Gold Coast Primary Health Network

STRATEGIC PLAN 2016 – 2021
“Building one world class health system for the Gold Coast”

Table of Contents

Setting our Strategic Directions 1
  National Context 1
  Local Context 2

The Gold Coast Primary Health Network Environment 3
  Identifying the Challenges 3
  Market Analysis 5
  Summary of Operating Pressures 7

Strategic Framework 8

GCPHN Strategic Measures of Success (5 Years) 9

Health Needs & Service Issues Identified through GCPHN Needs Analysis Process 10

Key National and Local Priority Areas - 5 Year Road Maps 11

1. Population Health 12
   Childhood Immunisation 12
   HPV Vaccinations 12
   Cancer Screening 13
   Access to health services for homeless/socioeconomically disadvantaged people 13

2. Mental Health 13
   Coordinated sector delivers seamless service delivery for people with mental conditions 14
   Client centered Alcohol & Other Drugs (Incl. Ice) 14
   Empowerment and choice for people living with mental illness 14

3. Chronic Disease 15
   Improve access to self-managed services 15
   Risk Stratification 15
   Gold Coast Integrated Care 16
   Persistent Pain 16

4. Aboriginal and Torres Strait Islander health 16
   Equity of Access 17
   Coordinated Management of Chronic Disease 17

5. Aged Care 17
   Support Older People to stay in their home 18
   End of Life Care Planning 18

6. Practice Support 18
   Practices actively engaged, submit clinical data and participate in CQI activity 19
   Increase General Practices involved in the uptake of evidence based interventions 19

7. Engagement 20
   Shared Ownership 20
   General Practitioner Engagement 20
   Clinical Leadership 21
   Practical Localised Resources 21

8. Digital Health 22
   Support Healthcare Providers to set up and Connect to Digital Health 22
   Communication with HHS/ Transfer of Care 22

9. Workforce 23
   Clinical Placements 23
   Regional Workforce Development 23
   Quality Primary Care Education 24

Building Organisational Capacity 24

1. Needs Assessment 25
2. Service Design/Development 25
3. Procurement 26
4. Monitoring and Evaluation 26
5. Stakeholder Engagement 27
6. Information Communication and Technology 27
7. Human Resource Management 28
8. Financial Management 28
9. Governance 29
Setting our Strategic Directions

National Context

On 1 July 2015, the Australian Government established 31 Primary Health Networks (PHNs) at the regional level across Australia. PHNs are expected to work collaboratively with Local Hospital and Health Services and key stakeholders to improve integration across the health system to reduce avoidable hospital admissions, and reduce duplication of effort and resources. All PHNs are responsible for purchasing and/or commissioning services to meet the programme objectives and national priorities.

PHNs operate in a complex and dynamic policy environment, which is still emerging. The role of PHNs and their performance may be affected by current and future reviews and changes to policies and initiatives at the Commonwealth, state and even the local government level.

The key objectives of PHNs are to:

- increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- improve coordination of care to ensure patients receive the right care in the right place at the right time.

PHNs are expected to achieve these objectives by:

- working directly with general practitioners, other primary health care providers, secondary care providers and hospitals to ensure improved outcomes for patients;
- understanding the health care needs of their communities;
- responding to identified national and PHN specific priorities;
- having a local purchasing or commission role; and
- being outcome focused and performing a critical function in networking health services.

The actions of the PHN’s are guided by a series of national priority areas:

- Population health
- Mental health;
- Aboriginal and Torres Strait Islander health;
- Health workforce
- EHealth; and
- Aged Care
Local Context

On 1 July 2015, the Primary Care Gold Coast Limited commenced as the Gold Coast PHN, establishing its vision and goals aligned with Commonwealth government expectations.

Vision

“Building one world class health system for the Gold Coast”

Strategic Goals

- Improve coordination of care to ensure patients receive the right care in the right place at the right time, by the right person.
- Increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- Engage the support of general practice and other stakeholders to facilitate improvement in our local health systems;
- Be a high performing, efficient and accountable organisation.

Values

- SUSTAINABLE: Efficient, Effective, Viable
- COLLABORATIVE: Partnerships, Integrated, Engaged
- INNOVATIVE: Flexible, Pioneering, Evolutionary
- INFLUENTIAL: Visible, Valued, Courageous
- EVIDENCE-BASED: Research, Documenting, Transparent
- ACCOUNTABLE: Respect, Responsible, Outcomes
The Gold Coast Primary Health Network Environment

Identifying the Challenges

Demographics

Population, Growth and Age Profile The Gold Coast has a population of 560,266 people (30 June 2014). The average annual growth rate is tracking slightly higher than Queensland over both the next 5 years (1.9% vs. 1.8%) and 10 years (2.5% vs. 2.1%). The population of the Gold Coast is projected to increase to 922,267 people between 2011 and 2036 (2.3% growth per year). This growth is predicted to see significant increases in the number of people in the 65 and over and 85 and over age cohorts.

The age profile of the Gold Coast is generally similar to that of Queensland. The Gold Coast has a slightly lower population of young children aged 0 – 14 (18.3%) compared to Queensland (19.8%). The Gold Coast has a slightly higher proportion of people aged 65+ (15%) compared to Queensland (13.6%).

Cultural Diversity The Gold Coast has proportionally less Aboriginal and Torres Strait Islander residents (6,350 people, 1.3%) compared to Queensland (3.6%). Due to a smaller proportion of Aboriginal and Torres Strait Islanders on the Gold Coast there is a risk that services are not tailored in a culturally appropriate manner to meet the needs of this population. In contrast the Gold Coast has a higher proportion of residents born overseas (27.8%) compared to Queensland (20.5%).

Social Disadvantage Social disadvantage is a leading indicator for poorer overall health. The Gold Coast region has a higher proportion of middle class residents (SEIFA quintiles 3 and 4) and fewer people that are either most disadvantaged or least disadvantaged (quintiles 1 and 5) compared to Queensland. The region does however have pockets of high disadvantage with Southport (28.4%) and Gold Coast North (23.6%) having higher rates of disadvantage compared to the rest of the region. The Gold Coast has a higher proportion of homeless people (63.4 persons per 10,000) compared to Queensland (44.5 per 10,000).

Health Services General Practice in 2012, 80% of Gold Coast adults reported seeing a GP in the previous year. Generally speaking, throughout the year 15% of patients access a GP 12 or more times. The highest proportions of ‘very high’ users were aged 75 years and older. Statistics show that people who visit the GP more often also tend to see a greater number of different GPs. Overall, people attending the GP twelve or more times per year also use more diagnostic imaging services, pathology episodes, medical specialist attendances, chronic disease planning and management appointment and after hours GP attendances. Those who were most socially disadvantaged were more likely to visit the GP. This suggests a combination of higher disease burden but may also be a positive indication of service accessibility.

Aboriginal and Torres Strait Islander Service Utilisation Encouragingly, the Gold Coast has seen an increase in Aboriginal and Torres Strait Islander health checks (715) between 2012 and 2014. This was in addition to the number of services provided to a person by a practice nurse or Aboriginal and Torres Strait Islander health practitioner almost doubling over the same period. Indigenous health checks are essential to effectively identify chronic disease at an early stage and improve self-management.

Vaccination Generally speaking the Gold Coast region has maintained steady child vaccination coverage at the 12, 24 and 60 month milestones for both the broader population and Aboriginal and Torres Strait Islander children. The quarters where immunisation rates fell below the 90% threshold may be attributable to a change in criteria to achieve ‘fully immunised’ status. In 2014, the Gold Coast achieved coverage rates of 75%, 72% and 59% among year 8 students and coverage rates of 64%, 57% and 42% among year 10 students for doses 1, 2 and 3 of HPV. This indicates that although coverage is improving, there is much work to do in relation to improving vaccination rates to the recommended threshold of 85%.

Disease Screening Screening rates generally for cancer on the Gold Coast are reportedly below the Queensland average. Compared to Queensland, Gold Coast screening rates are lower for total participation (55.2% vs. 56.9%), 70-74 year olds (50.6% vs. 52.7%) and 50 – 74 year olds (54.6% vs. 56.3%). Anecdotally, the participation rate in the bowel-screening
program has tended to be lower than the state average. Encouragingly, in 2011-2012 the participation rate in cervical screening in women aged 20 to 69 was 56.7% (compared to 55.7% across the state). There is expected to be 4,320 new cases of cancer on the Gold Coast by 2021, which will be a 34% increase from 2012. Prostate and breast cancer are expected to remain the cancers most commonly diagnosed. Similarly, in 2021, an estimated 1,435 cancer deaths are expected on the Gold Coast.

**Health Issues**

**Mental Health** According to Beyond Blue in Australia (in any one year) 1 million people will have depression and over 2 million have anxiety. General practitioners on the Gold Coast managed depression or anxiety in 7% of consultations during 2009-13. This suggests, general practitioners may only be seeing a small proportion of patients with mild and moderate mental health issues. General Practitioners are often the first contact for people needing mental health support. The Gold Coast has a very high rate of GP mental health treatment plans with an average of 5,596 per 100,000 population which is greater than both the State (4,297) and National averages (4,260). General practitioner led care coordination may be a challenge in the future as 55% of depression or anxiety consultations were prescribed psychotropic medications, 31% were referred to counselling and 16% to specialised care. Capacity and capability is required to be built into General Practice to ensure care coordination can be achieved between the hospital, psychosocial support (NGO sector) and primary care. Suicide was the leading cause of death in young people in 2010 with a total of 569 suicide deaths in Queensland. In 2013/14 a total of 781 episodes of care for suicide and self-inflicted injury were recorded on the Gold Coast. This rate was higher when compared to the prior ten years. Mental health and suicide continues to be an issue for young people. Anecdotally, the Gold Coast continues to see an increase in access demand for mental health services in the Emergency Department, community and inpatient mental health services. The increase in the amount of drug and alcohol related presentations has increased complexity and acuity levels of the mental health presentations. There has been a significant increase of illicit drug related presentations over the past 18 months. Service data confirms that rates of anxiety, schizophrenia and personality disorders continue to trend upwards. It is important to acknowledge and recognise the role that the NGO sector can play in ensuring the psychosocial needs of people with severe and complex mental health issues are addressed.

**Aging and Dementia** In 2014 there were 120 aged care services and 6,454 aged care service operational places on the Gold Coast. With the aged population continuing to grow it is important to bring focus to ensuring the aged care system is easily navigated and the health and care workforce is supported. It is estimated that 1.3% of Australians have dementia, which equates to around 7,283 people on the Gold Coast. Dementia becomes more prevalent as age increases and will provide challenges for the current health system to deal with effectively. In 2013/14 there were 2,637 episodes of care for dementia on the Gold Coast, which was proportionality higher compared to Queensland averages. Chronic Obstructive Pulmonary Disease (COPD), pneumonia and influenza episodes of care are also consistently higher for older persons adding to the complexity of care.

**Alcohol, Tobacco and Other Drugs** Alcohol and drug issues continue to be reported as an issue across Queensland with 15% of Queenslanders aged 14 years and older reporting the use of an illicit drug in the previous 12 months. Young users aged 20 – 29 were more likely to use ecstasy, cocaine, meth/amphetamines, hallucinogens and cannabis. Older users were more likely to use cannabis and pharmaceutical drugs. In terms of alcohol consumption, the proportion of adults on the Gold Coast who reported occasional risk drinking (at least weekly) was similar to the state average (14%). In 2013/14 there were 4,549 alcohol related episodes of care at GCHHS. Tobacco smoking continues to be a leading cause of preventable ill health. 12.9% of people on the Gold Coast smoke daily which generally falls below the Queensland average.

**Risk Factors** The proportion of Gold Coast adults (18+) who self-reported unhealthy weight range has risen from 51.2% in 2010 to 57.9% in 2013. This however represents both ends of the healthy weight spectrum including underweight, overweight and obese. Obesity alone accounts for 18.6% of the total number of people who fall into the ‘unhealthy weight’ category, which compares favourably to Queensland averages. The Gold Coast region is generally more physically active compared to the rest of the state. Among 18-75 year olds, 66% achieved fives sessions of 30 minutes of moderate or vigorous activity weekly, compared to 53% across Queensland. High blood pressure and high cholesterol are significant contributors to the death burden in Queensland broadly. The Gold Coast region has a similar prevalence of high blood pressure (29%) and high cholesterol (27%) compared to state averages.
**Chronic Disease**

Gold Coast has largely comparable rates of Diabetes, high blood cholesterol, mental and behavioural issues, circulatory system disease, hypertensive disease, respiratory disease, asthma, chronic obstructive pulmonary disease, musculoskeletal disease and arthritis when compared to Queensland averages. Cardiovascular disease however is one of the highest causes of illness and death amongst the Gold Coast community. Overall the rate of coronary heart disease episodes of care have trended downward over the ten-year period between 2002 and 2012, however this still represents over 3000 episodes of care in 2013/14 and a significant burden on the health system. Over 80% of coronary heart disease burden is associated with lifestyle and physiological risk factors. Stroke incidence rates had reduced between 2002 and 2012 but have risen again in recent years. As of 2013/14 almost 1500 episodes of care for stroke were provided on the Gold Coast.

Hospital utilisation for diabetes care continues an upward growth trend. In 2013/14 Gold Coast had 1121 hospital episodes of care for diabetes, which was higher than the count of episodes of care for 2010-2012. GCHHS however has the second lowest rate of hospitalisations for diabetes in Queensland.

In Queensland, respiratory conditions were the third largest broad cause of death in 2010 and a major cause of avoidable hospitalisation. Asthma rates have steadily risen over the last 10 years on the Gold Coast, consistent with State averages. In 2013/14 the age standardised rate of COPD for the Gold Coast was higher than the years between 2009 – 2012 but still low compared to the Queensland rate.

**Workforce Pressures**

The capacity for primary care to meet demand for service is heavily reliant on having the right people with the right skills in the right place. As the proportion of the population reaches traditional retirement age, it presents concerns over the availability of sufficient workforce capability to meet predicted increases in demand.

The number of Gold Coast people employed in the health and social assistance industries has more than doubled over the last decade, reaching 30,764 in 2013/14(NIEIR, 2015).

The key pressures facing the Gold Coast region are identified in the whole of Region Primary Health Care Workforce Planning, [South East Queensland Medicare Local, Final Report June 2014]:

- Workforce shortages among Registered Nurses, Personal Care Attendants and Community Care Workers in the aged and community care sector
- Future workforce shortages are predicted in the nursing workforce, and potential workforce shortages may occur among Occupational Therapists, Podiatrists, Speech Pathologists and Dietitians. The number of Aboriginal and Torres Strait Islander health workers remains comparatively low given the high importance of health services for this population
- Stakeholders consistently report the need for skills development for General Practitioners and other health practitioners in relation to multidisciplinary team care approaches, collaborative planning and case conferencing; along with awareness-raising about the kinds of services already available to support people with chronic conditions.

There are currently around 177 General Practices with 811 General Practitioners in the Gold Coast region. Apart from the coastal strip from Southport to Coolangatta, much of the Gold Coast region is currently defined as Districts for Workforce Shortage for General Practice.

**Market Analysis**

- GCPHN has collated and reviewed evidence related to the health market to support effective planning and decision making. This consideration of both macro and local market issues provides valuable insight as to the future direction of health on the Gold Coast and highlights potential opportunities for engagement, particularly with non-traditional partners.
- Global trends identified as impacting on health include - the evolving digital future; demographic shift;
changing natural resource management (natural disaster management, food security); urbanisation (healthy cities); consumer empowerment and a changing global marketplace (business models, spread of disease and economic diversification) (Queensland Health, 2016).

• Activity within Queensland public hospitals over the past decade has increased by 60 per cent, with only a 15 per cent growth in population (Queensland Health, 2016). This highlights the importance of supporting health across traditional silos (hospital, primary and community) and integrating care to reduce pressure on any single part of the system. This increase in partnerships and coordination is no longer an optional endeavour with changing business models required to successfully implement new care delivery in disability (NDIS), aged care (CDC) and soon in mental health. The health industry must adapt to these new business models with the impacts of these changes skilfully managed. Rising consumer expectations and the empowerment of individuals to be involved in decision making about their health is also a key consideration of the health market.

• Traditionally the Gold Coast’s economic profile was dominated by the tourism and construction industries. However, activity in recent years and current Council economic strategies support a strong diversification into knowledge-based industries particularly education, health and technology. The Council acknowledges the health and medical industry as a key sector of the local economy both now and for the future.

• The predominance of small businesses in the primary care sector presents challenges for coordination and systematic reform. A range of factors influence the service and workforce model in private practices, and the funding mechanisms directly influence service provision and service demand. There may also be opportunities to improve and/or expand services provided to people with chronic conditions by exploring alternative options for the funding of Medicare Benefits Schedule items related to chronic conditions.

Unlike many areas in Australia, the Gold Coast region is relatively compact geographically despite its population and has:

• a solid State government presence with 2 hospitals (including the state of the art Gold Coast University Hospital) and a third just over the border, with associated community services
• A strong private hospital sector
• Numerous large and small NGOs operating in the region, with more of the large national service providers establishing service delivery in a range of areas in recent years.
• While there are some exceptions, there are generally a good proportion of a range General Practice Providers and private allied health for our population.

However some local market issues include:

• services remain fragmented and are not structured around the needs of patients and consumers
• services compete for funding which can be inconsistent with integrated and coordinated services
• services are operating within restrictive funding silos
• service providers historically have not coordinated their care with other providers
• services and consumers have poor knowledge of available services and how to access them
• local service providers recognise the need to make most efficient use of existing resources

GCPHN is confident that where additional service capacity is required it is likely that appropriate and suitable providers could be found to meet the identified need. However in addition it is recognised that complex problems not currently being addressed require multidisciplinary collaboration between all of the multiple service providers involved in delivering services to the complex client. Using funding as a leverage to encourage all of the partners involved to work collaboratively with the consumer at the centre of care.
Summary of Operating Pressures

Sitting alongside the challenges above are the fiscal pressures facing the health sector. Both State and Federal Governments have given clear signals that they are looking at the whole health system to rethink how to deliver improved health outcomes in more cost effective ways. Primary Health Networks have been established by the Commonwealth Government to maximise return on investment by enabling them to administer both flexible funding providing increased leverage to effectively engage the primary care sector, Hospital and Health Services, the private sector, non-government organisations and other partners.

While there are some exceptions, in terms of the health and wellbeing of Gold Coast residents there is evidence to show the population is faring well. In addition there is evidence to show a relatively high rate of primary healthcare services in the region.

However, with ongoing population growth, an aging population and increasing chronic disease prevalence, service demand and associated costs will continue to increase over times in the region. Through General Practice and the broader primary care system, there are a number of potential intervention points to reduce demand on expensive tertiary services. These opportunities to deliver increased efficiency and effectiveness through better integrated care must be realised to maximise the health and wellbeing of our community now and into the future.
**Strategic Framework**

### National PHN Goals

- Increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes
- Improving coordination of care to ensure patients receive the right care in the right place at the right time

### GCPHN Vision

*“Building one world class health system for the Gold Coast”*

### GCPHN Strategic Goals

<table>
<thead>
<tr>
<th>Increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes</th>
<th>Improving coordination of care to ensure patients receive the right care in the right place at the right time</th>
<th>Engage and support General Practice and other stakeholders to facilitate improvements in our local health system</th>
<th>Be a high performing, efficient and accountable organisation</th>
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</table>

### GCPHN Strategic Outcomes

| People are healthier and take responsibility of own health | An integrated health system across the Gold Coast | Strong clinical leadership, capacity and innovation in the Gold Coast primary care sector | Strong and highly effective, governance, leadership and decision making |
| People with complex illness have improved health outcomes | People stay well in their own homes and communities | Strong partnerships facilitate service improvement | GCPHN has an integrated business model that ensures success |
| | | | GCPHN meets world class commissioning competencies |
GCPHN Strategic Measures of Success (5 years)

People are healthier and take responsibility of own health  
Exceed national immunisation targets for childhood & Human papillomavirus (HPV) immunisation  
KPI: Increase in immunisation coverage rates (Childhood & HPV)  

Exceed national screening rates for breast, bowel and cervical cancer  
KPI: Increase in cancer screening rates (bowel, breast and cervical)  

People with complex illness have improved health outcomes  
Improve clinical outcomes  
KPI: Improvements to clinical indicators for Chronic Disease management (Diabetes, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease)  

Increase in mental health treatment rates for severe and complex mental illness  
KPI: Reduction in suicide rates for Aboriginal and Torres Strait Islander people.  

Improved patient satisfaction and experience  
KPIs: % of patients rating >80% satisfaction with service contracted by the PHN  
% of patients with an increased confidence to self-manage their condition  
% patients rating (rating > 80%) service as integrated.  

Equity in health outcomes for:  
• Aboriginal and Torres Strait Islander (A&TSI) people  
KPI: Improvements to clinical indicators for Chronic Disease management (Diabetes, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Coronary Heart Disease)  
• Homeless  
KPI: Increasing service access for homeless people  

An integrated health system across the Gold Coast  
A regional collaborative Health Service Plan  
KPI: A single regional plan for the Gold Coast.  
Increase in access to pathways  

Adoption of My Health Record by patients, carers and health practitioners.  
KPI: % of e-transfers of care within agreed timeframes (Electronic Discharge Summary, referrals Outpatient Department letters)  
% of health practitioners and patients accessing My Health Record  

People stay well in their own homes and communities  
Reduction in potentially avoidable hospital admissions  
Increase in Advanced Care Plans in Residential Care Facilities  

Strong clinical leadership, capacity and innovation in Gold Coast primary care sector  
Strong clinical leadership  
KPI: Clinical networks facilitate service improvement  
Increased research in General Practices  
KPI: Number of GPs involved in Testing, Translation and Uptake of Evidence in General program (Bond CREBP)  
Increased application of evidence based practice in primary care  
KPI: % of Primary Care staff that have enhanced knowledge through education and training.  
Increased in primary care innovation  
KPI: Risk Stratification has improved patient health outcomes  

Strong partnerships facilitate service improvement  
Improved GP/stakeholder satisfaction  
KPI: % of GPs/stakeholders rating >80% satisfaction with the PHN  

Strong and highly effective governance, leadership and decision making  
Strong Financial & Program Performance  
KPI: Meeting annual financial audit requirement with no adjustments required, and a high level of internal control reported.  
High performing Board, Executive and Clinical and Community Advisory Councils  

GCPHN has an integrated business model that ensures success  
GCPHN is a world class commissioning organisation  
GCPHN meets world class commissioning competencies

Page 9
# Health Needs & Service Issues Identified through GCPHN Needs Analysis Process

<table>
<thead>
<tr>
<th>Health Needs/Service Issues</th>
<th>Key Topic Areas</th>
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<tbody>
<tr>
<td><strong>Cancer screening</strong> - Low awareness of screening target groups and eligibility among both community and health professionals</td>
<td>Population Health</td>
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<tr>
<td><strong>HPV vaccination</strong> - Very low rates</td>
<td>Population Health</td>
</tr>
<tr>
<td><strong>Childhood immunisation</strong> - Need for practice support and workforce training</td>
<td>Population Health, Practice Support</td>
</tr>
<tr>
<td><strong>Social disadvantage and homelessness</strong> - Access to health services for people of low socio-economic status, homelessness and social disadvantage</td>
<td>Population Health</td>
</tr>
<tr>
<td><strong>Mental health services for young people</strong> - Focus on suicide, particularly for A&amp;TSI youth</td>
<td>Mental Health, A&amp;TSI People</td>
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<tr>
<td><strong>Access issues due to growing demand and service capacity</strong> - Focus on hard to reach groups including males, people with cognitive impairment, co-morbidities LGBTI, A&amp;TSI, CALD and homeless people</td>
<td>Mental Health, Practice Support, Chronic Disease, A&amp;TSI</td>
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<tr>
<td><strong>Alcohol and Other Drugs</strong> - Including a focus on ICE</td>
<td>Mental Health, A&amp;TSI People</td>
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<tr>
<td><strong>Chronic disease early identification, self-management and medication management</strong> - Target groups to include diabetes and cardiovascular for A&amp;TSI people</td>
<td>Chronic Disease, A&amp;TSI People, Older People, Practice Support</td>
</tr>
<tr>
<td><strong>Chronic disease care coordination</strong> - Communication and co-ordination to support holistic transition of care for patients; focus on relationships between primary and acute services</td>
<td>Practice Support, Chronic Disease, Older People, Mental Health</td>
</tr>
<tr>
<td><strong>Persistent Pain</strong> - High numbers of people with persistent pain</td>
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<tr>
<td><strong>Access to information to support referrals and service access</strong> - Hampered by fragmented local services which are difficult to navigate for providers and community</td>
<td>Chronic Disease</td>
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<tr>
<td><strong>Palliative and end of life care planning</strong> - Including advanced care planning</td>
<td>Chronic Disease, Mental Health, Practice support</td>
</tr>
<tr>
<td><strong>Aged care pathways and coordination</strong> - System navigation for older people and primary care providers supporting them with focus on Dementia</td>
<td>Older People, Chronic Disease, Practice Support</td>
</tr>
<tr>
<td><strong>After Hours</strong> - Support older people and people with chronic disease to stay well at home</td>
<td>Older People, Practice Support</td>
</tr>
<tr>
<td><strong>Ensuring access and awareness of appropriate services for A&amp;TSI people</strong> - Including culturally appropriate mainstream services</td>
<td>A&amp;TSI People, Cancer Screening, Chronic Disease</td>
</tr>
<tr>
<td><strong>General Practice education and support</strong> - Resources and training required for GPs as the key coordinator of services for people with mental health issues, focus on holistic approach and low intensity services</td>
<td>Mental Health, Practice Support, Chronic Disease</td>
</tr>
<tr>
<td><strong>General Practice engagement</strong> - Focus on quality activities including access to best practice and evidenced based education to support clinical decision making</td>
<td>Practice Support, Mental Health, Chronic Disease</td>
</tr>
<tr>
<td><strong>Interoperability, General Practice Liaison Officer and My Health Record</strong> - Poor interoperability, use and understanding of clinical data systems between primary, secondary and other services further inhibits information sharing and care-coordination</td>
<td>Practice Supp, Chronic Disease</td>
</tr>
</tbody>
</table>

These priorities have been taken into account in the development of deliverables under the national and local priority.
Key National and Local Priority Areas - 5 Year Road Maps

1. Population Health
2. Mental Health
3. Chronic Disease
4. Aboriginal and Torres Strait Islander health
5. Aged Care
6. Practice Support
7. Engagement
8. Digital Health
9. Health Workforce
### 1. Population Health

#### Strategic Outcomes
- People are healthier and take responsibility for own health
- People stay well in their own homes and communities

#### Strategic Measure of Success
- Exceed national immunisation targets for childhood and HPV immunisation
- Exceed national screening rates for breast, bowel and cervical cancer screening
- Equity in service access – Homeless
- A regional collaborative service plan

### Childhood Immunisation

<table>
<thead>
<tr>
<th>5 year goal</th>
<th>Deliverable 2016/17</th>
<th>Deliverable 2017/19</th>
<th>Deliverable 2019/21</th>
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</table>
| Exceed national targets | • Joint GCH and GCPHN collaboration agreement endorsed  
• General Practice/vaccine education (Back to Basics and Catch Up)  
• Pilot vaccine hesitancy project  
• Review / develop models for Online GP education and Smartvax software  
• Host Annual Queensland PHN/PHU Immunisation Conference  
• Provision of practice support  
• Re - establish local steering committee  
• 92% target for 12 month cohort | • General Practice/vaccine education  
• Vaccine hesitancy project  
• Implement new programs  
• Annual PHN/PHU Queensland conference  
• Provision of practice support  
• 95% target for 12 month cohort | • GP education program/  
Vaccine provider education  
• Vaccine hesitancy project  
• Ongoing data processing and reporting  
• Provision of practice support  
• Annual Queensland PHN/PHU conference  
• 96% target for 12 month cohort |

### HPV Vaccinations

<table>
<thead>
<tr>
<th>5 year goal</th>
<th>Deliverable 2016/17</th>
<th>Deliverable 2017/19</th>
<th>Deliverable 2019/21</th>
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</table>
| Meet or exceed national school immunisation rates | • School program  
• Public awareness campaign  
• General Practice Data system refinements to enable access to, and increase surveillance of immunisation.  
• 82% target (national average 72%) | • Implement amended program  
• Public awareness campaign  
• Continue surveillance  
• 85% target | • Implement amended program  
• Public awareness campaign  
• Continue surveillance  
• 87% target |
## Cancer Screening

<table>
<thead>
<tr>
<th>5 year goal</th>
<th>Deliverable 2016/17</th>
<th>Deliverable 2017/19</th>
<th>Deliverable 2019/21</th>
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</table>
| Meet/exceed national screening rate targets or averages for breast, bowel and cervical cancer | • General Practice and Public awareness campaign, focus on bowel screening  
• Enhance accuracy in practice data re screening  
• Advocate for delivery of electronic reporting by Breastscreen and National Bowel Screening  
• Bowel target 35.5% (national average 37.3)  
• Breast target 57% (national average 54.2%)  
• Cervical target 57.3% (national average 57.3%) | • General Practice and public awareness campaign  
• GP software options identified, pilot of enhanced reminder processes and messages  
• Evidence based management of patients post screening  
• Bowel target 37%  
• Breastscreen target 57.5%  
• Cervical target 58% | • General Practice and Public awareness campaign: website, targeted mail out, community groups  
• Evidence based management of patients post screening  
• Bowel target 38%  
• Breastscreen target 58%  
• Cervical target 59% |

## Access to health services for Homeless/Socioeconomically disadvantaged people

<table>
<thead>
<tr>
<th>5 year goal</th>
<th>Deliverable 2016/17</th>
<th>Deliverable 2017/19</th>
<th>Deliverable 2019/21</th>
</tr>
</thead>
</table>
| Achieve improved access in service delivery for homeless people | • Continue to provide supported access to General Practice, advocacy, crisis intervention, referral via Social Work Student Hub in partnership with Southern Cross University  
• Podiatry services in-situ, via professionally supervised Podiatry students from Southern Cross University  
• Encourage other allied health services to deliver services in-situ | • Continue to provide supported access to General Practice, advocacy, crisis intervention, referral via Social Work Student Hub  
• Podiatry services in-situ, via professionally supervised Podiatry students  
• Evaluate social work student hub and consider feasibility of expansion | • Commission service model subject to outcomes of evaluations |

## 2. Mental Health

### Strategic Outcomes

- An integrated health system across the Gold Coast
- People with complex illness have improved health outcomes
- People are healthier and take responsibility for their own health

### Strategic Measure of Success

- Increased mental health treatment rates
- Improved patient satisfaction and experience
- Reduction in avoidable presentations to the Emergency Department
- Equity in service access
- A regional collaborative service plan
### Coordinated sector delivers seamless service delivery for people with mental health conditions

<table>
<thead>
<tr>
<th>5 year goal</th>
<th>Deliverable 2016/17</th>
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</tr>
</thead>
</table>
| **Coordinated seamless mental health service provision, one regional mental health and alcohol and other drugs plan** | - Commission services for A&TSI, youth, suicide prevention, Mental Health Nurses and, psychological services  
- Work in partnership to finalise detailed needs assessment and collaborative service plan for 2017/18  
- GP education on the management of patients with mental illness and supporting patients to self-manage  
- Education for clinicians to support key target groups  
- Commission ATAPS services, targeting local need  
- Community education on accessing a GP to manage individual’s mental illness. | - Commission services for youth and Mental Health Nurses and other services dependant on the outcome of the 2016/17 needs assessment and regional plan  
- Commence implementation for rollout of reforms such as packages of care for people with severe and complex mental illness.  
- Continue GP & community education  
- Commission ATAPS services, targeting local need, review model of care | - Evaluate how the PHN has implemented mental health reform projects/initiatives.  
- Commission services that are responsive to local needs as per regional plan  
- Continue GP and community education |

### Client centred alcohol and other drugs (including ICE)

<table>
<thead>
<tr>
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<th>Deliverable 2016/17</th>
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</tr>
</thead>
</table>
| **Coordinated and seamless alcohol and other drug service provision across all sectors** | - Explore treatment options for alcohol and other drugs, including ICE in partnership with the GCHHS.  
- Commission treatment services. | - Review and commission services that are meeting AoD funding outcomes. | - Review and commission AoD services |

### Empowerment and choice for people living with mental illness

<table>
<thead>
<tr>
<th>5 year goal</th>
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</thead>
<tbody>
<tr>
<td><strong>Facilitating better coordination of clinical and other supports and services for people with severe and complex mental health.</strong></td>
<td>- Continue as Partners in Recovery (PIR) lead agency and commission services across consortia partners achieving national and local outcomes and transitioning</td>
<td>- Annual review of program to ensure linkages for transitioning PIR individuals into NDIS. By 30/6/19 transition all PIR individuals into NDIS.</td>
<td>- A seamless transition of PIR into NDIS.</td>
</tr>
</tbody>
</table>
3. Chronic Disease

Strategic Outcomes

- An integrated health system across the Gold Coast
- People with complex illness have improved health outcomes
- People are healthier and take responsibility for own health

Strategic Measure of Success

- Improved patient satisfaction and experience
- Improved clinical outcomes
- Reduction in avoidable presentations to ED
- Reduction in potentially avoidable hospital admissions
- Reduction in re-admission rates

Improve access to self-management services

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<thead>
<tr>
<th>5 year goal</th>
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<th>Deliverable 2019/21</th>
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</thead>
<tbody>
<tr>
<td>Improve clinical outcomes for people with chronic disease; with a focus on A&amp;TSI people.</td>
<td>• Develop regional referral pathways/resources including particular focus on self-management services (focus on A&amp;TSI people, diabetes and cardiovascular)</td>
<td>• Implementation of referral pathways/resources including particular focus on self-management services</td>
<td>• Training and education for General Practice. • Evaluation and review • Implement recommendations from review</td>
</tr>
<tr>
<td></td>
<td>• Continue commissioning of afterhours services targeting people with chronic disease</td>
<td>• Audit and review of pathways</td>
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<tr>
<td></td>
<td></td>
<td>• Training and education for General Practice to support use of pathways/referral</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Commissioning of afterhours services</td>
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</tbody>
</table>

Risk Stratification

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<tr>
<th>5 year goal</th>
<th>Deliverable 2016/17</th>
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<th>Deliverable 2019/21</th>
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<tbody>
<tr>
<td>Increased application of evidence based practice in General Practice</td>
<td>• Implement use of risk stratification tool in identified practices (up to 4) to drive quality improvement (refer to Practice Support Page 18)</td>
<td>• Refine and extend model across more practices (up to 50)</td>
<td>• Refine and extend model across all Gold Coast General Practices</td>
</tr>
</tbody>
</table>

Page 15
# Gold Coast Integrated Care

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<tr>
<th>5 year goal</th>
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<th>Deliverable 2019/21</th>
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<tbody>
<tr>
<td><strong>Reduction in potentially avoidable hospital admissions</strong></td>
<td>• Commence first full year of operations delivering integrated care to identified eligible patients within a population of 136,000 people across 14 practices.</td>
<td>• Continue delivering to identified eligible patients across 14 practices.</td>
<td>• Implement strategy to increase coverage of an integrated care model across the Gold Coast based on the evaluation of GCIC.</td>
</tr>
<tr>
<td><strong>Improved Clinical Outcomes</strong></td>
<td>• Commission service navigator roles within model</td>
<td>• Participate in governance and evaluation mechanisms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Implement aged care strategy</td>
<td>• Review evaluation results and determine potential scale up options</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Participate in governance and evaluation mechanisms</td>
<td>• Develop regional plan to scale up implementation of model based on evaluation recommendations</td>
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</table>

## Persistent Pain

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<tr>
<th>5 year goal</th>
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<th>Deliverable 2019/21</th>
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</thead>
<tbody>
<tr>
<td><strong>Support people with persistent pain to take a strong self-management role and be supported in community</strong></td>
<td>• Commission the “Turning Pain into Gain” coordinated holistic model of care</td>
<td>• Commission the “Turning Pain into Gain” Review model and explore alternative funding models</td>
<td>• Transition to identified funding model as applicable</td>
</tr>
</tbody>
</table>

---

### 4. Aboriginal and Torres Strait Islander Health

#### Strategic Outcomes

- People stay well in their own homes and communities
- People with complex illness have improved health outcomes
- People are healthier and take responsibility of own health
- An integrated health system across the Gold Coast

#### Strategic Measure of Success

- A regional collaborative service plan
- Improved patient satisfaction and experience
- Improved clinical outcomes
- Equity of access (A&TSI people)
- Improved GP and stakeholder satisfaction
- Reduction in avoidable presentations to ED
- Reduction in potentially avoidable hospital admissions
- Reduction in re-admission rates
## Equity of Access

<table>
<thead>
<tr>
<th>5 year goal</th>
<th>Deliverable 2016/17</th>
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<th>Deliverable 2019/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve equity in service delivery for A&amp;TSI people</td>
<td>• Work in partnership to finalise detailed needs assessment and collaborative service plan&lt;br&gt;• Closing the Gap Education and practice support for service providers&lt;br&gt;• Cultural awareness training for General Practice and other primary health services providers</td>
<td>• Cultural awareness training for General Practice and other primary health services providers&lt;br&gt;• Implementation of a collaborative service plan for the Gold Coast</td>
<td>• Cultural awareness training for General Practice and other primary health services providers</td>
</tr>
</tbody>
</table>

## Coordinated Management of Chronic Disease

<table>
<thead>
<tr>
<th>5 year goal</th>
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<th>Deliverable 2019/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved clinical outcomes for A&amp;TSI people</td>
<td>• Commission integrated team care&lt;br&gt;• Support case conferencing for patients with relevant Primary Care providers and GCHHS&lt;br&gt;• Develop, promote and support referral pathways from mainstream General Practice to indigenous focused allied health and self-management courses&lt;br&gt;• Engage with Allied Health as key Primary Care Providers</td>
<td>• Review, refine and commission integrated team care&lt;br&gt;• Maintain and update referral pathways&lt;br&gt;• Forum with Allied Health</td>
<td>• Review Team based approach and amend as required&lt;br&gt;• Maintain and update referral pathways&lt;br&gt;• Forum with Allied Health</td>
</tr>
</tbody>
</table>

## 5. Aged Care

### Strategic Outcomes

- People stay well in their own homes and communities

### Strategic Measure of Success

- Reduction in avoidable presentations to the Emergency Department
- Reduction in potentially avoidable hospital admissions
- Reduction in re-admission rates
- Increase in advanced care planning
Support Older People to Stay in/Return to their home

5 year goal | Deliverable 2016/17 | Deliverable 2017/19 | Deliverable 2019/21
--- | --- | --- | ---
Reduction in avoidable presentations to Emergency Departments for Residential Aged Care Facility (RACF) residents | • In Partnership with GCHHS and RACFs implement agreed pathways for older people in residential care at risk of hospitalisation | • In partnership commission gaps in services identified as part of pathway implementation | • Evaluate and refine pathways accordingly
Reduction in potentially avoidable hospital admissions for RACF residents | • Continue access to GP service via telehealth in RACFs and evaluate Better Health Care Connections program | • Implement recommendations of Better Health Care Connections evaluation that align GCPHN needs assessment and prioritisation for investment | • Final Evaluation of Better Health Care Connections including recommendations on future strategies for implementation 2017/18 onwards

End of Life Care Planning

5 year goal | Deliverable 2016/17 | Deliverable 2017/19 | Deliverable 2019/21
--- | --- | --- | ---
Increase in advanced care planning in RACF’s | • Introduce “Decision Assist” training into GCPHN GP education and align with GCHHS implementation of State-wide End of Life Strategy | • Continue access to “Decision assist” training and implement program to increase number of RACF residents with an advanced care plan | • 50% of RACF residents who have advanced care plan
| • Continue to implement advance care plans for patients managed by GPs within Better Health Care Connections program | • Target 25% of residential care residents have an advanced care plan |
| • Target 50% of GPs involved in Better Health Care Connections with patients in RACF have advanced care plan in place |

6. Practice Support

Strategic Outcomes
- People stay well in their own homes and communities
- People with complex illness have improved health outcomes
- Strong clinical leadership, capacity and innovation in Gold Coast primary care sector

Strategic Measure of Success
- Improved clinical outcomes
- Reduction in avoidable presentations to the Emergency Department
- Reduction in potentially avoidable hospital admissions
- Increase research in General Practices
- Increased application of evidence based practice in General Practice
### Practices actively engaged, submit clinical data and participate in CQI activity

| 5 year goal                                                                 | Deliverable 2016/17                                                                                                                                                                                                 | Deliverable 2017/19                                                                                                                                                                                                 | Deliverable 2019/21                                                                                                                                                                                                 |
|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Improved clinical outcomes                                                | • 100% of practices have access to PHN information, education and targeted practice support (accreditation, digital health etc)                                                                                       | • Continue provision of access to PHN information, education and targeted practice support (accreditation, digital health etc)                                                                                                                | • Maintain number of practices submitting population level data                                                                                                                                                                                                                       |
| Reduction in potentially avoidable hospital admissions                     | • 80% of practices participate in tiered approach to quality improvement (in addition to above)                                                                                                                        | • 95% of General Practices will participate in tiered approach to quality improvement                                                                                                                                       | • 95% of General Practices will participate in tiered approach to quality improvement                                                                                                                                                                                                 |
| Increased application of evidence based practice in General Practice       | • Tier 1 Population level data submitted to PHN                                                                                                                                                                      | • Increase number of practices submitting population level data and progressing through the higher tiers                                                                                                                    | • Increase number of practices submitting population level data and progressing through the higher tiers                                                                                                                                                                                                                      |
|                                                                             | • Tier 2 As above plus entry level CQI, focus on data integrity, completeness and clinical coding. Review practice profiles and population target interventions                                                                 | • Evaluate and present findings at appropriate forums and publish articles                                                                                                                                                  | • Evaluate and present findings at appropriate forums and publish articles                                                                                                                                                                                                                     |
|                                                                             | • Tier 3 As above plus practices engaged in CQI to improve agreed clinical measures.                                                                                                                                     |                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                    |
|                                                                             | • Tier 4 As above plus risk stratification and evidenced based interventions                                                                                                                                         |                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                    |

### Increase General Practices involved in the uptake of evidence based interventions

| 5 year goal                                                                 | Deliverable 2016/17                                                                                                                                                                                                 | Deliverable 2017/19                                                                                                                                                                                                 | Deliverable 2019/21                                                                                                                                                                                                 |
|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Gold Coast Practices are national leaders in the translation of research into evidence based practice interventions | • Establish joint partnership agreements with key universities/key organisations                                                                                                                                               | • Joint projects with universities/key stakeholders that focus on GP uptake of evidence based interventions                                                                                                            | • Joint research plan and translate into evidence based practice for the Gold                                                                                                                                                                                                 |
|                                                                             | • Increasing GP engagement (especially through Tier 3 and 4)                                                                                                                                                              | • Support GP innovative activities                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                    |
|                                                                             | • Identify clinical leaders (who will drive CQI at the practice level supported by GCPHN GP Lead)                                                                                                                                 | • Improve engagement strategy based on Tier 3 learnings (aimed at Tier 2)                                                                                                                                             |                                                                                                                                                                                                                                                                                    |
|                                                                             | • Support and encourage uptake of evidence based practice, research and evaluation through clinical leaders.                                                                                                                                                                     |                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                    |
|                                                                             | • Support presentation and findings at appropriate forums and publish.                                                                                                                                                  |                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                    |
### 7. Engagement

#### Strategic Outcomes

- An integrated health system across the Gold Coast
- Strong clinical leadership, capacity and innovation in Gold Coast Primary Care sector
- Strengthen relationships with key stakeholders

#### Strategic Measure of Success

- A regional Collaborative Service Plan
- Improved GP /stakeholder satisfaction

### Shared Ownership

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>A regional Health Service Plan</td>
<td>Collaboration agreement with regular Executive Steering Committee Meetings</td>
<td>In principle agreement from sector for one strategic Gold Coast Health Service Plan</td>
<td>Establish joint governance and endorse plan</td>
</tr>
<tr>
<td></td>
<td>Scope other partners for joint planning mental health and A&amp;TSI health Regional Service Plans</td>
<td>Explore different governance models with partners</td>
<td>Regular interim reporting against Plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Draft Gold Coast Health Service Plan (incorporating joint plans) endorsed</td>
<td>Annual report against Joint Gold Coast Health Service Plan</td>
</tr>
</tbody>
</table>

### General Practitioner Engagement

<table>
<thead>
<tr>
<th>5 year goal</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Strong clinical leadership, capacity and innovation in Gold Coast Primary Care sector</td>
<td>Identify clinical leaders</td>
<td>Continue to develop of clinical leaders Align RACGP CPD points with all GCPHN education and training</td>
<td>Establishment of clinical leaders Clinical Specialists involved in training and education events and local publication and resources.</td>
</tr>
<tr>
<td></td>
<td>Align RACGP CPD points with all GCPHN education and training</td>
<td>GP lead involvement of clinical Specialists in training and education, local publication and resources.</td>
<td>Referral guidelines expanded.</td>
</tr>
<tr>
<td></td>
<td>GP lead involvement of clinical Specialists in training and education, local publication and resources.</td>
<td>Referral guidelines expanded</td>
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</tr>
<tr>
<td></td>
<td>Referral guidelines expanded including specialist contact details (secure area)</td>
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</table>
### Clinical Leadership

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<tr>
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<th>Deliverable 2017/19</th>
<th>Deliverable 2019/21</th>
</tr>
</thead>
</table>
| **Strong clinical leadership, capacity and innovation in Gold Coast Primary Care sector**
| • Disseminate and support clinical champions, Lead Clinicians Group, Clinician Council members to be on National and State bodies
| • Explore feasibility for joint partnerships to establish a Gold Coast Primary Care annual education program (GCHHS, Private Sector etc)
| • Clinician’s symposium highlighting outcomes from previous Clinician Challenge award recipients; announce new winners |
| **Practical Targeted Localised Resources**
| **An integrated health system across the Gold Coast**
| • HealthyGC continuous improvement to be responsive to primary care and community needs
| • Local directory of services up to date and informs National Health Service Directory
| • Completion and refinement of annual Primary Care Opinion Survey
| • Ensure linkages with integrated pathways that promote local, state and national resources
| • Design and implement systemic process to develop, review and update integrated pathways including clinical review
| • Continue provision of local resources including publications, templates, insight reports etc |
| **Improved GP /stakeholder satisfaction**
| • HealthyGC continuous improvement
| • Completion and refinement of annual Primary Care Opinion Survey
| • Ensure linkages with integrated pathways that promote local, state and national resources
| • Design and implement systemic process to develop, review and update integrated pathways including clinical review
| • Continue provision of local resources to support |
| **5 year goal Deliverable 2016/17 Deliverable 2017/19 Deliverable 2019/21**

STRATEGIC PLAN 2016 – 2021
8. Digital Health

Strategic Outcomes

- An integrated health system across the Gold Coast

Strategic Measure of Success

- General Practices are digital health compliant

Support Healthcare Providers to set up and Connect to Digital Health

<table>
<thead>
<tr>
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<th>Deliverable 2017/19</th>
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</table>
| General Practices are digital health compliant | • Implement a digital health program including communication and training program across all practices  
• Target priority groups including A&TSI people, homeless /disadvantaged people, older people and people with Chronic Disease  
• Work in partnership with GCHHS, other commissioning agencies and stakeholders to ensure linkages and integration across digital health programs and platforms | • Continue to implement a digital health program across all practices, enhancing a national and local requirement  
• Expand primary health digital health program to include other primary healthcare areas eg: aged care services, Specialists and after hours services | • Review and implement recommendations  
• Continue to support General Practice and expand to other primary healthcare areas eg: aged care services, Specialists and after hours services |

Communication with HHS / Transfer of Care

<table>
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<tr>
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</thead>
</table>
| Reduction in readmission rates | • Continue to refine and update Referral Templates and Guidelines with support from the General Practice Liaison (GPL) unit  
• Support implementation of State-wide Clinical Pathways program  
• GPL unit works to improve timeliness and appropriateness of Discharge Summaries and outpatient letters  
• Use of digital technology to support communication | • Continue to refine and update Referral Templates and Guidelines  
• GPL unit works to improve timeliness and appropriateness of Discharge Summaries and outpatient letters  
• Use of digital technology to support communication | • Continue to refine and update Referral Templates and Guidelines  
• GPL unit works to improve timeliness and appropriateness of Discharge Summaries and outpatient letters  
• Use of digital technology to support communication |
9. Workforce

Strategic Outcomes

- Strong clinical leadership, capacity and innovation in Gold Coast primary care sector

Strategic Measure of Success

- Improved General Practice / Stakeholder satisfaction

Clinical Placements

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<tr>
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<th>Deliverable 2019/21</th>
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</thead>
<tbody>
<tr>
<td>Strategies and systems will exist that assist in meeting the future demands of the Primary Health Care workforce</td>
<td>Continue provision of Clinical Placement Program</td>
<td>Renegotiate current contract with Universities for further 3 years</td>
<td>Continue provision of program/s with annual review and CQI</td>
</tr>
<tr>
<td></td>
<td>Explore opportunities to expand the clinical placements program for medical and nursing students to include supporting registrars and Allied Health Providers</td>
<td>Negotiate new contracts for additional clinical placement services</td>
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Regional Workforce Development

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<tr>
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</thead>
<tbody>
<tr>
<td>The Gold Coast region will have the skilled primary care workforce to meet the future demands for patient care</td>
<td>Review of health workforce data for 2017 Needs Assessment to inform annual planning and commissioning</td>
<td>Review progress of activities</td>
<td>Review progress of activities</td>
</tr>
<tr>
<td></td>
<td>Implement identified activities</td>
<td>Develop region wide workforce plan</td>
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<td></td>
<td>Establish Online forums for General Practices, Practice Nurses and Project Managers</td>
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<td></td>
<td>Regular face to face forums for general practice</td>
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# Quality Primary Care Education

## 5 year goal

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<tbody>
<tr>
<td><strong>Targeted, quality, primary care education with high attendance at GCPHN events</strong></td>
<td>• Establish education steering committee to advise and develop a regional three year (in line with RACGP Triennium) education plan</td>
<td>• Commence implementation of regional three year education plan including new strategies</td>
</tr>
<tr>
<td></td>
<td>• Implement a joint Annual Education &amp; Training Calendar</td>
<td>• Annual Education Calendar including contemporary modes of education</td>
</tr>
<tr>
<td></td>
<td>• Develop a business care to determine most efficient and effective contemporary education strategies</td>
<td>• Education event calendar based on review of Primary Care Survey and event evaluation forms, local and national priorities</td>
</tr>
</tbody>
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# Building Organisational Capacity

1. **Needs Assessment**
2. **Service Design/Development**
3. **Contracting/Procurement of Services**
4. **Monitoring and Evaluation**
5. **Stakeholder Engagement**
6. **Information Communication and Technology**
7. **Human Resource Management**
8. **Financial Management**
9. **Governance**

---

# Strategic Outcomes

- Strong and highly effective governance, leadership and decision making
- GCPHN has an integrated business model that ensures success
- There is clinically led and collaborative service development and reform
- GCPHN Infrastructure, systems and processes are “world class”
- Strengthen relationships with key stakeholders
- Strong clinical leadership, capacity and innovation in Gold Coast primary care sector

# Strategic Measure of Success

- Strong Financial and Program Performance.
- High performing Board, Executive and Clinical and Community Advisory Councils
- GCPHN meets world class commissioning competencies
### Needs Assessment

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<tr>
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<th>Deliverable 2019/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs Analysis which meets Funder requirements and is meaningful to local sector</td>
<td>• Review by expert external contractor and stakeholders amend policy and procedure</td>
<td>• Queensland PHN planning group and regional Planning and Engagement Stakeholder Group</td>
<td>• Participate in Queensland PHN planning group and regional Planning and Engagement Stakeholder Group</td>
</tr>
<tr>
<td>Acknowledged as leader locally and nationally in population health planning field</td>
<td>• Queensland PHN planning group and regional Planning and Engagement Stakeholder Group</td>
<td>• Information in repository reviewed and ranked according to veracity</td>
<td>• Update data, consultation and service mapping and summaries</td>
</tr>
<tr>
<td></td>
<td>• Summary for key needs/issues developed, for sector/public</td>
<td>• Update data, consultation and service mapping and summaries</td>
<td>• Update annual joint Population Health Profile</td>
</tr>
<tr>
<td></td>
<td>• Update joint Population Health Profile in collaboration with GCHHS</td>
<td>• Update joint Population Health Profile in collaboration with GCHHS</td>
<td>• Document and present process</td>
</tr>
<tr>
<td></td>
<td>• Increased consultation in development of updated needs analysis</td>
<td>• Document and present process</td>
<td></td>
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</tbody>
</table>

### Service Development and Design

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<tr>
<th>5 year goal</th>
<th>Deliverable 2016/17</th>
<th>Deliverable 2017/19</th>
<th>Deliverable 2019/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service design drives greater cohesiveness and integration across the sector and enhances quality and safety</td>
<td>• Develop integration principles including Service design informed by Clinicians, service providers and consumers.</td>
<td>• Service Design principles and methodologies are incorporated in quality management system and clearly defined and articulated</td>
<td>• Establishment of clinical leaders clinical Specialists involved in training and education events and local publication and resources.</td>
</tr>
<tr>
<td></td>
<td>• Identify range of service design methodologies, develop toolkits and training.</td>
<td>• Participants in collaborative design are satisfied with process and outcome</td>
<td>• Referral guidelines expanded.</td>
</tr>
<tr>
<td></td>
<td>• Build staff capability in collaborative service design</td>
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</tbody>
</table>
## Contracting/Procurement of Services

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</tr>
</thead>
<tbody>
<tr>
<td>Streamlined procurement process that maximises value</td>
<td>• Enhance organisational capacity in relation to market analysis, development, value for money assessment</td>
<td>• Implement standardised reporting and MDS collection and analysis methods methodology</td>
<td>• Staff capacity and experience is measured, shared and updated as required</td>
</tr>
<tr>
<td>Considered a leader in procurement nationally</td>
<td>• Commission external review of capability, current process and procedures and identify quality improvement plan</td>
<td>• Implement Information Technology Solutions to allow seamless collection and analysis of Data</td>
<td>• Staff capacity and experience is measured, shared and updated as required</td>
</tr>
<tr>
<td></td>
<td>• Determine Minimum Data Set (MDS) for contractor reporting and explore Information Technology solution for efficient collection, analysis and reporting</td>
<td>• Implement a comprehensive orientation program in relation to Commissioning for staff</td>
<td>• Staff capacity and experience is measured, shared and updated as required</td>
</tr>
<tr>
<td></td>
<td>• Enhance organisational capability in contract management and performance accountability</td>
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</tbody>
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## Monitoring and Evaluation

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<tbody>
<tr>
<td>Monitoring and feedback on commissioned services stimulates the sector’s performance</td>
<td>• Develop and implement benchmarking measures for contractor reporting</td>
<td>• Implement identified Information Technology solutions</td>
<td>• Tools to support contractors monitoring and benchmarking own performance</td>
</tr>
<tr>
<td>All outcomes based activities are externally evaluated and validated</td>
<td>• Scope potential Information Technology solutions for dashboard reporting and predictive modelling</td>
<td>• Implement dashboard reporting</td>
<td>• Results and predictions feeds into planning processes</td>
</tr>
<tr>
<td></td>
<td>• Strengthen links with local Universities</td>
<td>• Produce trend/predictive modelling reports for contractors and internal staff</td>
<td>• External evaluation for all outcomes based activities</td>
</tr>
<tr>
<td></td>
<td>• Identify 1-2 areas for summative evaluation and implement</td>
<td>• Benchmark performance</td>
<td>• Additional projects for evaluation</td>
</tr>
<tr>
<td></td>
<td>• Enhance organisational capability in contract management and performance accountability</td>
<td>• Identify additional projects for evaluation</td>
<td>• Results and predictions feeds into planning processes</td>
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## Stakeholder Engagement

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<tbody>
<tr>
<td>Clinicians, the health sector and consumers/community are well integrated into the different phases of commissioning</td>
<td>• Partnerships with General Practice and other stakeholders including GCHHS, Non-Government organisations service providers and private health insurers to address local needs</td>
<td>• Partnerships with General Practice and other stakeholders including GCHHS, NGO service providers and private health insurers to address local needs</td>
<td>• Partnerships with General Practice and other stakeholders including GCHHS, NGO service providers and Private Health Insurers to address local needs</td>
</tr>
<tr>
<td>GCPHN is highly respected as a key organisation adding value to the sector</td>
<td>• Relationships with stakeholders are effectively monitored and fostered</td>
<td>• Productive relationships with key stakeholders primarily General Practice and including GCHHS, NGO service providers and private Health Insurers are effectively monitored and fostered</td>
<td>• Productive relationships with key stakeholders primarily General Practice and including GCHHS, NGO service providers and private health insurers are effectively monitored and fostered</td>
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<tr>
<td></td>
<td>• Consumer participation embedded at key points across processes</td>
<td>• Consumer participation embedded in key forums</td>
<td>• Consumer participation embedded in key forums</td>
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<td></td>
<td>• Partners involved in co-design of new services</td>
<td>• Partners involved in co-design of new services</td>
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<tr>
<td></td>
<td>• Clinical Council and Community Advisory Council meetings contribute to GCPHN enhanced performance</td>
<td>• Clinical Council and Community Advisory Council meetings are well attended and inform/shape GCPHN activities</td>
<td>• Clinical Council and Community Advisory Council meetings are well attended and inform/shape GCPHN activities</td>
</tr>
<tr>
<td></td>
<td>• Regular publications to General Practice and stakeholders</td>
<td>• Regular publications to general practice and stakeholders</td>
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<td></td>
<td>• Primary Care Opinion Survey</td>
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## Information Communication and Technology

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<tbody>
<tr>
<td>Information sharing, access and increased interoperability which drives productivity</td>
<td>• Information architecture revised and updated</td>
<td>• Current client relationship system (CRM) reviewed</td>
<td>• Access to data through central open data portal</td>
</tr>
<tr>
<td>Data is easily accessible, visible and available for reuse by those that need it</td>
<td>• Collaboration platform through SharePoint</td>
<td>• Office 365 providing sharing; collaboration; cloud based access is embedded</td>
<td>• CRM replaced with integrated solution</td>
</tr>
<tr>
<td></td>
<td>• Office 365 introduced</td>
<td>• Information security management system developed</td>
<td>• Maintain SO/IEC 27001 standards</td>
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<td></td>
<td>• Information security management system developed</td>
<td>• Roadmap for infrastructure to Cloud environment developed</td>
<td>• Static Reports, on demand report, and dashboards tailored to user needs</td>
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<td></td>
<td>• Project management software trialled</td>
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<td></td>
<td>• General Practice data aggregation and analysis implemented</td>
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<td></td>
<td></td>
<td>• Increased predictive modelling and analytics capability</td>
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<td>• Dashboard reporting for contractors</td>
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<td></td>
<td></td>
<td>• Project management software embedded</td>
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</tbody>
</table>
### Human Resource Management

**5 year goal**  
A culture of staff engagement and continuous learning and innovation  
Staff are high performing, efficient and accountable

|---|---|---|---|
| | • Embed the Capability Leadership Framework  
• Develop and implement organisational Learning and Development Plan  
• Support staff to retain professional competencies aligned to role  
• Staff Consultative Committee  
• Formal Recognition and Reward Program  
• Develop specific competencies for key results areas such as commissioning and practice support  
• 360 degree feedback for performance reviews  
• Align policies to Federal/State Legislation  
• Review HR Delegations  
• Succession plan for the key positions  
• Implement quarterly HR Reports  
• Benchmark internally & externally | • Conduct an evaluation on training and development  
• GCPHN is viewed as an employer of choice  
• Improve the employer branding of the organisation  
• Review staff capability quarterly HR reports  
• Formal Recognition and Reward Program  
• Support staff to retain professional competencies aligned to role | • HR Strategies/Projects are continually reviewed and evaluated to meet the business needs of the organisation  
• Formal Recognition and Reward Program |

### Finance

**5 year goal**  
Demonstrated efficiency and effectiveness including value for money in all service areas  
A comprehensive, accurate and robust budget model.  
Leader in an active network of Queensland PHN finance professionals for collaboration and information sharing

|---|---|---|---|
| | • Financial KPIs developed for activities  
• Improved financial reporting  
• Upskill managers  
• Update preferred suppliers list  
• Review budget template  
• Balanced budget at year end  
• Develop consistent approach to PHN financial reporting to DOH and other funding bodies, and from subcontractors (in collaboration with other PHNs)  
• QLD PHN financial Benchmarking | • Analysis of financial KPIs for activities  
• Further refinement of financial reporting  
• Preferred Suppliers list reviewed and updated  
• Further refinement of budget template  
• Balanced budget  
• Collaboration and consistency in the approach to specific PHN financial issues  
• Financial benchmarkings | • Comparison and analysis of financial KPIs for ongoing activities  
• Preferred Suppliers list reviewed and updated  
• Review and update the procurement process  
• All staff to have knowledge of the updated procurement process  
• Balanced budget at year end  
• Collaboration and consistency in the approach to specific PHN financial issues  
• PHN financial |
## Transparent, accountable and practical governance mechanisms

### 5 year goal

- All Board Directors will undertake appropriate professional development as detailed in their Professional Development plans.
- Conflict of interest registers maintained.
- Training for Community Advisory Committee with health consumer experts.
- Internal governance training (open to advisory committees/partners).

### Deliverable 2016/17

- All Board Directors will undertake appropriate professional development as detailed in their Professional Development plans.
- Conflict of interest registers maintained.
- Training for Community Advisory Committee with health consumer experts.
- Internal governance training (open to advisory committees/partners).
- Primary Care Opinion Survey.
- Formal evaluation of Community Advisory Council.

### Deliverable 2017/19

- All Board Directors will undertake appropriate professional development as detailed in their Professional Development plans.
- Conflict of interest registers maintained.
- Training for Community Advisory Committee with health consumer experts.
- Internal governance training (open to advisory committees/partners).

### Deliverable 2019/21

- All Board Directors will undertake appropriate professional development as detailed in their Professional Development plans.
- Conflict of interest registers maintained.
- Training for Community Advisory Committee with health consumer experts.
- Internal governance training (open to advisory committees/partners).