Townsville Hospital and Health Service

Healthy Ageing in North Queensland

A strategy for improving healthcare delivery for older persons in Townsville Hospital and Health Service

2020-2030

Queensland Government

Healthy Ageing in North Queensland

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Acknowledgement to Traditional Owners

The Townsville Hospital and Health Service respectfully acknowledges the traditional owners and custodians both past and present of the land and sea which we service and declares the Townsville Hospital and Health Service commitment to reducing inequalities between Indigenous and non-Indigenous health outcomes in line with the Australian Government's Closing the Gap initiative.

A message from our Board Chair

I'm delighted to introduce 'Healthy Ageing in North Queensland', a strategy guiding healthcare services for a growing ageing population to 2030. Growing older is a privilege and the most profound legacy of healthy ageing is to live within a community that values those whose contributions have shaped it over many years.

The ageing journey should not be complexified by an unwieldly and inflexible healthcare system nor should factors such as remoteness, Indigeneity and socioeconomic status have a detrimental impact. Current challenges for care for the ageing in North Queensland include poor integration among gerontology services, multiple layers of service delivery, increasing demand for older persons living with dementia, and access to community supports for older people with behavioural mental health issues.

The goal of this strategy is to develop a whole-of-service model to support a holistic approach to healthcare for a non-metropolitan, culturally diverse ageing population. It is an ambitious aim but one which must be met head-on in order the ensure that older persons, including the frail aged, those from culturally diverse backgrounds, and older Aboriginal and Torres Strait Islander peoples, have a joined-up healthcare system that enables them, and their loved ones, to navigate the ageing journey with dignity and ease.

As a community and as a health service we need to plan for the journey ahead, ensuring the appropriate support mechanisms are in place for the people of the region who will be aged over 70 in the next 10 years. We need to listen to them, and to their families, about what services are needed and where and how they should be delivered. A proud hallmark of this strategy is that it involved focus groups and targeted surveys that heard from people who are invested in, and who will receive, the care and services that are being planned for in this document. Collaboration was key and has resulted in a clear roadmap that will guide service investment, healthcare modelling and continuous improvement.

I thank our consumers and community who contributed to this strategy and who told us clearly and unequivocally that they needed connected, integrated and compassionate care for ageing North Queenslanders. I ask our community to hold us to this as we implement this important strategy over the next decade.

Tony Mooney AM
Chair, Townsville Hospital and Health Board

A message from our Chief Operating Officer

The long-anticipated growth of North Queensland and Australia's elderly population is now upon us.

By 2036, there will be approximately 50,000 North Queenslanders over the age of 70 living within the Townsville Hospital and Health Service tertiary referral catchment.

While there has been improvement in the way we care for our oldest residents, there remains significant fragmentation in the way care is delivered and room for improvement in consolidating the patient journey.

This strategy for Healthy Ageing in North Queensland will be the guiding document for the Townsville Hospital and Health Service to improve and streamline care for older people over the next 10 years.

It highlights gaps in care, outlines the way our elderly have expressed their wish to receive healthcare and sets out practical steps to improve, streamline and consolidate the services we provide.

It also highlights the disparity in life expectancy for our Aboriginal and Torres Strait Islander community who, too often, are having to utilise older persons' services at far too young an age. In addressing this disparity an additional, dedicated priority area that focuses on healthy ageing for our older Aboriginal and Torres Strait Islander consumers has been included in this strategy.

The strategies contained within this document represent a clear direction to ensure our oldest residents receive compassionate and coordinated care, the way they want it delivered.

The steps outlined in this document represent the culmination of views from clinicians, community members and health partners who have collaborated closely to map a clear way forward in this complex and crucial area of healthcare.

I am proud to deliver the Townsville Hospital and Health Service's *Healthy Ageing in North Queensland - A strategy for improving healthcare delivery for older persons in Townsville Hospital and Health Service*.

Stephen Eaton
Chief Operating Officer, Townsville Hospital and Health Service

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INTRODUCTION

Introduction

As we continually work to deliver excellent care and improved health outcomes for older people, this strategy represents a clear commitment to the communities that we serve, both now and into the future.

Townsville Hospital and Health Service (Townsville HHS) is home to many who have made immense contributions to the communities in which we live, work and grow. The advancements of our communities and the opportunities we now have are the result of the hard work of our predecessors. It is now the duty and responsibility of younger generations to be the stewards for the future of our older community members, ensuring that they receive high-quality care that supports healthy ageing and rewarding final years.

The challenges facing our older community members extend beyond health, are complex and continue to grow as our population ages. Considering current global health events, it is more important than ever that we protect the sustainability of our services and work to support and maintain the health of our older community members, who are disproportionately affected in these challenging times.

Further considerations are required to address additional challenges faced by our Aboriginal and Torres Strait Islander consumers, who experience healthcare challenges at a much younger age than our non-Indigenous consumers.

Purpose

The purpose of the *Healthy Ageing in North Queensland Strategy* (the Strategy) is to provide guidance for the ongoing development of progressive and integrated health services for older people within our region.

The Strategy articulates the role of Townsville HHS in the delivery of services for older people, provides a framework for the organisation of services and a roadmap for investing in healthcare services both now and into the future.

At the core of the Strategy is the care of the older person as a unique individual, with the strategic priority actions promoting respect and empowerment across all service types within the healthcare system, while also including carers and families as healthcare partners.

Our older community members are one of our most vulnerable patient cohorts. It is therefore imperative that services for older persons are designed to ensure that the needs and preferences of older patients and their families are central to the development of high-quality and safe healthcare services.

In addressing these needs we must also plan and deliver services for our older consumers in a way that is culturally appropriate and safe for our older Aboriginal and Torres Strait Islander peoples.

The Strategy will enable further advocacy for the care of older people in a way that promotes health, wellness and independence and through services that are connected via an easy-to-navigate network, co-designed with patients, carers and families.

What we hope to achieve

The Strategy will support the continuation and enhancement of aged care services across the region, ensuring services are able to meet the increasing needs of the older population.

This Strategy will also support the implementation of a new older persons service delivery model that focuses on designing service delivery with the consumer at the core of each decision and care pathway. The new service model considers the changing landscape of healthcare delivery and includes an increased focus on preventative, community and home-based service delivery.

Through the development and implementation of this Strategy, Townsville HHS will evolve its service model to respond to the changing health and social needs of our older community members, to deliver a network

of healthcare services across the Townsville HHS that delivers connected, coordinated and compassionate care that places the older person, their families and carers at the core of all care decisions.

Stakeholder engagement

This Strategy is a culmination of a collaborative multidisciplinary effort that saw clinicians, patients, carers, community members, community service partners and expert health planners, all come together to map a clear way forward for Townsville HHS in the delivery of care for older people.

An extensive stakeholder engagement program led by Townsville HHS involved over 60 hours of consultation across various workshops, meetings, interviews and community surveys. In total around 140 attendees participated across these engagements including;

- Consumers (patients, carers and families)
- Townsville HHS Consumer Advisory Council
- Aboriginal and Torres Strait Islander Traditional Owners (Ingham)
- Clinicians from a range of disciplines including rural and remote health
- Non-government organisations including private aged care services
- Community partner organisations
- Mayors from across the Townsville HHS catchment
- Local general practice
- North Queensland Primary Health Network.

The engagement program was integral in forming a strong foundation for the development of the strategy, ensuring that across all consultation groups, key service gaps were identified, documented and ultimately informed the direction of the strategy.

How the strategy was developed

The development of the Strategy was governed by the Townsville HHS Healthy Ageing Steering Committee, endorsed for implementation by the Townsville HHS Health Service Chief Executive and approved for implementation by the Townsville HHS Board.

For the purposes of developing the Strategy, the scope encompasses those Townsville HHS services which are specifically focused on the care of the older person across the health continuum, where older people are defined as people aged 65 years and over and people who are Aboriginal and/or Torres Strait Islander persons aged 50 years and over.

The Strategy has been developed in line with directions detailed within the *Townsville Area Palliative Care Plan 2020-2024* and with projected health service activity detailed within the *Townsville HHS Health Service Plan 2018-2028 (2019 update)*. All health planning data used in the development of this Strategy is reviewed annually and will thus inform its annual review.

Implementation of the Strategy will occur across a 10-year cycle from 2020-2030 and will inform a number of planning processes during this time including workforce, research and education, information technology, infrastructure and operational planning.

The Strategy aims to prioritise actions and recommendations that seek to implement the suggested changes throughout the life of this plan, with a focus on five key priority areas:

1. A new integrated service model for the care of older people within Townsville HHS
2. Sustainable high-quality services underpinned by a culture of compassion
3. Supported to stay healthy, well and independent
4. Culturally appropriate services for older Aboriginal and Torres Strait Islander people
5. Nurturing partnerships and embracing community.

Part Two

ABOUT TOWNSVILLE HOSPITAL AND HEALTH SERVICE

About the Health Service

Townsville Hospital and Health Service (Townsville HHS) is the largest tertiary health service in northern Australia, delivering clinical services across a vast geographical expanse of almost 150,000 km^2. The Townsville HHS catchment services close to 240,000 people across northern Queensland, extending west to Richmond and Hughenden, north to Cardwell, south to Home Hill and east to Magnetic and Palm Islands.

Townsville HHS delivers healthcare services across 21 hospital and community health facilities including two residential aged care facilities, Eventide in Charters Towers and Parklands in Townsville. Townsville HHS provides acute, subacute and ambulatory services for older people as well as a large number of community-based services including mental health, Aboriginal and Torres Strait Islander health, community health and aged care services.

Our place within the community

As northern Australia's principal tertiary healthcare facility, Townsville University Hospital (TUH) is a level 6 facility and treats patients from across northern Queensland. TUH is also a major teaching hospital for James Cook University, TAFE Queensland North and universities nationally.

Townsville is a tactically well-placed location for northern Queensland's tertiary level health services, due to its central location within the northern half of the state, existing infrastructure and clinical service capability. This sees the health service playing a pivotal role for the region in the delivery of highly specialised and complex tertiary services for people and communities across northern Queensland, extending as far as the Torres Strait Islands and Papua New Guinea, to a population of around 700,000 people.

Townsville HHS is the largest employer in the region with over 6,000 staff employed, representing a sizeable portion of our communities. One in 17 of the people who work and live in Townsville, work for Townsville HHS. Townsville HHS is also a leader in clinical research across a range of disciplines, conducting research through TIHRI (the Townsville Institute of Health Research and Innovation) and through partnerships established under TAAHC (Tropical Australian Academic Health Centre) and TropiQ (Townsville's Tropical Intelligence and Health Precinct).

Our successes

There has been considerable work already undertaken in the past 12 months to improve services for older people within the Townsville HHS. A number of recently established initiatives with early indications of successfully addressing some of the key service gaps include commencement of the community geriatrician services and extension of the service to Charters Towers. A dedicated multidisciplinary older persons service is also well established within the community at the Kirwan Health Campus.

Another significant achievement that is already providing improved health outcomes for older people, is the establishment of the Frailty Intervention Team (FIT) for local implementation of the state-wide Frail Older Person Program.

To date the program has contributed to:

- Improved clinical and reporting processes through identification of residents from aged care facilities and front-loaded gerontic assessments in the Emergency Department (ED)
- Better tailored, individualised care though the identification of frailty using the Rockwood Clinical Frailty Scale
- Implementation of a consultative service for frail older persons at immediate risk of emergency presentation
- Implementation of the Residential Aged Care Support Service (RaSS) providing telephone triage and consultation to residential aged care facilities, follow up phone calls and ED substitutive care and/or community gerontology consultations within the aged care facility.

Although much of this work is still in the early stages of implementation it has been instrumental in laying the groundwork for the development of a comprehensive strategy for the care of older people in the region.

Our commitment to the health of older persons

To ensure services provide the best holistic care to older persons and contribute to the delivery of over-arching health service initiatives and strategies, this Strategy has been developed in alignment with the following:

- National frameworks and initiatives, including those arising from the Royal Commission into Aged Care Quality and Safety
- Queensland Government's Healthy Ageing: A strategy for older Queenslanders
- Townsville HHS Health Service Plan 2018-2028 (2019 update)
- Townsville HHS Strategic Plan 2018-2022 (2020 update)
- Townsville HHS operational plans
- Townsville Area Palliative Care Plan 2020-2024.

Across the above policy and strategy documents there are a number of key emerging themes that have been used as the planning foundation for this Strategy.

The Townsville HHS Healthy Ageing in North Queensland Strategy will focus on care that is:

Person-centred

Integrated

Holistic

Involving families

Closer to or in-home

Innovative

The older population is a heterogeneous group and older people experience ageing in different ways based on a variety of determinants such as finances, health, family circumstances, culture and location. These shape health outcomes and determine the length and quality of life experienced by older people.

Understanding the context of healthy ageing in North Queensland

Our population growth

As at 2017, the Townsville HHS catchment population was just over 240,000 residents with approximately 77 per cent of the population residing in Townsville. The current population projections predict an increase to 348,000 residents by 2036. Overall population growth has slowed in recent years due to reduced economic and social factors, however despite this, the population of older people in Townsville HHS is projected to increase rapidly.

Approximately 8 per cent of the Townsville HHS population are aged 70 years and over, and this cohort is predicted to increase at an annual growth rate of 4.1 per cent; much higher than the total population growth rate of 1.5 per cent. By 2036, it is projected that there will be almost 50,000 people aged 70 and over living in Townsville HHS accounting for 14 per cent of the total population.

This changing demographic will have significant effects on the future economy, population health status, and the composition of communities. These changes will also strongly impact the health system including an increase in service demand, older people with frailty, chronic disease and older people with neurological conditions needing care.

Appropriately responding to these impacts will require Townsville HHS to adapt and change the way services are designed and delivered. Services need to be developed in a way that ensures the most effective and efficient care is provided which requires more personalised care and more home-based care that meets the expectations and preferences of older people. This includes improving care for those older patients who are particularly vulnerable and face additional challenges in accessing healthcare such as; Aboriginal and Torres Strait Islander peoples, Culturally and Linguistically Diverse people, those living in Rural and Remote communities and people with disability.

Our cultural diversity

Aboriginal and Torres Strait Islander people account for approximately 8 per cent of the total Townsville HHS population and this population group is also expected to expand rapidly.

By 2026 it is projected that almost 17 per cent of Queensland's Aboriginal and Torres Strait Islander population will be aged 45 years and older (compared to 14 per cent in 2016). Older Aboriginal and Torres Strait Islander people generally have poorer health outcomes and increased rates of disability than non-Indigenous people of the same age. This can lead to increased needs for health care and support services, which can often be difficult to access in rural and remote areas and more broadly across North Queensland where many Aboriginal and Torres Strait Islander people live.

Aboriginal and Torres Strait Islander peoples often also have lower rates of accessing health services due to physical, cultural and financial barriers and prefer services to be local (i.e. 'on country'), community driven and flexible.

Our regional and remote locations

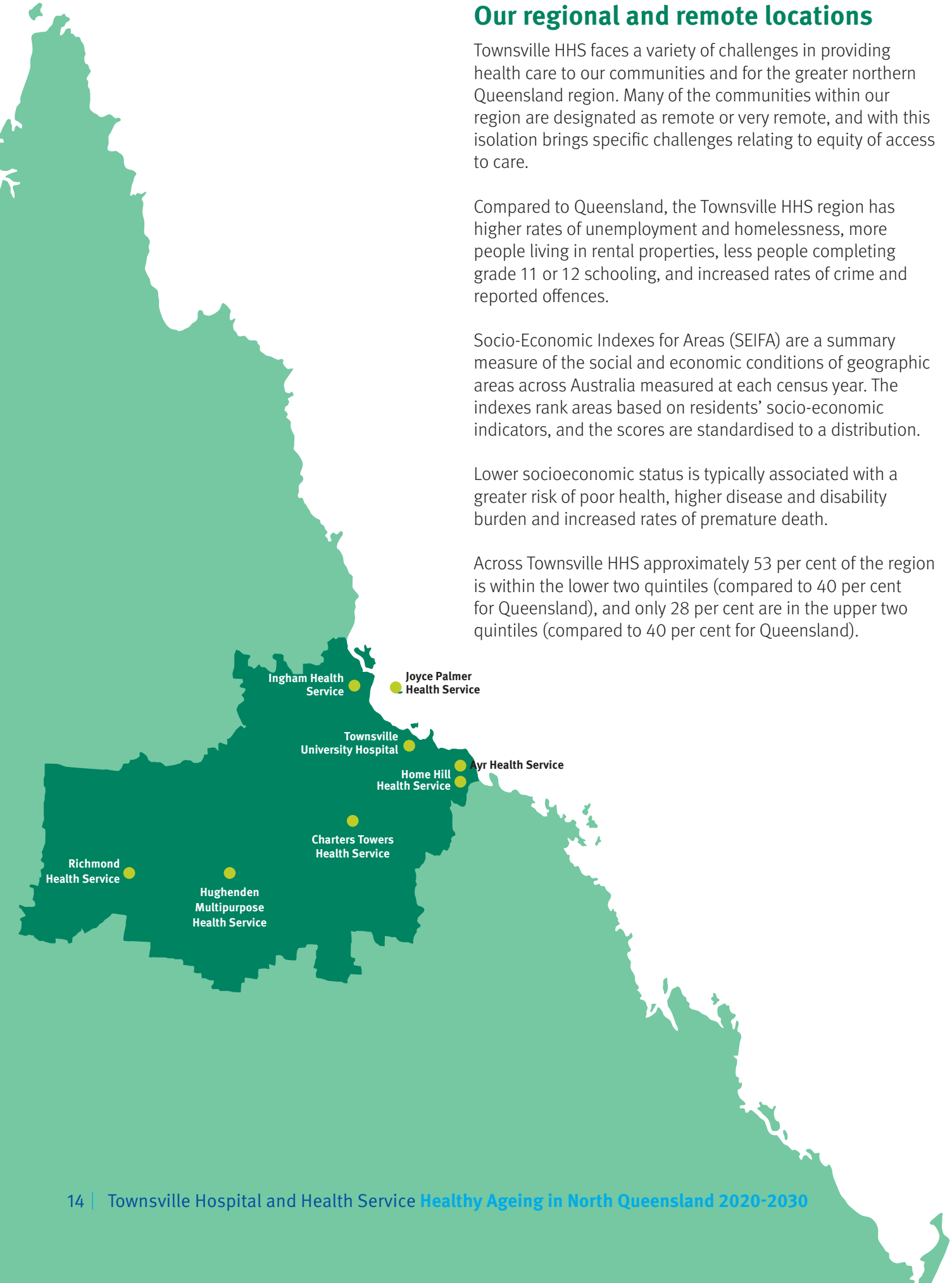
Townsville HHS faces a variety of challenges in providing health care to our communities and for the greater northern Queensland region. Many of the communities within our region are designated as remote or very remote, and with this isolation brings specific challenges relating to equity of access to care.

Compared to Queensland, the Townsville HHS region has higher rates of unemployment and homelessness, more people living in rental properties, less people completing grade 11 or 12 schooling, and increased rates of crime and reported offences.

Socio-Economic Indexes for Areas (SEIFA) are a summary measure of the social and economic conditions of geographic areas across Australia measured at each census year. The indexes rank areas based on residents' socio-economic indicators, and the scores are standardised to a distribution.

Lower socioeconomic status is typically associated with a greater risk of poor health, higher disease and disability burden and increased rates of premature death.

Across Townsville HHS approximately 53 per cent of the region is within the lower two quintiles (compared to 40 per cent for Queensland), and only 28 per cent are in the upper two quintiles (compared to 40 per cent for Queensland).



Our challenges

There are several challenges specific to Townsville HHS in the delivering of services for older people.

There is no system wide, whole-of-service model focused on the patient journey.

Care coordination

- The current service model offers limited connection and integration between acute inpatient, subacute, community health, older person mental health and other gerontology services.
- Due to the complexity of the services, there is no single care plan for patients and no single identified contact point for services. The process is, therefore, largely person dependent rather than systematic and standardised.
- There is increasing demand for services for older persons who are experiencing severe and complex behavioural and psychological symptoms of dementia.
- Access to appropriate education and support in the community for people with behavioural issues is an ongoing challenge.

Transfer of care, transition care and discharge planning

- Effective management of discharge planning and transitions of care between services is inconsistent despite ongoing efforts over many years to address these issues. Multiple entry and exit points to services compound the issue, with each service having developed their own model of care, defining target groups, eligibility criteria and referral processes.
- Patient and family involvement in discharge planning is not systematic, with risk of health professionals' expectations and risk management taking precedence over patient choice for their level of care at home.
- There is limited access to non-hospital interim and transition care, for people not able to be discharged directly from hospital to home. There is no residential transition care program (TCP) in the Townsville HHS and access to 'step down care' is limited.

Demand for some services exceeds existing capacity.

Community-based services

- The demand for community-based services to support people in their homes, such as access to multidisciplinary allied health and specialist geriatrician assessment, exceeds the range and capacity of the services available.
- There are delays for assessment and long wait lists for the allocation of home care packages.

Palliative care

- Access to palliative care and end-of-life support services is an issue especially in rural and remote areas.
- There are no hospice facilities available in Townsville and not all RACFs have the capacity and capability to provide palliative care.

Mental health

- There is increasing demand for Older Persons Mental Health Services which is inclusive of dedicated mental health inpatient beds for older persons.

Some challenges are exacerbated within the North Queensland context.

Culturally appropriate care

- Specific services for older Aboriginal and Torres Strait Islander peoples are limited particularly in relation to culturally appropriate home care.
- The cultural competence of mainstream services still requires improvement.
- There is a strong preference to die at home close to family. This is particularly an issue for Aboriginal and Torres Strait Islander patients who travel from North West and Torres and Cape regions and are often separated from their family and community.
- The prevalence of chronic disease and comorbidities in older Aboriginal and Torres Strait Islander patients requires a much-improved connection between adult medical services and older person services.

Rural and remote health

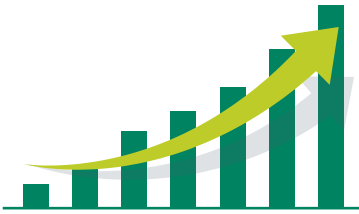
- Rural and remote areas face additional challenges in relation to the increasing needs of their ageing communities.
- Demand for specialist gerontology and allied health outreach and telemedicine clinics is expanding.
- There is also a need for improved access to respite and dementia services, and pharmacy telemedicine clinics for medication review.

Service models and the culture of care delivery have struggled to keep pace with the changing needs of the older patient.

- 'Deconditioning' of older people while in acute facilities is a major issue with increasing incidence. Contributing to this is both an inconsistent approach to recognition of frailty in the older person and a lack of awareness in the existing workforce as to the implications of this.
- Over time, services have become increasingly acute focussed and there is now a need to 'rebalance' management of acute illness, with approaches emphasising restoration of function, maintenance and prevention of deconditioning.
- The predominant caseload of many services is primarily older people. Given this, a continued focus on the education and training of staff is required to ensure that healthcare is delivered in a way that is sensitive to the culture and needs of older people, their families and carers.

Our key health issues

The 85+ age group is projected to demonstrate the **highest growth rate 8.4% per year**

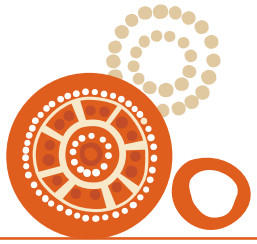


Remote areas within the Townsville HHS region will have higher rates of ageing populations

General population growth rate 1.5% per year
People aged **70+ growth rate 4.1% per year**

The **burden of disease is concentrated among the older population**, Aboriginal and Torres Strait Islander people, socio-economic disadvantaged and in remote and very remote communities

In Townsville HHS, of people aged 65 years and over, only **3.7 per cent are of Aboriginal and Torres Strait Islander decent**

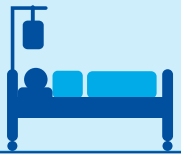


There is a **12.3-year gap in health adjusted life expectancy** between Aboriginal and Torres Strait Islander people living in THHS and the Queensland general population

Across Queensland, approx. 75 per cent of persons aged over 65 years and 83 per cent of persons aged over 75 years have **two or more chronic conditions.** Townsville HHS has higher levels of chronic disease compared to Queensland averages.

Over a one-year period from July 2018, people aged 70 years+ accounted for **14.3 per cent of all presentations to THHS emergency departments**

In 2017-2018, people aged 70 years+ accounted for approx. 31 per cent of separations and 45 per cent of beddays in THHS hospitals. **By 2036-2037 this group will account for 41 per cent of separations and 55 per cent of beddays.**



Consumer story

Townsville seniors Eric and Syd Collins are no strangers to the Townsville University Hospital, with Eric even crediting the facility with saving his life on several occasions.

"If Eric were a cat he would have used up his nine lives; the hospital has kept him alive," Syd said.

The couple said over the past few years their shared health diagnoses included prostate cancer, heart failure, a leg amputation, multiple myeloma and hip-replacement surgery, and while they have been grateful for the care they both received, they also know that for many older people, hospital can be a scary place.

"We are assertive, proactive people who are familiar with many different areas of the health system, so the system doesn't intimidate us," the couple said.

"However, for people who are not so familiar, hospital can be a very scary place.

"Many patients entering hospital tend to leave all the decisions in the hands of clinicians and are reluctant to talk about their symptoms or disabilities; however, I'm a big advocate of taking responsibility for my health," Syd said.

"I tell people 'you know your body, you've lived in it all these years, if you're concerned, speak up and do not be afraid to'."

Syd said that getting older meant facing a lot of unexpected challenges.

"This is a scary time of our lives and despite our personal belief systems, many of us dread old age and death itself," Syd said.

"For both of us, what is most frightening is losing the capacity to be in control of our lives.

"We older people are considered frail and vulnerable; we are in a different phase of our lives, with our different vulnerabilities and co-morbidities which can be difficult or impossible to treat."

"It's about the practical things; there are a lot of small and seemingly insignificant changes that can be made that would make a really big difference to the oldies' hospital experience."

Both Syd and Eric said remaining in their own home as they aged was central to their quality of life.

"We hope to stay in our home and we value the community-based care we presently receive," they said.

"Without this assistance we couldn't remain here in our home right now, although it was initially complicated navigating the paperwork and the system itself to access this care."

Eric said that it was also important that there was a focus on hospital patients' comfort and wellbeing.

"We need the balance between the technical clinical care and old-fashioned nursing," he said.

"Nursing is about making sure a patient is comfortable and attending to the patients' needs."

Syd added that it was often simple things that could make a big difference to good outcomes, especially for older, frail and ill patients.

"Administrators and decision makers need to 'walk the walk'; for example, spend a day in a wheelchair when designing hospital facilities." Eric said.

"It's about the practical things; there are a lot of small and seemingly insignificant changes that could be made that would make a really big difference to the elderly persons' hospital experience."

Syd and Eric said apart from one of Eric's experiences, Townsville University Hospital care had been excellent.

"The hospital staff we have come into contact with have generally been good, as well as the treatment we received," they said.

"However, it is vital that the people making important decisions listen to and respect those people working with patients and the patients themselves.

"This will ensure that we have a system that caters well, not only for older people, but for all those needing medical attention."

Eric and Syd Collins, Townsville HHS consumers

Community story

Connection the key to care for older Aboriginal and Torres Strait Islander people

Connections to country, family and spirit are just as important as clinical care when it comes to caring for older Aboriginal and Torres Strait Islander patients according to traditional owners Cynthia Payne, Faye Cashmere and Betty Ryan, and Ingham Health Service Indigenous health worker Diana Friday.

Betty, a Warrgamay woman, said the Indigenous community was good at looking out for each other, and that staying on country as they aged was important.

"[Staying home] as I get older is important; I do that now and it's been OK because I've got this mob here looking out for me," Betty said.

"But for the others, we need to look out for each other; we need to make sure if they are sick or something that they go and get help."

For Diana, culturally appropriate care at the end of life was a big consideration for older Aboriginal and Torres Strait Islander people.

"I think most would prefer to die at home, or on country, rather than at hospital, particularly in a hospital that is far away," Diana said.

"Being far from home not only has an impact on the patient, but also it puts a strain on the family because there's cost involved in travelling; supporting end-of-life care in the community with an emphasis on being close to home is really important."

Diana said cultural understanding from clinicians after an Indigenous person passes away was another important aspect of caring for older Aboriginal and Torres Strait Islanders.

"For clinicians, a patient is considered deceased once brain function stops but for us Indigenous people, we have body, soul and spirit; when that heart stops beating and you stop breathing, the soul and spirit leaves the body, then you say you're deceased. Until then, the person is still with us," Diana said.

“We also grieve differently; when someone passes away clinicians want to move the body quickly, but Indigenous people need to have the whole family say goodbye.

“Sometimes moving the person elsewhere before that has happened is culturally inappropriate.”

Cynthia, a Nywaigi woman, said staying flexible in providing community-based health care would help Indigenous families to better support their loved ones.

“I’m a carer for my sister and we move between Ingham and Bowen a bit, but when accessing community services the care packages often only work on a primary residence,” she said.

“There’s not a lot of flexibility for people who move around to different areas, or base themselves at different homes.”

Cynthia said it was also helpful having Indigenous health staff on the ground.

“I felt a bit lost while my sister was in hospital until I saw a young girl I knew who was a health professional; there was no other Indigenous person around, and I felt I could connect with her,” Cynthia said.

“Having an Indigenous health worker gives a sense of connectedness; it connects you with a person you trust and makes you feel safe.”

Faye, who is also a Warrgamay woman, added that it was important to have both male and female health workers for Indigenous patients, particularly when it came to mental health.

“Some people still have shame associated with mental health; women are a lot more willing to come forward and talk,” she said.

“Women connect with women health workers and men connect with male health workers; we need both.”

The three women agreed that the safer health care felt, the more likely it was that older Aboriginal and Torres Strait Islanders would access the services available to them.

“How do you make a felt place safe, how do you make a safe place felt; our emotions, our mental health and those things have an impact on us, outside of our physical being,” Cynthia said.

“We’ve come a long way but there’s always work to be done to help improve accessibility for Aboriginal and Torres Strait Islanders,” Diana added.

Older persons service delivery model

The proposed service model has been developed on the foundation of extensive stakeholder consultation and aims to increase the coordination of services in a highly complex system.

The principles of the model are to enable older people, their families and carers to:

- have timely access to effective, efficient and appropriate health care services as close to home as possible
- receive person-centred and coordinated care across the healthcare spectrum, in any setting and with any provider
- easily navigate health care services and have access to appropriate information from service providers
- return home from hospital quickly and safely and be able to remain in their home environment to receive support and care wherever possible
- receive timely, individualised, respectful and culturally appropriate care that is responsive to the physical, social, emotional and spiritual care needs of older people and their families and carers.

Key components of the model include entry points, processes for transfers of care, and service scope (both in Townsville and rural areas). These areas were identified, discussed and refined through an extensive consultation process involving Townsville HHS and external stakeholders.

Key features of the model include:

- **A new resource and information hub**

  The new hub would function as a single contact, coordination and entry point. The hub would include a team of skilled transition care services staff that can readily transfer and refer patients to the appropriate service, be it hospital or community based. The hub will also function as an exit point, with the discharge coordination team linking patients to Townsville HHS or external care providers.

- **An integrated network**

  An integrated network of distinct Townsville HHS service areas including inpatient (hospital-based), community (non-hospital based) and transition services, grouped together under an overarching Older Persons Service.

- **In-reach services**

  Comprehensive hospital-based older persons services at TUH for acutely unwell patients providing in-reach to rural facilities e.g. increased telehealth services

- **Increased support to rural and remote services**

  Each rural location having the right mix of health professionals with the requisite skills to provide a base-level of older person health services including community geriatrics (and/or GEM in the home), a rapid assessment team, allied health, home care, residential care, and palliative care. Each rural facility will function as a 'spoke' from the central resource and information hub in Townsville, which will provide access to higher-level specialist services.

- **Community-based care**

  A range of immediate, interim and long-term community-based care service options including more care delivered by non-medical staff. These are interconnected and liaise closely with hospital, community and external services. Increased capacity in community-based services including nursing and allied health services, streamlined referral pathways and greater consumer awareness of available services.

- **Communication**

  Technology systems to create a functioning and integrated common communication system that can interface with all the service groups involved in the patient's journey.

A description of how the proposed model will function is summarised over page.

Older persons service delivery model: proposed functionality

RURAL AND REMOTE HOSPITALS

- Rapid Assessment
- Community Geriatrics
- Allied Health
- Home Care
- Residential Care
- Palliative Care

HOSPITAL-BASED

- Acute Care of the Elderly
- Orthogeriatrics
- Inpatient Allied Health
- Inpatient Palliative Care
- GEM (SACU)
- Rehabilitation
- Indigenous Health
- Inpatient BPSD
- Consult Liaison Psychiatry
- Inpatient Mental Health
- ACAT
- ED Allied Health

PATIENTS, FAMILIES AND CARERS

TRANSFER OF CARE (Resource and Information Hub)

- Frailty Intervention Team
- Discharge Coordinators
- Nurse Navigators
- Long Stay Coordinators
- Palliative Care Outreach
- Elder Care Services
- Consult Liaison to GPs
- Step Down Care
- Interim Beds (GSNH)
- Residential TCP
- Community TCP

RACF AND HOME

Intake and Referral
(Community intake, MH referral, MyAgedCare)

LONG TERM

- Persistent Pain Management
- Continence Advisory Service
- Community Allied Health Team
- Age Awareness Clinic
- Community Mental Health
- Community BPSD
- Home Care
- CBRT Rehabilitation

INTERIM

- ACAT
- Complex Assessment Case Managers
- Community IV Clinic
- Dementia and Memory Clinics
- Community Geriatric MDT
- Outpatient Clinics

IMMEDIATE

- Older Persons Crisis Team
- Community Geriatrician
- GEM in the Home
- Hospital in the Home
- Post-acute Nursing Team
- Community Wound Care (TCHS)
- Community Pharmacy

Indigenous Health Team
(Social Worker, Liaison Officer, Health Worker)

Non-Hospital Based

Part Three

PRIORITY ACTION AREAS

The role of Townsville HHS

The role of Townsville HHS in delivering high-quality services for older people in the region is to provide:

- emergency, acute and subacute services in hospitals, community facilities and people's homes
- hospital avoidance programs
- chronic disease management (secondary and tertiary)
- timely and detailed handover and transfer of care
- communication and education to patients, families and primary care services
- governance and leadership.

Townsville HHS partners with a number of non-government organisations (NGOs), community service providers and private providers to support the delivery of care to older people. External providers deliver a range of services across the region including home care/Commonwealth home support programmes, day respite, retirement villages, and RACFs.

Other supporting partners include local General Practitioners (GPs); the Primary Health Network (PHN); James Cook University (JCU) and TAFE. The Commonwealth Home Support Program and Queensland Community Support Scheme are both offered on Palm Island by Townsville HHS.

Townsville HHS has an important future role in working with these external partners to advocate for improved services, better primary prevention and building community capacity. Priorities include:

- working with the North Queensland Primary Health Network and local councils to develop a sector wide approach to healthy ageing and increased social community supports
- lobbying for better access to residential care, appropriate supported accommodation, home care packages/complex processes related to NDIS and MyAgedCare
- working with external providers to improve access to Behavioural and Psychological Symptoms of Dementia (BPSD) services and dementia training
- working with external providers to further develop targeted, culturally appropriate programs, for our Aboriginal and Torres Strait Islander community members, with a strong focus on chronic disease prevention and management.

Implementation of this Strategy will ensure that these responsibilities are met by Townsville HHS, in order to provide coordinated, comprehensive and effective care for older people across the region.

A vision for future service delivery in Townsville HHS

The core vision for the delivery of older persons services for Townsville HHS is to provide a transparent, well-connected, sustainable care system that is responsive to the challenges and locational nuances within the North Queensland context.

The pathway to implement this vision is through the development of a new older persons service delivery model that seeks to build upon our current vast service offering, linking and providing better navigation of services for consumers.

This vision is driven by what our consumers and communities are telling us we need, such as more services in the community, support to stay in home for longer and services that wrap around the older person, respecting their time, social health and quality of life.

Providing safe, effective and efficient services that meet the needs of older people living in the region, requires a model that places a central and holistic focus on the older person. The model should promote health, wellness, independence and for older people to be partners in their own care.

Service models based on a whole-system approach to healthcare, with a focus on enhancing primary care and community-based capability and capacity have been consistently shown to:

- ensure that older people have access to the support they need in a timely manner as close to home as possible
- enable people to take more responsibility for their health
- support tertiary and specialist resources to be more responsive to episodic events, complex cases, and the provision of advice and support to primary and community care services.

Documenting an agreed service model enables Townsville HHS to clearly define and communicate its roles and responsibilities within the broader sector, the priorities for capital and recurrent investment, and governance arrangements to support the delivery of quality healthcare to older people across Townsville HHS, both now and into the future.

Over time, it is expected that there will be opportunities to further develop the model with external partners through an ‘alliance’ approach to progress the integration and coordination of external services with Townsville HHS. This will include a wide range of services spanning primary and tertiary health services, government, social and justice services and other community and supporting services.

Priority Action Areas

1. ***A new integrated service model for the care of older people within Townsville HHS.***
2. ***Sustainable high-quality services underpinned by a culture of compassion.***
3. ***Supported to stay healthy, well and independent.***
4. ***Culturally appropriate services for older Aboriginal and Torres Strait Islander people.***
5. ***Nurturing partnerships and embracing community.***

PRIORITY AREA 1

A new integrated service model for the care of older people within Townsville HHS.

Refocus existing services to support the implementation of the new, integrated model for older persons services within Townsville HHS (see page 22). The new model addresses clear service gaps resultant from fragmented and disparate services and processes and highlights the need for more community-based services, transition care, end of life support services, mental health and behavioural and psychological symptoms of dementia (BPSD) services.

The new integrated model for older persons services is a whole-of-service model that is focused on the patient journey, where care transitions between services and discharge planning is delivered through consistent and person-centred processes.

What our consumers told us ...

- I would like guidance and support to know who I can contact when I am in trouble or need
- I would like to be able access care, where and when I need it most
- I would like to see an information system that is accessible to the community
- I would like guidance and support to care for my loved ones as they get older
- There are a lot of services, I want to be assured that my loved ones are receiving the right support
- It's difficult to have important conversations with my loved ones about their care, especially when it's not clear what services are available to them.

PRIORITY AREA 1: A new integrated service model for the care of older people within Townsville HHS.

What we will do...

#	Actions
	By 2023-2024
1.1	Improve patient, carer and clinician access to information through the establishment of a Resource and Information Hub as a single contact point and coordination service for older persons services across Townsville HHS.
1.2	Enhance multidisciplinary community-based aged care services and resources to better meet demand for services and support people in their homes (e.g. by improving community pharmacy capacity and the uptake of telemedicine).
1.3	Establish streamlined communication and operational processes between internal hospital services including the articulation of requirements, criteria and pathways of the receiving service.
1.4	Establish multi-disciplinary consultation liaison in-reach services to GPs and RACFs to increase the level of community support for people with behavioural issues.
1.5	Develop evidence-based discharge processes that apply a consistent approach to discharge planning across all services with a focus on shifting the philosophy across Townsville HHS from 'discharge planning' to 'transferring care'.
	By 2025-2026
1.6	Consolidate community teams into a single community service that provides a central care coordinator to work across specialities to develop patient care plans.
1.7	Assess the use and integration of ieMR and other systems within services to unify processes for communication, information sharing and data capture.
1.8	Reduce the number of patients in TUH inpatient beds awaiting nursing home placement by enhancing transition care services, including assessing the opportunity to establish and fund a residential Transition Care Program in Townsville HHS.
1.9	Analyse and address perverse performance indicators, funding streams and financial incentives across all services to ensure effective and efficient service delivery and to support the implementation of the new service model.
1.10	Plan the establishment of a dedicated Acute Older Persons Mental Health Unit and same-day Geriatric Evaluation Management (GEM) Unit at TUH.
	By 2030-2031
1.11	Enhance palliative care services outside of TUH to increase the ability for people to palliate in home, hospice, RACFs and rural hospital settings.

PRIORITY AREA 2

Sustainable high-quality services underpinned by a culture of compassion.

Sustainable high-quality and high-value services for older people should focus on care that helps to 'rebalance' the management of acute illness, with approaches emphasising maintenance, restoration of function and prevention of deconditioning. Embedding compassion as a culture in the way we deliver care for our older community members will further improve health outcomes, assist in the early identification and recognition of frailty and connect older people with the services they need, sooner.

What our consumers told us...

- I want a health system that understands and respects an individual's need for privacy, dignity and respect.
- I want a health system that values empathy which is different to and takes precedence over sympathy.
- I want clinicians to understand the need to slow down and be patient with me when having conversations about my care.
- I want options as to how I am communicated with and not to feel as though technology will make do with traditional, more personal forms of communication.
- It's important to understand that the impact of poor health is also felt by the patient's children, families, carers and the community.
- It's hard to have conversations with my loved ones about their care.
- When I have to make care decisions on behalf of my loved ones, it can leave me with a terrible sense of guilt.

PRIORITY AREA 2: Sustainable high-quality services underpinned by a culture of compassion.

What we will do...

#	Actions
	By 2023-2024
2.1	Develop a plan for enhancing workforce culture and attitudes to promote effective care of older persons across the continuum, creating a focus on older persons care as 'everybody's business.'
2.2	Expand the use of the Queensland Health endorsed Clinical Frailty Scale into the Emergency Department and across the health service while encouraging the adoption of this tool with GPs and the Queensland Ambulance Service. Linking the frailty score to the patient's care plan will enable better support and identification of the most appropriate care for frail older patients.
2.3	Expand the role and use of nurse navigators to better support frail older patients in their care.
2.4	Review the processes and points of accountability for transfer of care (discharge planning) to clearly identify responsibility for moving patients out of hospital and connecting them with appropriate care while involving the patient and their family in determining appropriate care decisions.
2.5	Review and address coordination issues for older patients required to attend multiple outpatient appointments across specialities with varying days and times.
	By 2025-2026
2.6	Collaborate with the PHN to establish 'GP hot clinics' to undertake rapid assessments for patients with complex needs who require reablement or restorative care.
2.7	Deliver an education and awareness program championed by key clinical staff that aims to embed a culture that focuses on providing appropriate care for older persons, no matter your role. The program will assist staff in the early recognition of frailty and when a person is dying, to be able to provide appropriate, compassionate care.
	By 2030-2031
2.8	Test the feasibility for the creation of an enhanced nurse or allied health-led rapid assessment team to visit patients in their home, link them into services and develop into a wider community outreach team that can better support patients post-discharge, follow up on their status, and provide after-hours crisis support.
2.9	Identify and implement preventative programs such as 'Eat Walk Engage' to improve patient outcomes and reduce incidences of deconditioning in acute facilities.

PRIORITY AREA 3

Supported to stay healthy, well and independent.

In line with the new, integrated Interface Geriatrics model for older person services within Townsville HHS, there will be a renewed focus on the review of existing systems and processes to align resources with the new service model. The model will provide clear linkages, coordination and communication to improve the navigation of services for older people, supporting them to stay as healthy and independent as possible, for as long as possible. This includes the provision of flexible and responsive services for those living in our rural and remote communities. Rural and remote communities face additional challenges in relation to the increasing needs of their ageing communities and the need for improved access to respite, dementia services, pharmacy and telemedicine services.

What our consumers told us...

- For me to feel safe, I need to feel a connection to someone, whether that is in the clinical environment or in the community.
- Remaining in my own home is important to me but it's too expensive to receive all of the services I need to do so .
- As I get older, it feels that little by little, things are being taken away from me.
- I want to support my loved ones to stay in their own home but there is significant social and financial burden to do so.
- As people get older, they can reach a point where it is no longer easy or possible to make informed decisions, therefore early intervention and care planning is crucial in achieving quality health outcomes.

PRIORITY AREA 3: Supported to stay healthy, well and independent.

What we will do...

#	Actions
	By 2023-2024
3.1	Review the current services available at each rural and remote site and plan to expand services in order to provide a base level of services at each site that include community geriatrics, a rapid assessment team, allied health, home care, residential care and palliative care services.
3.2	Establish clear intake processes and criteria for each rural hub to function as the entry point for triage and coordination of care, with knowledgeable staff that can navigate across other services. This will also require: a. developing processes for connecting into the Resource and Information Hub and into other rural sites to improve interconnectivity b. establishing processes for linking to TUH for specialist services, and appropriate transfer and escalation processes to improve access to tertiary and specialist services in Townsville.
	By 2025-2026
3.3	Support home-based care delivery by enhancing multidisciplinary services including the further development of Hospital in the Home (HITH) services for older people to reduce the need for hospital-based treatments.
3.4	Develop an integrated cross-discipline model to streamline services and reduce the need for individual referrals to each service.
3.5	Work with the PHN and local service providers to increase access to key primary care services such as GPs, allied health and social support services in specific regions, as well as primary care services delivered into people's homes.
3.6	Increase the number of geriatrics, allied health, and pharmacy telehealth clinics to rural and regional hospitals and provide training and support to access online clinics and services.
	By 2030-2031
3.7	Collaborate with the PHN to expand primary care and community-based prevention strategies and build capacity for early care of older people to reduce hospital admissions.
3.8	Develop collaborative strategies and processes for prevention, early detection and management of chronic diseases such as diabetes and heart failure through an integrated network of primary health, community-based and acute services that span the care continuum.

PRIORITY AREA 4

Culturally appropriate services for older Aboriginal and Torres Strait Islander people.

Enhance service delivery for older Aboriginal and Torres Strait Islander People while improving cultural competence more broadly. There is further opportunity through this strategy to implement key actions from the Townsville HHS Cultural Capability Plan and Townsville HHS Health Service Plan, to further develop collaborative partnerships with Aboriginal and Torres Strait Islander peoples and service delivery partners to co-design culturally competent and respectful models of care, procedures, policies and pathways that are inclusive of older Aboriginal and Torres Strait Islander people and their families.

This strategic priority area details work to be undertaken specific to improving the health of older Aboriginal and Torres Strait Islander peoples. This work is in addition to all other actions detailed within this Strategy, in recognition of and in addressing the disparity in health outcomes for our older Aboriginal and Torres Strait Islander peoples.

What our consumers told us...

- Aboriginal and Torres Strait Islander people are faced with additional fears when we leave our home or community to visit hospital.
- We can feel unsafe when we are out of our comfort zone and when we are fearful that our cultural beliefs will be challenged or not acknowledged.
- Aboriginal and Torres Strait Islander people often feel very isolated and very disconnected from their family and culture when they visit hospital.
- I see what my parents went through and I don't want to continue that generational trauma.
- The family dynamics for Aboriginal and Torres Strait Islander people can be very different, and how they are involved in a loved one's care can be very different also.
- It is not just about health outcomes for Aboriginal and Torres Strait Islander peoples, it is also about empowerment.

PRIORITY AREA 4: Culturally appropriate services for older Aboriginal and Torres Strait Islander people.

What we will do...

#	Actions
	By 2023-2024
4.1	Review the criteria for providing services for chronic disease and comorbidity management for Aboriginal and Torres Strait Islander patients in hospital to better integrate older person services.
4.2	Through the Townsville HHS Community Indigenous Liaison Officer, work with external community providers to ensure that service delivery for older Aboriginal and Torres Strait Islander people meets a high-level of cultural sensitivity and safety.
4.3	Develop a consistent strategy and training program for improving cultural competency in older person services across THHS. The primary focus of training and support is to improve the cultural competence of the non-Indigenous workforce.
4.4	Develop new and fully utilise existing KPIs that measure service-wide performance of delivery of care to older Aboriginal and Torres Strait Islander peoples.
	By 2025-2026
4.5	Implement and support key priorities for health services on Palm Island, in partnership with local health service providers and the Palm Island Aboriginal Shire Council (PIASC) including: • supporting the delivery of a full range of aged care options to the frail aged on Palm Island to prevent the need for older people to move away to receive appropriate care where possible. • supporting the delivery of emergency care, inpatient care, renal dialysis, and pharmacy services from the Joyce Palmer Health Service; high-care aged-care services from JPHS Multipurpose Health Service; and, low-care aged-care services from Sandy Boyd Aged-Care Service.
4.6	Improve the connection with primary care and Aboriginal Medical Services in order to provide a holistic service offering throughout the care continuum.
	By 2030-2031
4.7	Working collaboratively with community owned and operated services to build the workforce and service capacity across the region with an emphasis on direct support roles servicing Aboriginal and Torres Strait Islander people.
4.8	Focus on proactively moving care for Aboriginal and Torres Strait Islander older people into the community and home setting (where possible) to avoid hospitalisation, and for chronic disease conditions to be managed in the community. This is inclusive of returning patients home and working with community to enable patients to access available services.

PRIORITY AREA 5

Nurturing partnerships and embracing community.

Develop collaborative partnerships with primary health networks (PHNs), local councils and the community to advocate for system-wide changes for the care of older persons across the region. Current arrangements are creating a disjointed care system and result in difficulty navigating services for both providers and patients. Better integration of Townsville HHS community-based services with primary care and external community services will help to develop a cohesive service offering across the care continuum. We can work together to provide a holistic care environment for older persons by ensuring timely access to community packages, increasing community-based healthy programs, improving access to MyAgedCare, improving funding models, improving care coordination and developing plans and initiatives to build age-friendly communities to better support healthy ageing across the region.

What our consumers told us...

- We want ongoing, strong community dialogue that continues to identify barriers to getting the care we need.
- I feel more confident to reach out for care when I know the person helping me is a part of my community.
- It has taken me years to convince my parents to engage with MyAgedCare.
- We need to make sure that we are looking after the very people who built the communities and the lifestyles that we now enjoy.
- We are all in this to support our community.

PRIORITY AREA 5: Nurturing partnerships and embracing community.

What we will do...

#	Actions
	By 2023-2024
5.1	Utilise the 'Resource and Information Hub' to maintain a directory of all available external community services within Townsville and across Townsville HHS to provide contact information, service scope and service access criteria for all providers.
5.2	Embed regular formal communication and information sharing pathways between community providers and hospital-based nurse navigators, social workers and discharge planners, to monitor and discuss requirements and issues for the availability of community-based services and to regularly collaborate on complex cases and streamline care plans.
5.3	Increase support services and education that enable older people to access and use technology to better receive health care (e.g. use telehealth and other in-home technologies, that support independence in the home).
5.4	Review processes for the provision of healthcare services to older people housed within corrective services to ensure future healthcare demand for this population is appropriately planned for.
	By 2025-2026
5.5	Develop education and training in Advanced Care and End of Life planning for Townsville HHS staff and GPs in collaboration with the PHN.
5.6	Explore collaboration opportunities with Aged and Community Services Australia (ACSA) to enhance workforce skill and availability in the region by supporting key ACSA priorities such as developing collaborative employment pathways programs into the aged care workforce.
5.7	Enhance relationships with local GPs to improve engagement and service delivery for older people, including reviewing and updating incentives and models to better support services for RACFs and providing support and education to upskill GPs to better identify and care for older people.
5.8	Review the funding mechanisms, incentives, and the availability of GP support services including care planning for older people and medical assessments for patients not managing at home.
5.9	Develop new community programs and support services for older people in collaboration with the PHN, Townsville City Council and regional Councils, to promote active ageing and wellness, including marketing to increase community awareness, projects to deliver age friendly environments and education about available programs and initiatives.
	By 2030-2031
5.10	Enhance linkages with PHNs, local councils, social services and other community providers to support social programs such as 'Compassionate Communities', suicide prevention, community awareness for loneliness, advanced care planning, end of life options etc.
5.11	Create a roadmap for developing an interagency aged care alliance (or similar) of service providers, with clear ownership and leadership responsibilities, processes and KPIs, holding providers to account to ensure quality, safety and timeliness of care.


Part Four
IMPLEMENTATION
AND REVIEW

Implementation and review

The implementation of the Townsville HHS Healthy Ageing in North Queensland Strategy will enable better delivery of effective and efficient services over the next 10 years for older people living in the region. This will ensure that as the population ages, the necessary frameworks, services and processes are in place to meet the increasing needs of older people.

Services will have a focus on promoting the health, wellness, and independence of older people, enabling them to live healthy lifestyles, and have direct agency in their healthcare pathways.

The Strategy will be monitored and reported on an annual basis across a 10-year period, enabling the priority areas and actions to be updated and refined as changes in health needs or demographics are identified.

At a local service level, further work will be required to develop work packages of key actions, identify responsible persons, and timelines that are tied to THHS-wide strategies and priorities.

At an organisational level, success indicators will be aligned with the measures within *Queensland Government Healthy Ageing: A strategy for older Queenslanders*.

What does success look like?

Successful implementation of this strategy will mean that older people are empowered, supported and confident to access high-quality, culturally competent services, no matter where they live.

Services will be co-designed with consumers and will support collective decision making for clinicians, carers, older people and their families.

Broadly, successful implementation of the Strategy will result in:

- the current dispersed services organised into a coordinated service model for older person services across Townsville HHS
- enhanced cultural capability of the health workforce increasing the confidence of Aboriginal and Torres Strait Islander peoples to access health care services and have greater control over their health and wellness
- workplace culture change and skills development focussed on a new way of working that supports safe, effective and efficient service delivery to older people as part of core business for everyone
- roles and responsibilities in the new model clearly defined and an appropriate governance structure embedded across services
- streamlined corporate and clinical governance arrangements across acute and community-based services to support service integration and collaboration by reducing waste and service-level barriers for undertaking quality improvement, education and service development.

Enabling future collaboration

This Strategy enables Townsville HHS to clearly define its role and purpose in relation to the delivery of services for older people across the healthcare sector and provides an opportunity for wider advocacy for the care of older people.

New arrangements will provide leadership to engage and work with other HHSs, PHNs, RACFs and external service providers, to deliver an integrated, whole-of-journey service for older people within Townsville HHS.

This integrated and holistic service network should involve primary and tertiary health services, government social and justice services and other community and supporting services.

The establishment of an older persons 'virtual committee' composed of stakeholder representation from all older person service groups across the Townsville HHS catchment, will also be explored.

Glossary

ACAT	Aged Care Assessment Team; are teams of health professionals who conduct comprehensive face-to-face assessments of older people who have complex aged care needs.
ACSA	Aged and Community Services Australia
Beddays	A bedday is a day during which a person is confined to a bed and in which the patient stays overnight in a hospital.
BPSD	Behavioural Psychological Symptoms of Dementia
Burden of disease	Burden of disease measures the impact of living with illness and injury and dying prematurely.
CBRT	Community-Based Rehabilitation Services
Chronic conditions	A chronic disease is a long term condition that generally does not get better on its own and is generally not cured completely. Chronic diseases can lead to other health complications, and can be associated with functional impairment and disability. They may affect you at any stage in your life; however, as you grow older, the chances of contracting certain chronic diseases can increase.
Discharge planning	If you are discharged from hospital then you may have a discharge plan. This is a plan developed by the hospital in close consultation with you, your carer and hospital and community service providers to ensure you receive appropriate and coordinated care when you leave the hospital. Discharge planning is when the patient, carer, family and any staff involved make the necessary arrangements to ensure there is a smooth transition from hospital to home, residential care or somewhere else.
ED	Emergency Department
FIT	Frailty Intervention Team
GEDI	Geriatric Emergency Department Initiative
GEM	Geriatric Evaluation Management
GP	General Practitioner
GSNH	Good Shepherd Nursing Home
Health adjusted life expectancy	Health-adjusted life expectancy reflects the average length of time an individual can expect to live without disease or injury.
HITH	Hospital in the Home
Home care packages	The Australian Government subsidises organisations to provide home care services called Home care packages to eligible older people.
Hospice	A hospice is a facility specifically for the palliative care of people with a progressive life limiting illness. It offers total care for the person including physical, emotional and spiritual support, and also cares for the person's family. Hospices are staffed by specifically trained doctors, nurses, social workers, physiotherapists and volunteers.
ieMR	Integrated electronic medical record
JCU	James Cook University
KPI/S	Key Performance Indicator/s
MDT	Multidisciplinary Team
MyAgedCare	My Aged Care makes it easier for older people, their families, and carers to have their aged care needs assessed and be supported to locate and access services. My Aged Care was introduced on 1 July 2013 and is made up of the My Aged Care website (myagedcare.gov.au) and My Aged Care contact centre (1800 200 422).
NDIS	National Disability Insurance Scheme

NGO	Non-government Organisation
NQ	North Queensland
Palliative Care	Palliative care is provided for people who have an advanced illness, with little or no prospect of cure. The aim of palliative care is to achieve the best possible quality of life for the person, their family and carers.
PHN	Primary Health Network
PIASC	Palm Island Aboriginal Shire Council
QAS	Queensland Ambulance Service
RACF	Residential Aged Care Facility
RaSS	Residential Aged Care Support Service
Re-ablement	The use of timely assessment and short term, targeted interventions to: - assist people to maximise their independence, choice, health outcomes and quality of life - appropriately minimise support required and reliance on future and or alternate support - maximise the cost effectiveness of programs - support people to continue to participate and remain engaged in their local communities as they wish. The provision of reablement services is part of the wellness philosophy.
Respite care	Respite care (also known as short-term care) is a form of support for carers or care recipients. It gives the carer the opportunity to attend to everyday activities and have a break from their caring role and the care recipient a break from their usual care arrangements. Respite care may be given informally by friends, family or neighbours, or by formal respite services.
SACU	Subacute Care Unit
SEIFA	Socio-Economic Indexes for Areas
Separation	Separation is the process by which an episode of care for an admitted patient is completed. A separation may be formal or statistical. An episode of care may be completed because the patient's treatment is complete, the patient no longer requires care, has deceased, is transferred to another hospital/care facility or the patient leaves the hospital against medical advice.
TAAHC	Tropical Australian Academic Health Centre
TCC	Townsville City Council
TCHS	Townsville Community Health Service
TCP	Transition Care Program
TIHRI	Townsville Institute of Health Research and Innovation
Townsville HHS / THHS	Townsville Hospital and Health Service
Transfer of care	The transfer of the care of a patient from one health care professional to another, can also be referred to as clinical handover.
Transition care	If you are an older person who is ready to be discharged from hospital, but you still need short-term care after your hospital stay to be as independent as you can be, then you may benefit from transition care (also known as 'after-hospital care'). This type of care is designed to ensure more people return home after a hospital stay rather than move into an aged care home prematurely.
TropiQ	Townsville's Tropical Intelligence and Health Precinct
TUH	Townsville University Hospital
Wellness	A philosophy that focuses on whole of system support to maximise clients' independence and autonomy. It is based on the premise that even with frailty, chronic illness or disability; people generally have the desire and capacity to make gains in their physical, social and emotional wellbeing and to live autonomously and independently. It emphasises prevention, optimising physical function and active participation. It focuses on finding the service solutions to best support each individual's aspirations to maintain and strengthen their capacity to continue with their activities of daily living, social and community connections.






A special thank you








The Townsville Hospital and Health Board would like to extend a warm thank you to all of the consumers, community groups and community members who came together to help us understand the experiences and needs of our ageing population. Without your valued contribution and passion for the health of your community this strategy would not be possible.

Whether you are one of the 80 Heart Foundation walkers who welcomed us to your walking group, a Traditional Owner who not only shared your stories but also your NAIDOC week damper with us, or one of 60 community members who responded to our online survey – thank you! Your generosity of time and the sharing of your experiences has enabled us to deliver a strategy that is truly representative of our community's needs.

As we move forward with the implementation of this strategy, we will continue to seek out opportunities to engage with you and to ensure we are developing our services in a truly co-designed and collaborative way. We look forward to working with you again soon.






Queensland
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