons acute unit beds, and admit acute older persons to acute adult beds. With the ageing population, there will be an increasing need for acute beds in addition to extended treatment beds for the 65+ age group. The community based component of extended treatment needs development.
- Allocation of dedicated drug and alcohol detoxification beds within one of the medical units to address the current issue of these patients being distributed throughout the hospital. Demand for withdrawal services is increasing. This service is run by the Mental Health Service via a day program, but there are no dedicated ATODS beds. Patients are detoxed in a general medical ward under a medical physician, with consult liaison by a psychiatrist. Dedicated withdrawal beds within the medical unit/ward would be preferred, with a dedicated team as part of the medical team looking after them. These patients would be admitted under a physician rather than under a psychiatrist for drug and alcohol withdrawal. 'DABIT' (drug and alcohol brief intervention team) would continue to operate in the ED and short stay at TTH, providing assessment and intervention to all patients presenting to the ED that have a drug and alcohol history.
- Expansion of Eating Disorders Services to increase community alternatives to care and to support more children to transition to adult services once they are aged 18. Adolescents with eating disorders who require medical treatment are currently managed in the paediatric unit.
- Creation of a Family Unit for treatment of mothers and babies and for children aged 0-11 years. Currently, adolescent inpatient beds (12-18 years of age) day program and inpatient beds are run together in the one building. Day patients are not currently admitted. While there are currently 8 beds, these are not at capacity and the preference would be that any additional funding be invested into the community service before more beds are added. Patients aged 0-12 years i.e. 'child and youth', are currently admitted to paediatric inpatient beds which is not an ideal model. Occupancy levels of the current child and adolescent beds are relatively low and the projected bed requirements for 12-18 year olds are likely to be in excess of demand for an inpatient service. There is currently no dedicated mothers and babies unit with these patients currently specialled in the maternity unit, with psychiatrist assessment on a daily basis.
- It is therefore proposed that the additional projected bed stock for child and adolescent beds be utilised to meet demand for the Family Unit. The unit would allow for longer stay extended care and service the whole of North Queensland. If a designated unit is not achievable, the preference would be to put an extra wing on the paediatric ward (but a designated unit is the preference).

  It was noted that the Townsville Private Hospital has 60 mental health beds (although stakeholders were unsure whether all beds are open), and they see outpatients and inpatients (including a lot of Defence Force patients).

Townsville HHS Mental Health services have seen minimal impact on demand as a result of this service being open for the last 12-18 months.
Provision of mental health services in the smaller rural facilities was also discussed. Currently, if a patient presents in-hours they are seen by the community mental health team. After-hours, the Medical Officer or Nursing Director sees them, assesses, contacts TTH acute care team for an immediate after hours assessment via VC, or admits them

overnight and makes contact in the morning. Transfer to TTH is then arranged if necessary or they are followed up by the community mental health team.

Ingham has a higher use of non-designated mental health beds due to this facilities relationship with TTH and the goal to build capacity there locally. Admissions are for low risk, low threshold for reassessment patients. The aim is to build generalist capacity in all rural and remote areas, including the use of telepsychiatry. There is an opportunity for Townsville HHS to take a lead in telepsychiatry for the whole of the North Queensland region.

6.3. Meeting Demand for Renal Dialysis Services

Stakeholders noted that while the Department of Health planning guideline projects chair requirements on the basis of a utilisation rate of 1.9 patients per day, 312 days per annum, chairs at Home Hill and Palm Island are used significantly less than this ("1 shift, 3 days per week", equating to 156 days per annum).

Of note, Townsville HHS home dialysis has remained relatively static at 32% according to a recent KPMG Investment Options Report, and the Department of Health benchmark is 40%. The home dialysis rate for residents of Townsville city versus other parts of Townsville HHS and Mt Isa HHS is not known and it is therefore not able to be determined whether the overall low rate is a result of geographic location specific factors.

Anecdotally, stakeholders reported that significant numbers of renal patients have permanently relocated to Townsville from their original place of residence and are now unable to be identified in the datasets. This makes identifying the actual level of demand coming from Mt Isa and regional / rural areas of Townsville HHS impossible.

With regard to the current model of care, TTH unit is under significant pressure and is treating both in-centre and satellite-type patients due to lack of availability to increase service delivery in other locations. While some stakeholders considered that a significant percentage (approximately one half) of current dialysis patients at TTH would be suitable for treatment in a satellite unit "in an ideal world", others considered this to be an overestimate.

The volumes of patients potentially suitable for self-care is unknown, however stakeholders from rural locations considered this to be an appealing service delivery option.

Discussion with stakeholders also revealed the following:

- Capital investment to increase the capacity of TTH for renal dialysis services is planned. This capacity will accommodate both satellite and in-centre-type patients for local Townsville residents
- Negotiations with Mt Isa for flow reversal of renal dialysis patients is well progressed, and Mt Isa should be providing this service for local residents from 2020 (or before)
- There is potential to commence providing renal dialysis services in Charters Towers and Ingham
- The potential for TTH to commence renal transplantation services needs to be fully investigated with the Department of Health. It was noted that the TTH Intensive Care Unit has historically performed well in relation to organ donation participation rates.

6.4. Impact of Aged Care Reforms

Representatives from Leading Aged Care Services Australia (LASA) Queensland were consulted. LASA is the national peak body

representing and supporting providers of age services across residential care, home care, retirement living and seniors housing.

LASA representatives advised that the key theme emerging in aged care is the paradigm shift to a consumer driven service where the patient/resident/consumer are choosing their provider; it is a deregulated consumer driven, open market.

Consumers desire to enter a retirement facility/ campus as opposed to a residential aged care facility where they can continue to live independently/ semi-independently with the ability to transition to higher care services when needed, without the requirement to move. Consumers want a continuum of care and are choosing providers based on this (CDC Homecare package).

There is a focus on building design so that consumers may age in place. The current government policy in planning is focusing on increasing the number of homecare packages rather than increasing beds to support people to remain in their homes, or transition to a retirement facility.

There is an increasing demand for care of dementia patients and also palliation congruent with an ageing population. There will be implications in relation to dementia and palliation, in relation to funding around these comorbidities with the pending review of the ACFI.

The aged care single quality framework focus is on the consumer, rather than results. The rights of consumer vs. risk are considered where the consumer has the right to make an informed decision to take risk in relation their care, therefore the consumer drives quality.

The concept of Wellness and Re-enablement is now being applied to the aged care sector however CDC (Consumer Directed Care) and Wellness and Re-enablement do not always align. CDC focuses on duty of care/wellness and it is almost counter-intuitive with the current ACFI funding model. It is difficult to focus on Wellness and Re-enablement as ACFI looks at care for the recipient while CDC looks at care with the recipient.

Richard Roseworne is tasked with the review of the ACFI funding tool in response to the University of Wollongong report, “Alternative Aged Care Assessment, Classification System and Funding Models”. The fixed costs of aged care and the need to move away from the current ACFI funding tool are beginning to be acknowledged.

Option 1 from the report is being pursued which is to refine the current ACFI model. The preferred option is number 5 which is a blended payment model, however in order to move forward to option 5 we must first work through option 1. There is another group pursuing option 2, which is a cost and clarification study that looks at fixed costs of aged care, understands what they are and breaks it down to individual components. It is estimated that 60-80% of aged care costs are fixed.

Although currently there are models that support autonomy and independence for as long as possible for example, HITH for aged care and other hospital avoidance models, there is a need to explore these further.

In terms of the workforce, it too faces an ageing population and there is a perception that aged care is not often a career aspiration. The average age of nurses in aged care is higher than in an acute facility. There is an increase in the use of a casual workforce/ sub-contracting aged care workers who work across multiple employers. This will make it difficult to implement a philosophical switch to a Wellness and Re-enablement approach that will replace an automated task orientated approach to aged care. The aged care workforce is highly

unregulated when considering skill-mix and the impact on accountability and responsibility.

Aged care patients coming into an acute care setting can become “stranded” if they are not able to access appropriate community facilities and or/ support. This is an international trend and there is currently some work being done in Brisbane as to how they could enhance/ improve the flow of the “stranded patient” into appropriate accommodation.

Another option could be to work with the Department of Housing to look at housing that provides a range of accommodation options that meet the needs of recipients. The aim is to support them to remain independent for as long as possible and support transition to an aged care facility when appropriate.

6.5. Impact of the National Disability Insurance Scheme

Advice provided from a representative of the National Disability Insurance Agency (NDIA) was that through the National Disability Incentive Scheme (NDIS), significant levels of funding are being built into individual disability support plans for allied health support in general. This is already having an impact on the Townsville and Mackay markets, where wait times are appearing for access to community based allied health services (indicating shortages of supply in the private market as a consequence of the NDIS).

Implications associated with this lack of, or delays to, accessing services should be considered, along with the opportunities that this could present for Townsville based services.

Additionally, the NDIA advised that there is demand for community based allied health services from Townsville HHS rural/regional areas, and a lack of private sector providers to service this demand.

APPENDIX A: List of stakeholders consulted

A.1 Key Internal Stakeholders

A.1.1. Surgical Service Group

Attendees at one of two sessions (29 May 16:30 - 18:00 and 30 May 16:30 - 18:00) were:

Name	Position	Service/Specialty
Adrianne Belchamber	Surgical Service Group Director	Surgical Services
Geoff Gordon	Director of ICU	ICU
Michael Corkeron	Staff Specialist	Surgery
Raymond Green	Nursing Director	Perioperative and Critical Care
Gary Kershaw	Director	Medical Imaging
Lynette Boyes	Consultant Radiologist	Radiology
Robert Tam	Medical Director – Surgical Services	Surgical Services
Eric Guazzo	Consultant	Neurosurgery
Sumit Yadav	Director of Cardiothoracic Surgery	Cardiothoracic Surgery
Donald Cameron	Staff Specialist	Surgery
Rhys Edwards	Orthopaedic Director	Orthopaedics
Ian Reddie	Staff Specialist	Ophthalmology
Philippe Wolanski	Staff Specialist	Urology
Donald Cameron	Staff Specialist	Surgery
David Mitchell	Director of Planning	Townsville HHS

A.1.2. Mental Health Service Group

Attendees at one session (31 May, 9am) were:

Name	Position	Service/Specialty
Dr Michael Catt	Service Group Director	Mental Health
David Mitchell	Director of Planning, Townsville HHS	Townsville HHS

A.1.3. Medical Service Group

Attendees at one of two sessions (29 May 12:30 - 13:30 and 30 May 12:30 - 13:30) were:

Name	Position	Service/Specialty
Stephen Eaton	Service Group Director	Medical Services
Luke Lawton	Staff Specialist	Emergency
Richard Corkill	Staff Specialist	Palliative Care
Richard White	Staff Specialist	Neurology
Virginia Carter	Nurse Unit Manager	Endoscopy
David Gilmore	Staff Specialist	Gerontology
Melanie Poxton	Nurse Unit Manager	Clinical trials
Helen Murray	Nurse Manager	Transition Care Coordinator
Jerry Minei	Staff Specialist	Medicine
John Dick	Clinical Director	Internal Medicine
Ramana Butters	Nurse Unit Manager	Oncology Ward
Aniko Cooper	Director	Townsville Cancer Centre
David Mitchell	Director of Planning	Townsville HHS

A.1.4. Allied health

Attendees at one session (29 May 14:30 - 16:00) were:

Name	Position	Service/Specialty
Karen Phillips	Director, Allied Health	Allied Health
Stephanie Van Ballegooyen	Program Officer	Allied Health
Han Pikaar	Team Leader, Speech Pathologist	Older Person AH Team
Josh Dunn	Cardiac Scientist	Cardiology
Julie Watson	Director	Social Work
Linda Morris	Director	Dietetics
Michelle Watson	Director	Occupational Therapy
Stephen McCormack	Director	Physiotherapy
Venkatesh Aithal	Consultant Clinical Audiologist/ Clinical Director	Audiology
Vidula Garde	Director	Psychology
Wendy Comben	Director	Speech Pathology
Gary Nolan	Senior Scientist	Respiratory and Sleep Unit
David Mitchell	Director of Planning	Townsville HHS

A.1.5. Aboriginal and Torres Strait Islander Health

Attendees at one session (30 May 11:30 - 12:30) were:

Name	Position	Service/Specialty
Liza Tomlinson	Service Group Director	Aboriginal and Torres Strait Islander Health
Diana Friday	Senior Health Worker (teleconference from Ingham)	Aboriginal and Torres Strait Islander Health
Salli-Ann Buttigieg	Aboriginal and Torres Strait Islander Health Coordinator	Aboriginal and Torres Strait Islander Health
Trevor Prior	Cultural Practice Coordinator	Aboriginal and Torres Strait Islander Health
David Mitchell	Director of Planning	Townsville HHS

Please note: Approval was sought via Liza Tomlinson to utilise outputs from the Palm Island Health Action Plan process for the purposes of this activity. Please refer to Section 6.1.2 for a summary of information drawn from this process. For this reason, consultation with representatives from Palm Island was not undertaken.

A.1.6. Paediatrics

Attendees at two sessions (31 May 14:00 - 15:00 and 12 June 15:30 - 16:30) were:

Name	Position	Service/Specialty
Vicki Carson	Director	Health & Wellbeing Service Group
Dr Paul Lane (second meeting only)	Medical Director	Health & Wellbeing Service Group
Andrew White	Director of Paediatrics	Paediatrics
Harry Stalewski	Senior VMO	Surgery
Greg Wiseman	Registrar	PICU
David Mitchell	Director of Planning	Townsville HHS
Amie Raymond (second meeting only)	Graduate Program Officer	Townsville HHS

A.1.7. Obstetrics and Gynaecology

Attendees at one session (31 May 13:00 - 14:00) were:

Name	Position	Service/Specialty
Vicki Carson	Director	Health & Wellbeing Service Group
Dr Paul Lane	Medical Director/Staff Specialist	Obstetrics and Gynaecology
Amanda Ostrenski	Midwifery/Nursing Director	Obstetrics and Gynaecology
Katrina Roberts	Nursing Director	Obstetrics and Gynaecology
David Mitchell	Director of Planning	Townsville HHS

A.1.8. Neonatal Services

Attendees at one session (31 May 12:30 - 13:00) were:

Name	Position	Service/Specialty
Guan Koh	Consultant	Neonatology
David Mitchell	Director of Planning	Townsville HHS

A.1.9. Rural Service Group

Attendees at one session (29 May 13:30 - 14:30) were:

Name	Position	Service/Specialty
Sara Shaughnessy	Director	Rural Hospital Service Group
David Mitchell	Director of Planning	Townsville HHS

Attendees at one further session (20 June 16:00 - 17:00) were:

Name	Position	Service/Specialty
Dr Michael Young	Medical Director	Rural Hospital Service Group
David Mitchell	Director of Planning	Townsville HHS
Amie Raymond	Graduate Program Officer	Townsville HHS

A.2 Engagement of Strategic Partners in Acute Clinical Service Delivery

A.2.1. James Cook University

Attendees at one session (1 June 15.00 - 16.00) were:

Name	Position	Service/Specialty
Ian Wronski	Deputy Vice Chancellor	Division of Tropical Health & Medicine (Townsville)
Lee Stewart	Dean	College of Healthcare Sciences (Cairns)
Maxine Whittaker	Dean	Public Health, Medical & Veterinary Sciences (Townsville)
David Mitchell	Director of Planning	Townsville HHS

A.2.2. Mater Health Services North Queensland

Attendees at one session (14 June 8:30 - 9:30) were:

Name	Position	Service/Specialty
Gerard Wyvill	Chief Executive Officer	Mater Health Services North Queensland
Karen Gerrard	Director of Nursing	Mater Health Services North Queensland
David Mitchell	Director of Planning	Townsville HHS

A.2.3. North Queensland PHN

Attendees at one session (14 June 8:30 - 9:30) were:

Name	Position	Service/Specialty
Gerard Wyvill	Chief Executive Officer	Mater Health Services North Queensland
Karen Gerrard	Director of Nursing	Mater Health Services North Queensland
David Mitchell	Director of Planning	Townsville HHS

A.2.4. Townsville Aboriginal and Islanders Health Services (TAIHS)

Teleconference (15 August 10am)

Name	Position	Service/Specialty
Kathy Anderson	Chief Executive Officer	TAIHS
Dr Theunis Kotzee	Medical Officer	TAIHS
Vanessa Priday	Program Manager	TAIHS
David Mitchell	Director of Planning	Townsville HHS

A.3 Engagement of North Queensland Hospital and Health Services

A.3.1. North West Hospital and Health Service

Attendees at one session (28 June 08.30 - 09.30am) were:

Name	Position	Service/Specialty
Lisa Davies Jones	Chief Executive	NWHHS
David Mitchell	Director of Planning	Townsville HHS
Amie Raymond	Graduate Program Officer	Townsville HHS

A.3.2. Torres and Cape Hospital and Health Service

Attendees at one session (28 June 11.30 - 12.00pm) were:

Name	Position	Service/ Specialty
Donna Richmond	Director of Strategy, Planning and Performance	TCHHS
Debra Smith	Planner	TCHHS
Dr Kate McConnon	Executive Director Medical Services	TCHHS
David Mitchell	Director of Planning	Townsville HHS
Amie Raymond	Graduate Program Officer	Townsville HHS

A.3.3. Mackay Hospital and Health Service

Attendees at one session (2 June 9:00 - 10:00) were:

Name	Position	Service/Specialty
Janet Geisler	Executive Director of Strategy, Performance and Governance	Mackay HHS
David Mitchell	Director of Planning	Townsville HHS

A.3.4. Cairns and Hinterland Hospital and Health Service

Attendees at one session (29 June 16:00 - 17:00) were:

Name	Position	Service/Specialty
Dr Peter Bristow	Chief Executive	Townsville HHS
Clare Douglas	Chief Executive	CHHHS
Consultant Planners for CHHHS	Consultants (x 2)	Deloitte
David Mitchell	Director of Planning	Townsville HHS
Amie Raymond	Graduate Program Officer	Townsville HHS

A.4 Engagement of Community Partners and Community Advisory Networks

A.4.1. Community Partners (Townsville)

Attendees at one session (13 June 10:00 - 11:00) were:

Name	Position
Wendy Gardam	Community Representative
Bruce MacCarthy	Community Representative
Estelle Dal Bello	Community Representative
Peter Phillips	Community Representative
Lyn Hinspeter (Chair)	Community Representative
Robyn Hegge	Community Representative
Crystal Gibbs	Community Representative
Peter Auliff	Community Representative
Alana Auliff	Community Representative
John Allen	Community Representative
Rhonda Wilkes	Community Representative
Robyn Andersen	Community Representative
Joanne Sherring	Person Centred Care Lead, Townsville HHS
David Mitchell	Director of Planning, Townsville HHS
Amie Raymond	Graduate Program Officer, Townsville HHS

A.4.2. Ayr Community Advisory Network

Attendees at one session (19 June 9:00 - 10:00) were:

Name	Position
Mary Vicary	Director of Nursing/Facility Manager – Ayr
Joyce Great	Community Representative
Joyce Henaway	Aboriginal and Torres Strait Islander Community Representative
Lyn McLaughlin	Mayor - Burdekin Shire Council
Sara Shaughnessy	Rural Hospitals Service Group Director, Townsville HHS
David Mitchell	Director of Planning, Townsville HHS
Amie Raymond	Graduate Program Officer, Townsville HHS

A.4.3. Charters Towers Community Advisory Network

Attendees at one session (19 June 10:30 - 11:30) were:

Name	Position
Joanna Meharg	Director of Nursing - Charters Towers HS
Graham Lohmann	Queensland Police Service - Charter Towers Charters Towers Regional Council Representative
Frances Williams	Waringnu Aboriginal and Torres Strait Islander Group
Verna Mitchell and Lorraine	Shane Knuth State Member for Dalrymple - Proxy x 2
Sharon Stevenson	Administration Officer - Charters Towers HS
Nigel Fairbairn	Principal - Blackheath and Thornburgh College
Dave Watson	60s and Better Organisation
Sara Shaughnessy	Rural Hospitals Service Group Director, Townsville HHS
David Mitchell	Director of Planning, Townsville HHS
Amie Raymond	Graduate Program Officer, Townsville HHS

A.4.4. Ingham Community Advisory Network

Attendees at one session (19 June 12:00 - 13:00) were:

Name	Position
Dr Michael Young	Medical Director - Rural Service Group
Peter Smith	Consumer Representative
Pam Smith	Consumer Representative
Dr Nick Milns	Medical Superintendent - Ingham
Pat Lynch	Consumer NQ Employment Representative
Marc Tack	Hinchinbrook Shire Council Representative
Sara Shaughnessy	Rural Hospitals Service Group Director, Townsville HHS
David Mitchell	Director of Planning, Townsville HHS
Amie Raymond	Graduate Program Officer, Townsville HHS

A.4.5. Hughenden Community Advisory Network

Attendees at two sessions (19 June 15:00 - 16:00 and 3 July 15:00 - 16:00) were:

Name	Position
Jane McNamara (second meeting only)	Mayor, Hughenden
Benjamin Lawrance (first and second meetings)	Director of Nursing - Hughenden
Cindy Moller (first meeting only)	HACC Manager Flinders Shire Council
Di Mahoney (first meeting only)	Rainbow Gateway
Erin Townley (first meeting only)	Hughenden CAN
Sara Shaughnessy	Rural Hospitals Service Group Director, Townsville HHS
David Mitchell	Director of Planning, Townsville HHS
Amie Raymond	Graduate Program Officer, Townsville HHS

A.4.6. Richmond Community Advisory Network

Attendees at one session (20 June 16:00 - 17:00) were::

Name	Position
Jo McClymont	Community Member
Angela Henry	Richmond Shire Council
Olivia Propsting	Community Occupational Therapist - Northern Australia Primary Health Limited
Ann-Maree Doyle	Hospital and Community Care
Christine Douglas	Consumer
Pam Suhr	Registered Nurse – Richmond MPHS
Robyn McMaster	Education
Sara Shaughnessy	Rural Hospitals Service Group Director, Townsville HHS
David Mitchell	Director of Planning, Townsville HHS
Amie Raymond	Graduate Program Officer, Townsville HHS

A.5 Discussion regarding the National Disability Insurance Scheme

Attendees at one session (27 June 14:00 - 15:00) were:

Name	Position	Service/Specialty
Desmond Lee	North Queensland Regional Manager	National Disability Insurance Agency
David Mitchell	Director of Planning	Townsville HHS
Amie Raymond	Graduate Program Officer	Townsville HHS

A.6 Discussion with Leading Age Services Australia (LASA) Queensland

Attendees at one session (16 June 2017) were:

Name	Position	Service/Specialty
Kerri Lanchester	State Manager QLD	LASA
Sharyn McIlwain	Principal Advisor Residential Care	LASA
Judith Sellen	Acting Nurse Director	Rural Hospital Service Group, Townsville HHS
Sara Shaughnessy	Director	Rural Hospital Service Group, Townsville HHS
David Mitchell	Director of Planning	Townsville HHS
Amie Raymond	Graduate Program Officer	Townsville HHS